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PRIVATE HEALTH INSURANCE IN INDIA: PROMISE & REALITY

February 2008



This publication was produced for review by the United States Agency for International Development and was prepared by BearingPoint.

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Prepared by

BearingPoint, Inc.

for the

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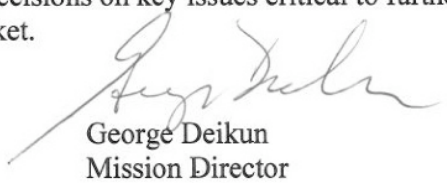
FOREWARD

India's health insurance market has experienced significant regulatory and institutional changes since the insurance industry was opened to private sector participation in 1999. The number of persons covered has been growing at a rate of around 25 percent year after year. Premiums have been increasing by 35 percent annually. The Government of India's Insurance Regulatory and Development Authority (IRDA) has worked extensively to build a strong enabling environment for health insurance by developing efficient regulations on products and consumer protection, and assisting in the development of information infrastructure. For the first time in India, specialized health insurance companies have entered the market. New types of health insurance products using a variety of risk-sharing models have been launched. An increasing number of microfinance institutions and healthcare NGOs are implementing innovative risk-pooling mechanisms to help the poor access healthcare when they need it while protecting them against financial ruin. In recent years, we have seen some good examples of public-private partnership in the provision of affordable healthcare financing facilities to the poor. The central government and several state governments are working closely with insurance companies and NGOs to develop and implement affordable health insurance plans for the vulnerable sections of the society.

Impressive though these developments are, full access to affordable and good quality healthcare remains a distant dream. For example, the percentage of the Indian population covered by health insurance is still small, yet there are only five other countries in the world comparable to India in such dependence on private financing for health services. Out-of-pocket payments for healthcare remain over 75 percent. Being a complicated business, health insurance requires substantial investment in know-how, development of a network of quality healthcare providers -- especially in underserved areas of the country, distribution channels and information infrastructure. Allowing the participation of other entities such as mutual benefit associations and cooperatives would go a long way in increasing access to affordable healthcare for the poor.

The U.S. Agency for International Development (USAID) has worked extensively over the past five years with IRDA and other key stakeholders of India's health insurance sector under the bilateral Indo-U.S. Financial Institutions Reform and Expansion (FIRE) project. This report emerges from these experiences and has been prepared by a team of international and Indian experts led by Bearing Point. It analyzes the key forces that have shaped the sector in recent years, and provides recommendations to develop an inclusive and sustainable health insurance market in India.

We hope that the report will stimulate discussion among policy makers, regulators, and practitioners and help them make informed decisions on key issues critical to further development of India's health insurance market.



George Deikun
Mission Director
USAID/India

ACKNOWLEDGEMENTS

This report has been prepared under the aegis of the Insurance sector reform component of USAID's Financial Institutions Reform and Expansion-Regulatory (FIRE-R) program. The report was prepared by BearingPoint, the FIRE-R implementing institution. The BearingPoint team that authored the report consisted of Mr. Edgar Balbin, Mr. Aloke Gupta, Mr. Neil Hollander, Mrs. Durga Kumari, Dr. Susan Matthies, Mr. Nimish Parekh, Ms. Kimberly Switlick, and Mr. John Wipf, under strategic guidance of Mr. Kenneth Cahill of BearingPoint.

The authors would like to thank the many people actively involved in implementing health insurance activities in India who took time to meet with them and provide their valuable knowledge and insight for this document. These people include: Dr. Prashanth of Karuna Trust; Mrs. Mukti Bosco of Healing Fields Foundation; Mr. P. Sai Gunaranjan of BASIX; Mr. V. Jagannathan and Mr. A. G. Gajapathy of Star Health and Allied Insurance Co.; Mr. M.K. Garg, of United India Insurance; Mr. M.S. Sreedhar, of Royal Sundaram Alliance, Dr. K.C. Mishra of National Insurance Academy; Mr. Shreeraj Deshpande and Mr. Bishwajit Nayak of Bajaj Allianz General Insurance Company; Mr. Bimal Balasingham and Mr. Sujata Dutta of Tata AIG Life Insurance Company; Mr. Binay Kumar Agarwala of ICICI Prudential Life Insurance Company; Mr. D.M. Satwalekar of HDFC Standard Life; Mr. Sam Ghosh of Bajaj Allianz Life; Mr. Nani B. Javeri and Mr. Aparna Samant of Birla Sun Life; Mr. S.K. Mutneja and Dr. R.K. Kaushik of New India Assurance Co.; Mr. Ritesh Kumar of ICICI Lombard General Insurance Co.; Dr. Rajshree Parkeh of Marsh India Private; Mr. Ashley D'silva of Aon Global; Mr. Asish K. Chakrabarti and Mr. Sekhar Roy of CHNHB Association; Dr. Utpal Ray of Medicare Services of India; Ms. Ujjaini Dasgupta of Bajaj Allianz Life Insurance Co.; Mr. Girish Rao, Dr. Nilima Kadambi and Ms. Anupama Attawar of TTK Healthcare Services; Mr. Madhavan and Mr. Suresh VV of Medi Assist; Dr. Hatim Companiwala and Mr. Arun Kumar of Family Health Plan; Dr. Nayan Shah of Paramount Health Services; Mr. Pawan Bhalla of Raksha TPA; and Mr. G.P. Sureka of Universal MediAid Service. The team would also like to thank Dr. Marc Socquet, Senior Social Security Specialist and STEP Coordinator for Asia, ILO, for providing access to the exemplary work that the ILO is doing in the area of microinsurance and for his insights on policy developments; and Mr. Denis Garand for providing details and insights into the SEWA and Yeshaswini cases.

The authors express special thanks to Mr. C.S. Rao, Chairman of the Insurance Regulatory and Development Authority (IRDA) and his team for providing access to data as well as knowledge and understanding of the directions of insurance regulation in India.

There were many who provided expert advice and suggestions to the cost containment appendix: Dr. Marilyn Field, Senior Program Officer, Institute of Medicine, National Academy of Sciences; Mr. Donald Sacco, former Director of Cost Containment of the Blue Cross/Blue Shield Association and President of Oregon Blue Cross/Blue Shield; and Mr. Steven Henning Sieverts, retired senior executive of Blue Cross and Blue Shield and a former adjunct associate professor at Georgetown University's School of Medicine.

Ms. Rebecca Black and Mr. Ashok Jha of USAID provided project oversight, valuable inputs on technical and strategic aspects of the report.

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ACRONYMS

ACCORD	Action for Community Organization, Rehabilitation and Development
ACME	Association of European Cooperative and Mutual Insurers
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AIIMA	All India Integrated Medical Association
AMS	Adivasi Munnetra Sangam
ANM	Auxiliary Nurse Midwife
ASHWINI	Association for Health Welfare in the Nilgiris
ASSOCHAM	Associated Chambers of Commerce
BPL	Below Poverty Line
BPO	Business Process Outsourcing
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CAGR	Compound Annual Growth Rate
CARD	Centre for Agricultural Research and Development
CAT Scan	Computer Axial Tomography Scan
CBHI	Community Based Health Insurance
CBO	Community Based Organization
CBR	Crude Birth Rate
CDR	Crude Death Rate
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CHID	Committee on Health Insurance Data
CHI	Community Health Insurance
CHNHB	Calcutta Hospital & Nursing Home Benefits Association
CI	Critical Illness
CII	Confederation of Indian Industry
CINI	Child in Need Institute
CME	Continuing Medical Education
COB	Coordination of Benefit
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPD	Center for Population Dynamics
CPOE	Computerized Physician Order Entry
CRM	Customer Relationship Management
DALY	Disability Adjusted Life-year
DCHRC	Dharamshila Cancer Hospital and Research Centre
DKV	Deutsche Krankenversichreung
DOTS	Directly Observed Treatment Short Course
DRG	Disease Related Groups
EBM	Evidence-Based Medicine
ESIS	Employee State Insurance Scheme
FHPL	Family Health Plan Limited
FICCI	Federation of Indian Chambers of Commerce and Industry

GDP	Gross Domestic Product
GIC	General Insurance Company
GIPSA	General Insurance Association
GOI	Government of India
HDFC	Housing Development Finance Corporation, Ltd.
HEDIS	Healthcare Effectiveness Data and Information Set
HFF	Healing Fields Foundation
HIV	Human Immunodeficiency Virus
HIWG	Health Insurance Working Group
HMI	Health Micro Insurance
HMO	Health Maintenance Organization
HR	Human Resource
IBU	Insurance Business Unit
ICD	International Classification of Diseases
ICU	Intensive Care Unit
IGS	Indian Grameen Services
IHF	Indian Healthcare Federation
ILO	International Labor Organization
IMR	Infant Mortality Rate
IPA	Insurance and Pensions Authority
IPD	In-Patient Department
IRDA	Insurance Regulatory and Development Authority
ISQua	The International Society for Quality in Health Care
LIC	Life Insurance Corporation of India
LOS	Length of Stay
LSA	Livelihood Service Advisors
MBA	Mutual Benefit Association
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCO	Managed Care Organization
MFI	Micro Finance Institution
MHFP	Max Happy Family Plan
MHI	Max Healthcare Institute
MI	Micro Insurance
MIRC	Micro Insurance Resource Center
MoHFW	Ministry of Health and Family Welfare
MPCE	Monthly per Capita Consumer Expenditure
MRI	Magnetic Resonance imaging
NABH	National Accreditation Board for Hospitals and Health Care Providers
NCQA	National Committee for Quality Assurance
NCAER	National Council of Applied Economic Research
NCR	National Capital Region
NGO	Non-Governmental Organization
NHA	National Health Accounts
NIAC	New India Assurance Corporation
NIC	National Insurance Company

NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
OPD	Out-Patient Department
PAP	Persons reporting ailment
PED	Pre-existing Diseases
PHC	Primary Health Centre
PPO	Preferred Provider Organization
PREM	People's Rural Education Movement
PRHPS	People's Rural Health Promotion Scheme
PSU	Public Sector Undertaking
QAC	Quality Assurance Committee
RAHA	Raigarh Ambikapur Health Association
RBC	Risk-Based Capital*
RBI	Reserve Bank of India
RBRVS	Resource-Based Relative Value Scale
RPG	Redressal of Public Grievance Rules
Rs	Rupee
RSA	Royal Sundaram Alliance
RSM	Required Solvency Margin
RTI	Reproductive Tract Infections
SC	Scheduled Caste
SEWA	Self Employed Women's Association
SHG	Self-Help Group
SME	Small and Medium Enterprises
SOP	Standard Operating Procedure
ST	Scheduled Tribe
TAC	Tariff Advisory Committee
TB	Tuberculosis
TPA	Third Party Administrator
UCR	Usual, Customary and Reasonable
UHI	Universal Health Insurance
UIIC	United India Insurance Company, Ltd.
UMSB	Utkal Mahila Sanchay Bikas
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UR	Utilization Review
USAID	United States Agency for International Development
VDC	Village Development Committees
VMD	Village Medical Depots
WHO	World Health Organization
WTP	Willingness to Pay
YCFHS	Yeshasvini Farmers Co-operative Health Care Scheme

EXECUTIVE SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS

The purpose of this study is to investigate the impact of private insurance (or quasi-private in the case of the five government-owned companies) on health coverage in India and based on our findings, to suggest the way forward for government policy, effective regulation and enforcement, and private sector activity. The primary findings and consequent recommendations are summarized below by chapter.

Chapter 2: Financing of Health Care in India - Sources and Uses of Health Expenditures

The Government of India (GOI) spends considerably less on health care as a percentage of Gross Domestic Product (GDP) than other Asian countries. However, total public expenditure is increasing and the emphasis on public health and disease prevention in the federal budget is improving. Although hospitalization coverage is the basis for almost all health insurance, according to the most recent census only 1.7 percent of admissions were reimbursed and the average reimbursement was only 258 rupees (or 3.6 percent of the average hospitalization cost of 6,225 rupees). Despite the higher cost, a majority of both rural and urban Indians prefer private care. The primary reason for this preference is the perceived inferior quality of public care. Generally, health insurance coverage does not correspond well to the primary sources of the burden of disease in India.

Recommendations

- Increase public health care spending to a level above the rate of GDP growth. To stay ahead of medical inflation, government and private expenditure on health care will have to increase more rapidly than the rate of GDP growth, with emphasis in financing and payment methods on cost containment.
- Include effective primary care and prevention, safe maternity care, and chronic disease management in public and private insurance. The burden of disease as measured by Disability Adjusted Life-Years (DALYs) could be reduced significantly if both health insurance coverage and publicly provided care included these services.
- Emphasize quality improvement, particularly in public hospitals and in village primary care and prevention, otherwise those who most need publicly provided services will continue to be reluctant to use them.
- Make a major effort to educate the public about the importance of primary care and prevention, particularly with regard to the purchase of insurance coverage whether publicly or privately provided.

Chapter 3: Private Health Insurance

Results of Insurance Liberalization:

The results of liberalization have been significant. Since 1999, the Insurance Regulatory and Development Agency (IRDA) has licensed 24 new private insurance companies, of which 21 have foreign equity

participation. Major global players like Aegon, Fortis, Future Generali, Principal and Dai-ichi have joined with Indian partners to set up life insurance operations. Further, 11 Indian banks are planning to enter the insurance market in joint ventures with overseas insurance companies in 2007. Although liberalization has led to better regulatory policy and the beginning of private health insurance, the market is still largely dominated by government-owned insurance companies.

Demand for health insurance has been growing at a rate of 25 percent per year, driven by rapidly increasing costs of health care and the expanding middle class. However, no one in the industry is taking responsibility to develop knowledge and awareness of health insurance among the public nor is specific expertise in health insurance being developed within the private sector, an expertise that is essential to dealing effectively with providers of health care services. Because of this absence of specific capacity, Indian companies writing health insurance seem to have focused on controlling claims payout by following strategies designed to minimize the insured person's ability to collect on claims. Thus there is an excessive emphasis on disqualification because of pre-existing conditions and post-claim underwriting. Because of these practices health insurance has become one of the largest litigation areas for insurers, exceeded only by motor third party cases.

Private insurers' administrative costs may be as high as 40 percent of total premiums, double the benchmark target of 20 percent. Much of the actual administrative work is being done by Third Party Administrators (TPAs) but at a fixed rate varying regionally from 5.2 or 5.4 percent by public insurers and from 7 to 10 percent by private insurers. While insurers take the risk, set the rates for health insurance and in most instances provide the official marketing and sales function, TPAs have become their "back office", handling enrollment, pre-authorization, utilization review, claims processing/denial, etc.

Health insurance policies cover many but not all of policy holders' hospitalizations but have little or no impact on controlling costs nor improving quality of care. Mediclaim (the dominant health insurance policy) has been modified in ways that make it less a program to control the cost of care and more a reimbursement target for providers. As a result, policy holders pay higher charges for services than those without insurance. Products such as dread disease insurance and critical illness policies may make money for the insurance companies but usually have low utilization, provide limited coverage and can lead to public perception that insurance coverage is not useful.

A More Dynamic TPA Market

Consolidation of the TPA market is taking place due to very tight fixed pricing enforced by the public insurers. This is likely to increase the overall profitability of the remaining TPAs. The increasing costs of health services will force insurers to give greater priority to effective management of claims and containment of the unrestrained costs of providers. This should lead insurers to demand more extensive and higher quality services from TPAs and more effective use of their capabilities. Alternatiavely, some TPAs may be absorbed directly into the insurers' organizations.

Some TPAs are beginning to partner with international reinsurance companies (including selling stakes in their own organizations) to offer their combined services to existing insurance companies which lack appropriate expertise in health care.

They plan to develop turnkey health insurance capability, providing services such as plan design, pricing, network management, underwriting, cost containment and reinsurance under contract to the direct insurer, which needs only to ascertain the level of risk that it would like to retain. Other TPAs are examining whether they might venture directly into health insurance as part of a managed care organization. In one case that is presently under negotiation, a TPA is combining with a hospital-owned parent and a foreign health insurer in a joint venture to create a stand-alone health insurance company.

Despite the uncertainties of de-tariffing, government action to broaden coverage and increase the number of people covered is still possible, as the government itself controls the major portion of the industry.

Recommendations

- Encourage competition by allowing mutual insurance companies and other non-profit companies into the market. Insurance law now prohibits them, but they are more likely to serve the public interest as, for example, in the use of community rating instead of age/experience rating exemplified in the Calcutta case study.
- Level the competitive "playing field" by phasing-out or otherwise modifying the ownership of government-owned insurers. These highly bureaucratic entities have provided no positive major innovation since the 1980's. They could be transformed, for example, into regional non-profits with special responsibilities to serve all and be given special tax breaks commensurate with their non-profit status.
- Evolve gradually the respective roles of IRDA and insurers in the regulation of TPAs as the capacities of the regulator and the health insurance companies increase. Firstly, IRDA should retain responsibility for licensing TPAs and determining that TPAs have the capabilities and financial status to perform the activities for which they are licensed or are seeking to be licensed. Secondly, to safeguard the assets over which it has control each TPA should be expected to have its own errors and omissions insurance policy equal at least to the value of its turnover.. Thirdly, as the IRDA increases its capacity for effective regulation of the behavior of health insurers, other existing areas of TPA regulation may be gradually transferred from IRDA to the insurers, to be managed through the contractual relationship they have with their TPAs. Lastly, the insurers should then be held wholly accountable by IRDA for the behavior of the TPA(s) with which they have contracts.
- Enable the creation of alternative delivery systems linking the integrated provision of health care services with their financing. Examples include community, provider and CGO-sponsored plans.
- Regulate health insurance as a separate market. While all licensed companies should be able to participate (multi-line as well as health insurance only) there should be separate health-insurance-focused requirements and separate regulations that must be met by all participants in health insurance.
- Create training and education programs that specialize in health insurance and require special licenses for people who sell health insurance.
- Involve the Ministry of Health in insurance regulation with respect to quality improvement and medical effectiveness. For example, health ministry expertise in accreditation, practice guidelines and licensing standards is needed to establish and require these credentials for providers included in insurance networks.
- Create incentives for companies to expand their markets to a broad section of the population and remove tax advantages for those that do not.
- Allow foreign organizations to establish significantly increased ownership of companies. Their greater participation would provide both capital and knowhow to the health insurance industry.
- Provide for dedicated funding of public education about health insurance through IRDA and insurance companies. For example, use dedicated licensing fees paid to IRDA for public awareness about health insurance. Similarly, require insurance companies, through their associations and with oversight from IRDA, to provide better information on both the pitfalls and the promises of health insurance coverage.
- Involve consumers, business and labor in health care cost containment and quality assurance. Encourage the development of business/labor, etc., groups on health to educate their members and advocate for desired public policies.
- Set up a consumer advisory board to IRDA.

Chapter 4: Health Insurance for the Poor

In 2004 the central government introduced the Universal Health Insurance (UHI) scheme, which was aimed at those living below the poverty level. The UHI, also referred to as the "Government Rupee-a-Day" scheme (because the annual premium is Rs 365 per person[2]), has been unsuccessful at attracting the poor for several reasons. Firstly, the insurance companies that are required to implement the scheme find it loss-making and do not market or sell it sufficiently which leads to low enrollment. Secondly, identifying the eligible families who are willing and able to pre-pay the annual premium in lump sum also causes difficulty in encouraging people to sign up for the scheme. Thirdly, the financial results of the public carriers with respect to these products have also been poor because of adverse selection. For example, Mediclaim and Jan Arogya policies experienced claims ratios in the range of 120-130 percent.

Despite the mediocre success of these public-initiated schemes, there are numerous community-based organizations (CBOs) engaged in providing financial access to healthcare services through micro insurance (MI). Some of them offer worthy examples for both government and other CBOs in India. MI refers to insurance for low-income people and while there is no rigorous definition, it differs from commercial insurance in that it is a lower-valued product with modest benefits, modest premium amounts, and simpler documentation requirements. The International Labor Organization (ILO) estimated in 2005 that there were 51 micro-insurance schemes operating in India covering approximately 5.1 million lives.

Microinsurance schemes in India vary with respect to bearing the insurance risk. The majority of them operate within a partner-agent model in which an insurance company is the "partner" insuring the risk of the group, and with a second organization such as a community based organization (CBO) acting as implementer or "agent" handling marketing and administration. However, some are entirely self-insured and some are a combination of the first two, partnering with a health insurance company which assumes part but not all of the risk with the CBO.

The performance of microinsurance schemes varies widely. No single model or scheme can be considered exemplary. Firstly, inefficiency as measured by administration costs, including marketing, is either known to be high or is not properly documented. However, there is evidence from the Karnataka scheme that increased size may reduce these costs as a percentage of premiums. Secondly, schemes with comprehensive coverage are heavily subsidized while for-profit microfinance insurance channels such as BASIX provide very inadequate coverage. Thirdly, most of the schemes do not emphasize health education, prevention or primary care. Lastly, most of them also currently receive subsidies from government, donors or both, without which they are unsustainable.

The strengths of these schemes reside in their membership/volunteers and the willingness of their leaders to request and use feedback from members to improve services and resolve problems. Self-governed schemes can create tailor-made policies and design products specific to membership needs. Additional advantages of member-owned self-insured schemes include lower risk of moral hazard since the membership has an economic stake in the risk pool and "one for all and all for one" solidarity, conducive to improved participation. In addition, local knowledge and administration of self-insured schemes result in better service such as reduced time required to process claims. Lastly, all profits/surpluses remain with the members and can be used to build up additional reserves or to increase benefits in the future.

Policy Recommendations

The growth of this sector to include comprehensive and widespread coverage of the Below Poverty Line (BPL) population will require time, experimentation and innovation, and very importantly, a favorable and flexible policy environment. Based on the results of this study, a number of policies, which would favorably affect microinsurance development, follow.

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[2] The UHI is offered at a price of Rs. 365 per year for a single person; Rs. 548 for a family of five (with three children); or Rs. 730 for the family plus two dependant parents.

- Permit micro-insurance products and services to be tax free in all respects, including investment taxes of reserves, service taxes, and income taxes.
- Encourage public-private partnerships. As has been demonstrated by the Yeshasvini and Karuna Trust programs, such partnerships can work well but require public and private oversight to assure that resources are used effectively. The Social Security for Unorganized Workers (SSUW) legislation, which has been cleared by the government and is expected to be introduced into the parliament in early August, as currently drafted includes health insurance and would require such partnerships among local groups, public insurers and state governments.
- Provide incentives within the SSUW legislation or its implementing requirements to give microinsurers and, where relevant, their insurance company partners, the ability to reward improved performance by public sector facilities through their contracts with government. For example, Karuna Trust has pioneered an interesting approach to improve services by negotiating with the Karnataka state government to manage the Public Health Centers (PHCs) in some districts in Karnataka in return for the lion's share of the state budget allocated for those PHCs it manages.
- Promote and legally recognize self-insured schemes. This could be achieved by amending the relevant sections of the current Insurance Act so that mutual insurance programs can be registered, or by creating a special microinsurance law. The law should provide for reasonable capital requirements that reflect the low risk products that are being sold only to members of the organization, not to the general public.
- Constitute a separate regulatory framework for microinsurance enabling participation in its management of informal sector trade unions, cooperatives, women's organizations, self-help groups and other NGOs, CBOs, etc., which are better informed and sensitive to the needs of the microinsurance sector.
- Require that self-insured programs be not-for-profit. This advantage, together with tax exemption and increased operational efficiencies, would contribute substantially towards reducing costs of delivering services.
- Experiment with approaches that combine service delivery with coverage by creating an enabling policy framework, as also recommended for private health insurance. As noted above, Karuna Trust, with its direct management of PHCs for the benefit of its members and the broader community, is an example of an MHI that is moving in the direction of a comprehensive health plan.

Additional recommendations:

- Improve microinsurers' management skills. This problem could be addressed if the federation or trade association of MHIs could also act as a resource center that would provide technical assistance and capacity-building services to mutual insurance companies.
- Provide access to and assistance in reinsurance. Smaller risk pools are more vulnerable to ruin and as such, mutuals will need technical assistance to set up reinsurance programs and obtain access to reinsurers. Alternatively, a secondary risk pool for the microinsurance industry could be set up once the base of insured BPL population is large enough, but this may be something for the more distant future.

Chapter 5: Regulation of Health Insurance

Reforms in the Indian financial sector led to the enactment of the Insurance Regulatory and Development Authority Act (IRDA Act) in 1999.[3] The Act established the Insurance Development and Regulatory Authority (IRDA) and constituted it as the executive entity to "protect the interests of holders of insurance policies and to regulate, promote and ensure orderly growth of the insurance industry."[4] The entry of

[3] The IRDA Act took effect on April 19, 2000 vide Notification No. SO 397 (E) dated 19-4-2000.

[4] See Preamble or Introductory Statement of the IRDA Act, 1999.

privately owned insurers in the market initiated the development of a competitive insurance environment and prompted technical capacity building across the industry. Insurance awareness campaigns of the IRDA, complemented by various company and product advertisements and active recruitment and training of agents by insurers, produced an increasing level of public awareness about insurance. However, there is still very little growth in health insurance, particularly in number of people insured and product variation, that meets particular needs and means of the general public. Industry expertise in private health insurance, while beginning to develop, is still considered inadequate. Development and growth of health insurance require a legal and regulatory framework that strengthens consumer protection, safeguards the financial stability of insurers, controls risk selection and allows participation of other health risk carries.[5] Similarly, they require supportive regulation of healthcare providers, including the enforcement of standards of healthcare quality, provider accreditation, professional credentialing and enactment laws relating to medical malpractice. While many regulations have been promulgated and implemented, there are still many areas where additional legislation and regulation are needed as described in the following section.

Recommendations

- Additional and separate educational and practical training should be required in the licensing of health insurance agents and intermediaries to strengthen policyholder protection and to promote and develop industry's technical competence in health insurance.
- Separate "file and use" guidelines that address special features and characteristics of health insurance should also be adopted as a measure to monitor and ensure that the premium charged under a health cover is reasonable in relation to benefits covered.
- Separate reserving rules should be considered for the different categories of health insurance, especially taking into account the short-term versus long-term nature of contracts, whether policies provide indemnity or assured benefits, and considering the particular loss experience of varying health insurance products.
- Redress of Public Grievance (RPG) Rules should be enhanced. Redress is integral to insurance and the RPG system has proved to be the most effective mechanism for external resolution of policyholders' complaints and grievances,

In addition to the above there are areas where the IRDA should frame and promulgate separate regulations specific to health insurance, including the following:

- Minimum regulatory definition of pre-existing illness or condition to provide clarity and uniformity of its interpretation, including prescribing maximum "look-back" and "look-forward" periods.
- Incontestability of a health insurance contract after it has remained in force for a specified period of time from date of inception.
- Prohibition of post-claims underwriting.
- Requiring insurers to offer both group and individual policies.
- Prescribing standards on point-of-sale and after-sales disclosures specific to health insurance.
- Adopting separate guidelines for "file and use" and, in certain (microinsurance and rural health insurance) cases, "use and file" for health insurance products.
- Adopting reserving rules specific to the different types of health insurance contracts.
- Particularly for medical expense covers, additional regulations that prescribe the following:
    a) Availability or accessibility

[5] (Such as, managed care organizations ncluding HMOs, and self insured plans of employers, mutual benefit associations and cooperatives establishing rules to licensing (registration) and supervision.

b) Transferability or portability

c) Continuity (renewability and cancellation)

d) Rules on over-insurance, in the case of individual covers, and coordination of benefits, in the case of group covers.

- Refinement of the Microinsurance Regulations in the following aspects:

  a) Elimination of the minimum and increase of the maximum sum insured

  b) Elimination or relaxation of the "one-partner-one-agent rule"

  c) Elimination of commission caps

  d) Expanding the authorities of microinsurance agents who are also organizers of health microinsurance to specifically include, among others, enrolment of members, collection of premium and post sales servicing including settlement of claims.

  e) Adopting special agent licensing rules to allow officers and staff of Panchayats, rural health practitioners and postmen to solicit health microinsurance.

Conclusion

The legal and regulatory framework of private health insurance, particularly because it operates in the voluntary market, should continually balance competing goals of access, affordability and quality of healthcare and provide health coverage to a larger fraction of the population with varying risk characteristics and ability to pay. Regulations, aside from their aim of providing protection of health insurance policyholders and beneficiaries, can be potent tools to promote access to healthcare, control pricing of health coverage vis-à-vis healthcare providers and enhance quality of healthcare. Allowing the participation of other entities that provide health coverage, such as MCOs, HMOs, Hospital and/or Professional entities, and self-insured health insurance schemes of Mutual Benefit Associations and Cooperatives would further increase the reach and depth of private health insurance. Licensing standards for compliance which are enforced on health care provider facilities as well as self-regulation in the medical profession and within provider groups are necessary for continuing improvement of healthcare quality. Private health insurance cannot grow if reasonable consumer expectations relating to access, cost and quality of healthcare remain promises rather than realities.

1 OVERVIEW OF THE STUDY

USAID commissioned this study to evaluate the state of private health coverage in India as part of USAID's Financial Institutions Reform and Expansion—Regulatory (FIRE-R) Project in support of USAID/India's Strategic Objective to Increase Transparency and Efficiency in the Allocation and Mobilization of Resources. When the FIRE-R project was contemplated, public insurance companies offering an undifferentiated and limited set of products dominated the Indian health insurance market. "This monopoly [of public insurance companies] restricted innovation, fostered inefficiency and retarded growth of an effective regulatory system to promote sound business practices and consumer protection. It has also slowed the development of the intellectual capital necessary to becoming members of the world research community in areas such as insurance principles [and] actuarial science."[6] The Insurance Regulatory and Development Agency (IRDA) was established in 1999 to regulate the newly enabled private insurance industry. In addition to its objective of increasing transparency and efficiency in insurance operations, IRDA was tasked with creation of a regulatory environment that would promote the development of health insurance in India.

Purpose of Study

The purpose of this study is to investigate the impact of private insurance (or quasi-private in the case of the five government-owned companies) on health coverage in India and, based on our findings, to suggest the way forward for government policy, effective regulation and enforcement, and private sector activity. Although emphasis has been placed on the role of financial intermediation in facilitating and expanding the number of persons covered by private commercial and micro-health insurance, the study also examines the effectiveness of the insurance sector in meeting the health needs of its beneficiaries. Given the purpose of the study, health insurance is defined as "A mechanism to provide financial access to needed health care services by distributing the costs and risks. Health insurers manage and guarantee these costs and risks of providing health care services. Health insurance is purchased by employers, directly by individuals, through state and federal government programs"[7] and through Associations and other NGOs.

While following basic principles of insurance is necessary for success, health insurance is a special branch of insurance. First, it includes concepts such as prepayment for health services through which large portions of the insured are not only expected but also are encouraged to use primary care services so as to reduce the risk for future and often costlier services. Pre-natal care and well-baby care are excellent examples of services that when properly provided can actually save the insurer from future claims. Health insurance is also different in that the providers of care whose services are covered by insurance enjoy high prestige, income and political influence and because of their unique skills are often granted by the state extensive independence and autonomous power over medical decisions. Their efforts are focused on preserving one of the most precious of human assets, life itself, and it requires special skills to work with them to make sure insurance enhances access and the quality of care while keeping costs reasonable.

Private health insurance, whether it is micro-insurance or large public or private insurers, cannot be examined in a vacuum. The extent of coverage depends upon the health services delivery system, cultural values and desires, philosophy about the extent to which government should direct the process, as well as the ideas of the insurance executives themselves. At its best, insurance can provide needed, affordable coverage to those individuals who either purchase insurance or have it purchased for them; at its worst, those who need coverage face prohibitive premium costs and low benefit payouts. At its best, it can be a laboratory for

[6] BearingPoint Inc., Proposal for technical assistance through FIRE-R, 2003.

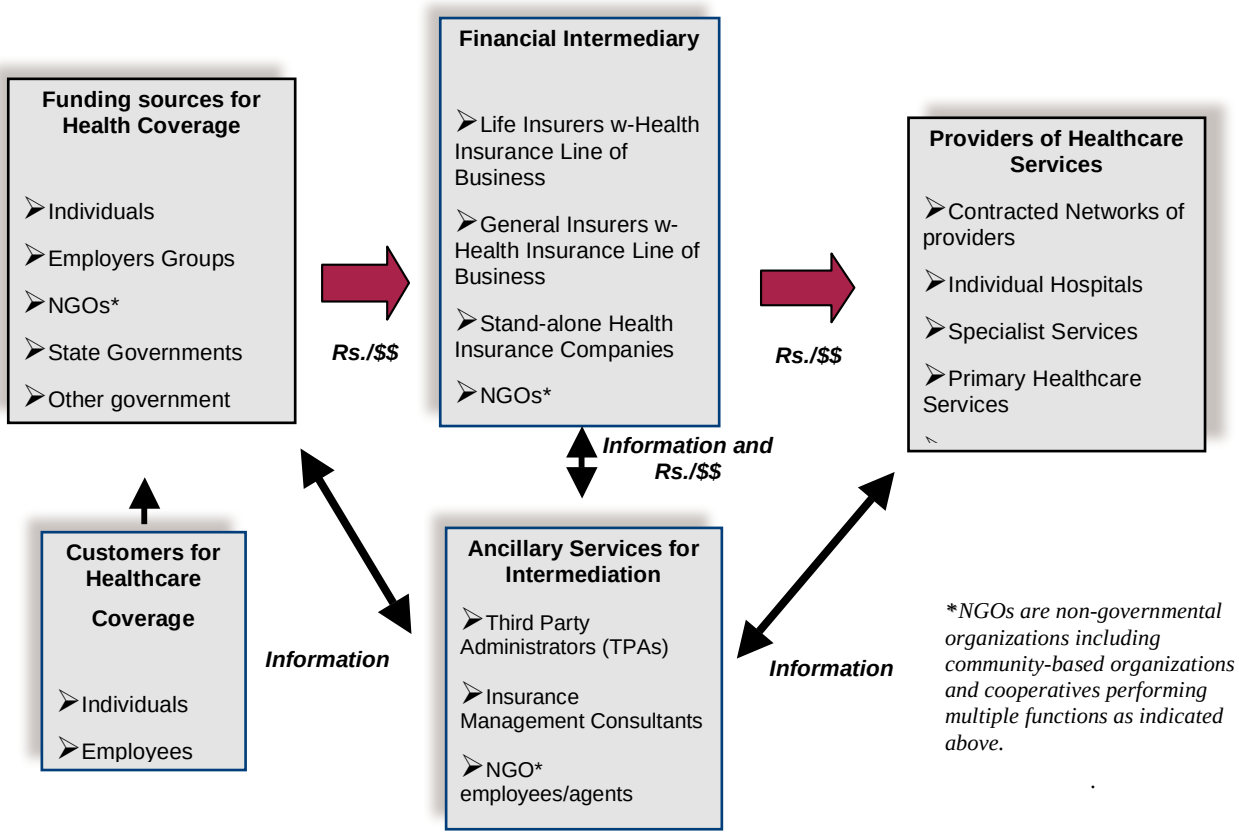
[7] Washington State Health Department. Health Coverage, July, 2002. http://www.doh.wa.gov/HWS/doc/HS/HS_INS.doc

experimentation and worthy innovations where communities and organizations work to broaden benefits and coverage to as many people as possible; at its worst, it can be a safety valve for the well-to-do and a niche player in the goal of making coverage available to all. In this sense it is too important to leave the development of private health insurance to insurers or regulators alone. Consumers, businesses, labor and health care professionals all have a stake in how health insurance develops. It is important for them to understand their interests and to forge a role for themselves in making sure their interests are served.

Financial Intermediation

In the context of this study, "The term **financial intermediary** may refer to an institution, firm or individual who performs intermediation between two or more parties in a financial context. Typically the first party is a provider of a product or service and the second party is a consumer or customer."[8] The context here is confined to health products and services. Given this definition of financial intermediation there are a number of private sector actors within the Indian health care system that qualify as intermediaries. This study encompasses the health sector roles not only of private and public health insurers and self-insured organizations but also of those providing ancillary services to these intermediaries. Ancillary services include third party administrators (TPAs), non-governmental organizations (NGOs) acting as agent/administrators and/or fund holders on behalf of their members, insurance management consultants, provider-sponsored health plans, self-insuring companies, commercial banks and other collection and distribution systems. The figure below illustrates very generally the flow of information and monies among the consumers, intermediaries, ancillary service and providers identified in the Indian health sector at present.

Figure 1.1: Private Intermediation in the Indian Health Care Sector



[8] Wikipedia: http://en.w k pedia.org/w ki/Financial_ ntermediaries

Just as the FIRE-R project has a strategic focus on transparency and efficiency in the mobilization of resources, so, too, the overarching goals of health policy incorporate transparency, efficiency and mobilization of necessary resources. Additionally, health policy makers typically seek to accomplish these goals within a system that promotes equity, innovation and consumer choice. "Recent developments in macroeconomic theory have shown that financial intermediation influences not only the level of production per worker in a country but its long-run rate of growth. By solving some of the transaction costs and information problems between savers and investors, financial instruments allow for a more efficient allocation of investments."[9] Health status of the population is also recognized increasingly as an essential component of economic growth. "Improvements in health may increase output not only through labor productivity but also through the accumulation of capital."[10] Because improved health status is associated with greater longevity, opportunities for savings and investment are thereby increased. However, health services do not necessarily contribute to improvement in health status in proportion to the size or type of the expenditure. The specification of services covered or excluded by private insurance, particularly given the asymmetry in information[11] that characterizes health care markets, is critical to achieving the desired increases in efficiency and individual productivity. Therefore, this study brings together an investigation of the growth of financial intermediation in the health sector with its intended result of providing access to health care services for a greater fraction of the population of India. Given the critical importance of context in determining how effectively insurance improves health status, in Chapter Two covered services are contrasted with the burden of disease in India.

Study Methodology

We assembled a team of international and Indian experts in health policy, regulation, finance, economics, insurance and micro-insurance. The team has been involved in each aspect of the study and has been very important because of the paucity of quantitative information available about health insurance performance. The information that has been available is often outdated. Therefore, many of the judgments made are qualitative, based upon experience and interviews.

Our methodology has several components. First, we identified the desired characteristics of health insurance programs whether public or private. This evaluation "framework" is described in the following section. Second, we determined the scope of the study. Since there are two very different and distinct insurance approaches—micro-insurance, providing highly variable coverage primarily to the poor, and private commercial insurance, serving the middle and upper classes principally with a single hospitalization policy—we used somewhat different methods to measure the market. In the case of micro-insurance, which is largely unregulated, the number of plans and their approaches are unknown. We selected a sample of plans which in our judgment represent good examples of different models that are being implemented and offer lessons in how to improve current and future micro-insurance initiatives. Private health insurance is largely regulated and the numbers of insurers and their plans are relatively small and well known. Therefore we were able to meet with most the large health insurers as well as most of their agents (TPAs) who administer much of the health insurance for them. Several unique examples of health coverage in India were also described to illustrate directions in which the insurance sector might be expected to innovate and expand.

Third, in both cases we began by developing assessment/interview guides to gather information on the context for and effectiveness of each health insurance type. (See Appendix IV for the data collection guides used for private insurance, TPAs and micro-insurance respectively.) Fourth, we analyzed the information we had collected and prepared several case studies as examples of how some health plans in India have

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[9] Gross, Dominique M., *Financial Intermediation: A Contributing Factor To Economic Growth And Employment*, Social Finance Programme, International Labour Office, December 21 2001. http://www.ilo.org/public/english/employment/finance/download/gross.pdf

[10] Bloom, David E., Canning, David, Sevilla, Jaypee, "Health, Human Capital, and Economic Growth". *WHO Commission on Macroeconomics and Health (CMH) Working Paper Series*, No. WG1: 8. April 2001; http://www.cmhealth.org/docs/wg1_paper8.pdf

[11] "Asymmetric information" occurs when one party to a transaction has more or better information than the other party. In health care, providers know more about health services than their customers. However, insurance beneficiaries know more about their own health status than their insurers. Both of these asymmetries cause major problems for health care insurance and all third party payers.

broadened coverage by using community rating and intensive medical management. In addition to evaluating where the present system of health insurance is today compared to the benchmarks in our framework, we added our judgments about where various parts of the system are headed. Fifth, in keeping with the project mandate to "increase transparency and efficiency" in the insurance sector, we focused on the roles and effectiveness of private health insurance regulation. Given their importance for the future of health insurance in India, appendices have been added describing private sector cost containment and quality improvement approaches that have been followed in other parts of the world (see Appendix I and II). We conclude with policy recommendations which we believe are necessary for the private sector to make a greater contribution to improving health care services and health status in India.

The Evaluation Framework

The framework we use to evaluate health coverage mechanisms that rely on financial intermediaries is based upon basic policy concerns facing all health systems.[12] A summary of these desired characteristics, suggested means of measuring the characteristics, and benchmarks against which the study team measured the current situation in India are shown in Table 1.1 below.

Table 1.1: Framework for Evaluating Health Insurance Coverage in India

Characteristic	Measures/Indicators	Benchmark
Scope of population covered and growth trend	Thousands of persons, individuals or families covered Annual increase in percentage covered	1) Target population clearly defined 2) Growth exceeding 20% until close to saturation 3) For large groups, exceeding 50% by year 5
Scope of population covered and growth trend	Thousands of persons, individuals or families covered Annual increase in percentage covered	1) Target population clearly defined 2) Growth exceeding 20% until close to saturation 3) For large groups, exceeding 50% by year 5
Covered services	Limits on coverage, including rupee amount, waiting periods, pre-existing conditions, renewability, etc. Included benefits, e.g., catastrophic care, primary care & prevention.	Essential basic services including primary care and prevention, hospitalization, disease management, etc.
Geographic access to care	Kilometers or hours of travel	Within 20km from a PHC, within 50km from hospital
Financial access to care	Lost wages/salary Costs of travel to hospital covered	Benefits include wage loss and travel costs
Affordability—including Subsidies	Annual policy cost less subsidy/ Average Income for Group; size of subsidy	1 to 3% of income depending on coverage
Efficiency of operations	Administrative costs, time lapsed for reimbursement or cashless, appropriate use of technology and services	Administrative costs < 20% (includes all administrative ancillaries)
Cost containment	Demand side, e.g. co-pays, co-insurance, subsidies Supply side— utilization management/physician incentives	Strong case/disease management programs; effective preauthorization and utilization review, strong provider contracts regarding quality/cost expectations and incentives.
Consumer Satisfaction	Ability to choose among sources of care or network; other access limitations, process for resolving grievances.	Measures of consumer satisfaction tracked and actions taken to resolve complaints and improve services.
Consumer Awareness and Understanding	Actions taken by the industry, the regulator and other stakeholders to educate the public about both the advantages and the potential for misrepresentation of health insurance benefits.	Coverage clearly explained by well-trained and effective marketing personnel. Literature and other communication devices in local vernacular used to raise awareness, as applicable.

[12] The above Framework is adapted from: Hsiao, William C., *An International Assessment of Health Care Financing.* Chapter II, World Bank Economic Development Institute. 1995; and Preker, Alek and Langenbrunner, J., *Spending Wisely, Buying Health Services for the Poor.* The World Bank. Washington DC. 2005.

Characteristic	Measures/Indicators	Benchmark
Innovation	Market research, new products, percentage of policy-holder renewals	Consumer feedback, lessons learnt, challenges, etc. translated into innovations that improve effectiveness.
Management Attributes	Years of experience of management, HR practices Financial accounting systems in place which provide complete picture of financial situation; loss ratios and trend in loss ratios	HR plans and continuing skill improvement programs in place for all staff. Strong internal and external financial controls and accountability.
Organizational Structure	Organization chart available to beneficiaries, qualifications and determination of membership on Board of Directors, consecutive years in business.	High functioning Board of Directors provides transparent and sustainable financial and beneficiary results.
Regulatory compliance	Regulations adopted for registration/licensure and performance monitoring Number of registered/compliant plans Percent of coverage of individuals in compliant plans Sanctions in place for non-compliance with regulation	IRDA requires registration of all carriers of health risks and risk-pooling arrangements and all TPA activities. GOI passes enabling legislation enabling entities and/or organizations other than insurance companies to provide health insurance arrangements/ schemes to individuals or groups and bring their operations under regulatory oversight. Effective enforcement in place.
Sustainability	Level of reserves Fraction of income from donors Net income/deficit Trend in net income/deficit	Long term sustainability requires buildup of resources and reserves. positive net income after year 3, and independence from donor subsidies.

Measurement of Indicators and Population Segmentation

Given the diversity in insured populations, available resources, pooling arrangements, benefit designs and other aspects of coverage, particularly in the micro-insurance market, measurements will necessarily be approximations using qualitative as well as quantitative information and professional judgment.

Not surprisingly, there are trade-offs implicit in meeting all of the criteria. For example, greater freedom of provider choice is generally at the expense of increased cost of service. Similarly, cost containment strategies that focus on decreasing demand appear to be less successful than strategies that restrict supply such as global budgets and financial penalties on providers for exceeding volume targets. However, global budgets may result in inequitable access to care or reduced incentives for innovation. The contracted provision of services in contrast to publicly provided services appears to offer greater consumer choice and potentially greater efficiency if there is effective competition.

"Nevertheless, the evidence shows that not every single individual will be served even under the most comprehensive financial sector. Financial intermediaries, whatever their form, will always perceive some individuals as too risky either in terms of involuntary default (inability to repay) or in terms of strategic default (unwillingness to repay)."[13] For this reason, private voluntary health insurance cannot provide the answer for all individuals. Micro-insurance and statewide schemes that include a publicly provided subsidy will be required to provide essential services to the majority of Indians who remain poor. In the interim, private voluntary health insurance and micro-insurance can fill a part of the large existing gap in access to health care services, preventing the impoverishment of individuals who are the victims of illness and accident and permitting government budgets to focus on the provision of services to those for whom privately funded services are not available or affordable.

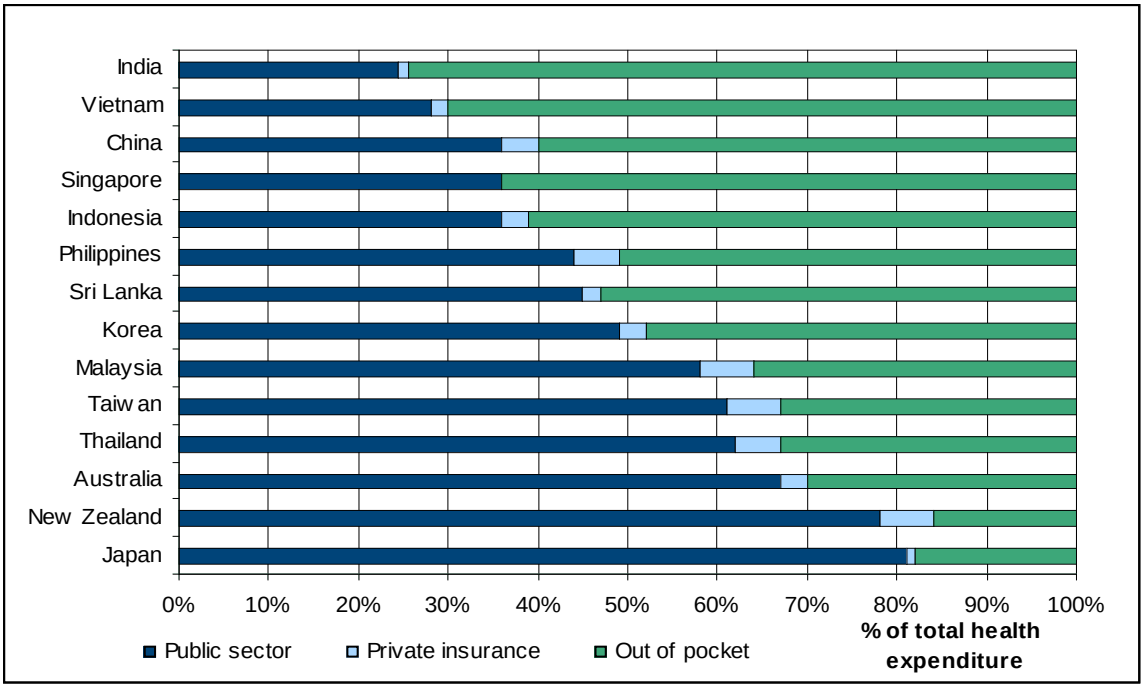
[13] Gross, Dominique M. *Op. Cit.* pg. 28.

2 FINANCING HEALTH CARE SERVICES IN INDIA : SOURCES OF FUNDS AND HOW THEY ARE USED

Developing countries account for 84 percent of the global population, 90 percent of the global disease burden, and 20 percent of the global GDP, but only 12 percent of global health spending.[1]

This statement is particularly true for India. In comparison with other Asian countries, the Government of India contributes the least to healthcare as a percentage of GDP leaving the bulk of the healthcare financing to households.

Figure 2.1: Sources of health care spending in Asia (2004-2005)



Source: Swiss Re: Economic Research & Consulting, 2006, presentation at 10th Insurance Summit CII, Mumbai, India, October 10, 2006.

In this chapter, the sources of funds used to pay for health care services in India are presented and discussed. As is true of most countries, Indian health care is financed through a combination of sources including:

- Household and individual out-of-pocket payments,
- Central and state government tax revenues,
- Mandatory social insurance,

[1] Gottret, Pablo and George Schieber,. *Health Financing Revisited: A Practitioners Guide*. Washington, DC.: The World Bank., 2006.

- Voluntary health insurance,
- Micro-insurance, and
- Other employer/mutual schemes not using public or private insurance companies.

Additionally, this chapter will present data on how these funds are expended, particularly by households and government. Lastly, the chapter will discuss the burden of disease and disability in India with the objective of illuminating the relationship between ability to pay for services, and therefore access to needed care, and the current allocation of funds.

Overview of Sources of Payment

The World Health Organization's *2005 World Health Report* estimated the total health expenditure (THE) in India, as a percent of the gross domestic product (GDP), was 4.8 percent in 2003. Of the THE, as depicted in Figure2.1, government expenditure makes up only 24.8 percent, whereas out of pocket expenditures on healthcare services is by far the largest contributor to total health care spending in the country. It is estimated that over 70% of total health expenditure in India is borne by households. This puts a tremendous strain on households which often lack the economic means to live.

Table 2.1. Sources of Funding for Health

Financing Agent	Expenditure in Rs millions	% Distribution
Ministry of Health and Family Welfare	24,629	2.3
Other Central Ministries/Departments	2,132	0.2
State Government Department of Health	141,699	13.4
Other State Ministries/Departments	2,311	0.2
Urban Local Bodies and Panchayat Raj Institutions	31,784	3.0
Social Security Funds	790	0.1
Central Government Employee Schemes	25,797	2.4
State Government Employee Schemes	5,119	0.5
Employee State Insurance Scheme	17,954	1.7
Public Health Insurance Providers (GIC Companies)	7,823	0.7
Private Health Insurance Providers	202	0.0
Households	***744,225***	***70.4***
NGOs	8,540	0.8
Private Firms and Public Firms	44,336	4.3
Total funds provided	**1,957,341**	**100.0**

Government expenditure

Out-of-pocket

Source: National Health Accounts 2001-2002; No updated information on NHA was available from the MoHFW

Out-of-pocket Payments

As presented in Table 2.1, household out-of-pocket expenditure is by a wide margin the most important source of financing for health care services. However, the average amounts spent and the distribution of these expenditures across states and by urban and rural populations vary considerably. This variation, demonstrated in the tables that follow, has implications for both policies on the distribution of public

spending and the importance of micro-insurance and other forms of health coverage as a complement to public spending.

The micro-insurance schemes that will be discussed in depth in a separate chapter of this study are based in five Indian states: Andhra Pradesh, Gujarat, Karnataka, Orissa and Tamil Nadu. Data from the same five states are presented in this chapter to provide a broader context for the micro-insurance schemes and to illustrate the diversity in ability to pay for health care and in health care spending across India. Data from four additional states are included in much of this analysis to better represent the geography and population of India. These are: Assam, Bihar, Maharashtra and Uttar Pradesh. Taken together these nine states include well over half of the country's population. They also include the major cities where financial services, including insurance, have developed rapidly to serve growing Indian and foreign IT and related companies; cities such as Mumbai, Bangalore, Chennai and Hyderabad.

Average monthly per capita consumer expenditure (MPCE), as estimated using the most recently published rounds of the National Statistical Survey (NSS)[2], is a reasonable proxy for disposable income. Averages for the nine states by rural and urban population are shown in Table 2.2. Columns (2) and (4) illustrate the near doubling of expenditure on average in urban areas compared to rural areas[3]. Tamil Nadu is not only the state with the highest MPCE for both rural and urban populations but also has the lowest ratio of urban to rural expenditure of the five states shown. In contrast, Orissa has the lowest MPCEs for both demographics and across both surveys, and appears to have the highest ratio of urban to rural MPCE.

The MPCEs for the most recent period (July '04 to June '05) obscure large differences within each state. However, even across states the MPCE varies from a high of 1148 in urban Maharashtra to a low of 696 in urban Bihar. Similarly, the rural average ranges from 647 in Uttar Pradesh to 399 in Orissa, which has the highest percentage of poor households—nearly 40 percent of its population is below the poverty line[4]. There is also a considerable dispersion in the ratio of urban to rural MPCE as shown in columns (2) and (4). For example, the ratio of 203 for Karnataka contrasts with a ratio of 151 for Uttar Pradesh indicating that urban MCPEs are from one and a half to two times as high as rural MCPEs despite the fact that poverty is growing in Indian cities. Although rural/urban income disparities exist in many countries, their presence in India has very important implications for access to health care services.

Medical expenditures were captured in the NSS in two categories: expenses paid to institutions (inpatient care) and all other expenses.[5] Table 2.3 below shows the level of these expenditures by urban/rural within each selected state. Among noteworthy differences are the following:

1. For both rural and urban populations, non-institutional (outpatient) expenditure is nearly three times as high as the amount spent in institutions. Total institutional medical expenditure excludes public spending on public hospitals. (Government spending on curative care is shown in Figure 2.7.)

2. As one would expect, average medical expenditure is positively correlated with average MPCE with the exception of the rural population of Gujarat which has the highest MPCE but one of the lowest average levels of medical expenditures. Differences in the cost of living and in access to private health care services between northern and southern Indian states are among the possible explanations.

3. Of the nine states, Tamil Nadu is exceptional in that rural and urban average medical expenditures are very similar. This is in contrast to the other eight states and the average shown for all of India.

4. In columns (4) and (5) urban/rural expenditure ratios are illustrated for total medical expenditure and MPCE respectively. Assam is exceptional in the relatively high average institutional expenditure by the

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[2] National Statistical Survey, Round 61, 2004-2005.

[3] The Survey Report notes that this d fferential would be smaller in real terms f urban/rural differences in prices were factored nto the estimates.

[4] InfoChangePoverty, accessed, October 20, 2006, http://www.infochangeindia.org/Povertyltop.jsp?section_idv=7

[5] The survey nstrument asked for spec fic information on all main types of medical expenditure includ ng physician and other provider services, pharmaceuticals, diagnostic tests and procedures, distinguish ng between services received on an outpatient basis and those received n conjunction with a hospitalization.

urban population and low medical expenditure of its rural population. For most of the states shown, (Bihar and Karnataka are also exceptions), the urban population is spending a smaller fraction of average income on medical expenses than the rural population although unit costs for medical care are known to be much higher in urban areas.

Table 2.2: Average Monthly Per Capita Consumer Expenditure (MPCE)[6] for Selected States and by Rural/Urban for January 2004 - June 2005

Selected States	Average MPCE in Rs Jan. –June 2004	Urban as Percentage of Rural Expenditure	Average MPCE in Rs July 2004—June 2005	Urban as Percentage of Rural Expenditure
	(1)	(2)	(3)	(4)
Andhra Pradesh		198		174
Rural	557		586	
Urban	1102		1019	
Assam		192		195
Rural	532		543	
Urban	1019		1058	
Bihar		177		167
Rural	442		417	
Urban	784		696	
Gujarat		178		187
Rural	613		596	
Urban	1092		1115	
Karnataka		187		203
Rural	502		508	
Urban	937		1033	
Maharashtra		221		202
Rural	569		568	
Urban	1259		1148	
Orissa		211		190
Rural	414		399	
Urban	872		757	
Tamil Nadu		188		179
Rural	603		602	
Urban	1131		1080	
Uttar Pradesh		154		151
Rural	538		647	
Urban	827		978	
ALL INDIA		188		188
Rural	565		559	
Urban	1060		1052	

Source: NSS Report on Level and Pattern of Consumption, Round 61, Report 508, p. 15 and NSS Report on Consumer Expenditure, Round 60, Report 505, p.12, Schedule Type 1.

[6] Monthly per capita consumer expenditure (MPCE): For a household, this is the total consumer expenditure over all items divided by its size and expressed on a per month (30 days) basis. A person's MPCE is understood as that of the household to which he or she belongs.

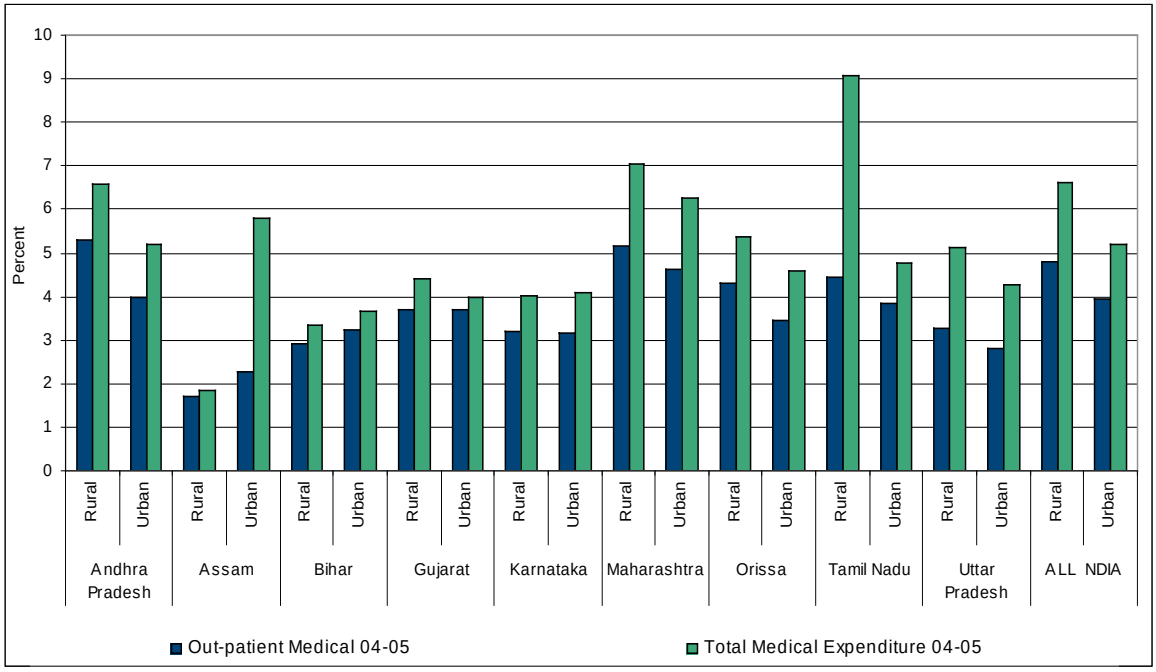
Table 2.3: Average Household Medical Expenditure by Selected State and by Rural/Urban, in Rs

Selected States	Non-Insti. Medical – 04-05	Medical – Institutional 04-05	Total Medical Expenditure 04-05	Urban as Percentage of Rural Expenditure	
	(1)	(2)	(3)	Medical (4)	MPCE (5)
Andhra Pradesh				137	174
Rural	31.11	7.50	38.61		
Urban	40.42	12.41	52.83		
Assam				609	195
Rural	9.28	0.78	10.06		
Urban	24.14	37.17	61.31		
Bihar				184	167
Rural	12.13	1.76	13.89		
Urban	22.52	3.06	25.58		
Gujarat				169	187
Rural	22.06	4.37	26.43		
Urban	41.27	3.37	44.64		
Karnataka				208	203
Rural	16.38	4.04	20.42		
Urban	32.78	9.66	42.44		
Maharashtra				180	202
Rural	29.38	10.72	40.10		
Urban	53.14	18.93	72.07		
Orissa				162	190
Rural	17.10	4.36	21.46		
Urban	26.21	8.53	34.74		
Tamil Nadu				94	179
Rural	26.82	27.87	54.69		
Urban	41.56	9.81	51.37		
Uttar Pradesh				126	151
Rural	21.20	12.03	33.23		
Urban	27.63	14.19	41.82		
ALL INDIA				148	188
Rural	26.93	10.03	36.96		
Urban	41.54	13.05	54.59		

Source: NSS Report on Level and Pattern of Consumption, 61st Round Statement 4R and 4U, pp. 50-55

Figure 2.2 shows the percentage distribution of medical expenditure by state and by rural/ urban. Medical expenditure is clearly regressive, the poorer rural population spending a higher percentage of MPCE for medical care than those in urban locations. While these data show medical expenditure, they do not represent "need" for medical care based on incidence of disease or disability which may also be higher among the rural poor.

Figure 2.2: Percent of MPCE used for Out-Patient Medical Expenses by Selected States and by Rural/Urban



Source: NSS Report on Level and Pattern of Consumption, 61st Round Statements 5R and 5U, pp. 56-61

Poverty and its implications given the rate of household medical expenditures

"The NSSO has estimated that poverty declined by a mere 0.74% during the 11-year period ending 2004-05, although there are signs of things moving a little faster, at 0.79%, between 1999-2000 and 2004-05. The study also shows that the steepest decline in poverty was in India's poorer states. Leading them was Assam and the northeastern states, where the percentage of people below the poverty line decreased by nearly 4% annually during the five-year period, followed by Jharkhand (2.51%), Chhattisgarh (2.15%) and Bihar (1.69%). The survey's findings also show that the percentage of Indians living below the poverty line (BPL) was 22.15% in 2004-05, compared with 26.09% in 1999-2000. In the same period, the country's GDP grew at around 6%, compared to the present GDP growth of over 8%."[7] The report further notes that "The BPL population in the country's rural areas decreased by 4.68% between 1999-2000 and 2004-05; this was over twice the rate of poverty reduction in urban centres, estimated at 2.12%."

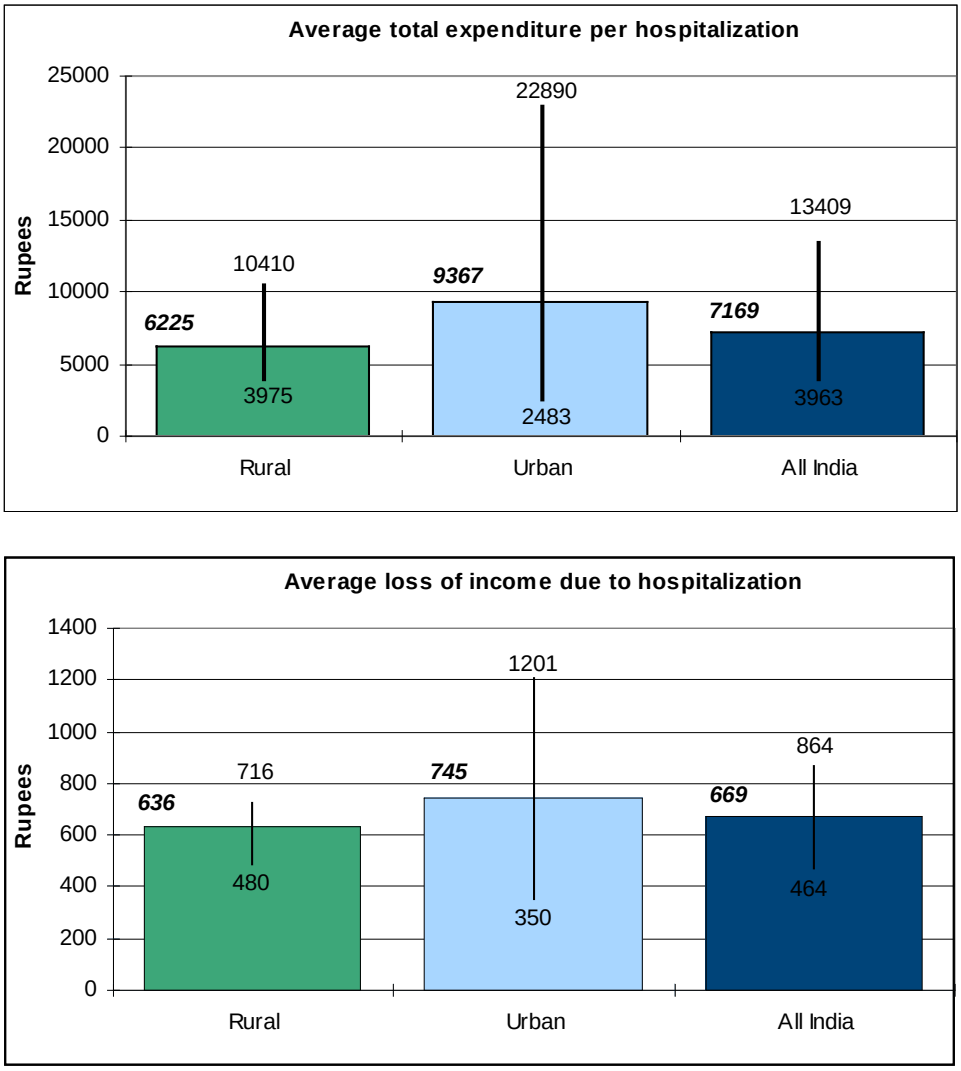
Given the incidence of extreme poverty, many are unable to access necessary services due to their inability to pay for care. Average medical expenditures across the entire surveyed population do not adequately capture the cost of outpatient services or of an individual hospitalization. For example, 77 and 88 percent of outpatient care in rural and urban populations respectively was financed by households' own 'income and savings'.[8]

Figure 2.3 summarizes the average total cost per hospitalization as well as the estimated average loss of income due to a hospitalization. Taken together, the average loss in India due to a hospitalization in 2004-05 was about Rs 8,000. However, costs are much higher in urban than in rural areas as indicated by the averages and the range across all states presented below. Additionally, if medical costs have been increasing at the same

[7] From: http://www.infochangeindia.org/Povertyltop.jsp?section_idv=7; BPL is def ned as any adult consum ng less than 2,100 calories in urban areas, and 2,400 calories in rural areas. www.oneworld.uk, October 20, 2006;

[8] NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*. Report No. 507: p. 32. March 2006.

Figure 2.3: Average Expenditure per Hospitalization by Rural/Urban Populations, (Numbers indicate Average, Minimum and Maximum) & Loss of Income Due to Hospitalization by Rural/Urban Populations



Source: NSS 60th Round, *Morbidity, Health Care and Condition of the Aged.* Report No. 507: p. 56-61, 2006.

rate as other costs, and the average crude inflation rate for India is now estimated at more than 7 percent[9], hospital costs would be at least 10 percent higher than they were in mid-2005 when the NSSO survey period ended.

The proportion of persons hospitalized varies across states and between urban and rural populations due to differences that include ability to pay, morbidity and geographical access to a hospital. The variation is shown for the selected states in this study in Table 2.4. Wealthier states such as Tamil Nadu and urban dwellers in general have higher rates per 1000. Given that the populations of both Orissa and Bihar are extremely poor: the difference in their rates per 1000 are surprising, with Orissa's being nearly three times as high.

[9] India has two price indices, one based on agricultural workers for rural areas and the other on ndustrial workers used in urban areas. Rates are cited in *The Economist*, February 3rd-9th, 2007, p.69.

Table 2.4: Proportion (per 1000) of Persons Hospitalized in Rural and Urban Areas and Population per Bed in Selected States.

State	Rural	Urban	Pop. per Bed[10]
Andhra Pradesh	22	28	1057
Assam	11	16	1782
Bihar	10	10	3029
Gujarat	29	36	709
Karnataka	23	26	1319
Maharashtra	30	36	920
Orissa	23	30	3064
Tamil Nadu	37	37	1135
Uttar Pradesh	13	20	2647

Source: NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*. Report No. 507: p. 25, 2006.

Based on the entire sample, the NSSO estimated the number of hospitalizations in the previous 365 days from all sources at 18,657,000 in rural areas and 8,517,200 in urban areas. Given that the rural population is approximately 2.33 times greater than the urban population, if morbidity were roughly equivalent in both populations, there would have been about 19,845076 in rural areas or about 6.4 percent more than were reported.[11]

A very small proportion of hospital admissions are reimbursed. Report 507 provides data on reimbursements by incidence, by average amount and by source as shown in Table 2.5 and Figure 2.4. Urban dwellers are more than five times as likely to be reimbursed and their reimbursement is nearly nine times as much on average as rural dwellers. Government employment is the principal basis for reimbursement for the rural population. Government employment and medical insurance are equally important sources of reimbursement for the urban population. Note however, that Indian households spend three times as much on outpatient care as they do on hospitalizations but private insurance rarely covers outpatient care.

Table 2.5: Average Number & Amount of Reimbursement for Hospitalized Cases

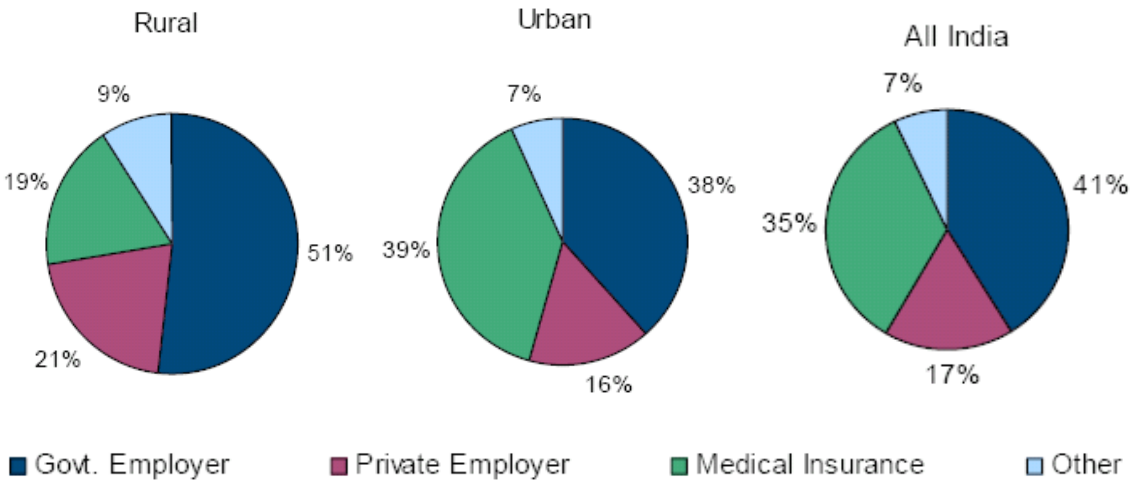
Population	No. of Cases Reimbursed per 1,000 Hosp. Persons	Average Amount Reimbursed Rs
Rural	7	78
Urban	39	677
All India	17	258

Source: NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*. Report No. 507 pp. A-124-126. 2006.

[10] Data relate to various dates: Andhra Pradesh (1998), Assam (1991), Bihar (1992), Gujarat (1995), Karnataka (1998), Orissa (2001), Maharashtra (2000), Tamil Nadu (1990) and Uttar Pradesh (1986) and are taken from *Health Information of India* (2003), Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health and Family We fare, Govt. of India. All beds should not be regarded as equivalent in terms of quality of care provided.

[11] NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*. Report No. 507, Maarch 2006, pages A-52 and A-58, Table 22.

Figure 2.4: Percentage Distribution of Reimbursement by Source



Source: NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*. Report 507, 2006, pp. A-124-126..

As shown above in Figure 2.4, the government is the single most important source of reimbursement for hospital expenses. The social insurance programs, to which government is a major contributor either through sponsorship of the scheme or public provision of covered services, are described in this section. Although they constitute only a small fraction of total health financing (estimated at about 3 percent in 2001), they are the most important sources of health insurance for families in India.

Mandatory Social Insurance and other Government-Subsidized Coverage

The Employee State Insurance Scheme (ESIS) is a health insurance program for non-seasonal power-using factories employing 10 or more persons and non-power using factories employing 20 or more persons[12]. Employees must make under Rs 10,000 per month to participate in the scheme. In 2006, there were nearly 355 lakh beneficiaries (see Table 2.6), 4% of which are women[13].

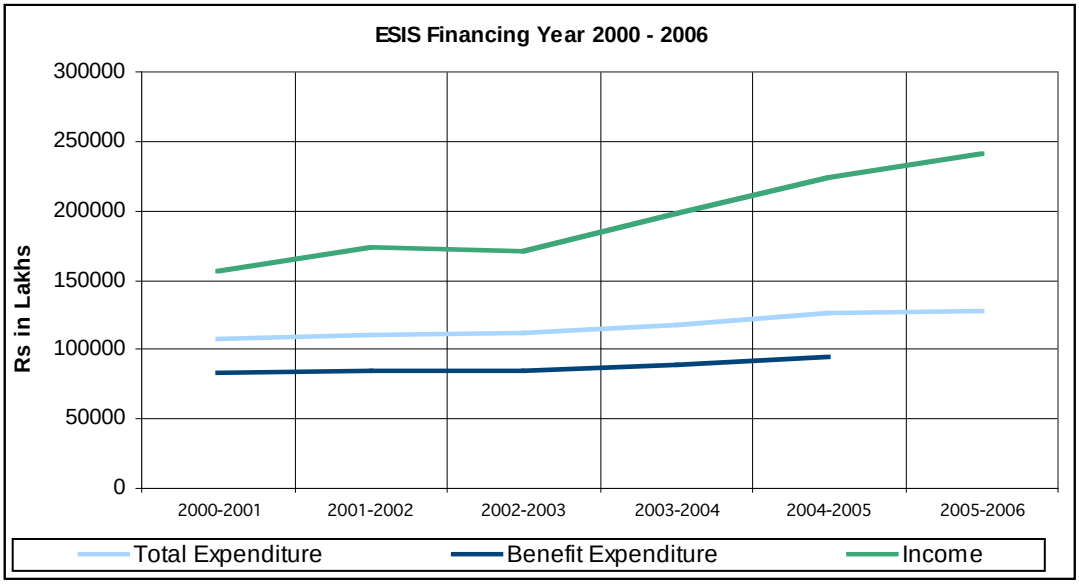
Table 2.6: Number of Insured Persons and Beneficiaries under ESIS

Coverage (As of 31st March 2006)	
No. of Insured Person family units	91,48,605
No. of Employees	84,00,526
Total No. of Beneficiaries	3,54,96,589
No. of Insured women	15,43,250
No. of Employers etc	3,00,718

[12] Under Section 1(5) of the Act, the Scheme has been extended to shops, hotels, restaurants, c nemas ncluding preview theatre, road motor transport undertakings and newspaper establishment employ ng 20 or more persons.
[13] Employee State Insurance Corporation. ESI Schemes, Financing website. Accessed February 10, 2007. http://esic.nic.in/coverage.htm

The sources of financing for ESIS are illustrated in Figure 2.5. Employers pay a contribution of 4.75% of the wages payable to the employee; employees contribute 1.75% of their wages. Beneficiaries can use the services in ESIS facilities, which are financed by the State Governments[14]. In 2005-2006, contributions to the scheme amounted to Rs 2,41,061.77 lakhs; during the same year, the total expenditure for ESIS (provision of care and claims expenditure) was Rs 1,27,896.16 lakhs.[15]

Figure 2.5: ESIS Financing, 2000-2006



Source: Employee State Insurance Corporation. ESI Schemes, F nanc ng Website. Accessed February 10, 2006. http://esic.nic. n/finance.htm

The Central Government Health Scheme (CGHS) is a mandatory social health insurance scheme for employees and retirees of the central government. Coverage includes: OPD, emergency, drugs, lab tests, family welfare services, specialist visits, and a 90% advance for specialized procedures. In 2004, CGHS covered approximately 44 lakh people, or 0.5% of the population and according to the Ministry of Health and Family Welfare annual report, 11.44% of the total health budget (MOHFW) was spent on CGHS in 2004-2005. The total cost of CGHS has fluctuated in the past six years, as has the percentage of health expenditure on CGHS. At its peak in 2003-2004, CGHS was 18% of the total health budget. This is in part due to CGHS allowing beneficiaries to purchase drugs at pharmacy shops and introducing contracting with private hospitals for providing healthcare to CGHS beneficiaries. However, in recent years, the expenditure on CGHS has come down dramatically (in 2005-2006 it is expected that CGHS will be 6% of the total health budget).[16]

[14] The State Governments share expenditure on the provision of medical care.

[15] As shown figure 2.5, there is an ncreasing discrepancy between ncome generated and the expenditures made through ESIS. Though ESIS is mandatory for certa n class of workers, the scheme is not hugely popular. The discrepancy may reflect ESIS beneficiaries' use of private facilities for secondary and tertiary care payable out of pocket in preference to the apparently lower quality of services available through public facilities and/or private facilities with which ESIS has contracts; nonethless those eligible cont nue to pay their share of membership contr bution because it is relatively small and mandatory, thus creating a growing surplus.

[16] Rao, Sujatha. "Health Insurance n India". From: National Commission on Macroeconomics and Health Report: Financ ng and Delivery of Health Care Services n India: Background Papers. New De hi, India. 2005.

Table 2.7: Total Expenditure on CGHS (Rs in crore) for period 1999-2006

Expenditure Type	1999-2000	2001-2002	2003-2004	2004-2005	2005-2006 (outlay)
Establishment (a)	117.1125	125.3384	139.4496	NA	NA
Supplies and materials (b)	106.1760	165.3858	222.9404	NA	NA
Professional services (c)	47.8071	65.7699	140.7256	NA	NA
Total CGHS (a+b+c)	271.0956	356.4941	503.1156	331.63	230.00
Total MOHFW budget	2132.46	2577.04	2800.64	2897.64	3801.79
% Share of CGHS	12.7	13.8	18.0	11.4	6.0

Source: Adapted from Rao, Sujatha. 2005; MoHFW Annual Report 2005-2006[17]

In 2004, the Central Government introduced the Universal Health Insurance (UHI) scheme, which was aimed at those living below the poverty level. The "Government Rupee-a-Day" scheme (because the annual premium is Rs 365 per person[18], i.e., a rupee a day), is centrally financed and implemented through the LIC and the four public sector insurance companies. The Central Government subsidizes the premium costs for the BPL community by reimbursing the insurance companies after a policy has been sold to a BPL[19]. There has been little uptake of the UHI, as can be seen from the low levels of subsidy reimbursement to the implementing insurance companies presented in Table 2.8.

Table 2.8: Subsidies to LIC and PSUs for Implementing the UHI, Rs in crores

	2003 - 2004	2004 - 2005	2005 - 2006	2006 - 2007
Subsidy to LIC	70	-	-	-
Subsidy to 4 PSUs	2	5 (planned in 2003-2004 budget)	2.34	3 (planned)

Source: Ministry of Finance Demands for Grants, 2003-2004, 2005-2006 and 2006-2007

A Family Planning Insurance Scheme was launched in 2005 by the Central Government out of concern that the State and Government doctors were facing an excess of litigation from patient claims for compensation due to medical complications of sterilization. The scheme, which is implemented solely by Oriental Insurance Company, is intended to protect both acceptors of sterilization and the public and private health providers that are handling the procedures. The insurance scheme offers benefits to both the beneficiaries undergoing sterilization and the health providers conducting the sterilization. On the side of the client, the insurance scheme provides compensation of Rs one lakh to the patient in case of death in the hospital subsequent to sterilization; Rs 30,000 for death within 30 days of discharge from the hospital after the sterilization procedure; Rs 20,000 for failure of sterilization (either resulting in a terminated pregnancy or full term); and Rs 20,000 for medical complications.

All providers and health facilities of the Central/State/Local Government, and all the accredited doctors and health facilities within the private sector that render family planning services are indemnified against potential

[17] Ministry of Health and Family Welfare Annual Report, 2005-2006, accessible at: http://mohfw.nic.in/Annual0506/chapter%203%20funding%20for%20the%20programme%20f nal.pdf

[18] The UHI is offered at a price of Rs 365 per year for a single person; Rs 548 for a family of five (with three children); or Rs 730 for the family plus two dependant parents.

[19] The four public sector nsurance companies would sell the policy to the BPLs at Rs 365 (for an individual) minus the subsidy provided by the government. Initially, the subsidy was Rs 100 for an ndividual, but was increased to Rs 200 in 2005.

claims that could arise out of the failure of the sterilization, death of the client, or medical complication. The coverage is up to Rs 2 lakhs per physician/health facility per case. The coverage also covers legal fees, which would be covered by Oriental Insurance Company.

The Family Planning Insurance Scheme is compulsory: all married men and women who undergo a sterilization procedure in a government facility or an accredited private facility are covered under the scheme. A consent form that is to be filled out by the person undergoing sterilization is the proof of coverage under the scheme; the premium for the policy is provided by the Government of India.[20] Third party administrators manage the claims and administer the insurance scheme for Oriental Insurance Company.[21]

The goal of public health expenditure should be to reduce as much as possible, given available resources, the mortality, suffering and disability attributable to disease and injury. In the following section, the "burden of disease" in India is examined.

Burden of Disease in India

India has a population of over 1.1 billion (roughly 16.6% of the global population) and contributes 20 percent to the global burden of disease.[22] Despite the development gains that India has made, she still lags behind many countries with respect to the burden of disease, as measured by disability-adjusted life years (DALYs). One DALY represents the loss of one year of full health. Calculated by the summation of the years of life lost due to premature mortality in the population and the years lost due to disability, DALYs are a health measure that looks beyond the concept of potential life lost due to premature death and includes the potential years of "healthy" life lost (i.e., disability).[23]

The most recent data on DALYs for India come from the WHO *World Health Report, 2004*. The data are categorized by: communicable diseases, maternal, prenatal, and nutritional conditions; non-communicable diseases; and injuries. As noted in Table 2.9, mental illnesses, unintentional injuries and cardiovascular diseases account for the greatest share of burden of disease in India. However, the data in this table demonstrate that despite India's growth and development, India still has yet to complete the epidemiological transition, which is characterized by improved health and nutrition and a change in principal causes of mortality from infectious diseases to mortality from chronic conditions.[24] For example, 23.5 percent of the total burden of disease is attributed to prenatal conditions (low birth weight, birth asphyxia and birth trauma), respiratory conditions (lower and upper respiratory infections and otitis media) and diarrheal diseases, all of which affect the poor in greater proportions and are generally preventable with public health measures.

Data from 2004-05 on hospitalizations by diagnosis distinguishing between rural and urban populations also indicate a burden of disease associated with both poverty (dysentery and unknown fevers) and with more modern causes (heart disease and accidents, particularly in crowded urban areas). However, all could be mitigated through preventative strategies. See Table 2.10.

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[20] The premium is pre-paid to Oriental Insurance Company and is based on the estimated number of sterilizations that are to take place during the year.

[21] As of the publishing date for this report, BearingPoint has been unable to obtain information from Oriental Insurance Company regarding this subsidized coverage. Thus, no data on number of insureds have been presented.

[22] Calculated from DALYs in WHR 2004.

[23] WHO website, About the Global Burden of Disease Project, accessible at: **http://www.who.int/healthinfo/bodabout/en/index.html**

[24] Defined by the French National Institute of Demographic Studies; http://www.ined.fr/en/lexicon/bdd/mot/Epidemiological+transition/motid/106/

Table 2.9: Health Conditions and Disability-Adjusted Life Years in India, 2002

Disease/health condition	DALYs lost (x1000)	Share in the total burden of disease (%)
Communicable diseases, maternal, perinatal and nutritional		42.21
Perinatal conditions	29,213	9.74
Respiratory infections	26,094	8.70
Diarrheal diseases	15,254	5.09
Childhood diseases	10,323	3.44
HIV/AIDS	10,178	3.39
Maternal conditions	8,650	2.88
Tuberculosis	8,478	2.83
Nutritional deficiencies	8,120	2.71
Tropical diseases*	3,805	1.27
STIs excluding HIV	2,931	0.98
Meningitis	1,586	0.53
Malaria & other vector borne illnesses	1,254	0.42
Hepatitis B and C	607	0.20
Leprosy	86	0.03
Non-communicable conditions		40.74
Mental illness	32,666	10.89
Cardiovascular diseases	30,481	10.16
Sense organ diseases	13,649	4.55
COPD and asthma	10,789	3.60
Digestive diseases	9,488	3.16
Cancers	8,800	2.93
Congenital anomalies	6,105	2.04
Musculoskeletal diseases	4,336	1.45
Diabetes	3,009	1.00
Genitourinary diseases	2,474	0.82
Endocrine disorders	409	0.14
Injuries		13.27
Unintentional injuries	32,209	10.74
Intentional injuries	7,598	2.53
All listed conditions	288,592	96.23
Others	11,318	3.77

*Includes shistosomiasis, chagas, trypanosomiasis, leishmaniasis, onchocerciasis, and lymphatic filariasis

Source: WHO World Health Report 2004

The degree to which preventive and primary care services are available in India is indicated by the data in Table 2.11 on maternity care. The average expenditures shown are out-of-pocket. Although most Indian women are receiving both pre-natal and post-natal services, there are significant gaps. For example, in Orissa, among the poorest of states, 40 percent of women do not receive post-natal care. Of more concern is the relatively high expenditure on private care paid by women for both pre- and post-natal services. In Maharashtra, for example, the amount spent in private rural hospitals is more than double the MPCE for rural households. Yet Indians prefer private services to public services according to the NSSO survey. Seventy-eight percent of rural households use private services, of which forty-one percent give as their reason dissatisfaction with the quality of public facilities. Eighty-one percent of urban households use private facilities. Forty-five percent of them report that they are not satisfied with the quality of care provided in public facilities.[25] An Appendix to this report describes the history of quality improvement programs in the United States, a history that parallels development in other Western countries. The public and private health sectors of India are lagging badly in the development of quality standards and continuous quality improvement programs.

[25] NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*, Report No. 507: pp. A-180-183. 2006.

Table 2.10: Per 1000 Distribution of Persons Hospitalized by Type of Ailment, all India

Type of Ailment*	Rural	Urban
Diarrhea/ dysentery	76	62
Gastritis/ gastric or peptic ulcer	48	39
Hepatitis/Jaundice	15	22
Heart disease	43	80
Hypertension	18	32
Respiratory incl. ear/nose/throat ailments	35	30
Tuberculosis	30	17
Bronchial asthma	34	30
Disorders of joints and bones	25	26
Diseases of kidney/urinary system	37	49
Gynecological disorders	52	50
Neurological disorders	32	32
Psychiatric disorders	10	6
Cataract	29	24
Diabetes mellitus	18	24
Malaria	32	36
Fever of unknown origin	79	67
Locomotor disability	13	9
Accidents/injuries/burns/etc.	101	88
Cancer and other tumors	28	32
Other diagnosed ailments	164	166
Other undiagnosed ailments	19	15
Any ailment	1000	1000

*Ailments with at least 1% share are only listed separately

Source: NSS 60th Round, *Morbidity, Health Care and Condition of the Aged,* Report No. 507: p. 26. 2006.

Recognizing this deficit and perhaps to limit its liability under the sterilization insurance program described above, the Government created criteria for conducting the sterilization procedures. To ensure that physicians and health facilities are in compliance with the procedures, Quality Assurance Committees (QACs) were set up at the State and District level to enforce the pre- and post-operative guidelines. The standards include staffing and equipment requirements for male and female sterilization and are summarized in Table 2.13 in an Addendum to this chapter.

Data on infant mortality and the percentage of persons reporting an ailment, referred to as PAP, are presented in Figure 2.6. The data "reveals a broad positive association between MPCE and PAP, in both rural and urban areas. The range of variation in PAP was larger in the rural areas than in the urban areas. If MPCE is considered to be a proxy for level of living of the households, the data appear to show that the level of morbidity tends to rise with the level of living. This may mean either that the poor are less prone to sickness than the rich, or that the reporting of morbidity improves with improvement in the level of living. Of the two hypotheses, the second seems to be the more plausible.[26]" Particularly so as the infant mortality rate (IMR) is highest for both the rural and urban populations in the poorest state, Orissa.

Optimally, the allocation of public funds should reduce the burden of disease as efficiently as possible. Under an optimal allocation those most afflicted with cost-effective treatable or preventable diseases and with the

[26] NSS 60th Round, *Morbidity, Health Care and Condition of the Aged*, Report No. 507: p. 18. 2006.

Table 2.11: Percent of Women who used (i) Antenatal Care Services (ii) Post-natal Care Services with Average Expenditure by Source of Service for Selected States

Selected State by Urban/Rural	Ante-Natal Services			Post-Natal Services		
	Percent of Women*	Ave. Expenditure Rs		Percent of Women*	Ave. Expenditure Rs	
		Govt	Pvt.		Govt.	Pvt.
Andhra Pradesh						
Rural	90.6	407	1446	71.9	220	476
Urban	92.5	630	1614	82.0	341	533
Assam						
Rural	75.3	167	624	70.3	306	401
Urban	100.0	412	687	95.3	503	1663
Bihar						
Rural	53.0	408	473	52.4	238	339
Urban	75.3	266	603	72.4	522	344
Gujarat						
Rural	76.3	61	1872	50.3	139	1781
Urban	88.2	337	1568	69.3	243	955
Karnataka						
Rural	87.6	113	948	79.6	178	447
Urban	92.0	293	1271	76.6	236	867
Maharastra						
Rural	80.9	142	1246	60.9	115	485
Urban	86.3	341	1636	76.3	314	779
Orissa						
Rural	77.5	186	752	73.8	246	421
Urban	88.9	617	916	60.1	137	1540
Tamil Nadu						
Rural	95.4	116	1730	77.5	63	596
Urban	98.6	126	1739	74.4	130	732
Uttar Pradesh						
Rural	54.4	109	556	64.2	175	395
Urban	64.0	225	665	71.0	282	464
ALL INDIA						
Rural	69.8	230	918	66.6	232	541
Urban	83.6	356	1377	72.9	367	762

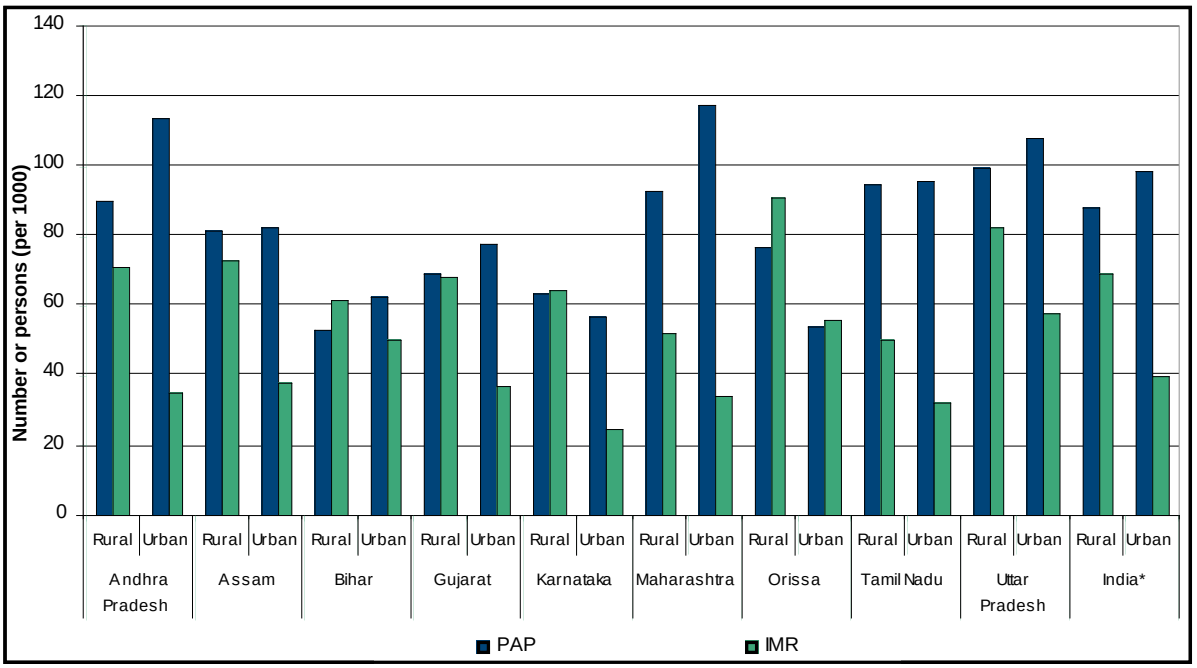
* Women aged 15 – 59 years who were pregnant anytime during the last 365 days

Source: NSS 60th Round. *Morbidity, Health Care and Condition of the Aged*, Report No. 507: pp. 52-53. 2006.

most limited ability to pay for their own care would be the greatest beneficiaries of public funding. However, in India as in many other countries, health subsidies favor those who are well off.[27] In the section that follows, data are presented on public health financing and the allocation of public health expenditure by function.

[27] NCAER, "Who Benefits From Public Spend ng n India", pp. xix- xx. 2002.

Figure 2.6: Number (per 1000) of Persons Reporting Ailment (PAP) During Last 15 Days, with Mortality Rate (IMR) for Selected States



The data on Infant Mortality Rate (IMR) are est mates for 2002 obta ned by the Sample Registration Scheme of the Registrar-General of India. India. *Excludes Nagaland.

Source: NSS 60th Round, Morbidity, Health Care and Condition of the Aged, Report No. 507. 2006.

The Allocation of Government Expenditure by Function and Income Group

Despite the high proportion of DALYs for preventable ailments, health expenditure by State Departments of Health does not align with the disease burden in the country. Further, the public health expenditure skews towards curative care that more often benefits the better off, whereas preventive health care services that could greatly benefit the poor is not well-funded. According to the NHA published in 2005 (for the 2001-2002 fiscal year), 47% of the State Government health expenditure in 2001-2002 was for curative care, by far the largest segment of the State health budget as shown in Table 2.12.

Further analysis conducted by the World Bank (2001) showed that public spending on curative services was clearly inequitable. The author estimated that the government spent three times the amount on the wealthiest quintile compared to the poorest quintile as shown in Figure 2.7 below.

More recent data are presented in Figure 2.8. Through the National Rural Health Mission (NRHM), launched on 12th April 2005 for a period of 7 years (2005- 2012), the central government's goal is to provide accessible, affordable, accountable, equitable, effective and reliable health care, especially to poor and vulnerable sections of population in the rural areas.[28]

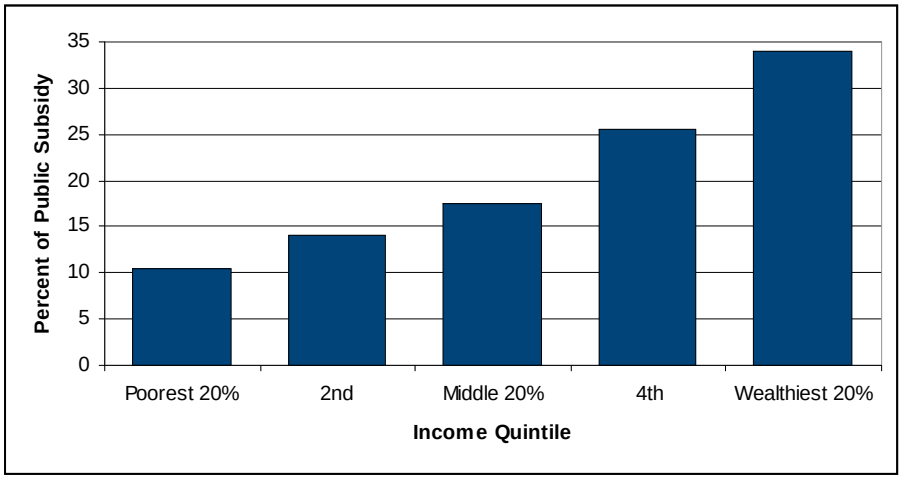
[28] MoHFW Annual Report, 2005-2006, Involved states: with special focus in 18 States viz. Eight Empowered Action Group States (Bihar, Jharkhand, M.P, Chhattisgarh, U.P., Uttaranchal, Orissa and Rajasthan), eight North East States (Assam, Arunachal Pradesh, Man pur, Meghalaya, Mizoram, Nagaland, S kkim and Tr pura) Himachal Pradesh and Jammu and Kashmir. p.23.

Table 2.12: Health Expenditure by State Government by Functions 2001-2002

Health care functions	% Distribution
Services of curative care	47.6
Rehabilitative or long term nursing care	0.2
Ancillary services & therapeutic appliances	1.9
Reproductive and child health services	12.2
Drugs control	0.3
Nutritional program of State Dept of Health	0.1
Control of Communicable diseases	6.2
Control of non-communicable diseases	0.4
Public health or RCH education/training	0.5
Other public health related activities	1.3
Health administration	8.4
Capital expenditure	4.7
Medical education and training of health personnel	8.7
Research and development	0.2
Food adulteration	0.2
Function from other sources	7.1
Total	**100**

Source: NHA 2001-2002, Op. Cit.

Figure 2.7: Distribution of Public Expenditure on Curative Care by Income Quintile

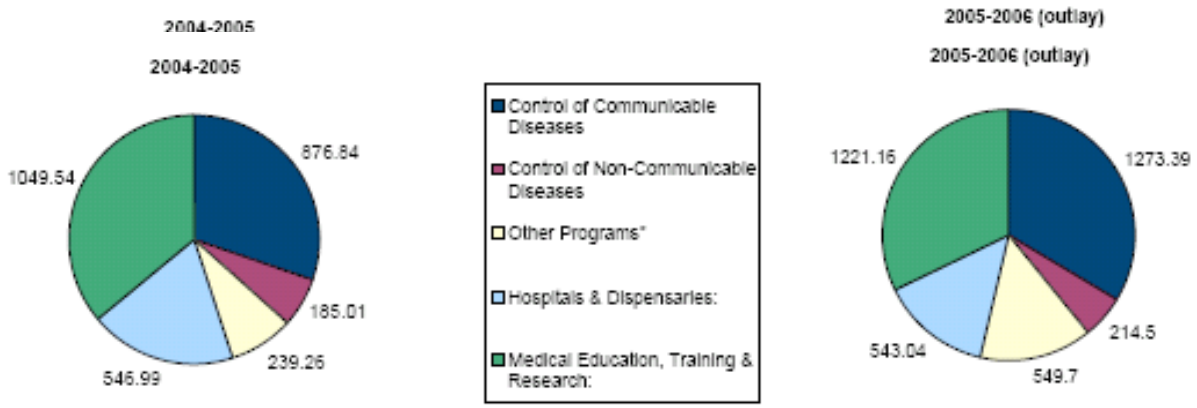


Source: Peters, et al. 2002, as cited in Preker, et al, ed. 2006.

"The Mission is an articulation of the commitment of the Government to achieve the goals and objectives of National Health Policy and Population Policy and increase the outlays for Health from the current 0.9% to 2-3% of GDP over the next five years, and to undertake systemic correction of the health system to effectively utilize such increased outlays for sustainable outcomes."[29] All community health care centers are to provide

[29] bid. p.24.

Figure 2.8: Scheme-wise Break-up of Actual Expenditure in 2004-2005 and Outlay for 2005-2006 (Rs in Crores)



* Includes Capacity Build ng, Waste Management, Food & Drugs, New Initiatives, Support for National Institutes, Drug Standards Health Accounts, Disaster Preparedness, Emergency Relief
Source: MoHFW Annual Report, 2005-2006

obstetric and new-born care, patients' rights are to be enforced through effective monitoring and new and improved infrastructure for the public health system are priorities. Based on the approved budget for 2005-06, about 40% of the funds were to be focused on prevention, up from about 37% in the previous year. Support for hospitals and dispensaries (infrastructure) and for medical education and training were also major components of the budget. The total budget increased 24% year-to-year, a small start on the government's promise to triple health expenditure as a percent of GDP. Meanwhile GDP continues to grow at rates approaching nine percent.

The data presented in this chapter provide a foundation for understanding the financing of health care in India at present. More importantly given the purposes of this study, they provide the context for appraising the achievements and the limitations of the micro-insurance schemes presented in Chapter Four, and also for estimating the affordability of private health insurance as described in Chapter Three. The chapters that follow will further explore the linkages among income, access to and payment for medical services and availability of various types of health coverage in India.

2 Addendum

GOVERNMENT STANDARDS FOR MALE AND FEMALE STERILIZATION

The standards that are being monitored by the QAC for compliance include:

- The appropriate training of the doctor performing the sterilization (e.g. an MBBS doctor trained to carry out Minilap Tubectomy can perform the minilap tubectomy)
- The empanelment/accreditation of private doctors and health facilities (private doctors and facilities must be accredited and empanelled by the QAC to participate in the program)

Accredited private doctors/health facilities must conform to the clinical and infrastructure standards as listed below.

Table 2.13

Clinical/Personnel Requirements

Female Sterilization	Male Sterilization
1. One MBBS Doctor trained to carry out Minilap Tubectomy or One gynecologist with DGO/MD/MS qualification or One surgeon with MS degree and trained in laparoscopic sterilization 2. One operation theatre staff nurse 3. One operation theatre assistant 4. One anesthetist (hired if necessary)	1. One doctor trained in conventional vasectomy 2. One staff nurse 3. One operation theatre assistant 4. One male worker for counseling and administrative work

Infrastructure requirements

	Female Sterilization	Male sterilization
Facilities	• Well ventilated, fly proof room with concrete/tile floor which can be cleaned thoroughly • Running water supply • Electricity supply	• Well ventilated, fly proof room with concrete/tile floor which can be cleaned thoroughly • Running water supply • Electricity supply
Space required	• Area for reception • Waiting roomk • Counseling area • Laboratory for blood and urine examination • Clinical examination room • Pre-operative preparation room • Hand washing area • Sterilization room • Operation theatre • Recovery room • Adequate toilets • Storage area • Office area	• Area for reception • Waiting room • Counseling area • Laboratory for blood and semen examination • Hand washing facility • Sterilization room • Operation theatre • Recovery room • Adequate toilets

	Female Sterilization	Male sterilization
Examination room requirement	• Examination table • Foot stool • Blood pressure apparatus • Thermometer • Stethoscope • Examination light • Weighing scale • Instrument for pelvic examination	• Examination table • Foot stool • Blood pressure apparatus • Thermometer • Stethoscope
Laboratory	• Heamoglobinomter and accessories • Microscope • Red blood cell and white blood cell pipettes • Neuber counting chamber • Apparatus to estimate albumin and sugar in urine • Reagents	• Microscope • Red blood cell and white blood cell pipettes • Neuber counting chamber • Apparatus to estimate albumin and sugar in urine • Reagents
Sterilization room	• Autoclave • Boiler • Autoclave drums • Cidex solution	• Autoclave • Boiler • Autoclave drums • Cidex solution
Cleaning room	• Hand brushes • Heavy duty gloves • Basins • Detergents • Chlorine solution	• Hand brushes • Heavy duty gloves • Basins • Detergents • Chlorine solution
Operation theatre	• Operating table capable of Trendelenburg's position • Step-up stool • Spot light in operation theatre • Instrument trolley • Mini-laparatomy kit • Laparoscopy kit • Blod pressure instrument • Stethoscope • Syringe with needles • Emergency equipment and drugs • Room heater • IV stand • Waste basket, storage cabinet, buckets, basins for decontamination	• Operating table • Step-up stool • Spot light in operation theatre • Instrument trolley • Conventional vasectomy kit • No-scalpel vasectomy kit • Emergency equipment and drugs • Room heater • Waste basket, storage cabinet, buckets, basins for decontamination
Recovery room	• Patient cot • Blood pressure instrument • Stethoscope • Thermometers	• Patient cot • Blood pressure instrument • Stethoscope • Thermometers
Emergency equipment and supplies	• Stethoscope • Blood pressure instruments • Oral airways • Nasal airways • Suction machine with tubing and two straps • Ambu bag • Face masks and tubing and oxygen nipple • Oxygen cylinder with reducing valve and flow meter • Blanket • Gauge pieces • Kidney tray	• Stethoscope • Blood pressure instruments • Oral airways • Nasal airways • Suction machine with tubing and two straps • Ambu bag • Face masks and tubing and oxygen nipple • Oxygen cylinder with reducing valve and flow meter • Blanket • Gauge pieces • Kidney tray

	Female Sterilization	Male sterilization
	• Torch • Syringes and needles, including butterfly sets, IV cannula • Intravenous infusion sets and fluids • Sterile laparotomy instruments	• Torch • Syringes and needles, including butterfly sets, IV cannula • Intravenous infusion sets and fluids • IV stand •
Emergency drugs	• As specified in the Standards • Adrenaline • Atropine sulphate • Corticosteroids (dexamethasone or hydrocortisone) • Physostigmine • Aminophylline • Diazepam • Pentazocine • Sodium bicarbonate (7.5%) • Calcium chloride • Frusemide • Dopamine • Dextrose 5% in water • Dextrose 5% in normal saline • Glucose 25% • Ringer lactate solution	• As specified in the Standards • Adrenaline • Atropine sulphate • Corticosteroids (dexamethasone or hydrocortisone) • Physostigmine • Aminophylline • Diazepam • Pentazocine • Sodium bicarbonate (7.5%) • Calcium chloride • Frusemide • Dopamine • Dextrose 5% in water • Dextrose 5% in normal saline • Glucose 25% • Ringer lactate solution

3 PRIVATE HEALTH INSURANCE

India's Insurance Market

The development of health insurance in India is a reflection of broader policy changes that are being felt in the Indian economy. Many economic functions that had been restricted to the public sector since independence are now being opened to private sector involvement, including the conversion of previously governmental organizations to private or semi-private entities that theoretically must survive without direct government support. The financial sector is no exception.

As a part of its financial sector reform agenda, the Indian Government liberalized the Indian insurance industry by the enactment of the Insurance Regulatory and Development Authority (IRDA) Act by the Indian Parliament in 1999. This led to the opening up of the sector for participation of private insurance companies. Prior to liberalization, the insurance sector consisted of the government-owned Life Insurance Corporation of India that had a monopoly on life insurance business and the General Insurance Corporation of India and its four non-life subsidiaries namely, National Insurance Co., New India Assurance Co., Oriental Insurance Co. and United India Insurance Co. The new act did not provide for independent health insurance companies and the new market has continued the established practice of selling health insurance products through the existing public and new private insurance companies.

The results of liberalization have been significant. Since 1999, IRDA has licensed 24 new private insurance companies, of which 21 have foreign equity participation. Major global players like Aegon, Fortis, Future Generali, Principal and Dai-ichi have tied-up with Indian partners to set up life insurance operations.

Growth of the Insurance Industry

In 2006-2007, the insurance industry in India registered real growth (measured by first-year premiums) of 94.96 percent, exceeding the growth of 47.94 percent achieved in 2005-2006. The impressive growth has also resulted in greater insurance penetration: insurance penetration, or premium volume, as a ratio of GDP for 2006 was at 4.1 percent for life insurance and 0.6 percent for non-life insurance. The total premium for life and non-life insurance market in India was Rs. 181971.61 crore, or $41.74 billion.[1]

The insurance industry is also witnessing significant changes in the types of products being offered and channels being used by insurance companies to reach underserved segments of population and geographical regions. New insurance products such as weather insurance, group health insurance for the poor, product liability insurance, life insurance with a critical/terminal illness rider and Small & Medium Enterprises (SME) insurance have been introduced. Private insurers are also using banks, microfinance institutions and cooperatives to increase their market share and compete with well-entrenched state-owned insurance companies. This has been caused in part by regulatory mandates to expand insurance into the rural and social sectors that have been underserved by insurance.

[1] IRDA Journal 2006; IRDA Annual Reeport, 2006-2007.

Private Insurance: Capital and Ownership

The Indian Insurance market (March 2006) consisted of 16 Life insurance companies and 15 Non-Life companies. Their ownership and capitalization details are provided in Tables 3.1 and 3.2.

Table 3.1: Paid Up Equity Capital of Life Insurance Companies

Sl. No.	Life Insurance Co.	Ownership Type	Ownership Structure		Equity Capital 2005-2006 in Rs (millions)	Equity Capital 2006-2007 in Rs (millions
			Indian Partner	Foreign Partner		
1	ICICI Prudential Life	Private for Profit	ICICI Bank	Prudential Plc. (U.K.)	11,850	13,123
2	HDFC Standard Life	Private for Profit	HDFC	Standard Life (U.K.)	6,200	8,012
3	Max New York Life	Private for Profit	Max India	New York Life (U.S.A.)	5,574	7,324
4	Bajaj Allianz Life	Private for Profit	Bajaj Auto	Allianz AG (Germany)	1,502	1,503
5	Birla Sun Life	Private for Profit	Aditya Birla Group	Sun Life (Canada)	4,600	6,715
6	Reliance Life	Private for Profit	Reliance(ADA) Group	None	3,310	6,640
7	TATA AIG Life	Private for Profit	Tata Group	AIG (U.S.A.)	4,470	5.470
8	Aviva Life	Private for Profit	Dabur Group	CGU (U.K.)	4,587	7,580
9	ING Vysya Life	Private for Profit	Gujarat Ambuja Cement, Exide Industries	ING (Netherlands)	4,900	6,900
10	SBI Life	Private for Profit	State Bank of India	Cardiff (France)	4,250	5,000
11	Met Life	Private for Profit	J&K Bank	MetLife (U.S.A.)	2,350	5,300
12	Kotak Life	Private for Profit	Kotak Finance	Old Mutual (South Africa)	2,445	3,303
13	Sahara Life	Private for Profit	Sahara Group	None	1,570	1,570
14	Shriram-Sanlam Life	Private for Profit	Shriram Transport Finance	Sanlam (South Africa)	1,250	1,250
15	Bharti Axa Life	Private for Profit	Bharti Enterprises &	AXA (France)	11	1,500
16	Life Insurance Corporation of India	Public for Profit	Government of India	None	50	50

Licensed during 2006-07

Sources: Businessworld, July, 24 2006; Business Standard, June, 20, 2006; Business Standard, August, 18, 2006; IRDA Annual Report 2006-2007.

Table 3.2 Paid Up Equity Capital of General Insurance Companies

Sl. No.	General Insurance Co.	Ownership Type	Ownership Structure		Equity Capital 2005-2006	Equity Capital 2006-2007
			Indian Partner	Foreign Partner	In Rs (millions)	in Rs (millions)
1	ICICI Lombard	Private for Profit	ICICI Bank	Lombard (Canada)	2450	3357
2	HDFC Chubb	Private for Profit	HDFC	Chubb (U.S.A.)	1250	1,250
3	Royal Sundaram Alliance	Private for Profit	Sundaram Finance	Royal Sun Alliance (U.K.)	1400	1400
4	Bajaj Allianz General	Private for Profit	Bajaj Auto	Allianz AG (Germany)	1100	1100
5	Cholamandalam	Private for Profit	Murugappa Group	Mitsui Sumitomo (Japan)	1419	1,419
6	Reliance General	Private for Profit	Reliance (ADA) Group	None	1020	1030
7	TATA AIG General	Private for Profit	Tata	AIG (U.S.A.)	1950	2250
8	IFFCO Tokio	Private for Profit	IFFCO	Tokio Marine (Japan)	2200	2200
9	Star Health & Allied Insurance	Private for Profit	Group of Investors	Oman Insurance	1050	1,050
10	New India Assurance	Public for Profit	Government of India	None	2000	2000
11	National Insurance	Public for Profit	Government of India	None	1000	1,000
12	United India Insurance	Public for Profit	Government of India	None	1000	1,5000
13	Oriental Insurance	Public for Profit	Government of India	None	1000	1,000
14	Agricultural Insurance Co. of India	Public for Profit	Government of India	None	2000	2000
15	Export Credit & Guarantee Corp.	Public for Profit	Government of India	None	7000	8000

Source: Businessworld, July, 24, 2006; Business Standard, June, 20, 2006; IRDA Annual Report 2006-2007.

Development of Private Health Insurance

While the new law establishing the framework for the private insurance industry did not create a separate legal structure within which private health insurance would operate, it anticipated a modern broadly defined health insurance market through the establishment of an independent regulator of companies. In implementing regulations in 2000 for the registration of insurance companies, IRDA defines health insurance as: the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient, on an indemnity, reimbursement, service, prepaid, hospital or other plans, including assured and long term care.

There is some debate whether the regulatory definition of health insurance actually enables either life or non-life companies to write health insurance policies. However, in practice, both do. Since liberalization, most

health insurance policies have been written by non-life insurance companies whereas life-insurers sell health insurance in the form of health riders[2] to their life policies. Of late this line of differentiation has dimmed. Non-life insurers have introduced long-term policies and benefit plans covering critical illnesses and policies that provide cash payments if an insured person is hospitalized with certain illnesses.

Although most insurers are covered under the new insurance Act, Section 118 of the Insurance Act, 1938, exempts the application of the Act to any trade union registered under the Indian Trade Union Act, 1926; or to any provident fund to which the provisions of the Provident Funds Act, 1925, apply; or to any insurance business carried on by the Central Government or a State Government relating to properties belonging to it or undertakings owned wholly or mainly by the State Government; or to properties belonging to any semi-Government bodies; or any board or body corporate established by the State Government under any statute; or any industrial/commercial undertaking in which the State Government has substantial financial interest, whether as shareholder, lender or guarantor. To date, there are twenty-eight exempted entities underwriting insurance, specifically in the area of State Government properties.

The Insurance Act of 1999 required that all companies selling insurance must be for-profit and, as a result, except for exempted organizations, there are no non-for-profit companies that are licensed, with one exception: in the private sector, the CHNHBA Association (formerly known as The Calcutta Hospital & Nursing Home Benefits Association Limited), which has been operating since 1948, was grandfathered into the Act and allowed to keep operating as a mutual insurance company. (See the Addendum to this chapter on Case Studies.)

In addition to insurance companies, businesses are allowed to operate their own health plans without regulation and many small and some large companies do so in spite of tax incentives to do otherwise.[3] Interestingly, some important examples of expanded coverage flow from the exempted, mutual and self-insured companies. (See the Addendum to this chapter on Case Studies.)

The absence of stand-alone, for-profit insurance companies is notable. Many reasons have been given for this, including excessive capital requirements and unfair competition by existing companies that can cross subsidize their heath business. However, recently the Star Health and Allied Insurance Co. became the country's first stand-alone health insurance company when it launched its operations in May, 2006. The Chennai-based health insurer was financed largely by a consortium of Indian promoters with a 10 per cent equity stake held by the Dubai-based Oman Insurance Company. In the absence of a provision in the Insurance Act, 1938, for registration of stand-alone health or any specialized insurer, the company has sought a non-life license and undertaken to write only three lines of business, i.e., health, accident and travel insurance, to be marketed on an individual and group basis.

Growth of Health Insurance

Health insurance has experienced dramatic growth over the past two decades. The number of persons covered has increased annually by over 25 per cent from 1991-92 to 2005-06. The premiums have increased annually by 35 per cent during the same period. While this growth is impressive, the base was exceedingly small and the industry still insures only a small portion of the Indian population.

During 2005-06 the non-life health insurance companies collected premiums of Rs 22.6 billion and covered an estimated 17 million persons. During the same period, life insurance companies covered around 66,000 lives under health riders and generated Rs 94 million as health insurance premium. This was a substantial change (at least in premium) since the premium collected by life companies from health riders increased from Rs 76 million in 2004-05 to Rs 94 million in 2005-06, an increase of nearly 30 per cent. However, the number of new lives covered under health riders during the same period decreased from 126,000 to around 66,000. Given the increasing cost and declining number of lives covered by riders, it is clear that they are not

[2] Health Riders—All riders related to Critical Illness benefit, Hospitalization benefit and Medical Treatment.
[3] Subject to ceilings on amount, premiums are deductible from gross income in determining taxable income.

Table 3.3. Health Insurance Coverage by Life Insurance Companies

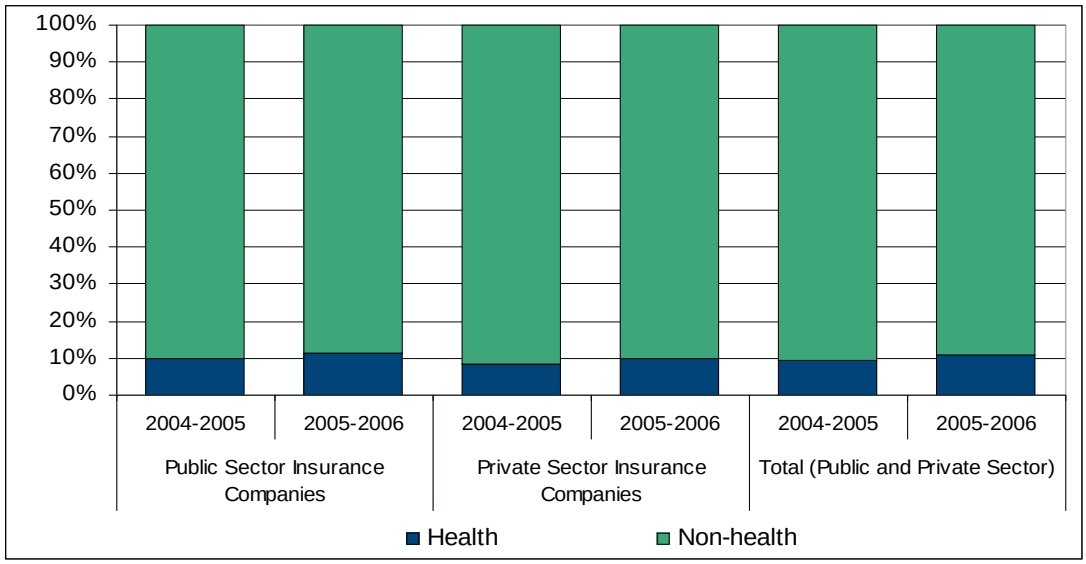
	Premium (Rs Mlns)		No of Policies		Lives Covered	
	2004-05	2005-06	2004-05	2005-06	2004-05	2005-06
Individual New Business (including Rural & Social)	62.39	88.74	86,544	47,006	86,544	47,006
Group New Business (including Rural & Social)	7.87	5.24	76	32	39,674	19,724
Total Individual & Group New Business (including Rural & Social)	70.26	93.98	86,620	47,038	126,218	66,730
Number of lives covered under Individual New Business is assumed to be the same as the number of polices sold.						

Source: IRDA Journal, *August 2006, with analysis.*

currently popular among the insuring public. Table 3.3 provides information about health insurance coverage by life insurance companies.

Despite the impressive growth of health insurance, it remains a small percentage of the overall insurance business of non-life insurers and an insignificant proportion of the life insurers. Figure 3.1 depicts the relative growth of health insurance among non-life insurance companies.

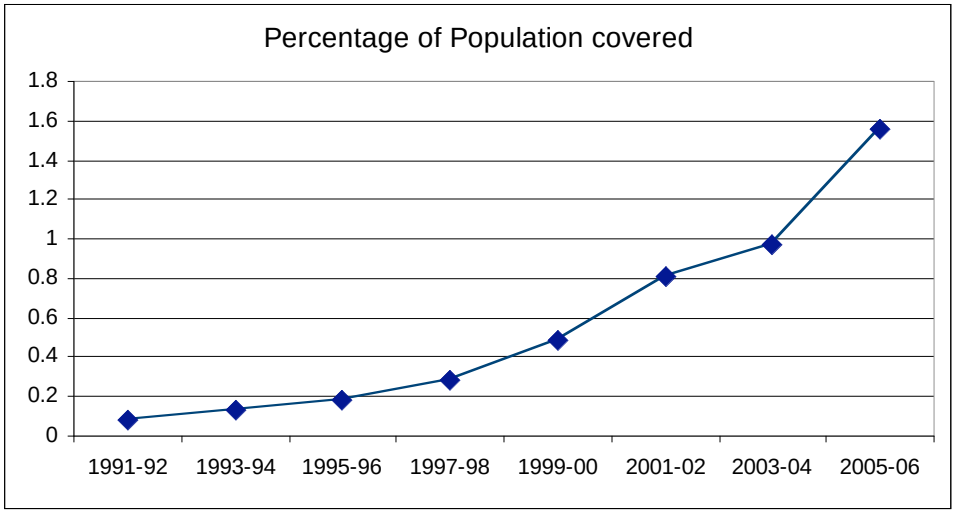
Figure 3.1: Health Insurance as a Percentage of Total Business of Non-life Insurers



Source: IRDA Journal, August 2006, with analysis

Figure 3.2 depicts penetration of private health insurance in the country. Although the number of persons covered has grown from 0.69 million in 1991-92 to 3.5 million in 1998-99 and around 17 million in 2005-06, it is still a very small percentage of the population, only 1.56 per cent in 2005-06.

Figure 3.2: Private Health Insurance Penetration 1991-92 through 2005-06



Source: Statistical Outline of India (,www.statistics of India.cim), IRDA data and our analysis

These numbers do not include persons covered under health insurance schemes in the unorganized sector, namely NGO's operating their own health insurance schemes, health coverage provided by central and state governments to their employees and cancer insurance schemes run by some cancer hospitals, self-insured employers, etc. There is also an indeterminate though small number of persons who purchase health insurance from international insurers such as BUPA (British Underwriters Provident Association), International Health Insurance (IHI) Denmark and others. Purchases of health insurance from international health insurers by high net worth individuals has been supported by the Reserve Bank of India by allowing remittance[4] of premiums for buying this kind of health insurance.

Government versus Privately Owned Companies

Prior to the passage of the 1999 IRDA Act, all insurance was sold in India through government-owned insurance companies. While private insurance has grown, government companies still write the great majority of business, particularly for the individual market. Table 3.4 provides a breakdown of health premium between government-owned and private non-life insurers. The health insurance market share of government owned insurers declined from 98 per cent in 2001-02 to 76 percent in 2005-06. Conversely, the health insurance market share of private non-life insurers increased twelve fold from two per cent to 24 per cent during the same period.

The relationship between group business and individually purchased insurance has remained relatively stable. Table 3.5 provides information on health insurance premium break-up between individual and group segments. Government companies tend to write more individual and private companies more group business.

[4] Reserve Bank of India through its Circular No. 20 dated 25th October 2004, Foreign Exchange Management Act (FEMA), 1999 relaxed foreign exchange remittance for health nsurance. Quoting relevant section 2 (i) of the Circular – "In terms of item 10 of Schedule II, payment for secur ng insurance for health from a company abroad requires the approval of M nistry of Finance (Insurance Division). It has since been decided that Government's approval would not be required and Authorised Dealers may freely allow such remittances."

Table 3.4. Break-Down of Health Premium between Government-owned and Private Non-Life Insurers

Name of Non-Life Insurance Company	2001-02 (Rs Mn)	Market Share	2002-03 (Rs Mn)	Market Share	2003-04 (Rs Mn)	Market Share	2004-05 (Rs Mn)	Market Share	2005-06 (Rs Mn)	Market Share
New India	2,759	36	3,544	34	3,662	30	4,797	29	6,693	30
National	1,761	23	2,253	22	2,980	24	3,186	19	3,304	15
United India	1,526	20	2,111	20	2,342	19	2,939	18	3,593	16
Oriental	1,507	19	2,041	20	2,295	19	2,735	16	3,599	16
Total Govt.	7,553	98	9,949	95	11,279	92	13,657	82	17,189	76
Tata AIG	-	-	-	-	-	-	264	2	306	1
Royal Sundaram	42	1	96	1	161	1	297	2	499	2
ICICI Lombard	-	-	134	1	333	3	1,188	7	2,745	12
Iffco Tokio	19	0	77	1	134	1	283	2	520	2
Bajaj Allianz	123	2	120	1	227	2	706	4	976	4
Reliance	3	0	51	0	74	1	80	0	86	0
Cholamand-sda	-	-	11	0	91	1	201	1	211	1
HDFC Chubb	-	-	-	-	-	-	20	0	46	0
Total Private	187	2	489	5	1,019	8	3,038	18	5,388	24
Grand Total	7,740	100	10,438	100	12,298	100	16,695	100	22,576	100

Source: *IRDA with analysis*

Private Health Insurance Today

Given its relative infancy, private health insurance has certainly progressed over the past 20 years, although there is much to do if it is to cover the current and future needs of a large number of individuals and families. To discover where it can or should develop it is first important to consider where it stands today. In what areas should the industry improve its capability, including the details of its offerings, its operations and its administration? Specifically, this means looking at what products are on the market, how and to whom they are marketed, how the industry relates to its customers and to the delivery system and its administrative capabilities.

Virtually all health insurance products in the Indian insurance market are designed to meet the hospitalization expenses of the policyholder. This has not changed significantly since the introduction of health insurance in 1986. Health insurance policies do not cover dental services, vision services, preventive care, home health services or long-term care and, rarely, out-patient services. In many cases policies exclude certain kinds of care, even if a hospitalization occurs.

In addition to basic hospitalization, the health insurance market has witnessed the introduction of hospital cash (cash payments to the individual if they are hospitalized) and critical illness products, which cover a list of designated diseases. Additionally, some newly developed surgical procedures which do not require hospitalization, such as lithotripsy and laparoscopy, are now accepted by insurers for reimbursements under the hospitalization policies.

Table 3.5. Individual and Group Insurance Coverage by Government and Private Companies 2002-03 and 2003-04

	2002-03				2003-04			
	Lives Covered (In Mn)	% of Total	Premium (Rs Mn)	% of Total	Lives Covered (In Mn)	% of Total	Premium (Rs Mn)	% of Total
Government Companies								
Individual	5.0	53	6,769	65	5.9	57	7,353	60
Group	3.6	38	3,180	30	3.8	37	3,927	32
Total	8.6	91	9,949	95	9.7	94	11,280	92
Private Companies								
Individual	0.7	7	89	1	0.1	1	205	2
Group	0.2	2	349	3	0.5	5	739	6
Total	0.9	9	489	4	0.6	6	1019	8
Combined Totals								
Individual	5.7	60	6,858	66	6.1	59	7,558	61
Group	3.8	40	3,529	34	4.3	41	4,666	38
Grand Total	9.5	100	10,438	100	10.3	100	12,298	100

Source: *IRDA with analysis*

While there are two basic types of policies there are several variations, for example policies directed at women or the elderly, or coverage for diabetes or cancer. These tend to be the exception rather than the rule and most are for the general population.

Hospitalization Policies

These policies are offered only by non-life insurers and are based on a product called Mediclaim, which reimburses for hospitalization expenses. This policy, first offered by Government-owned non-life insurance companies, has been marketed since 1986. Privately owned companies have also adopted it. Since its inception it has undergone changes in both premium charges and benefit design and has remained focused (with the exceptions mentioned above) on coverage for hospitalization.

In its present form, as shown in Box 3.1, Mediclaim covers expenses incurred by a policyholder during hospitalization and/or domiciliary hospitalization[5] due to illness, diseases or injury. It is available to persons between the ages of 5 and 80 years (maximum age of coverage can be increased to 85 years if the policy has been renewed without any break in coverage). Children between the age of 3 months and 5 years of age can be covered if one of the parents is also covered.

The benefit limit varies from Rs 15,000 to Rs 500,000 per annum, while the premium reflects a calculation based upon the benefit amount and the age of the person. These policies can be written for groups or individuals and can cover individuals or families under a single benefit amount (often called "a family floater"). Mediclaim requires new enrollees above 45 years of age to undergo a pre-acceptance medical check-up and has stringent pre-existing condition/disease exclusions. It excludes expenses on hospitalization for certain diseases during the first year.

[5] Domiciliary Hospitalization Benefit: A built in benefit under a Mediclaim policy, it covers those situations, which in normal course would require care and treatment at a hospital or nurs ng home but actually taken whilst confined at home under the following c rcumstances, a) the condition of the patient is such that he/she cannot be removed to the hospital/nursing home, or b) The patient cannot be removed to hospital/nurs ng home for lack of accommodation.

Mediclaim requires new enrollees above 45 years of age to undergo a pre-acceptance medical check-up and has stringent pre-existing condition/disease exclusions. It excludes expenses on hospitalization for certain diseases during the first year. To encourage health insurance, the government has allowed a deduction from taxable income for premiums up to Rs 15,000and for senior citizens up to Rs 20,000.[6] After the introduction of Third Party Administrators (TPAs) in 2002, the policy was changed to a "cashless hospitalization benefit" with payments made directly to providers. (TPAs are discussed at length in a later section of this chapter.) Prior to the coming of TPA's it was the responsibility of patients claiming reimbursement to submit bills directly to their insurer for payment. Cashless hospitalization allowed the TPA to prospectively guarantee payment to the hospital and thus remove the burden of filing claims from the patient.

Box 3.1: Mediclaim Policy – Scope and Coverage

Mediclaim Policy, offered by the Government-owned non-life insurance companies, has been marketed since 1986. It is a hospitalization expenses reimbursement policy. Since its inception, it has undergone both premium rate and benefit design changes.

In its present form, it covers expenses incurred by a policyholder during hospitalization and/or domiciliary hospitalization[7] due to illness, diseases or injury. Hospitalization Expenses covered include:

- Room and boarding expenses incurred at a hospital/nursing home
- Nursing expenses
- Surgeon, Anaesthetist, Medical Practioner, Consultants, Specialists Fees
- Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-Ray
- Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial limbs and Cost of Organs and similar expenses

Hospitalization benefit also allows relevant medical expenses incurred during period up to 30 days prior to hospitalization and 60 days post hospitalization.

Exclusions include:

- Pre-existing condition/disease
- Any disease/illness contracted within first 30 days of the commencement of the policy
- During first year the expenses on treatment for certain diseases
- Preventive treatment, e.g. vaccination
- Plastic surgery, cost of spectacles, contact lenses, hearing aids
- Dental treatment
- AIDS
- Maternity
- Naturopathy

Mediclaim is available to persons between the age of 5 years and 80 years (maximum age of coverage can be increased to 85 years if the policy has been continuing without any break). Children between the age of 3 months and 5 years of age can be covered provided one of the parents is covered simultaneously.

The sum insured/benefit limit varies from Rs 15,000 to Rs 500,000, while the premium is calculated from a matrix of sum insured and age of the person.

Mediclaim requires new enrollees above 45 years of age to undergo a pre-acceptance medical check-up. It excludes expenses on hospitalization for certain diseases during the first year. Additionally, it has stringent and often indeterminate pre-existing condition/disease exclusions.

Policy also provides for Family Discount, Cumulative Bonus and Cost of Health Check-up

To encourage health insurance, the Government has allowed Income Tax benefit up to Rs 10,000 paid as premium. However, for senior citizens, the Income Tax benefit is higher at Rs 15,000 paid as premium. The policy now offers cashless hospitalization benefit after the introduction of Third Party Administrators (TPAs) in 2002.

[6] These amounts are the latest allowances as per the 2007-2008 national government budget.

Mediclaim was originally designed to be more sophisticated with the use of individual benefit limits and deductibles and included direct payment to providers. However, it has been modified to be much more of an indemnity policy with a single benefit limit even though the cashless hospitalization feature has been recently reintroduced. The present Mediclaim policy is described in Box 3.1 above.

In addition to the standard Mediclaim policy a few insurers have introduced new and expanded approaches to coverage. Cholamandalam General Insurance Co. is offering a new hospitalization expenses policy developed with assistance from Munich Re, the international reinsurance company. The policy provides a maximum benefit limit of Rs one million and covers pre-existing conditions after four years of continuous coverage. An important feature of the Cholamandalam policy is that it introduces claims costs control measures such as co-insurance for non-network hospitals, and links the type of room/bed paid for to the purchased amount of coverage. Expenses for over 100 minor same day surgeries not requiring hospitalization, ambulance and daily hospital allowance are paid. This policy has not yet been widely purchased by consumers since they view it as complicated in design and more expensive than the cost of Mediclaim policies. Importantly, it may reflect the Indian public's inexperience in choosing the best value for themselves in insurance.

New India Assurance Company has also introduced a second-generation health insurance policy called Health Plus Medical Expenses Policy. The policy covers pre-existing conditions after four continuous renewals, allows Ayurvedic treatment expenses, (per illness restricted to 20% of Sum Insured or Rs 25000/- whichever is less) covers day care surgical procedures, and allows extension of the policy benefits for treatment abroad.

Finally, Bajaj Allianz recently introduced its Silver Health policy, primarily aimed at senior citizens. It is a unique but high cost product since it covers individuals between the ages of 46 and 75 years. With insurers putting restrictions on entry age for their health plans, this is the only plan specifically designed for older persons. (See Box 3.2 for Policy and Table 3.6 for Premium details.)

Table 3.6. Bajaj Allianz's Silver Health Premium Rates

Sum Insured	Annual Premium AGE (In Years)					
	46-50	51-55	56-60	61-65	66-70	71-75
Rs 50,000	Rs 1,995	Rs 2,495	Rs 3,824	Rs 4,780	Rs 7,170	Rs 8,963
Rs 100,000	Rs 2,993	Rs 3,742	Rs 5,736	Rs 7,170	Rs 10,755	Rs 13,444
Rs 150,000	Rs 3,741	Rs 4,677	Rs 7,170	Rs 8,963	Rs 13,444	Rs 16,805
Rs 200,000	Rs 4,676	Rs 5,846	Rs 8,963	Rs 11,203	Rs 16,805	Rs 21,006
Rs 300,000	Rs 5,845	Rs 7,308				
Service Tax as applicable						

Socially-oriented hospitalization expenses policies. These policies, mainly promoted by the government owned insurers, cover hospitalization expenses with lower benefit limits and affordable premiums for economically weaker and rural segments of the populations. Coverage for these populations is explored at length in Chapter Four.

Critical Illness Policies

Critical illness (CI) policies were the second type of product offered in India. Originally, these policies were sold exclusively by life insurance companies as riders to their basic products. Recently, non-life companies have started marketing them as a separate product. As indicated above, today they are not as popular as the Mediclaim products and cover only specified illnesses of a potentially catastrophic nature, such as heart attacks, cancer, brain tumors, etc. As shown in Table 3.7, these policies do not cover all catastrophic care but only those illnesses defined by each insurance company. The variation in coverage is likely to lead to

Box 3.2: Bajaj Allianz's Silver Health – Individual Health Insurance for Senior Citizens

Coverage:

- The policy covers hospitalization expenses and an amount equivalent to 3 per cent of admissible hospitalization expenses in respect of any and all pre and post hospitalization expenses
- Covers ambulance charges in an emergency subject to a limit of Rs 1,000.
- Pre-existing illnesses are covered from the second year of the policy
- The Company's liability in case of pre-existing illness from the second year of the policy is restricted to 50 per cent of the limit indemnity in a policy year.
- The policy has a lifetime indemnity limit of three times the limit of indemnity specified in the earliest senior citizen plan, if the policy is renewed continuously.

Eligibility:

- Age from 46 years to 75 years
- Age at entry restricted to 70 years
- Pre-acceptance tests at the costs of the applicant. However, the costs of the medical tests are reimbursable if the application is accepted by the company.

Benefits:

- Cashless treatment at network hospitals
- Option for members to seek treatment in out of network hospitals. In such case, admissible medical expenses incurred would be reimbursed to the member within 14 working days
- 20 per cent co-payment of the admissible claim would be applicable in case of treatment taken at out of network hospitals
- Cumulative bonus of 5 per cent of limit of indemnity for every claim-free year
- Health Check-up at the end of continuous four claim-free years
- Family discount of 5 per cent on premium
- Income Tax benefit on the premium paid as per section 80D of the Income Tax Act

Exclusions:

- All diseases/injuries existing at the time of application
- Any disease contracted during first 30 days of commencement of policy
- Diseases like hernia, piles, cataract, benign Prostatic hypertrophy to have a 1 year waiting period
- Non allopathic medicine
- All expenses arising out of AIDS or related disorders
- Cosmetic, aesthetic or related treatment
- Use of intoxicating drugs or alcohol
- Joint replacement surgery (except arising out of an accident) has waiting period of 4 years
- Treatment of mental illness, or psychiatric treatment

confusion among policyholders but the industry has shown little interest in adopting standard definitions so that policyholder confidence and interests are not compromised.

These policies are generally a poor substitute for the more comprehensive Mediclaim health insurance policy since they do not cover hospitalization expenses due to accidents, infectious diseases or acute illnesses and are felt by some to be a marketing gimmick for selling to uninformed, unsophisticated semi-urban or rural policyholders. In many countries these policies would not be considered particularly effective health insurance since they do not pay for medical services but merely pay a set amount of money if policy holders can document that they have a particular disease. It is reported that critical illness coverage has met with a cautious response from policy holders, though some life insurers claim that almost 65 per cent of their policyholders have opted for critical illness riders.[8]

[8] Interviews with nsurance executives.

Table 3.7. Critical Illnesses Covered by Non-Life Insurers

Royal Sundaram Alliance	Bajaj Allianz	Iffco Tokio	National	Tata AIG	ICICI Lombard
Cancer	Cancer	Cancer	Cancer	Cancer (except Cancer of skin	Cancer
Stroke	Stroke	Paralytic Stroke	Stroke	Stroke	Stroke
Major Organ Transplant	Major Organ Transplant	Major Organ Transplant	Major organ transplants like kidney, lung, pancreas or bone marrow	Major Organ Transplant	Major Organ Transplant
Total Renal Failure	Kidney Failure (End-stage renal disease)	Renal Failure	Renal Failure i.e. Failure of both Kidneys	Kidney Failure	Kidney Failure
Coronary Artery Bypass Surgery (CABG)	Coronary Artery Disease Requiring Surgery	Coronary Artery Disease	Coronary Artery Surgery		Coronary Artery Bypass Surgery (CABG)
Multiple Sclerosis	Multiple Sclerosis		Multiple Sclerosis	Multiple Sclerosis	Multiple Sclerosis
Heart Attack (Acute Myocardial Infarction)	First Heart Attack (Myocardial Infarction)			First Heart Attack	Myocardial Infarction
Major Burns				Major Burns	
Heart Valve Replacement Surgery					Heart Valve Replacement Surgery
	Primary Pulmonary Arterial Hypertension				
	Paralysis			Total Blindness	Paralysis
	Surgery of Aorta	Injuries		Coma	
9	**10**	**6**	**6**	**9**	**9**

Source: *Interviews with insurance executives*

Recently, recognizing the need for and hence market opportunity in health insurance, life insurers like Tata AIG and ICICI Prudential have introduced stand-alone health and critical illness products.

Tata AIG was the first life insurer to offer what it considered a comprehensive policy ("Health First") that included five benefits, namely –

- Critical illness benefit: covering 12 critical illnesses
- Surgical benefit
- Hospitalization allowance or hospital cash
- Post hospitalization benefit
- Term life insurance

This policy, first introduced in 2004 was an attempt to develop comprehensive health coverage with guaranteed premium for five years at a time. However, the product so far is not popular among buyers of health insurance due to its complexity and expense.

A second life insurer, ICICI Prudential, is also attempting to make a dent in the health insurance market. It has introduced critical illness products called Health Assure Plus covering six critical illnesses and a wider cancer care policy covering most types of cancer.

Hospital Cash and Dread Disease Policies

Some insurers have recently introduced what are called Hospital Cash Policies. These policies, which are in fact supplemental income insurance, provide for a daily allowance during the days of hospitalization. Their purpose is to help policyholders to meet-out-of pocket expenses that are not covered under a hospitalization policy. These policies may facilitate access to care in extremely poor populations where the costs of transportation to a hospital and the resulting loss of income would otherwise be prohibitive. Hospital cash plans operate like critical illness policies; all that is necessary to claim payment is proof of hospitalization (in the form of hospital admission and discharge summary or similar hospital documents) which become the basis of claims settlement. Many of these policies are part of an emerging trend of providing integrated health insurance products that include elements of critical illness and hospital cash/allowance benefits. ICICI Lombard and Cholamandalam are pioneers in this approach. To date they have not been popular with the general public since the per diem amounts that they pay are small but as indicated above they may be very important for low income populations.

Several companies are also offering dread disease policies which protect against the risk of contracting a particularly serious illness such as cancer or diabetes. While in many countries these kinds of policies are not considered an important part of health insurance coverage since they are not linked to delivery of comprehensive medical services, in India they are accepted and regulated as such. An interesting example of the kind of dread disease policy being introduced into the market is one designed by ICICI Prudential to meet expenses arising out of complications from diabetes mellitus type II. Key benefits of ICICI Prudential's Diabetes Care policy are listed in Table 3.8.

Table 3.8. ICICI Prudential's Diabetes Care Policy

Key Benefits of Diabetes Care
Lump-sum payment on diagnosis of any one of **six critical illnesses**: Heart Attack, CABG, Cancer, Stroke, Kidney Failure and major Organ Transplant
Diabetes Enhanced Benefit Rider: **Optional cover** for eye & foot complications (Laser Treatment and Limb Amputation).
Wellness program: 3 Free check-ups and a consultation with a doctor every year.
Reduced Premium: on display of good control.
Tie-ups with leading healthcare partners for diabetes management.
Web support for better diabetes control.
Tax benefit under Section 80D of the Income Tax Act.

Employer-Based Group Policies

In theory everyone in India uses the basic Mediclaim policy. However, as in many other countries, group insurance is more flexible and many variations of benefits and coverage are found. Most employers in the formal sector who provide health coverage purchase insurance rather than self-insuring. Both self-insured and insured companies can deduct the costs of medical expenses and premiums as legitimate business expenses but there are different tax implications to employees depending upon whether their plan is insured or not. Employees of self-insured plans must use Income Tax Department approved providers or have the costs of care treated as income and therefore taxable. Also, the costs of maternity care are not considered to be an allowable medical expense for employees of self-insured companies. Insured employees face neither of these restrictions. The newer, privately owned insurance companies have been most successful in the group market (as shown above in Table 3.5) and are directing much of their marketing effort in this area. This is also where

international influences are directly felt through the influx of outside investment into India. While international companies usually have to follow the practices of the countries in which they are working, their programs are often very generous and for competitive or other reasons tend to provide the most extensive benefits. Two examples are instructive. One multi-national company interviewed not only provides coverage for the worker but also for up to five other family members through an overall annual family benefit level (the family floater). This floater can include spouses, children, parents and in-laws. There is no waiting period for complete coverage and children are covered from birth (most policies in India cover children from three months of age). Although the insurance plan only covers in-patient hospitalization with the normal exclusions, the employer provides a tax-free amount to each eligible employee to pay for outpatient services such as non-hospital physician fees, pharmaceuticals, etc. Similarly, it also provides funds for dental services and an annual "healthy check" package. Dentists and physicians periodically visit the company to provide free-of-charge minor medical and dental services to the employee. While an insurance company underwrites the hospitalization package and its TPA reimburses hospitals directly, the employee must save bills for outpatient services and submit them to the TPA to be reimbursed by the company.

A second company also has a family floater covering up to four people including the employee and also provides a broad annual outpatient benefit to its employees and their families. However, the extent of coverage for hospitalization and outpatient care varies directly with the employee grade. The company reported it was planning to institute an employee-contributed medical savings plan to enable employees to cover even more expenses with non-taxable income[9]. In addition, employees who have larger families are permitted to purchase insurance provide coverage for the additional members under the company's group policy.

To the extent that competition for employees between multinational and Indian companies becomes more intense, particularly for highly skilled and professional people, additional companies may be forced to provide more generous health plans in order to retain or recruit desired employees.

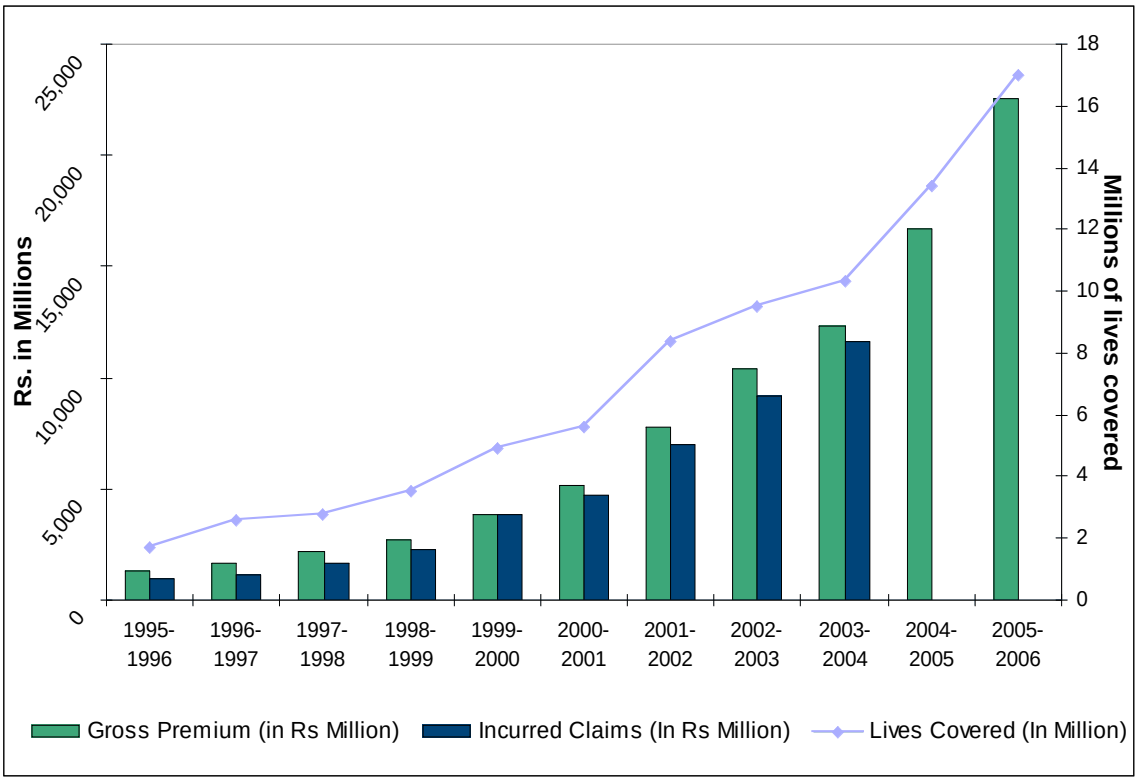
Premiums and Pricing

In India the Tariff Advisory Committee (TAC), which is a statutory body under the Insurance Act, has been responsible for administered prices or tariffs in the non-life insurance market.[10] Insurers are statutorily required to adhere to the established rates. . Breach of tariff is an offence and attracts punitive action from the TAC. Differences in prices charged to customers by insurers are related to administrative costs, brokerage fees, profits, etc. Most of the classes of business in general insurance (marine, fire, engineering and motor) are governed by a tariff, which is laid down by TAC. Certain segments which are defined as the miscellaneous class of insurance like health, livestock etc., are not tariffed. However, they have been placed under 'market agreements' by the government owned insurers to standardize premium rates, coverages, terms and conditions, all with a view to prevent sister insurers competing against each other over price. Over the years these agreements were less and less enforced and today they have been dissolved. Many in and outside of the insurance industry have claimed that continued tariff-based pricing of non-life insurance products has resulted in unprofitable underwriting, cross-subsidization across different lines of business and distortions in the market. The basis of their argument is that insurance companies offer miscellaneous class products to purchasers of insurance at prices below cost to compensate for historically overpriced tariffed insurance. An illustration of this argument can be seen in Figure 3.3 depicting the performance of health insurance since 1995. Note that the claims ratios (medical loss ratios) for both individual and group segments have been generally increasing over the years. Since the ratios depicted here are only medical loss ratios and do not include insurers' costs for distribution and management, which are an additional load of nearly 25-30 per

[9] The employee is able to cla m from the company expenses up to the amount allowed. Under the employee contr bution to the medical sav ngs account would also not be included in taxable ncome.

[10] A tar ff is def ned as a pre-determined "rack" rate for a risk, which cannot be mod fied. It has the effect of creating a "floor" to the price of a given risk based on the "provider" costs.

Figure 3.3: Performance of Health Insurance 1995-96 to 2004-05[11]



Source: IRDA and GIPSA[12]

cent, it is argued that the companies are obviously under pricing their health products and absorbing large losses. (Claims information for years 2004-05 and 2005-06 is not available.)

The declining profitability in the industry's most recent experience cannot be challenged, but its cause is not clear. The problem could be the result of the inefficiency and ineffectiveness of the industry itself in managing costs. In a study published by United Health Care, the total cost of Mediclaim by its various cost components is Risk Premium (58 per cent), Broking Commission (18 per cent), Management Expenses (18 per cent) and Administration Expenses (6 per cent).[13] Based on international experience for commercial insurers which usually have the lowest payout for actual claims, a 58% medical cost ratio for hospitalization expense is very low, raising the possibilities of bloated bureaucratic costs and/or lack of effective development of quality health products. While the data can support either the cross-subsidization or poor management views, it is clear that the industry is not doing very well in recovering the costs of its health products through premiums.

There are some underlying factors that may help to explain the lack of a business response to rectify the situation. Historically, the non-life Indian insurance industry has not had actuarial capacity for pricing or analyzing the underlying causes of health services cost and utilization increases. Instead it has used so-called intuitive pricing. Also, when the Mediclaim policy was introduced in the mid-1980s it was the first health insurance product available to individuals and households and premium affordability to the insuring public was one of the key premium rate-setting considerations. While the basic risk factors have been upgraded periodically they have not kept pace with medical inflation. From an analysis of its claims data, United Healthcare India

[11] This includes both group and individual insurance.

[12] GIPSA—General Insurance Public Sector Association—An association of the four government-owned non-l fe insurance companies, namely National Insurance, New India Assurance, Oriental Insurance and United India Insurance.

[13] United Healthcare India (Pvt.) Ltd – published in *FORTE*, September 2004.

estimates that annual medical cost inflation in India between 1996 and 2002 was in the range of 18-22 per cent. The corresponding increase in Mediclaim rates during this period ranged between five and 30 per cent for selected age categories and did not approach the increase in medical inflation. With the higher annual rate of medical inflation, increasing claims frequency (presently approximately seven per cent), and escalating claim severity (average claim size rose from Rs 8,500 in 1995 to Rs 30,000 in 2002), United Health Care judged that Mediclaim premium increases were not adequate to keep up with medical costs.[14]

Differential Pricing

Amounts paid for insurance can vary significantly. In the group business it is a matter of negotiation between the purchaser and the insurance company. For example, as is widely reported, tariff prices of non-health insurance have been set too high and companies can negotiate discounts below the cost of the insurance on health products when they purchase all their coverage from one insurer, as is customary. There are also significant differences in the individual purchase market as illustrated in Table 3.9, comparing health insurance premium rates for the hospitalization products among non-life insurers by age. The premium rate per annum for a benefit limit of Rs 100,000 ranges from approximately one per cent of the insured amount for 20-year-olds to seven per cent of the insured amount for an 80-year-old person. With the exception of Reliance General Insurance Co, private companies offer better rates for ages less than 50 years whereas government owned insurers (except Oriental Insurance) and Reliance are more competitive at ages 50 years and greater. Health insurance rates of Oriental Insurance Co. are higher than other insurers because of their decision in September 2006 to unilaterally increase prices.

Table 3.9. Health Insurance Premium Rate Comparisons of Non-Life Insurers

Age/Insurance Company	Star Health	Bajaj Allianz	IFFCO Tokio	Govt. Owned	Reliance	Royal Sundaram	Oriental
20 Years	1,200	1,254	1,098	1,310	1,310	985	1,179
30 Years	1,200	1,453	1,195	1,310	1,310	1,692	1,310
40 Years	1,350	1,453	1,441	1,425	1,425	1,692	1,566
50 Years	2,447	2,793	2,116	2,039	2,039	2,275	2,447
60 Years	3,000	-	2,783	2,322	2,322	3,277	3,483
70 Years	4,547	-	3,396	2,598	2,598	4,719	5,196
80 Years	6,029	-	-	3,445	3,445	-	6,960
Premiums indicated are in Rs and are for a benefit limit of Rs 100,000							

Source: Indian Express, *"60-plus, don't come to us!" September, 2006*

Medical and Other Underwriting Practices

Premiums for health insurance in India are determined only by two factors: the age of the insured and the amount of insurance chosen. Unlike life insurance, there is no differential rating between sexes in India. Under most health insurance policies, entry age for coverage ranges from 3 years to 55 years, although some insurers cover a new-born child provided that the parents are simultaneously covered. Coverage is extended to 85 years if it is continuous and the claims ratio is deemed acceptable by the insurance company (in effect negating any guaranteed renewability of policies for those over 85). Faced with continuing adverse claims ratios, government insurers are taking steps to minimize their losses. The Oriental Insurance Company has taken the lead by withdrawing commissions to agents and brokers for policies sold to persons above 55 years of age. Further, it has more than doubled the premium for Mediclaim policies for elderly people, while having a lower increment for younger groups and reducing premium for those aged below 20. Other insurance firms are expected to follow suit. Oriental has increased its coverage age limit to 90 years.[15]

[14] Parekh, N mish. "The Progress of Health Insurance n India". *FORTE Journal*. September 2004.
[15] *Times of India*. "Elderly to pay more for health cover", August 31,2006.

Coverage can be purchased in amounts from Rs 15,000 to Rs one million annually. Believing that they are facing adverse selection because people with existing conditions are purchasing insurance at lower limits, insurers are increasing the minimum sum insured from Rs 15,000 to Rs 50,000. In an attempt to demonstrate this, one insurer interviewed provided the following example of the experience it has had with people using the total benefit available in a given year. He indicated that the smaller benefit-limit policies are used to make claims for pre-existing conditions, for example hernias, piles and cataracts. While there could be other explanations for the information summarized in Table 3.10, such as a poorer population using a large number of services to meet unmet need, the insurer is convinced his analysis is correct.

Table 3.10. Percentage of Insured Making Claims per Year

Benefit Limit/Year	1st Year	2nd Year	3rd Year	4th Year onward
Up to Rs 50,000	33%	20%	15%	32%
Rs 50,000 to Rs 100,000	20%	15%	12%	53%
Rs 100,000 & Above	13%	10%	10%	67%

Source: *A government-owned non-life insurance company*

In addition, to contain adverse selection in the individual health insurance market, especially by the 40 years plus group, insurers have started pre-enrolment health examinations for new enrollees who are 45 years and older. The cost of the pre-enrolment health examination is borne by the customer, unlike a life insurance policy where such cost is borne by the insurer.

Subsidization and Age Band Rating of Insurance Policies

As shown in Table 3.9 above, polices in India are age-rated in increments of ten years. This has the advantage of making insurance less expensive to younger people who infrequently utilize high cost hospitalization services but it makes insurance more expensive as people age, losing the average costing benefit of insurance pools that mix the premium of the healthy young with the more expensive older population. While there is no right or wrong in either approach (except as defined by rule or policy makers), in health insurance the more age bands are used in health insurance the more expensive it becomes when it is most likely to be needed.

Since the existing private insurance market is made up almost exclusively of for-profit organizations, planned subsidies for particular groups of policyholders, such as the lower income insured, do not exist. However, by regulation companies are required to have a certain percentage of their total insurance business in poverty areas. Although most of their business to meet this requirement is in accident or life some is in health care and it is generally assumed that companies in fact do end up subsidizing that portion of their business.

National versus Regional Rating

In India pricing of health policies by insurance companies is always based upon a national rate. While there is no law prohibiting geographic rating it has not been tried by any of the companies. However, healthcare costs vary widely based on the level of facility and location. Healthcare expenses in the metro towns are higher than non-metro towns. Among the metros, Mumbai is most expensive followed by Delhi, Bangalore, Chennai, Hyderabad and Kolkata. This price variation has resulted in non-metros subsidizing health insurance claims of metro towns and is likely to make the purchase of insurance less attractive in non-metro areas and may be one contributing factor to the concentration of insurance coverage in metro areas. According to Nayan Shah, Director, Paramount Healthcare, a leading TPA, the average claim amount at about Rs 23,000 is the highest in Mumbai, Bangalore and Delhi, followed by Rs 16,000 in Kolkata and Rs 10,000-12,000 in rural areas.[16]

There have been suggestions in the industry to introduce regional pricing, but no one had attempted to do so until recently. Star Health and Allied Insurance Co. prudent wrote to IRDA seeking permission to charge 20 per cent more in Northern and Western markets owing to high hospitalization costs in these regions. According to Mr. Jagannathan, Chairman-cum-Managing Director, Star Health, "In the Southern region, the

[16] *Business Standard.* December, 20, 2006.

claims ratio is not more than 60 per cent if one is prudent. But in North and West the claims ratio was as high as 90 per cent". Mr. Jagannathan also indicated that "IRDA has promised to support this differential pricing."[17]

Pre-existing Conditions, Exclusions and Other Issues

Although insurance companies have been losing money on their health business, their health products are often perceived as having limited value by the insuring public. This is mainly due to stringent pre-existing diseases exclusions, delays and repudiations in claims settlements, problematic continuity of coverage if one becomes ill, and lack of portability of coverage between insurers.

Pre-existing Conditions

In spite of the fact that originally Mediclaim excluded all pre-existing conditions, in reality there is no uniform practice among insurers regarding coverage of pre-existing conditions. For group health insurance, insurers are covering pre-existing conditions on new contracts by charging an additional amount. Mediclaim today excludes a declared pre-existing condition for all subsequent renewals. However, some insurers cover pre-existing conditions after three to five years. The absence of any standard definition of pre-existing conditions or ailments within the health insurance industry further aggravates the problem. This leads consumers and outside observers to conclude that companies use this mechanism to retroactively exclude from coverage individuals who become ill, as reported in a recent IRDA working group report on innovations in health insurance.[18]

The IRDA Report on Innovations in Health Insurance[19] makes the following recommendations:

- A standard interpretation should be framed on an acceptable definition of pre-existing conditions/ailments.
- All insurance companies should adhere to this definition and interpretation.
- Establish a "look back period". This concept would restrict insurance companies from looking beyond a period of 18 months for pre-existing conditions or ailments in the medical history of a claimant.
- Coverage of pre-existing condition/ailment should be age-related, implying that the number of years of PED (Pre-existing diseases) exclusion should be a function of the age. While there may be no PED waiting period up to 40 years of age, there may be 2 years wait for PED coverage for the age band 41-50 years and so on.
- A common pool should be created that covers policyholders denied coverage on account of pre-existing conditions/ailments. Such common pool should be administered by the IRDA.

To date there has been no regulatory or voluntary action taken by the industry to change the situation.

Continuity of Coverage

The ability of the policyholders of individually purchased insurance to renew coverage at least on the same terms and conditions as originally purchased, as against the privilege of the insurer to decline renewal based on adverse claims experience, is an area of legal and regulatory conflict. This right of non-renewal has been claimed by insurers even when a person has a history of chronic illness. Gujarat High Court, in a recent judgment, has upheld the right of the policyholder to renew the policy on the same terms and conditions, whereas the IRDA and one of the government-owned non-life insurers have stated that renewing a policy is the prerogative of an insurer.

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[17] *Hindu Business Line.* December, 7, 2006.
[18] Excerpt from IRDA Work ng Group on Innovations in Health Insurance Policies and Effect of Pre-existing Medical Conditions – 2005.
[19] bid.

In a less contentious area, Mediclaim and its clone products contain a no-claim discount feature in the form of cumulative bonus. Cumulative bonus implies that on each claim-free year, for a policy renewed without a break, the insurer can grant a percentage increase in the level of benefits without a corresponding increase in premium. The percentage of cumulative bonus ranges from 5-15 per cent per annum, depending on the insurer. A policyholder loses the cumulative bonus in the event of a break in the renewal period. Mediclaim allows a seven-day grace period under exceptional circumstances, but subject to medical examination and exclusion of any disease incurred during the break period.

Continuity of coverage also is important to the beneficiaries of employer-based group health insurance. With the growing mobility of employees from one employer to another, or from a job to temporary or permanent unemployment, *transiting* employees and their dependents can face uncovered medical exigencies. There is no mandatory provision, like the COBRA[20] in the United States, to allow a departing employee to purchase coverage. However, individual health insurance policyholders of government insurers enjoy full portability while moving coverage from one government company to another. Portability of coverage is not available for policyholders moving between government and private insurers or between two private insurers. Some issues, such as whether satisfied periods of preexisting conditions apply to the new coverage, remain unresolved.

Policy Cancellation Provisions

Present market practice by insurers allows health insurance polices to be cancelled by the insurer at any time by sending the insured a 30 days notice by registered letter to the insured's last known address. When the policy has been cancelled by the insurer, the company refunds *pro rata* premium to the insured for the unexpired period of insurance. Nevertheless, the insurer remains liable for any claims which arise prior to the date of cancellation.

Similarly, the insured can at any time cancel an existing health insurance policy and the insurer is obligated to refund the remaining premium which is determined on an abbreviated period as indicated in Table 3.11 below (provided no claim has occurred on the policy up to the date of cancellation).

Table 3.11. Refund of Premium - Short Period Scale

Period of Risk	Rate of Premium to be charged
Up to one month	1/4th of the annual rate
Up to three months	1/2nd of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

Source: Mediclaim Policy

Administration of Health Insurance Policies

Marketing

Insurance companies are legally required to take responsibility for marketing and sales. However, in interviews TPAs report that they sometimes identify group business and then select the appropriate insurance company to take the risk while hiring the TPA to do most of the administration. Insurers have not put a priority on marketing their health insurance products, often offering coverage as a "courtesy" in order to obtain the more lucrative fire, life, etc., business. Choice of distribution channels for health insurance largely depends on the segment targeted. Group policies are generally marketed directly by the insurers or through brokers. Individual policies are mainly sold through agents, direct sales agents, credit cards and bancassurance. Commercial banks are slowly and steadily increasing their presence in marketing insurance.

[20] COBRA—Consolidated Omn bus Budget Reconciliation Act—A U.S. Law that requ res employers with group health plans to offer partic pants and beneficiaries the opportunity to purchase the continuation of heath coverage for a limited period of t me after the occurrence of a qual fy ng event, which is usually the termination of employment.

There has been a spurt in bancassurance tie-ups and banks such as ICICI are aggressively promoting tailor-made health insurance policies to their clients under a group policy or as a retail product. In some cases, banks also own insurance companies whose products they may distribute. Similarly, credit card companies have partnered with insurers to provide health and personal accident coverage to their subscribers. Notable examples among them include Citibank and HDFC Bank. In some instances, to promote their services healthcare providers have partnered with insurance companies and developed tailor-made health insurance plans that are being sold through direct marketing (see provider based insurance in a later section of this chapter). Also, insurance brokers have developed co-branded health insurance products for their customers.

Bajaj Capital, an insurance broker with a national footprint, is an example. Bajaj Capital presently promotes a retail co-branded health insurance policy in tie-up with Royal Sundaram Alliance General Insurance Company. The policy is essentially a hospitalization policy, but it additionally covers maternity expenses, not generally covered by insurers for their retail customers.

Demand for health insurance has been increasing at 25 per cent per annum, with very little focused marketing by the insurance companies. The growth has been 'demand-driven', responding to increased medical costs and rise in incidence of life style diseases. Health insurance is most prevalent in urban areas. Factors that seem to have driven this increase and will likely continue to drive this growth are:

- Employers moving to insurance for financing employee healthcare benefits;
- Increasing awareness among self-employed individuals of the need to plan/provide against medical exigencies which can be financially devastating;
- Availability of greater product choice that matches the needs of different income segments;
- Demographic changes in population:[21]

  a. Increase in population leading to increase in number of treatments.

  b. Change in socio-economic mix: rapid growth in the numbers of the two richest income classes. These are estimated to increase from 28 per cent in 2001 to 43 percent of the population in 2012 and will result in a 30 per cent increase in average price paid for treatments.
- Change in the disease profile[22]: it is estimated that by 2012 there will be a 50 per cent increase in prevalence of lifestyle diseases (cancer, coronary artery disease etc.) with an accompanied decrease in acute infections. This is leading to a 12 per cent increase in treatment rates and seven per cent increase in prices.
- New technology and changes in prices[23]: technological progress is leading to increases in the cost of equipment and consumables resulting in an estimated 26 per cent increase in price per treatment.
- An increasing understanding among the population of the tax advantages of purchasing insurance.

Government Relations

The insurance industry in India is well organized to make sure that its interests are represented. IRDA, as the insurance regulator, forms the nodal point for insurers to influence government policy. Insurers individually or through their associations, the Life Insurance and General Insurance Councils, approach the regulator for discussions on issues that impact the insurance industry. Since none of the existing insurers, except Star Health, are stand-alone health insurers, their advocacy of health reforms has been muted within the general insurance interest.

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[21] McKnsey & Co. *Healthcare in India.* October 2002, p. 62. Figures derived from *Population Projections for India and States,* 1996-2016, Registrar General, 1996.

[22] McKnsey & Co. *Healthcare in India,*October 2002, p. 62.. Figures derived from *The Global Burden of Diseases*, WHO 1996.

[23] bid. Figures derived from McKinsey analysis.

Major national Trade associations like Federation of Indian Chambers of Commerce and Industry (FICCI), Confederation of Indian Industry (CII) and Associated Chambers of Commerce (ASSOCHAM) have championed the cause of health insurance and have partnered with the insurance industry as well as the provider community to influence health policy reforms. Healthcare providers also have their trade associations namely, Indian Hospitals Association (IHF), Indian Medical Association, etc., which are working to influence government health policy and thus health insurance. Many of the issues that presently confront insurance are reflect ideological differences among the members of the ruling government coalition, some of whom, for example, are opposed to greater foreign direct investment in the insurance sector. How these political issues are resolved will influence the extent to which the private insurance sector plays a role in broadening the number and class of individuals who are covered by their products.

Systems and Claims

With the development of the Mediclaim program in 1986 insurers attempted to administer the program themselves, including establishing a network of participating providers paid directly by the insurer. Due to their lack of experience in provider contracting and medical claims management, together with an initial adverse selection of insureds, they were soon faced with skyrocketing claims. This led the insurers to quickly annul their provider contracts and move to an indemnity payment system. Today, except for one insurer which recently purchased a TPA (Reliance General Insurance Co), and one (Bajaj Alliance) which has decided to service its own products, the insurers are dependent upon the TPAs for medical claim processing.

Development of Human Resources

Most non-life insurers are basically property and casualty insurers, hence their insurance personnel are trained in related business segments like motor, fire, marine and engineering insurance. Since health insurance is a relatively small portion of their business, they have has lacked individuals specifically trained to work in this area. As a result, there is lack of health insurance professionals in the country.

General insurance skills are always important in working on any kind of insurance, but health insurance additionally requires unique abilities to deal with health providers who often are given sole power to determine what medical procedures should be delivered and paid for as medically necessary. Usually, in the fee for service environment in which India operates, the more services provided the more the provider's income increases, making the ability to control and monitor delivery behavior even more important. Because of this absence of capacity to deal with providers, Indian companies writing health insurance seem to have focused on controlling claims payout by following strategies designed to minimize the insured person's ability to collect on claims. Thus there is an extreme emphasis on disqualification because of pre-existing conditions and post claim underwriting. Because of this, health insurance has become one of the largest litigation areas for insurers, exceeded only by motor third party cases.

This lack of health insurance specialists has impacted the introduction of newer products, actuarial pricing of existing products and professional provider contracting for claims cost control. The absence of specialized skills has also inhibited the introduction of sophisticated managed care products or the expansion of benefits.

The insurance industry has been apathetic in developing intellectual capacity in the health insurance discipline, as evident from lack of professional courses in health insurance both at the insurance industry and university level. The Insurance Institute of India, the parent insurance education and certification body in the country, does not have any specific health insurance course. The so-called liberalization of the insurance sector has witnessed rapid growth of insurance management courses being taught in a number of management institutes in the country. Though none of them offer any specialized courses on health insurance, the course of insurance management does include some credits on health insurance. However, there is virtual absence of qualified or experienced faculty to teach health insurance in these institutes. Similarly, the Actuarial Society of India, which imparts actuarial education and grants certification, does not have any course for health actuaries although it has recently undertaken an exercise to revise its health insurance study material which is based on the government-run U.K. health system.

To compensate for this lack of knowledge, the Third Party Administrator business has grown in India and was subsequently made subject to regulation by IRDA. By sub-contracting with insurance companies, these organizations attempt to provide the expertise that insurers lack. However, while these companies, if effective, can provide much of the expertise that insurers need, they are agents, not policy makers, and the special monitoring and policy expertise necessary to supervise these kinds of organizations does not exist in the industry. An interesting example of this lack of health expertise was the 2006 national meeting of the Insurance Federation which had a plenary session devoted to the issues of health insurance. One of the session speakers surveyed the room of several hundred executives and not one physician or medical professional was present representing an insurance company. While it is not necessary to be a physician to know how to work with delivery organizations, every health insurer requires health care delivery capacity to be effective.

Third Party Administrators

Introduction

Third Party Administrators (TPAs) have taken over many of the important functions of providing health insurance in India. While insurers take the risk, set the rates for health insurance and, in most instances, provide the official marketing and sales function, TPAs have become their "back office". In some situations the TPAs report that they act informally to identify customers and bring corporate accounts to individual insurers. They also deal with providers to pay for hospitalizations, obtain agreement on rates of payment and determine if care is necessary and covered. Further, TPAs establish the eligibility of individuals to be insured under specific policies and provide a membership identification card and description of their coverage to the insured. TPAs carry out these health insurance functions under contract as agents of individual insurance companies but they are licensed and regulated by IRDA. Because of this unique regulatory arrangement and their significant role in health insurance they are treated here as a separate entity in private insurance.

Background

The development of the TPA industry, how it came into being and its relationship to the insurance industry in India, is important to understanding its present role, its successes and failures and the directions the industry is taking today. The establishment of TPAs begins with the development of Mediclaim, which was introduced in 1986 by the public insurance companies and prompted by demand from employer groups which purchased traditional non-life insurance from these insurers. By the mid 1980's most employers had made some financial commitment towards reimbursing expenses for healthcare for their employees. Over time, these expenses increased and employer groups began to put pressure on the non-life insurers to issue a health insurance program that they could purchase to cover employee medical expenses.

Mediclaim, as it was launched, was a simple hospital indemnity program that had a set of clearly defined benefits with caps on items such as room rent, surgeon's fees, nursing charges, etc. There were 5-6 levels of benefits with the lowest benefit set costing as little as Rs 350 per person per annum and the highest costing Rs 1,200 per person per annum and an annual maximum allowable payout ranging from Rs 83,000 to Rs 96,000 based on the level of benefit purchased. Since Mediclaim was an indemnity policy, consumers could select a hospital, pay a deposit to gain admission, and gain treatment from their physician at the hospital, including any surgical intervention (inpatient only, with a minimum 24 hour stay). Once treatment was provided and the patient was discharged, the consumer would have to submit a claim form to the insurance company, with a discharge summary and all medical bills together with supporting documentation for diagnostics, prescription for drugs, etc. The insurance company would review the submitted claim and issue a reimbursement as per the limits and sub-limits to the Mediclaim policy.[24]

[24] Mediclaim insurers originally tried to institute a negotiated hospital cashless program but their lack of capacity to effectively administer it caused them to abandon it.

By 1995 two million members had enrolled in the Mediclaim program sold by all four public sector insurers. In 1996, the Finance Minister, in his budget speech, announced that since the Mediclaim policy was a reasonable method of creating a large risk pool but benefits under the policy were not commensurate with current healthcare costs, he was urging the public sector insurance companies to remove the sub-limits under the plan and increase the annual maximum to as much as Rs 300,000 per annum. In response, the public sector insurance companies re-launched Mediclaim without any sub-limits or member risk-sharing and increased the annual maximum to Rs 300,000.

The result was an increase in enrolments and in the number of claims. At this point, a few organizations recognized that there was a gap in the offering for medical insurance in India and that some areas of the Mediclaim policy needed to be improved, for example,.

- Having to pay a deposit upon admission to the hospital.
- Paying the entire hospitalization expense, then having to submit a claim to obtain reimbursement and then waiting for the insurer to process and reimburse the claim.
- Lack of knowledge as to how much of the overall expenses would be reimbursed by the insurance plan or even if the claim would be admissible.
- No easy customer service mechanism to gain clarity on policy details or questions on reimbursement and shortfalls.

A few organizations saw these problems with Mediclaim as a business opportunity and in 1996, with a view to providing employers with advice on health benefits and related administrative services, established businesses to facilitate access to the health care system for their clients' employees and dependents. Each covered member was issued a photo-ID card at enrolment that would allow them access to select hospitals without having to pay a large deposit. The company also offered direct settlement with hospitals so patients did not have to pay their hospital bill at the time of discharge from the hospital. Sedgwick Parekh also offered a 24x7 call center for covered members whereby they could call to gain admission to a hospital, obtain information on their benefits, and determine the status of any expenses they may have claimed directly, etc.

By 1997 many large multinationals were offering their employees access to these services. Initially, most of the business came from self-funded organizations but by late 1997 and early 1998 employers who purchased group Mediclaim insurance as the primary financial mechanism began using this service. This required "medical service support organizations" to offer their services as an overlay to the insurance plan and to liaise with the insurance company for claims settlement on the employers' behalf, leading to the creation of TPAs in India. Several of these early organizations, including Sedgwick Parekh Health Management, Paramount Healthcare, and Medicare Services, remain important actors in the business today.

Early Innovation and the Introduction of Regulation

The advent of TPAs created an interesting market situation. The Group Mediclaim policy was and still is sold using a rating table that varies per member by age and an annual maximum expenditure limit. Over and above the per member rate, groups were eligible for discounts ranging from 2.5 percent for groups of fewer than 100 members to as much as 50 percent for groups above 50,000 members. Enterprising organizations decided that since the TPA services provided a nice "wrapper" to the insured Group Mediclaim plan, by taking advantage of large discounts they could "sell" the combination of Mediclaim with TPA services and still be able to provide the market with a product that was cheaper than the retail rates of Mediclaim. One example of this was the Medicare Services Club, a subscription-based organization promoted by Medicare Services, an early TPA. Subscribers to the Medicare Services Club were able to purchase a Mediclaim policy combined with TPA services at rates far below the retail Mediclaim rates. Many consumers, who would normally have purchased Mediclaim at retail rates, were now able to purchase it at far lower rates, bundled with TPA services through the pooling effect of club membership.

In 2000, public sector insurers recognized that there were several organizations that were forming groups of individuals and obtaining substantial discounts thereby drastically reducing the average per member premiums they were receiving. Simultaneously, since rates had not been revised since 1996, medical inflation also took its toll on the premium pool and loss ratios for the public sector companies rose far above 100 percent. Their immediate reaction was to redefine "Group" in their policies and prevent legitimate organizations that had the concurrence of their employer customers to work closely with the insurer. As a result, most TPAs offering services directly to employers found it difficult to continue and were forced to reconsider their model or quit the business altogether. The existence of companies whose sole purpose was to aggregate membership to obtain discounts led to concerns that fly-by-night companies could abuse the model substantially and that many consumers could be duped by them. Some of the legitimate players approached the IRDA and suggested some form of regulation for TPAs. The IRDA agreed that this could prevent potential abuse of the health insurance system and in 2000 decided that it was appropriate to regulate TPAs.

Regulating TPAs as well as Insurers

IRDA set up a working committee in 2000 to suggest regulations for this new type of intermediary dealing with the administration of health insurance. The committee was made up of representatives of the existing TPAs, several public and private sector insurance companies (non-life) and members of the IRDA. The committee deliberated on a white paper that was circulated by IRDA and the result of these deliberations, over a period of one year, was a set of regulations notified as The IRDA (Third Party Administrators - Health Services) Regulations, 2001 on September 17, 2001.[25]

The regulations stipulated the eligibility, scope of services, capital requirements, solvency margins, operating guidelines and code of conduct for TPAs. The regulations also maintained that TPAs were indeed intermediaries as per the scope of the IRDA Act, 1999, and therefore were fully under the jurisdiction of the IRDA.

Salient features of the regulations are:

- The minimum paid up capital will be Rs 10 million (1 crore).
- The TPA will have to maintain its net worth at Rs 10 million at all times.
- At least one of the directors of the TPA will be a qualified doctor registered with the Medical Council of India.
- The aggregate equity shareholding for a foreign shareholder shall not exceed 26 percent at any point in time.
- A TPA can serve more than one insurance company and, similarly, an insurance company may engage more than one TPA.
- A Code of Conduct is included in the regulations.
- The regulations also contain a strict requirement for confidentiality of information and data.

The IRDA has subsequently issued several circulars affecting the conduct of business by the TPA.

Licenses

Applications for a TPA license were sought by IRDA in early 2002. Between March 20 and June 11, 2002, 23 companies were granted TPA licenses and all licenses but one have since been renewed. As of August 21, 2006 there were 26 licensed TPAs operating in the market. See Addendum IV to this chapter for a list of these TPAs.

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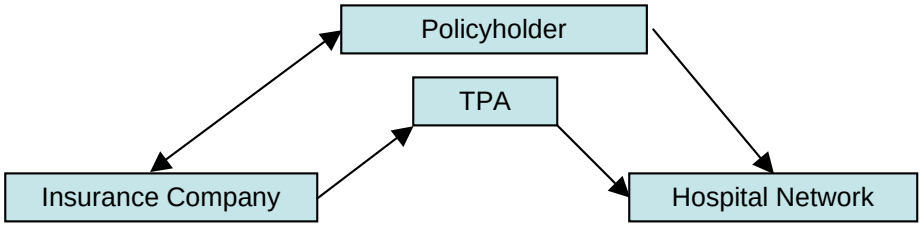
[25] *The Gazette of India, Extraordinary*, Part II – Section 3 – Sub-section (ii), Published by Authority, Insurance Regulatory and Development Authority, Notification, New Delhi, September 17, 2001. The IRDA (Third Party Administrators – Health Services) Regulations, 2001. www. rdaindia.org

Figure 3.4: Operational Processes Envisioned by the TPA regulations



The IRDA regulations position the TPA at the center of the health insurance operational model so that it interacts with all the players: insurer, policyholder and hospital. Per the regulations, the TPA is responsible for providing:

- Enrolment services – enrolment of policyholder and dependents into its systems, issuing a photo-ID card to the policyholder and dependents;
- Call-center services – for pre-authorization of hospital expenses and deposit-waiver for admission to the network hospital;
- Access to hospital network – allows policyholder access to negotiated services and rates at a network of hospitals, including admission deposit waiver and direct settlement of the bill;
- Claims administration – adjudication, processing and settlement of claims for in-network and out-of-network claims;
- Information reporting – generating pre-defined reports for enrolment, claim related statistics and operational performance statistics to the insurer. Generating financial, claims information and operating performance reports to the IRDA periodically.

Launch of the Regulated TPA system

The official TPA system began in earnest in mid-2002. At this time, the public sector insurance companies (non-life) had over 90 percent market share. The initial bidding and selection process of TPAs was important because it determined the attitudes of the parties towards each other and for their business relationships in the future.

In June 2002, the General Insurance (Public-Sector) Association or GIPSA issued a tender for TPA services for the administration of ALL its Mediclaim policies, both individual and group.[26] In spite of the stipulations for licensure, the GIPSA had additional requirements for its TPAs and each was to submit a bid for the tender along with pricing for all services required, as a percentage of premium collected by the insurance company. For the purposes of submitting a bid, the country was divided into four zones, i.e., North, South, East and West, and TPAs were required to submit bids for each zone.

Almost all TPAs submitted bids for two zones, i.e., North and West. Some bid for only the South zone. A few TPAs submitted bids for all four zones. In August, TPAs were asked to make a personal appearance at each Public Sector Company's headquarters for an interview with the selection panel of each company.

In September, the public sector insurance companies decided rates for each zone based on the lowest bidder. The lowest bid for North and West zones (L1) was 5.4 percent of premium whereas the lowest bid for South and East zones (L1) was 5.2 percent of premium. There was concern among TPAs about the low rate as many had submitted rates in excess of 10 percent. It emerged that the submitted rates varied widely between

[26] This organization represents all of the public sector companies.

5.2 percent and 15 percent of premium. There was some speculation that a TPA owned by a hospital group, which IRDA had licensed to bid (in spite of concerns that they would be reviewing claims and costs of their owners) had submitted the lowest bid. The belief was that the hospital group would use its TPA as a way to steer patients to their hospitals.

Shortly after the rates had been decided by the government insurers acting in unison, ten TPAs received letters of selection from the various public sector companies defining which of their Regional and Divisional offices would work with each TPA. There was no reference to the membership or total premium associated with any of these regional offices. The selection of TPAs and their assignment to regional business units of the public sector appeared arbitrary and had no supporting scientific methodology. Speculation again ran rife that many TPAs had used less-than-fair means to garner the most "profitable" zones.

The controversial selection process slowly died down with the realization that the government expected that all policies issued on and after January 1, 2003, would include TPA services. The public sector insurers raised all Mediclaim premium rates by 6 percent to accommodate the cost of including TPA services in their Mediclaim policies. The ten TPAs began the process of discussion and negotiation on the contract to be signed between each insurance company and TPA.

The ten TPA owners came from varied backgrounds. For example, some former insurance company executives launched TPA companies, e.g., Genins, E-Meditech, and ICAN, but entrepreneurs promoted most. Parekh Health, Paramount, TTK, Medicare and Medi-Assist were all promoted by independent entrepreneurs, two of whom were physicians. Two TPAs were promoted by hospitals. The Apollo Hospitals Group promoted one, Family Health Plan, and Dr. Naresh Trehan of Escorts Heart Institute promoted another, Raksha TPA.

It is important to note that the senior leadership of the public sector insurers carried out the TPA selection process, under significant pressure from the Ministry of Finance (a stakeholder in each of the Companies) and then "imposed" it on their operating divisions. It became evident in the course of the first couple of years that the divisional leadership of the public sector insurance companies was not consulted regarding the decision to engage the TPA system for health insurance. As a result, the divisional leadership considered the "imposition" of TPAs an unnecessary distraction. So a reluctant divisional leadership along with its operational teams went about engaging TPAs without understanding the model and its implications. Most operational teams within the public sector insurance companies viewed TPAs with suspicion and never engaged them as true partners. This lack of clarity and trust between insurers and TPAs has formed the cultural backdrop for this important relationship and has led to a significant deterioration in customer satisfaction rates due to service lapses and process inadequacies.

Early and current operational status of the TPA system

The early relationship between TPAs and insurers, particularly the public sector insurers, was tenuous at best. Most of the operational staff at the divisional offices of public sector insurance companies believed that despite the imposition of the TPA system there really was no need for their services. There was also confusion about who would drive the operational negotiations between insurer and TPA and this led to contradictory instructions to the TPAs and chaos for the insurance policyholder. Insurance company staff in general did not believe that the TPA system was going to improve any of their operations and was convinced that the cashless system would prove to be a large failure and cause for further dissatisfaction among consumers. Finally, there were those who were convinced that TPAs were corrupt organizations with operations designed to "bleed" the insurance companies by perpetrating large-scale fraud. This deep skepticism among insurers did not bode well for the successful launch of the new TPA system.

As a result, the insurance companies never considered TPAs as partners. This rift in attitude resulted in TPAs being blamed for the failure of any operations rather than the insurance company accepting its share of responsibility as the primary service provider and TPA as its subcontractor. In contrast,, the experience of private insurers with TPAs resulted in more of a partnership, as private insurance companies understood that the TPAs would contribute to their success. The reasons for this seem to be because:

- They did not have any legacy claims and other health insurance operations that they could depend on; and
- TPAs allowed them to launch a health insurance product quickly and efficiently.

The private insurers were also able to gain access to TPA services at low fees due to the already negotiated rates between TPAs and public insurers.

By 2006 the TPA system had settled into a kind of equilibrium. The larger TPAs have ironed out most of their teething problems and also overcome some of their initial operational capacity and delivery issues. Some of these larger TPAs have also begun to enjoy improved customer satisfaction rates which initially were very poor. However, issues such as a lack of consumer education on the processes of the TPA system, unclear expectations of the insurers from TPAs and the inherent mistrust that continues to exist between insurers and their selected TPAs creates a tenuous situation for most TPAs with their end customer, the consumer.

In addition, TPAs have had to focus on increasing medical costs. The advent of the TPA system and the direct settlement arrangements between TPAs and hospitals has also led to uncontrolled price increases by hospitals. It is commonly known that hospitals maintain differential pricing for insured and uninsured patients, with insured patients having to pay from 25-50 percent higher charges and some even higher. As a result, the general focus on operational glitches has shifted to the alarmingly high claims costs paid by insurers.

In late 2005, Bajaj Allianz General Insurance Company chose to bring the administration and management of its health insurance plans in-house, creating an internal health administration team that would perform the functions of a TPA from within. This continues to be the only non-life multi-line insurance company that insists on handling the TPA functions internally. Late 2006 saw the launch of the first "standalone" health insurance company, Star Allied and Health Insurance Company, which has also established its own administration team rather than using the service of TPAs.

The lack of deep relationships and clear dialogue between TPAs and hospitals has often led to contentious situations between the two, leading to further operational glitches, inaccurate billing and in many cases, outright fraud and abuse. There have been some attempts by larger TPAs to bring in price rationalization by using techniques like "price banding", categorizing hospitals by "quality/reputation" into bands and then assigning schedule of rates for services in each band. In New Delhi, several hospitals have come together to form the Indian Health Federation, a loose association of premier hospitals in the National Capital Region (NCR) of New Delhi. The Indian Health Federation created its own price band structure and presented it to insurers and TPAs. This initiative was borne out of the providers' concern that they would have unreasonably low prices imposed on them by insurers. Most TPAs and insurers have not yet accepted this rate schedule. For the most part the efforts to reign in the skyrocketing costs for in-patient care have remained largely ineffective as the TPAs, for whatever reason, have been unable to bring any price discipline to the system. One of the fundamental flaws remaining in the design of the Mediclaim plan and its variants, i.e., the annual sum assured limit, is the tendency of every hospital to focus on the limit as a "bull's eye" for invoicing services.

There have been recurring feuds and contentious discussion between various TPAs and hospitals, but what has recently been acknowledged by many private "corporate" hospitals is that the number of their patients that are insured and serviced by TPAs has increased to as much as 30 percent over the last three years. Per the IRDA, the inpatient volume being administered by TPAs at hospitals across the country is 15 percent. Some TPAs have recognized their growing leverage over hospitals and are using it to gain some pricing advantage through package pricing and discounts on diagnostics but they have as yet been unable to use different approaches, such as provider risk-sharing to ensure that hospital service rate inflation is controlled.

From a consumers' standpoint, the services offered by TPAs are now well established. The number of complaints and the overall satisfaction rate has begun to increase. The level of trust between consumer and TPA, however, remains tenuous due to the perceived inconsistency in paying claims, once again reflecting a

lack of consumer education and awareness of the insurance plan benefits and operational processes of the TPA. Given that the incidence of hospitalization lies between 6-8 percent of the population, most people who have not had to be admitted to hospital rarely understand the process flow and administrative intricacies of pre-authorization, claims settlement and on-going communication with the TPA and/or the insurer and neither has done enough to cause this to change nor has the regulator taken any action in this area.

The financial viability of TPAs based on the current insurance premium rating and the low fee rate that TPAs feel insurers are paying them, remains a question. It has been stated by a few TPAs that the 5.2–5.4 percent rates on the existing average premium of Rs 1,200 per member per annum is unsustainable and does not even cover their variable costs. There has been some speculation that TPAs have had to counter this by finding different revenue streams, including charging hospitals on their network a fee for each hospitalization (a nice way of describing a kickback), thereby impacting healthcare cost inflation and insurance premiums adversely.

Structure & Capacity of TPAs

It is important to understand the present capabilities of the TPA industry in order to gauge its capacity to expand to provide the services it is regulated and contracted to provide. This is particularly true since it has had more than six years to develop to where it is today. Its current state is also a reflection of the interest and the capacity of the insurance industry to ensure that its agents provide the services that are important in administering health insurance.

Leadership and management

TPA regulations identify two positions that must be present in an approved organization: a Chief Executive/Administrative Officer who has to have taken a course in TPA management through the Administrative Staff College of India (endorsed by the IRDA), and another director who has a recognized medical degree (MBBS). Most TPAs have a lean management structure and are led by strong individuals who are of an entrepreneurial bent. Some of the larger ones are now building formal management structures with a CEO, COO, and Medical Director. Others have used a more distributed management structure with regional leaders and a decentralized operational structure.

For most TPAs, the CEO has little or no healthcare experience, except a few large TPAs (Paramount & Medicare) where the CEO and/or promoter is also a trained physician. Likewise management in general is not trained in health insurance and learning comes primarily from experience. At least one TPA hires physicians to approve claims and establish the eligibility of an individual for coverage since the TPA can pay more than can be earned in starting up a medical practice.[27] This was in spite of the fact that the TPA indicated that it only rarely did any medical management.

Operations & Technology

At the inception of the TPA system, TPA operations were similar lines to those of the insurance companies they worked for. Operations were primarily manual and did not have any quality control systems, defined processes, standard operating procedures (SOPs), etc. A system of supervisors managed the workflows for the massive amounts of paper that needed to be processed, both inward and outward.

TPAs today have invested in in-house software development teams and most software utilized by them is homegrown and customized to meet each TPA's specific operational needs. A few have begun to plan to meet the needs of a much larger and quality oriented insurance industry. Many have developed and documented SOPs and protocols to ensure efficient processing of claims. Some have developed extensive web-based capabilities and have offered their customers significant self-service tools, thereby reducing the TPAs operational costs while improving customer service.

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[27] Family Health Plan (FHP) – TPA in Hyderabad Meeting: May 3, 2006 with Dr. Hatim Companiwala (Senior Manager – Medical Management and Claims) and Mr. Arun Kumar (Assistant Manager).

Customer Service/Account Management

Almost all customer service personnel have had to learn on the job and their support operations are not technology driven. One exception is Parekh Health Management which has deployed Customer Relationship Management (CRM) software at its call centers to track customer queries, etc. It has also deployed an automated e-mail-based customer service contact desk in addition to the call center-based service, and a web-based enrolment platform for their commercial accounts to make available to their employees.

From our analysis, only one TPA had used sophisticated software for business process management. One larger TPA had developed a sophisticated data capture and adjudication system for claims processing. Most of the other larger TPAs also had in-house software development but their claims systems were rudimentary and primarily captured financial data.

Processes

Enrollment

According to the contracts between insurers and TPAs, the primary responsibility for the collection of enrolment information is with the insurance company. TPAs, however, cannot effectively administer the product unless the enrolment information is transmitted to them in a timely fashion. For the first several years of the relationship and due to the lack of technology deployment among public sector insurers, this often involved sending messengers to insurance company divisional offices to pick up the latest enrolment lists and then bring them back to the TPA's regional operational center where the information was re-entered into their systems by hand. The inefficiency of this system caused many operational problems at the point-of-service for members. This was particularly true for employer groups at renewal and for hospital admissions within the first month of enrolment for individuals as the information was never available at a TPAs call center in a timely fashion.

TPAs have since streamlined the physical enrolment processes but the lack of technology penetration in the public sector insurance companies continues to plague timeliness of enrolment information. In the past two years some TPAs have built their own enrolment portals providing a boost to the enrolment process but the linkage with the insurance company continues to be a handicap.

ID Cards

When TPAs began work, the operational processes for issuing ID cards were manual and cumbersome. TPAs attributed the problems to the low fees they felt they were being paid, although one TPA did introduce a hologram to ensure authenticity and prevent fraud. Cards were then dispatched to members with a cheap paper booklet that contained the names of hospitals in that TPA's network. These cards were usually sent through the Indian postal service and were usually late in reaching the member (typically three months late) and sometimes were lost in the mail with little or no recourse to the member.

Over time, TPAs have improved this process, for example, by using web-based enrolment portals through which a self-service ID card can be generated on the Internet. While ID cards remain a feature of the TPA services, their role has diminished over time as the credit authorization for "cashless" hospitalization continues and now revolves around the pre-authorization process between TPA and hospital.

Cashless Hospitalization

What should have been a key benefit to consumers, namely admission to a hospital of their choice (on the TPA's network) without having to pay a cash deposit, soon became the Achilles heel of the TPA system, especially for TPAs that had not understood the complexities of this process.

Initially the process for most TPAs went as follows:

- Member calls the TPA's call center requesting authorization for admission to a particular hospital on the TPA's network on a particular date.

- TPA faxes a pre-authorization form to member, to be filled in by the member and the treating physician describing the ailment, procedure to be performed and estimating length of stay, and total cost of hospitalization.
- Member faxes authorization back to TPA for verification and authorization.
- TPA processes the request for authorization and, if authorized, informs member of the authorization by sending them a Letter of Authorization.
- TPA simultaneously faxes the Letter of Authorization to the network hospital, thereby facilitating admission with a cash deposit waiver. TPA also acknowledges liability for payment of the bill upon discharge of the patient from the hospital.

The preauthorization process was a new feature of the TPA system. The insurance companies did not understand the complexities and nuances of this process, nor did they invest any time in educating themselves or their customers. The TPAs and insurers also did not recognize that disparate claims adjudication guidelines and contracts that left clauses subject to interpretation could not support the preauthorization process as it required consistency and clarity in the insurance policy guidelines. Due to the several steps involved, the process often failed leading to serious customer service lapses and in many cases disagreement between the hospital and the TPA. Also, the use of communication methodologies such as faxes and telephone calls caused many mistakes. For example, the TPAs refused to authorize admission if the claim was deemed inadmissible based on the pre-authorization information provided when matched to the insurance plan benefits and eligibility requirements. In particular, the pre-existing conditions exclusion in the insurance plan led to a large number of denied authorizations. The TPA was responsible for making a judgment on whether a pre-existing condition would lead to inadmissibility of the claim based on sparse information contained in the pre-authorization form or willful non-disclosure by the member. Insurers were unwilling to participate in this process and support the TPAs' verdict for a variety of reasons. First, insurance companies are not equipped to provide claims adjudication services over the telephone or via electronic technology. Second, turn around times for these verdicts are short, mostly within two hours as patients are waiting to be admitted to the hospital. Most public sector insurers were not in a position to offer such a fast turn around time on their claims verdicts. Finally, insurers were not willing to deploy staff to support 24x7 operations like those of the TPAs. As a result, TPAs could not establish a process to request additional information before denying a preauthorization request.

The pre-authorization process was put in place with little member education or awareness building and led to a significant dilution of trust for TPAs. An important point in this early history is that the insurers, in spite of their oversight responsibility for TPA actions in administering their insurance policies, left the TPAs to fend for themselves and to receive large-scale retaliation in the media and from the public. Likewise, the TPAs despite being licensed to perform a service lacked the necessary capability to do so.

An added complication to this process was the issue of non-admissible expenses or non-medical expenses. By definition this should not have been a problem; however this clause in insurance policies was not clearly defined and was subject to interpretation by both the insurance company and the TPA. As a result, there remained many expenses incurred by a patient, e.g., the cost of thermometers, hot water bottles, skin lotion for bedsores, etc. that would not be paid by the insurance plan. Hospitals would charge these to the patient in the hospital bill and the TPA would then disallow them at the time of claim settlement, leaving a short fall in the payment to the hospital. What made this situation worse was that each divisional office within the various insurance companies viewed this clause differently, so that one divisional office in an insurance company would not pay for, say, a thermometer while another divisional office of the same insurance company would pay for the thermometer!

The situation today has improved somewhat as both insurance companies and TPAs have become more accustomed to the workflows and processes. However the probability of failure in the processes and the resultant customer dissatisfaction continue to plague the industry.

Claims management

The agreements between TPAs and insurers make the TPA responsible for adjudication of a claim, while the insurer reserves the right to audit the claim settlement records of a TPA at any time. If there are discrepancies between the individual policies and TPA actions, the TPA is responsible for making restitution to the insurance company. Public sector insurance companies established a protocol whereby the TPA opened an independent bank account into which the insurer credited funds towards claim payments. The amount credited, however, is not related to the estimated funds the TPA would have to pay out, but to the level of a bank guaranty that the TPA provides to the insurer. Therefore the funds available to a TPA towards claim settlement are commensurate with its credit worthiness rather than the volume of claims it is required to settle in a given time period. This is a very strange relationship between an agent and its principal and says a lot about the trust between the two contracting parties.

The requirement became even more problematic for the TPAs because even if they were able to issue sufficient guarantees for claim funds, the public sector insurers were often unable to disburse funds on time due to complex and bureaucratic internal authorization protocols for fund disbursement. For example many divisional or branch offices of Public Sector insurers had the authority to authorize and disburse only a small amount of funds, and had to apply to their regional headquarters and in some cases to their main headquarters for authorizations for disbursement, which took days and weeks. Awaiting authorization from these layers of bureaucracy, TPAs had to bear the brunt of provider dissatisfaction about timely payment, even though there was nothing they could do about it. Because of this problem many hospitals refused admission to patients who were eligible for credit and in some cases hospitals refused to recognize certain TPAs and their patients, requiring the patients to pay cash deposits and thereby defeating the TPA system's benefits. The situation has improved somewhat as TPAs have grown larger and have improved their process efficiencies and insurers have also streamlined their claims cash flow to the TPAs.

The audit system has led to some significant issues between the TPAs and the insurers they work for. TPAs found to be negligent in their adjudication of claims by the insurer have to make restitution to the insurers, sometimes for amounts significantly more than their total income from the insurer.[28] A better system to deal with mistakes made by a TPA is necessary to permit reasonable judgments about hospital admissions and improve customer and provider satisfaction. The liability of the TPAs must be limited if the system is to improve.

It is important to note that some TPAs have made serious mistakes and that their actions may not have always been above board. In cases of fraud or incompetence insurers do have a responsibility to act and to cull out poor performers. It should also be noted that TPAs report that their relationships with private insurance companies have become less contentious due to fewer bureaucratic requirements and protocols that are far more efficient and customer-focused.

Call Center Services

TPAs are required by regulation to provide 24x7 toll-free call-center services to their members for enabling admission to network hospitals and resolving general queries. Initially, most TPAs had set up a rudimentary system of answering a toll-free line at a single site even though they were providing multi-site service across the country. The call-centers were not manned with an adequate number of agents nor were enough telephone lines requisitioned to take up the initial onslaught of calls. As a result, phones went unanswered, leading to significant dissatisfaction among consumers and a lot of frustration for insurers. At the time of setup, TPAs were unable to gauge either required call-center capacity or cost. Once the calls started coming in, the TPAs realized that the costs and needed capacity were going to be significant. They often chose to leave telephone lines unanswered thereby avoiding the cost of the call. The quality of call-center services, the lifeline of the cashless hospital admission process, were therefore another area of concern for the development of the TPA model in India.

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[28] For example, a TPA that covered over 100,000 lives for a public sector insurer paid a claim of Rs 300,000 that was repudiated at the time of audit. The TPA earned a total fee of Rs 6,245,000 from the insurer for the whole year. The restitution amount represented almost 5% of the total fee earned by the TPA.

Provider Networks

A fundamental selling point for using TPA services is their promise of access to a provider network of hospitals where the primary negotiated benefits to the consumer would be cashless admission and direct settlement of the hospital bill by the TPA. As described above, this benefit has often proved illusionary. In late 2002, the TPAs selected by the public sector insurance companies scrambled to contract with hospitals across the country. The four TPAs that had already been offering services prior to government regulation simply expanded their existing networks to ensure that all regions were covered.

Most early TPA contracts with providers were simple agreements to provide deposit waivers for patients at admission and direct settlement of bills with the TPA. Some TPAs, which had been in the business earlier, used the opportunity to build more value into their contracts by negotiating discounts on a subset of services such as diagnostics, room and board and surgeon's fees. In most cases, these discounts brought in a reasonable amount of cost reduction as the discounts were based on published "rack" rates. In some cases, particularly with smaller hospitals, discounts were simply applied to an exaggerated fee rate. This was possible as these hospitals did not publish rates for services provided and could change them at a whim. In many cases, hospitals were careless and would submit bills for similar episodes of care but with different rates for the same services provided. A vigilant TPA would then be able to confront the hospital and rectify the problem.

Hospitals which were initially wary of TPAs became much more cooperative after the public sector insurance companies engaged TPAs to work with their members. The large corporate hospitals, in particular, assumed that TPAs would form a key source of revenue for them in the coming years. The larger hospitals were amenable to discounted rates on select services, much to the delight of TPAs and insurers. The TPAs discovered eventually that these hospitals had simply hiked their rates to accommodate the discounts without impacting their revenue.

The selection of network providers is very problematic. Most TPAs use unsophisticated selection criteria and the lack of a national accreditation system hampers their ability to make any judgments on the quality of care. Often, hospitals are selected based on demand from customers so TPAs end up contracting with providers who may not have demonstrated either their charges/costs or their quality of care.

Contracting has evolved marginally since 2002 with the advent of efforts to "band" providers in categories and fix schedules of charges for each band by TPAs and providers alike. However, providers continue to arbitrarily modify their charges. Another burgeoning issue is a growing dichotomy in pricing for insured and uninsured patients, with insured patients bearing the brunt of inflated pricing as compared to their uninsured counterparts. The ability to arbitrarily charge uncontrolled fees for services remains a major lacuna in the health insurance system that has not been solved by the insurers, the TPAs or the government.

Recently, TPAs report that hospitals have begun recognizing that TPAs are responsible for generating a reasonable share of their revenue, with smaller hospitals experiencing about 20 percent of hospital revenues coming through TPAs. A number of hospitals in New Delhi have reported that patients covered under insurance plans and managed by TPAs account for 34 percent of their revenues on average.[29] This has begun to make it much easier for TPAs to gain the cooperation of providers.

Marketing and Servicing to the Group Customer (Employers)

Only one TPA has specialized in working with employer groups whereas most other TPAs continue to work with all markets. TPAs maintain corporate sales teams that approach employers directly to engage their services. In many cases, employers choose a TPA first and use the TPA's recommendation to select the insurer. Recently (as of 2002) brokers such as Marsh and Metis have begun to play a role in this area and have set up specialized teams focused on employee benefits. They are becoming a major distribution channel for

[29] Presentation at CII National Healthcare Committee meeting n in New Delhi, January 2007, by Escorts Heart Institute.

insurers and TPAs alike. Some TPAs have even appointed broker liaison managers to manage relationships with brokers.

TPAs have recognized that managing health plan administration for employers is lucrative and therefore have invested in recruiting account managers from other industries. Overall the quality of account managers is below average, with TPAs tending to pay significantly more attention to their employer customers than to their individual (retail) customers.

Marketing and servicing the insurer

TPAs usually have a strong relationship management team to liaise with the insurer. This is to ensure continued business from the insurer and also to manage the heavily manual workflows involved in interfacing with most public-sector insurers.

Marketing and servicing the individual customer

With the advent of the TPA system, individuals have been left with little or no choice of TPA and the TPAs, by regulation, have no ability to market directly to retail consumers. As a result, individual customers choose their insurer and are provided with the corresponding TPA. They become dependent upon the call center and web-based approaches of the associated TPA. Thus, choosing an insurer in India means choosing the associated TPA services and provider network, as is also customary in the United States.

Self-Insured Companies In India

Prior to independence in 1947, companies in India (both British and Indian owned) viewed medical expense reimbursement as a philanthropic activity for most of their workers and a perquisite for their senior employees. While the benefits offered to blue-collar workers were pegged at a month's salary, benefits offered to white-collar workers were commensurate with a person's grade in the organization, and thus more a perquisite than a philanthropic gesture.

The mid-1900s (post independence) saw the election of the first independent Socialist Indian Government. Many industries such as energy and petroleum, telecommunications, tourism, etc., were nationalized through acts of Parliament and many British-owned businesses were taken over by the Indian government. These nationalized businesses had large employee populations and, following the British tradition, the Government continued to offer housing, allowances towards various expenses and medical reimbursement. In many cases, these organizations were located in "backward" areas with little or no economic development. As a result, the companies created townships close to their factories and worksites and provided pharmacies, clinics and hospitals so that workers could have access to free or heavily subsidized medical care.

Thus was born the first set of self-funded health plans in India. Large Indian industrial houses such as the Tata Group, Birla Group, and Godrej Group have all provided healthcare services or financial reimbursement to their employees and in most cases continue to be self-funded. Even large multinationals such as Hindustan Lever (Unilever) and Procter & Gamble have fully self-insured health benefits.

Reasons for choosing self-insurance

The most common reasons for companies to choose self-insurance are historical precedent and lack of availability of insurance products that meet the specific needs of their unionized employees. Other companies have recognized that self-insurance allows them the flexibility to design their own benefits structures without the typical health insurance exclusions, thus minimizing labor relations issues due to claim rejections. In some cases, employers have utilized Employee Welfare Trusts to create a more structured approach to providing health benefits. The Boards of Trustees of these Trusts are comprised of representatives of labor and management who then determine what benefits are paid out and to whom. The Trust structure brings with it some tax and governance benefits, allowing the employer to negotiate all benefits through the Trust.

Types of organizations that self-insure

Two types of organizations that typically self-insure are Public Sector Undertakings (PSUs) with an employee population of 10,000 and above and with a large-scale unionized workforce, particularly in the areas of manufacturing, energy, and transportation. In the private sector, organizations with employee populations of 10,000 and above and more than 50 years of operation in India and which have large-scale unionized workforces in manufacturing, energy, transport, textiles, consumer goods and pharmaceuticals also tend to be self insured.

The public sector insurance companies are an exception to the above. Between the General Insurance Corporation (with four public sector non-life insurance companies) and the Life Insurance Corporation the employee population exceeds 400,000 and the resultant membership is almost 1 million. These organizations have always fully insured their own health benefits.

There are also an unidentifiable number of small businesses that make informal arrangements with a hospital or doctor to provide some degree of coverage to their employees and, in some cases, employees' families.

Benefit Design, Funding Options and Taxation

Benefit Design

Benefit design approaches for the self-insured often place limits on various items such as room and board and surgeons' fees. However, most self-insured plans are comprehensive, covering inpatient as well as outpatient benefits. Pharmaceuticals are usually covered fully and some self-insured programs will cover dental and vision as well. A few of the large PSUs have even negotiated extended credit terms and rates for procedures. Others have contracted with popular hospitals for preferred and cashless access for their covered employees. For example, Hindustan Aeronautics Limited (HAL), in Bangalore, has negotiated rates with several private hospitals in Bangalore to allow their employees access at rates that are 20-30 percent lower than published rates. HAL has over 100,000 employees in Bangalore and as a result provides significant volume to these private hospitals.

The disadvantage to providing benefits with annual limits, both for the insured and self-insured population, is that the benefits table has to be revised frequently to ensure that benefits stay in line with healthcare cost inflation. In many cases, the benefits tables have not been revised for long periods of time. While most benefits designs do not directly employ risk-sharing with the employee, the cap on the benefit and lack of automatic revision leads to both risk-sharing and the devaluation of the benefit from the employees' perspective.

In some cases, employers have used doctors on their staff to act as gatekeepers. This usually leads to better performance of the plans as the company doctors check utilization of expensive benefits such as inpatient care. In many organizations the company doctor also plays a critical role in the management of health benefits as he/she tends to advise management on the status of the benefit program and its effectiveness, and is an important source of capturing employee feedback. However, the importance of this position also leads to a concentration of power and often becomes the single point of authorization for discretionary benefits. This, at times, can lead to irrational and inconsistent benefits utilization, sometimes leading to discriminatory practices and employee dissatisfaction.

Funding Options

Most employers fully fund the benefits offered. In some cases, e.g., Hindustan Lever, certain bands of employees participate in a contributory plan whereby both employee and employer contribute towards a risk pool. Employers typically do not purchase stop-loss insurance for self-insured plans.

Taxation

The tax code applicable to self-insurance is complex. The relevant sections of the tax code that apply for employers are section 17 of the Income Tax Act, which defines taxation on salary and benefits for employees

and allowable benefits for employers, and section 80 DD and 80 DDB of the Income Tax Act, which defines what types of expenses are allowable expenses under the income tax code.

For employees, Section 17 of the Income Tax Act defines what part of any medical reimbursement is tax exempt. It also identifies which hospitals are approved by the Income Tax authority under which expenses reimbursed by an employer are considered tax exempt. Rule 3A of the Income Tax Rules defines the ailments for which expenses reimbursed are considered tax-exempt.

Organizational Structure and Approaches

Self-administration vs. Contracting out

Currently most self-insured programs are self-administered. In some cases, such as Hindustan Lever, claims adjudication and processing are outsourced but this is a rarity. Most self-insured employers continue to view the health benefit as an essential entitlement for employees and do not invest in professional adjudication and data-capture nor collect any information other than the highest-level data elements such as overall cost per employee. This gives them little capacity to modify or appropriately design their benefits or, as described below, to do any kind of complex utilization analysis.

Systems and Claims Capacity and Approaches

Most self-insured claims management is the responsibility of the employer, and sophisticated claims and technology capacity has not yet been developed. For the most part, information capture is limited to the amount expended and whether it was for outpatient or inpatient care and these are accounting entries rather than true claims administration. In some situations larger companies allow employees to submit claims over-the-counter to the finance department and receive cash reimbursements immediately. As a result, data capture is rudimentary at best.

Provider Relations, Contracting, and Management

Contracting and ownership

Self-insured employers vary in their relationships with providers. Large-scale employers with townships and remotely located facilities tend to operate their own healthcare facilities. This is particularly true of PSUs and older local employers. Other large employers have rudimentary contracts with hospitals allowing employees access to their facilities without paying a security deposit and with direct settlement of claims made by the employer. In some cases, for example, the Central Government Health Scheme (CGHS), employers contract with and negotiate prices with providers. Employees covered under CGHS have cashless access to various hospitals all over India at rates that have been negotiated.

Cost containment and quality assurance approaches

Self-insured organizations rarely undertake explicit cost-containment measures with the providers in their networks. In the case of owned facilities, they are considered sunk costs so use of these facilities is encouraged. These facilities are usually capable of providing primary and secondary care, and contracted facilities with private providers are used extensively. Although rates are often negotiated there is also little effort made to detect fraud and abuse.

Quality assurance is rudimentary at best. Most companies have a Chief Medical Officer (CMO) who is responsible for the entire medical benefits program. However, quality assurance is not systematic and depends upon the interests of a particular medical team.

Directions of Self-Insured Market in India

Probability of growth of this segment

With the deregulation/detariffing of non-life insurance rates of as of January 1, 2007, there is an expectation that premiums for most non-life insurance products will drop significantly. However, health insurance rates were never fixed and, in fact, were heavily discounted to counter the high fixed prices of other types of insurance. For this reason health insurance rates are expected to rise significantly. (Some expect that health

insurance rates for groups will rise by 100 percent or more over the first 18-24 months following deregulation.) This rise in rates should lead employers to search for alternatives. One such alternative will likely be self-insurance. The most serious stumbling block that exists to limit this movement is the asymmetry in taxation between private health insurance and self-insurance. For example, taxes associated with reimbursement of medical expenses for normal childbirth is tax exempt if insured, but taxable (for the employee) if self-insured. This rule can only be changed by the Ministry of Finance and if this were done self-insurance might become prevalent and even commonplace in the Indian group market.

Ability to change health insurers

Since many employers, particularly large multinationals (with employee populations exceeding 10,000), have long purchased health insurance at below cost. We expect that as rates increase in the newly deregulated environment those large employer groups with very high utilization rates will not be able to find affordable benefits by switching insurers. These groups may choose to self-insure to avoid paying rates commensurate with employees' previous claims experience.

TATA Steel

Some private companies both finance and deliver health care. For example, TATA Steel provides health care facilities to employees and non-employees living around its steelworks in Jamshedpur and its mines and collieries in over 600 villages in and around its manufacturing and raw materials operations, including Noamundi, West Bokaro, Sukinda, Bamnipal, and Jamadoba. At Jamshedpur, the company runs an 850-bed hospital that has specialists and dispensaries to reach out to its employees as well as many of the citizens living in the steel city. TATA Steel has also created a network of specialized medical care units that offers low cost, high quality medical care for the poorer people in the community.

They have also established a Blood Bank to provide safe blood to those in need and have worked to establish a culture of blood donations. The health staff that work in the hospital and medical clinics put forth a lot of effort to educate the community about public health concerns, such as HIV/AIDS, eye care, tuberculosis treatment, and maternal and child health. TATA Steel also works to ensure safe drinking water for the community members. They have installed new tube wells and are also repairing and maintaining existing ones.

It is estimated that TATA Steel spends Rs. 9,25,000 [30] per annum on health activities and to date, has shared Rs 378.40 million [31] for the welfare of the people in the community.

Provider-Based Insurance

There has been much discussion among insurers, providers and policy makers about the potential for developing a form of health insurance which aligns the interests of the providers in delivering services with the needs of people for broad quality services at reasonable prices. This occurs, for example, when both patients and providers are financially motivated to maintain health status in order to reduce costs. The development of these types of organizations is discussed in Appendix I on Cost Containment.

With growing competition in healthcare delivery among the secondary and tertiary private healthcare sectors in India, healthcare providers have been searching for ways to increase revenues. Likewise some insurers have been looking for ways to broaden their reach into the world of more comprehensive coverage. Although preliminary provider insurance plans are being developed, the absence of both appropriate insurance regulation and individuals with appropriate skills to create and manage these kinds of programs are important limiting factors.

Examples of existing "provider-based health insurance" can be categorized as follows:

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[30] TATA Steel website, Corporate Susta nability, accessed March 1, 2007. http://www.tatasteel.com/corporatesusta nability/uthnau_page5.asp

[31] ILO. "Workplace Interventions on HIV/AIDS Prevention and Care: TATA Steel Case Study, Jamshedpur", www.ilo.org/public/english/region/asro/newdelhi/aids/download/tisco.pdf

- Risks underwritten entirely by the healthcare provider
- Some risks underwritten by the insurer and some by the provider

Risks Underwritten by the Healthcare Provider

"Health insurance plans" underwritten by healthcare providers largely apply to cancer treatment. Cancer hospitals in the country have experimented with one time pre-payment plans and one such scheme is presently being operated by Dharamshila Cancer Hospital based in Delhi. These plans are unregulated by the IRDA and their services are backed up only by the promise of the provider to provide them. Rajiv Gandhi Cancer Institute based at Delhi operated a similar scheme for 6-8 years but stopped operating in 2004. Experience of the scheme is not known. It is quite likely that similar plans are in operation in other cancer hospitals in the country but there is little knowledge about them. There is however a great deal known about the Dharamshila scheme described below.

DHARAMSHILA CANCER RAHAT YOJNA

Dharamshila Cancer Hospital and Research Centre (DCHRC) is located in the National Capital Region of Delhi. DCHRC is one of the leading centers devoted exclusively to cancer patient care, research, education and prevention. Opened in 1994 in southeast Delhi close to Noida on 3.5 acres of land, DCHRC was founded with the goal of treating only cancer. In the last twelve years the hospital has evolved into North India's premier cancer institute, treating all types of cancer and is one of the first centers to explore gene therapy.

Rationale: Dharamshila Cancer Rahat Yojna is a pre-paid cancer "insurance" scheme aimed providing affordable cancer treatment. Incidence of cancer has been increasing due to increasing longevity, changing lifestyles, increasing pollution and genetic predisposition.

Scheme Features:

- Open enrollment for individuals and families not suffering from cancer.
- One-time payment/donation based on benefit scale.
- Waiting period of one year.
- Discount of 10 percent if spouse, parents and children covered.
- Option to upgrade to higher benefit level on payment of additional donation, subject to one year waiting for increased benefits.
- Donations are exempted from income tax under section 80G of the Income Tax Act. Hospital has been "innovative" by denoting the "premium" a donation, thus allowing tax rebates on the donation to the "policy holder".
- By defining the "premium" as a donation, DCHRC has avoided charging the "policyholder" the service tax levied on insurance premiums.

Other Benefits:

- Free annual physical examination to rule out any disease (consultation only).
- Members diagnosed with cancer are entitled to all investigations, including mammography, C.T. scans, bone scans, endoscopies and lab investigations.
- Members also entitled to radiotherapy, brachytherapy, chemotherapy, surgery, drugs, disposables, blood, blood component therapy and admission in the desired category of wards.

Table 3.12. Dharamshila Cancer Rahat Yojna Benefit Scale

One Time Donation	Life Time Benefit Limit
Rs 7,000	Rs 200,000
Rs 10,500	Rs 300,000
Rs 14,000	Rs 400,000
Rs 17,500	Rs 500,000
Rs 24,500	Rs 700,000
Rs 35,000	Rs 1,000,000

Potential Problems

- The scheme is not backed by any insurer and as a result the entire risk is borne by the hospital. If the insured has another policy this acts as supplementary coverage. As the hospital increases its charges, the value, measured in services, of the life-time benefit is reduced.
- The hospital has not used any actuarial analysis to arrive at the donation/premium rates.
- The scheme operates as an insurance scheme since it covers a contingent liability on pre-payment of a consideration, i.e., donation/premium. However, even though it is being operated as an insurance scheme, it is not subject to any insurance regulations for minimum capital, solvency or reserving requirements. This exposes the beneficiary to a possibility of non-availability of services should utilization exceed the capacity of the hospital.
- No policyholder protection regulations apply to this scheme by virtue of its being outside the purview of insurance regulators.
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Risks Underwritten by Insurer and Provider

Max Healthcare Institute (MHI) is a division of the Max group, which seeks to deliver quality healthcare in India through a chain of primary and secondary care centers and hospitals. MHI has six hospitals with a total of 800 beds in the National Capital Region of Delhi (NCR) and has an up-market branding in the NCR.

MAX HAPPY FAMILY PLAN

The Max Happy Family Plan (MHFP) began operations in August 2006. It is designed to provide comprehensive healthcare benefits to individuals or families. MHFP provides benefits for outpatient care (day-to-day healthcare which is paid for by Max Healthcare) as well as unforeseen instances of in-patient (hospitalization) care covered through a health insurance policy. Max Healthcare had plans to cover 5,000 lives by 31st March 2007. Table 3.14 summarizes the schedule of benefits under Max Happy Family Plan.

The hospitalization insurance provided under a Group health insurance policy of United India Insurance Company has the following characteristics**:**

- The coverage is optional upon payment of an insurance premium.
- It offers cashless hospitalization at Max facilities and other hospitals across India.
- The benefit limit for inpatient hospitalization can vary from Rs 100,000 to Rs 500,000 on a Family Floater basis.
- In addition to the hospitalization benefit, for inpatient coverage the plan has made available bundled coverage such as personal accident, critical illness coverage (for eight critical illness) and hospital cash.

- Personal accident coverage is 100 percent of the sum insured for the insurance applicant, 50 percent for the spouse and 25 percent for the first two children, subject to a maximum sum insured of Rs 300,000.
- Maternity benefit is available for up to four percent of the sum insured. In subsequent years the percentage of the sum insured increases by two percent each year.
- The hospital cash benefit is limited to Rs 200/- per day, after three days of continuous hospitalization. The allowance doubles to Rs 400/- per day in case of hospitalization in the ICU.
- Ambulance charges within defined limits are payable.
- The enrolment age ranges between three months to 60 years.
- Coverage for pre-existing diseases begins from the third year onwards.
- Premium paid for in-patient coverage is eligible for income tax rebate under Section 80D of Income Tax Act.
- Administration of inpatient benefits is outsourced to a Third Party Administrator by the insurance company.

The Max Happy Family plan is designed as a comprehensive product covering both outpatient and hospitalization benefits for individuals and families. However, only the in-patient care is actually covered by insurance. As noted, the medical professionals at Max Healthcare are at-risk to provide all the outpatient services included in the plan.

Table 3.13. Max Happy Family Plan—Summary of Benefits

MAX HAPPY FAMILY PATIENT PLAN				
Features		**Family of 2**	**Family of 4**	**Family of 6**
Out Patient Benefits	Free unlimited consults with a FP* at Max Facilities	Unlimited	Unlimited	Unlimited
	Free consults with a FP* in your neighbourhood**	10	10	15
	Free consults with a specialist#	2	4	6
	Free diagnostics#	Rs 500/-	Rs 800/-	Rs 1,000/-
	Free health check-ups#	1	2	3
	Prescription drugs	5% discount	5% discount	5% discount
In Patient Benefits	Health insurance policy: Hospitalization expenses, critical illness cover, hospitalization allowance, personal accident cover	Floater cover based on age, sum insured and family size.		

20% discount over this limit ** 50% discount over this limit

* Family physician: there is a network of more than 30 Designated Family Physicians, located across the NCR, to provide geographical proximity.

Marketing companies have developed similar plans such as Hygeiacare and Instant Healthcare, both based in Delhi. Such companies offer integrated healthcare services including general and specialist consults, discounts on diagnostics and an insurance cover to meet hospitalization expenses. The major difference between the Max Happy Family Plan and others is that Max Healthcare owns its facilities and therefore has the potential to monitor quality and volume of service more easily. The other marketing organizations have contracts with healthcare providers without much control over quality or volume of service.

Insurers, other than United India Insurance Co., have been reluctant to jointly develop healthcare plans with healthcare providers because they are concerned that the hospitals will market the plans directly to their patients thus creating extremely high utilization.

Future Directions of Private Health Insurance

Looking to the future, there is little doubt that as the economy continues to expand the number of people covered by insurance will also grow proportionately, fueled by medical cost increases that in turn reflect a demand for higher quality and more technologically sophisticated medical care. This phenomenon is already evident in the increase in medical costs and insurance coverage that has taken place within the past few years despite minimal marketing efforts. Whether this growth contributes to well balanced, broadly available, affordable care is dependent on whether growth occurs in spite of the development of the private health insurance industry or because of the leadership it demonstrates. Today health insurance generally covers many but not all hospitalizations of policy holders but with little or no control on the costs or quality of that care. As a result policy holders pay higher uncontrolled charges for services than those without insurance. Thus, while those who purchase insurance may reap the benefits of risk spreading and guaranteed payment when hospitalization occurs, it comes at a high price. In addition, the extensive use of excludable preexisting conditions by insurers makes the coverage less certain. If hospital costs are left unchecked, private insurers will find it difficult to play an important social role in making health care services available to the population.

The modern Indian insurance industry traces its origins to the establishment of the Mediclaim program in the mid-1980s but product development since then has grown very slowly and in some respects has retrogressed in the breath of products available to meet comprehensive health needs. Products such as dread disease insurance and critical illness policies may make money for the insurance companies but usually have low utilization, provide limited coverage and can lead to public perception that insurance coverage is not useful. Mediclaim itself has been modified in ways that make it less a program to control the cost of care and more a reimbursement target for providers.

"Liberalization of the insurance market" which took place in 1999 with the establishment of the IRDA and licensing of private insurance companies has led to better regulatory policy and the beginning of private health insurance but today the market is still largely dominated by government-owned insurance companies. Their policies are determined by boards appointed by the government and a regulator whose budget is dependent upon government resource allocations. This domination by government-directed organizations with little expertise in health insurance has so far not encouraged much change in the government insurers nor in the newer private companies which have entered the market. The introduction of TPAs, with their potential to supply some of the expertise needed by these companies, has been so dominated by the oligarchic control over their pricing and services that their potential value in many areas has not yet been realized.

The lack of progress in the industry is also an opportunity since there is plenty of room for change. While there are many vested interests and long-standing ways of doing things, the market remains small and change will be relatively simple to implement. Government action to broaden coverage and increase the number of people covered is still possible, particularly since it is the government itself that controls the major portion of the industry. Change is never easy and maintaining a socially responsive private sector will take a great deal of leadership and skill.

De-Tariffing

Clearly the most important change taking place is the long anticipated move to de-tariffing of the insurance industry. Excluding commercial motor vehicle coverage and health insurance, premiums on fire, engineering and property insurances are forecast to drop by at least 40 per cent in the de-tariffed regime.[32]

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[32] *The Hindu Business Line*, "A Cover for All", December 5, 2006.

Since it is widely agreed that health insurance pricing has been offered below cost and is the pricing beneficiary of overly generous fixed prices for tariffed insurance, it is assumed that the removal of these tariffs will cause insurers to raise health insurance prices to reflect the actual cost of health insurance. This in turn will force insurers to increase their health insurance and actuarial skill levels as they will no longer be able to afford large subsidies for health policies. An example of this attitude is reflected in an interview with Sandeep Bakshi, Managing Director, ICICI Lombard General Insurance Co., a market leader in the private non-life insurance sector whose health insurance portfolio represents 17 per cent of its total business: "Health insurance will be the next growth driver for the general insurance industry. After de-tariffing, group health insurance will no longer be subject to cross subsidization and will find its own price level based on standard underwriting norms. As far as retail health insurance is concerned, insurance companies have the flexibility to define the coverage and premiums according to the performance of the portfolio." Further, "The task lies with the insurers to expand and build the health insurance category. This will result in segmentation of customer needs and development of innovative and relevant value propositions. Systemic changes such as standardization of procedures, availability of claims data for product development and streamlining of claims administration coupled with higher customer awareness will be the drivers for development of health insurance in the country."[33]

Discussions with various government and private insurance companies indicate that they are now closely monitoring claims ratio, geographical variations in healthcare costs, medical inflation, incidence and costs of major diseases and procedures, and the distribution, frequency and costs of claims among different sex and age groups in order to actuarially determine adequate health insurance premium rates to manage the effects of de-tarriffing. In another example of the anticipated effect of de-tariffing, Oriental Insurance, a government insurer, faced with adverse claims ratios and impending de-tariffing, has taken the lead in trying to rationalize its health insurance portfolio by withdrawing commissions to agents and brokers for policies sold to persons above 55 years of age and substantially increasing the premium for Mediclaim policies for elderly people, while reducing premium for those aged below 20. It is believed that other insurance firms will follow suit.[34] This action is clearly designed to minimize enrollment of older people who use more services while encouraging younger individuals to join their plans. It may be justified under the present system of age-band rating and the real costs of serving the older population, but it points out a strong possibility that de-tariffing may, in the short run, discourage insurance coverage for those who need it the most.

De-tariffing has taken on the air of a "magic bullet" in the insurance industry and there is no question that health insurance prices should reflect real costs. However, it is also clear that the largest government insurers can choose to continue cross subsidization at some level, particularly in the group market where multiple insurance products are sold. Other possible effects of de-tariffing that may be less positive are reduction of benefits and number of people covered by the price-sensitive individual market, and shifting of some groups to self insurance as prices increase with resulting loss of tax deductibility. Nonetheless, it is still likely that de-tariffing will be a positive move for the insurance industry.

Changes in the TPA Market

While de-tariffing is occurring there are many changes taking place in the TPA business. As the industry develops, a consolidation of the TPA market is likely to increase profitability, particularly if fixed pricing continues to be enforced by the large insurers. Today, there are several TPAs that are openly for sale and one that has just been purchased by an insurer. Although attitudes between insurers and TPAs have bordered on hostile in the past, increasing costs of health services will force insurers to give greater priority to effective management of claims and containment of the unrestrained costs of providers. This should lead to more effective use of TPA capabilities by insurers or their direct absorption into the insurers' organizations.

Initially, TPAs had to be responsive to the demands of the insurers in order to survive and many are planning to continue to do so. Others have realized that they are crucial to the process of administering health insurance and have begun to develop strategic options that go beyond simply administering health insurance

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[33] Interview with Mr. Sandeep Bakshi, *Economic Times*, December 11, 2006.
[34] *Times of India*, "Elderly to pay more for health cover." August 31, 2006.

policies for others. To accomplish this some are beginning to partner with international reinsurance companies (including selling stakes in their own organizations) to offer their combined services to existing insurance companies which lack appropriate expertise in health care. They plan to develop turnkey health insurance capability providing services ranging from plan design, pricing, network management, underwriting, cost containment and reinsurance under contract to the direct insurer, who needs only to ascertain the level of risk that it would like to retain. Other TPAs are examining whether they might venture directly into health insurance as part of a managed care organization. In one case that is presently under negotiation a TPA is combining with a hospital-owned parent and a foreign health insurer in a joint venture to create a stand-alone health insurance company. Another TPA is providing TPA services to TPAs outside the country, in particular in the United States. The basic point is that with consolidation, expansion of their roles and even as the core for development of new types of health insurance companies, the TPA market is going to be very dynamic in the future.

Provider-based Insurance

Attempts to develop provider-based insurance have yet to be successful, primarily due to the lack of expertise on the part of providers and/or insurers, but the competitive impetus to do so is great amongst the so-called corporate hospitals and more experiments are likely. The absence of regulation, which could guide development of such enterprises, has also contributed to poor design and implementation. However, large international reinsurers are increasingly interested in working with large hospital-based organizations. Eventually provider-based products will develop to compete with conventional insurance products.

Expansion into Government Markets

Expansion of private coverage for public employees appears to be unlikely given the current capacities of the private insurance market but it would have a profound effect if it were to occur. Government sector employees form nearly 69 per cent of the organized employment market where insurance companies operate. They have, for India, liberal self-funded employee healthcare benefits and they are facing falling government budgetary support and a need to limit expenses. National and state governments and even paramilitary forces are reported to be evaluating the option of financing employee healthcare expenses through group health insurance. If insurers are able to develop the necessary capabilities, including coverage for outpatient expenses, establishing extensive provider networks and setting up servicing capabilities in rural and remote areas, it would expand private insurance to a level not presently possible.

Table 3.14. Evaluation of Private Health Insurance Against Framework Criteria

Characteristic	Benchmark	Private Health Insurance Evaluation
Population covered and growth trend	1) Target population clearly defined. 2) Growth exceeding 20% per year until close to saturation	17 million persons, approx 1.6% of population Growth Rate 25%+ from 1992-2006
Covered services	Essential basic services including primary care and prevention, hospitalization, disease management, etc. Guaranteed renewable	Hospital coverage with Rupee limits. Some dread disease and critical illness coverage. (Exception: The Max Happy Family Plan (MHFP) which provides comprehensive healthcare benefits to individuals & families.) Renewability at option of insurer for individual and variable for group business. Extreme and ambiguous pre-existing conditions faced by individual policy holders.
Geographic Access Financial Access to care	Within 20 minutes from a PHC, within 30 minutes from hospital Benefits include wage loss and travel costs for poor	Dependent upon providers in the area where insured live or receive services. Financial access not covered.
Affordability, including Subsidies	3% to 6% of income depending on coverage	Reputably highly subsidized because of cross-subsidization with other kinds of insurance

Characteristic	Benchmark	Private Health Insurance Evaluation
		and social concerns. A 2004 study shows 58% payout for medical care for hospital claims only on Mediclaim. Rating by age in ten-year increments so older persons pay significantly more.
Efficiency of operations	Administrative costs (incl. all ancillaries) < 20% Reimbursement time < 30 days Technology used appropriately	Administrative costs and profit (losses) estimated to be 42% in 2004 study. Cashless system now in place for most Mediclaim policies. Poor coordination between TPAs and companies Virtually no health insurance experience.
Cost containment	Strong case/disease management programs; effective preauthorization and utilization review, co-payments. Strong provider contracts regarding quality/cost expectations and incentives	Rudimentary pre-admission review by TPAs, mostly on benefit determination. Little or no constraints on hospital or physician pricing. Co-insurance very rare, although see Cholamandalam policy Rudimentary efforts at PPOs without effective management.
Consumer Satisfaction	Ability to choose insurance products, among sources of care, or between network; Measures of consumer satisfaction tracked and actions taken to resolve complaints and improve services.	Few choices of type of policy available in the market. Little confidence in health insurance, particularly in direct-pay market. Regular process for settling disputes exists. Many disputes over pre-existing conditions; TPA and insurer behavior make this the second most litigious area of insurance.
Consumer Awareness and Understanding	Coverage clearly explained by well-trained and effective marketing personnel. Literature and other communication devices used to raise awareness, by the industry, the regulator or another reliable source.	Little apparent effort.
Innovation	Market research undertaken to determine product satisfaction and design requirements Consumer feedback, lessons learnt, challenges, etc. translated into innovations that improve effectiveness	No market research. Product development if it exists is intuitive. Little cost and utilization information exists except with TPAs and no indication that it is being used.
Management Attributes	HR plans and continuing skill improvement programs in place for all staff. Strong internal and external financial controls and accountability	Insurance companies have training for staff but no specialized heath insurance training available. Individual TPAs do have specialized training. Lack of trust, incompatible system interfaces, and unclear policy's disallowances between Insurers and TPA's cause much cross-checking of claims. Potential key areas of abuse (e.g. kickbacks to TPA's from providers) are neglected.
Organizational Structure	High functioning Board of Directors provides transparent and sustainable financial and beneficiary results	All organizations have Boards of Directors but there is no information available on how they behave.
Regulatory compliance	IRDA requires registration of all carriers of health risks and and risk-pooling arrangements and all TPA activities. GOI passes enabling legislation so entities and/or organizations other than insurance companies can provide health insurance arrangements/schemes to individuals or groups & bring their operations	Although life and non-life insurance companies provide health insurance for individuals and groups, IRDA has not yet set up regulations specific to health insurance. For other organizations there is currently no regulations or supervision.

Characteristic	Benchmark	Private Health Insurance Evaluation
	under regulatory oversight. Effective enforcement.	
Sustainability	Long term sustainability indicated by buildup of resources and reserves, and absence of subsidies, either explicit or indirect except where intended to support access to insurance by the BPL population.	Insurers have strict capital reserve requirements, TPA's are not generating enough revenue for long-term sustainability.

3 ADDENDUM

I. TWO CASE STUDIES

Case Study: The CHNHB Association[35]

MAKING INSURANCE AFFORDABLE BY AVERAGING MEDICAL EXPENDITURES

Overview

The CHNHB is an excellent example of how a well-managed health insurance plan can succeed due to a long history of a strong board with a vested interest in making its coverage and rates meet the needs of its members. Since it is only in the business of insurance it is focused on making its plan work. Through its management and philosophy it has been able to provide more liberal benefits than normal and through its virtual elimination of age rating it has overcome one of the major deficiencies of the Indian Health Insurance industry. By offering affordable coverage at a single price to its members as they move through life, members are able to maintain access to benefits at the point when they are most likely to need them. This compares to other private insurers who heavily weight premiums by using age bands and often medically underwrite after a certain age. A comparison of insurance rates between the age rating Oriental Insurance Company and CHNHP Association is shown in Table 3.15 below.

Table 3.15. Comparison of Premium Rates

CHNHBA vs Oriental Insurance Company's Mediclaim Policy[36]

Age/ Sum Insured	Mediclaim Premium Rates*					CHNHBA
	20 Years	46 Years	56 Years	61 Years	Above 70 Years	Premium above 18 years
Rs 50,000	Rs 609	Rs 1,265	Rs 1,799	Rs 2,688	Rs 3,600	Rs 1,000
Rs 100,000	Rs 1,179	Rs 2,447	Rs 3,483	Rs 5,196	Rs 6,960	Rs 1,565
Rs 200,000	Rs 2,221	Rs 4,680	Rs 6,687	Rs 10,018	Rs 13,678	Rs 3,850
Rs 250,000	Rs 2,660	Rs 5,672	Rs 8,133	Rs 12,222	Rs 16,778	Rs 4,400
Rs 300,000	Rs 3,100	Rs 6,664	Rs 9,581	Rs 14,428	Rs 19,878	Rs 4,950
Rs 400,000	Rs 3,867	Rs 8,483	Rs 12,267	Rs 18,562	Rs 25,735	Rs 6,600

** Revised premium rates in effect from 2006*

[35] This analysis is based upon interviews with the management and d rectors of the plan, and on their official reports. It also draws on the knowledge of the interviewer.

[36] Readers should not read too much into the actual price d fferences between the two companies s nce CHNHB is relatively small and its membership is not necessarily representative of the larger company's pool. Also, as noted in the body of this report, its rates are heavily offset by investment ncome. On the other hand, Oriental Insurance Company's rates, as with most private insurers, are set at great discounts to actual costs and are not necessarily computed on an actuarial basis. However, the effect of smoothing the premium costs of CHNHB's insurance pool for the benefit of its older members is clearly demonstrated.

Background and Description of the CHNHB Association

The CHNHB Association (formerly known as The Calcutta Hospital & Nursing Home Benefits Association Limited) is a pioneer in the health insurance business in India. CHNHA is a public limited company registered with the Insurance Regulatory and Development Authority. Established in 1948, the Company has offered health insurance for fifty-eight years.

The CHNHB was exempted from nationalisation under the General Insurance Business (Nationalisation) Act of 1972, because it was considered to be a non-profit distributing mutual benefits association. It was exempted from the provisions of the Insurance Act, 1938, which in practice allowed only stock companies to participate in the business of insurance, and as a result is the only licensed mutual health insurance company in the Indian insurance sector.

The company is run by an active Board of Directors whose members (except for the Medical Referee who is an eminent surgeon) have years of experience at director's level in corporate bodies and professional firms. A Chartered Accountant is the Chief Executive/Secretary of CHNHB and operates the affairs of the Company under the overall supervision and guidance of the Board. There are three other executives, among them a Chartered Accountant who is also the Finance Manager/Assistant Secretary. The Company has 15 employees.

The Association is relatively small and stable with approximately 22,000+ members and most of its business is centered in Kolkata (Calcutta) and the State of West Bengal. It does however, have members in several other states throughout the country. Most of its membership comes from corporate accounts although it does enroll individual members.

A description of the operations of the Association and it health insurance activities is provided below.

Table 3.16. CHNHB Association - Financial Results – 2005-06

	2005-06	2004-05
Income:		
Income from Premium	Rs 26,777,000	Rs 26,603,000
Income from Interest and Dividend	Rs 15,481,000	Rs 14,920,000
Miscellaneous Receipts	Rs 260,000	Rs 12,000
Provision for fall in value of investment written back	Rs 19,000	Rs 137,000
Total Income	**Rs 42,537,000**	**Rs 41,672,000**
Less: Expenditure:		
Claims	Rs 31,980,000	Rs 32,197,000
Operating Expenses	Rs 6,698,000	Rs 6,160,000
Depreciation	Rs 164,000	Rs 165,000
Commission	Rs 53,000	-
Total Expenses	**Rs 38,895,000**	**Rs 38,522,000**
Income less Expenses	**Rs 3,642,000**	**Rs 3,150,000**

CHNHB - Financial Performance[37]

The company is very stable financially and the volume of its claims and average cost per claim have remained stable for the past two years in spite of medical cost and utilization increases in the health care industry. Its board actively oversees the business and has accumulated significant reserves (although as a mutual company it is not required to maintain a set amount). The investment income from this reserve is used to subsidize the premium prices and to keep the plan profitable. The Board, in effect the owner of the Plan, decides when to increase the premiums it charges itself. Table 3.16 shows the financial results for 2005-06 and the impact of the investment portfolio.

CHNHB Health Insurance Policies

CHNHB health insurance policies are liberal but typical for the industry. They provide coverage against hospitalization expenses in a registered hospital or nursing home in India. The policy also covers domiciliary hospitalization expenses subject to meeting certain limits. CHNHBA reimburses directly to the policyholder and no cashless facility is available. At present, the claim settlement period is around 9 working days. There are no unusual efforts to contain costs beyond the efforts of management to make sure they are paying only covered care is reimbursed.

Benefits

The Association offers several benefits that would be considered very liberal for the Indian market. They include:

Maternity: Benefits are extended to the policyholders under the normal provisions of the schedule of benefits. CHNHBA's maternity benefit has a waiting period of nine months.

Coverage of children: A child can be covered from date of birth as long as a relatively small payment is made at least two months in advance of birth. However, the post-natal benefit for the first two months of expenses is capped. Otherwise, coverage begins after two months.

Dental Treatment: Coverage is quite flexible in paying claims for dental treatment within specified limits.

Ambulance coverage: Charges for hiring an ambulance are paid up to Rs 300/- for each trip subject to a maximum of Rs 1,200/- per hospitalization.

Miscellaneous: Coverage is provided for procedures such as circumcision under normal circumstances and voluntary termination of pregnancy in the first year of membership, contrary to the industry practice.

Membership

Coverage under the policy is liberal for the industry and is available to members' spouses and dependant children. Membership commences with a waiting period of two months before coverage begins and is extended for life without any medical examination. While there is an age restriction of 60 years for entry into the policy, the policy can continue above 60 years if renewed without break. In case of death of a policyholder, membership is offered to the dependents. Separate membership is offered to dependents included in the policy on attainment of 18 years of age.

Premiums

Prices charged to all members for insurance are set irrespective of the group to which they belong. As long as they are members there are only two different rates, one for individuals up to 18 years of age and another for all above 18 years which can be extended to the rest of their life with no age cut-off points. The present rate schedule is shown in Table 3.17.

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[37] Financial performance nformation based on 58th Report and Accounts of CHNHB Association and analysis

Table 3.17. CHNHBA Health Insurance Policy - Premium and Coverage

Schedule	Annual Premium Per Member		Total Coverage	
	Age Up to 18 Years	Age Over18 Years		
I	Rs 350	Rs 430	Rs 30,000	With Sub-limits
II	Rs 720	Rs 900	Rs 60,000	With Sub-limits
III	Rs 1,200	Rs 1,440	Rs 1,15,000	With Sub-limits
IV	Rs 1,020	Rs 1,200	Rs 60,000	Without Sub-limits
V	Rs 1,560	Rs 1,800	Rs 1,15,000	Without Sub-limits
VI	Rs 3,630	Rs 3,850	Rs 2,00,000	Without Sub-limits
VII	Rs 4,180	Rs 4,400	Rs 2,50,000	Without Sub-limits
VIII	Rs 4,730	Rs 4,950	Rs 3,00,000	Without Sub-limits
IX	Rs 6,380	Rs 6,600	Rs 4,00,000	Without Sub-limits

Notes:
i) Premium rates applicable for age over 18 years remain unchanged for life under the existing policy conditions.
ii) Domiciliary hospitalization benefits, dental treatment benefits and baby coverage not shown above.
iii) Premiums do not include service tax and education cess.

Case Study: Andhra Pradesh Police Department's Arogya Bhadratha Health Insurance Scheme

Overview

The Andhra Pradesh Police Department's Arogya Bhadratha Health Insurance Scheme is an excellent example of expanding health benefits and access to providers by building on a government-sponsored scheme to increase financial access to care for the AP Police employees and their families. The impetus for the scheme was a concern in the Police Department about the quality of care that the Police were receiving by being limited to using only public hospitals. Arogya Bhadrath, operated by the Department's Social Services Trust, works through a system of solidarity and risk pooling, which supplements the basic government plan's reimbursement. It demonstrates the value of spreading risk and shows that an affordable insurance premium (presently R60 per month) if spread over all police officers, can provide broader access to perceived high quality services for government employees. The compulsory monthly premium allows the plan members to receive health services at participating providers without fees (cashless) up to an expanded allowance of 8 lakh per family per year (the basic government scheme pays up to 1 lakh). The benefit package that the employees and their dependents receive covers life-saving illnesses requiring hospitalizations but outpatient and preventative care services are not covered. Hospital bills are submitted to Arogya Bhadratha for review and payment. It then submits claims to the AP Government plan and covers the remainder of any bill through its monthly premiums. The scheme has also established quality and service standards for participating hospitals and pays them a negotiated fee for service.

Background

In 1999, the Andhra Pradesh Police Department established the Arogya Bhadratha Health Insurance Scheme for all employees of the Andhra Pradesh Police Department. While the police employees were provided health coverage under the Government Employee Health Plan, Police Department employees continued to face significant out-of-pocket costs and financial burdens due to the limitations of the Government Plan. Therefore, in 1999 the Police Department built on the existence of the Andhra Pradesh State Government

Health Plan utilizing a system of solidarity and risk pooling to increase coverage and reduce financial risk for its employees.

When the Scheme first began, it was voluntary and initial enrollment was low. Since then, it has become mandatory for each new employee to join. It is estimated that approximately 90% of the Police Force is covered under the Scheme. Since 1999, nearly 13,500 of the 89,000 members have received services amounting to payments of Rs 43 crore.

Enrolment

All categories of employees at the Police Department are eligible to enroll in the Scheme. There are no exclusions based on pre-existing conditions or age; however employees are only allowed to include one spouse and three children (under the age of 24, unemployed males, and unmarried girls) as dependents. If there are more than three children in a family, then the oldest three children are covered until one of them is no longer eligible, at which point the next oldest child becomes covered.

A premiuim of Rs 60 per month per employee[38] and a one-time initiation fee of Rs 10 were established by the Board of Trustees which manages the Health Scheme. The premium, which is deducted from the employees' salaries, is a fixed fee and does not change due to number of dependents or utilization of the services under the Scheme. This premium covers the cost, up to 8 lakh, of permissible health services required by the member or his/her family regardless of the amount of social tax paid by the member or income of the member. Risk solidarity in a health plan is one of the most efficient ways to spread risk amongst a population group. Solidarity in the Arogya Bhadratha Scheme has allowed expansion of health services and increased utilization of higher quality services in better hospitals.

The Arogya Bhadratha Health Scheme is cashless, provides coverage for a defined set of services with no co-payments or deductibles for the covered services. When a member of the scheme requires medical attention for an ailment that is covered, he or she must go to the Unit Officer for authorization. In cases where there is an emergency, the member can go directly to a participating hospital and show his ID card. After receiving authorization, the member can seek treatment and pays nothing upon service. After the member is discharged, the hospital sends all specified documents and bills to the TPA, where the TPA scrutinizes the bill. The TPA then submits the bill to Arogya Bhadratha Office, where it is again scrutinized, at which point Arogya Bhadratha submits payment to the Hospital. A bill is also sent to the government (Directorate of Medical Education (DME)) for certification of reimbursement to Arogya Bhadratha, upon which the DME Government Accounts pays the Trust up to 1 lakh per case. If for any reason the hospital bill is disputed and not paid, the member is held harmless. It takes the TPA and Arogya Bhadratha Health Administration one month to receive the bill from the hospital, scrutinize charges and make payment to the hospital, and two months for the government to reimburse Arogya Bhadratha.

Benefit Package

The Health Scheme benefit package covers "life-saving" hospital services only, and excludes preventative services and outpatient visits. Medications that are utilized during a hospital stay are also covered; however medications that are needed after a member is discharged are not, with the exception of a few that are vital, such as heart and cancer medications. Medications that are needed for chronic ailments such as diabetes or asthma are not covered under the Scheme.

The Andhra Pradesh Police Department has contracted with 27 private hospitals in and around Hyderabad where members can access services, each of which has undergone inspections based on standards set by the Andhra Pradesh State Government. The criteria for hospitals are that they must have at least 50 beds and should have facilities for treatment for all types of diseases and surgeries as listed in the Scheme. Further, the specialist physicians, general physicians and para-medical staff should be adequately qualified. To qualify, the hospital must have its own pharmacy, lab facilities, theater facilities, and ambulatory services and must be able to provide services to patients 24 hours per day. The hospitals must abide by regulations relating to providing

[38] Former employees or retirees of the AP Police Department do not qualify for this scheme.

free services to the white card holders of the State of Andhra Pradesh or the BPL population and they must adopt at least two villages to demonstrate that they provide better medical and health services to rural groups.

The contracts outline negotiated fixed-rates for "service packages" that are covered under the Scheme. The service packages define the agreed upon length of stay for each ailment covered and the agreed upon rate that will be paid to the hospital should a member be admitted for that ailment. If a member requires an approved longer length of stay than the negotiated days, the hospital charges a daily rate to the Scheme.

Financial Systems and Performance

The financial management of the Scheme is fairly straightforward. Because there are no exclusions to enrollment, other than the number of family members that can receive coverage, it has no underwriting practices. Further, the current TPA that administers the claims for the Trust provides its services free of charge to the Scheme. The claims ratio (premium + government reimbursements) / (Hospital bills paid + administrative costs) has changed a great deal since the introduction of the Scheme. In the first year, the Arogya Bhadratha had a loss with an approximate claim payout of 127 percent. This was alleviated by taking out a loan in 1999 and repaying it by 2005. From financial year 2005 – 2006, however, there was a surplus and an estimated claim payout of 65 percent. The total claim payout from January 1999 to March 2006 was approximately 86 percent.

Table 3.18. Claim payout percentage of Arogya Bhadratha

January 1999 to March 2006

Date (financial year is April 1 to March 31)	Claims Payout Percentage
Jan 15 1999 - March 31 2000	127.0%
April 1 2000 - March 31 2001	103.3%
April 1 2001 - March 31 2002	80.9%
April 1 2002 - March 31 2003	97.0%
April 1 2003 - March 31 2004	90.5%
April 1 2004 - March 31 2005	87.4%
April 1 2005 - March 31 2006	64.7%
TOTAL from 1999 to 2006	**85.8%**

In conclusion, while the benefits of this scheme don't approach those offered in some private sector programs, by blending the benefits of a public program with a supplementary employee-financed program and by spreading the risk, over the whole force, the Police Trust has been able to substantially enhance the benefits and quality of the providers in the Scheme and thereby increase the protection and satisfaction of their members. In doing so it has added some discipline and standards to the selection of providers and negotiated prices for services that helps it control the amount it pays for those services.

II. CURRENT APPROVED HEALTH INSURANCE POLICIES IN INDIA (AS OF MAY, 2007)

Policies from Non-Life Insurers

Indemnity-based Hospitalization Expenses Policies include:

a. Mediclaim Policy from govt. owned insurers
b. Health Guard from Bajaj Allianz
c. Silver Health Plan from Bajaj Allianz – a policy for senior citizens
d. Health Insurance Policy from Cholamandalam
e. Health Shield from Royal Sundaram
f. Medishield policy from Iffco-Tokio
g. Health Saver Plan from ICICI Lombard
h. Family Floater Health Plan from ICICI Lombard
i. Mediclaim Policy from Reliance General
j. Medi Premier from Star Health & Allied
k. Medi Classic from Star Health & Allied
l. Health Plus Medical Expenses from by New India
m. Uni-Medicare from United India

Assured Benefit-based Critical Illness Policies include:

a. Critical Illness Policy from Bajaj Allianz
b. Critical Illness Policy from National Insurance
c. Critical Illness Policy from ICICI Lombard

Assured Benefit-based Hospital Cash Policies include:

a. Hospital Cash Policy from Bajaj Allianz
b. Hospital Cash Policy from Tata AIG (exclusive tie-up with HSBC Ltd.)

Socially oriented, Indemnity-based Hospitalization Expenses Policies includesubheading:

a. Universal Health Insurance Policy from government-owned insurers
b. Jan Arogya Health Insurance Policy from government-owned insurers
c. Micro Health Insurance Policies from private and government-owned insurers

Policies from Life Insurers

a. Health Protector Policy from Tata AIG – an accident & health policy
b. Health First Policy from Tata AIG – a hospital allowance policy
c. Cancer Care Policy from ICICI Prudential
d. Health Assure Policy from ICICI Prudential
e. Diabetes Care Policy from ICICI Prudential
f. Medicare Policy from Birla Sun Life
g. Lady Guard Plan from Birla Sun Life
h. Jeevan Bharti Critical Illness Plan for women from LIC
i. Ashadeep II from LIC – Critical Illness cover

Major Health Insurance Schemes run by Non-Governmental Organisations (NGOs):

a. Yeshasvini Health Insurance Scheme for farmers in Karnataka
b. SEWA's VimoSEWA

III. ANALYSIS OF HEALTH INSURANCE PORTFOLIO OF A GOVERNMENT-OWNED NON-LIFE INSURER

During our meetings with different insurers, one of them provided an analysis of their health insurance portfolio. The three-year claims analysis may be indicative of the health insurance claims experience of most insurers:

The claims experience is higher in older age group *vis-a-vis* the premium contribution, clearly indicating inter-age group claims subsidization by younger age groups for the older age group as shown in Table 3.19.

Table 3.19. Performance of Health Insurance based on Age Group of Insureds

Age Group	% of premium	% of Claim
0-35 years	30	23
36-55 years	45	36
56 and onwards	25	41

Source: *A government-owned non-life insurance company.*

Major diseases – There are 20 diseases that account for 65-70 per cent of the claim outgo. These diseases are

- Coronary artery disease
- Ischemic heart disease
- Heart block
- Degenerative diseases of knee and hip
- Pregnancy
- Cataract
- Hernia
- Fistula in ano
- Appendicitis
- Cholelithiasis
- Fibroid in uterus/adenomyosis
- Benign hypertrophy of prostrate
- Hydrocele
- Fissure in ano
- Acute gastroenteritis
- Diabetes mellitus
- Tuberculosis
- Hepatitis
- Urolithiasis

Composition of claims costs under various components is as follows:

- Doctor's Fees: 20-25%
- Medicines: 20-25%
- Room Charges: 15-20%
- Tests and Investigations: 12-15%
- Not attributed: 15-33%

IV. LICENSED TPAs OPERATING IN THE INDIAN INSURANCE MARKET*

TPA
Alankit Health Care Limited
Anmol Medicare Ltd.
Anyuta Medinet Healthcare Pvt. Ltd.
Bhaichand Amoluk Insurance Services Pvt. Ltd
Dawn Services Pvt. Ltd.
Dedicated Healthcare Services (India) Private Limited
E Meditek Solutions Ltd.
East West Assist Pvt. Ltd.
Family Health Plan Ltd.
Focus Healthcare Pvt. Ltd.
Genins India Ltd.
Good Healthplan Ltd.
Grand Healthcare Services India Private Limited
Heritage Health Services Pvt. Ltd.
MD India Healthcare Services (Pvt.) Ltd.
Med Save Health Care
Medi Assist India Pvt. Ltd.
Medicare TPA Services (I) Pvt. Ltd.
Paramount Health Services Pvt. Ltd.
Parekh Health Management (Pvt.) Ltd.
Park Mediclaim Consultants Private Ltd.
Raksha TPA Pvt. Ltd.
Safeway Mediclaim Services
TTK Healthcare Services Private Limited
Universal Medi-Aid Services Ltd.
Vipul Med Corp. Pvt. Ltd.

*As of August 2006.

4 HEALTH COVERAGE FOR THE POOR

As documented in Chapter Two, affording healthcare poses a significant challenge for the majority of the Indian populace. A 2002 World Bank report estimated that 40 percent of people who are hospitalized need to take out a loan or sell assets to cover their hospitalization expenses.[1] The same study reports that once hospitalization expenses are met, 25 percent of those hospitalized will fall below the poverty line.

Poor households are vulnerable to catastrophic expenditures caused by sickness and premature death. Providing them with access to financial protection services is an important strategy to mitigate the risk of an inevitable fall back into a cycle of poverty. In spite of this, such services are not readily accessible for the poor in India. The public sector insurance companies have been directed by the central government to provide health financial protection products for the poor but these have not shown good results. One such policy named "Jan Arogya Bima" was introduced in 1998 and was aimed at providing affordable medical insurance to the poorer segments of Indian society. The policy is a variation of the Mediclaim policy and covers health costs up to Rs 5,000 per person aged from 5 to 70 years with no internal limits. Annual premiums for an individual adult range from Rs 70 for adults under 46 years, Rs 140 for ages 66-70 years, and Rs 50 for dependent children up to age 25. Paid premiums qualify for tax rebates and no service tax is levied on the premium. Jan Arogya Bima suffered from poor enrollment, particularly because the claim settlement process was unreliable and the product was not deemed appropriate to the poor.[2]

In 2004 the central government introduced the Universal Health Insurance (UHI) scheme, which was aimed at those living below the poverty level. The UHI, also referred to as the "Government Rupee-a-Day" scheme (because the annual premium is Rs 365 per person[3]) is centrally financed and implemented through the four public sector insurance companies who are charged with selling the scheme. The central government subsidizes the premium costs for the BPL community providing insurance companies an add-on to the premium after a policy has been sold to a BPL.[4] The UHI scheme has been unsuccessful at attracting the poor for several reasons.[5] First, the insurance companies that are required to implement the scheme find it loss-making and do not market or sell it sufficiently which leads to low enrollment. Identifying the eligible families who are willing and able to pre-pay the annual premium in lump sum also causes difficulty in encouraging people to sign up for the scheme.

As could be expected for a voluntary participation health insurance plan supported by lackluster marketing, financial results of the public carriers with respect to these products were poor because of adverse selection.[6] For example, Mediclaim and Jan Arogya policies experienced claims ratios in the range of 120- 130 percent.[7]

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[1] Peters, David. Better Health Systems for India's Poor: Findngs, Analysis, and Options. The World Bank. Washngton, DC, 2002.

[2] Krause, Patrick. "Non-Profit Insurance Schemes for the Unorganized Sector in India." Social Policy Working Paper, No. 22e. GTZ http://www.gtz.de/de/dokumente/en-non-profit-insurance-in.pdf.

[3] The UHI is offered at a price of Rs. 365 per year for a single person; Rs. 548 for a family of five (with three children); or Rs. 730 for the family plus two dependant parents.

[4] The four public sector insurance companies sell the policy to the BPLs at Rs 365 for an ndividual minus the subsidy provided by the government. Initially, the subsidy was Rs 100 for an individual, but was ncreased to Rs 200 n 2005.

[5] Rao, Sujatha. "Health Insurance in India". From: National Commission on Macroeconomics and Health Report: Fnanc ng and Delivery of Health Care Services n India: Background Papers. New Dehi, India. 2005.

[6] Krause, Patrick. "Non-Profit Insurance Schemes for the Unorganized Sector in India." Social Policy Working Paper, No. 22e. GTZ http://www.gtz.de/de/dokumente/en-non-profit-insurance-in.pdf.

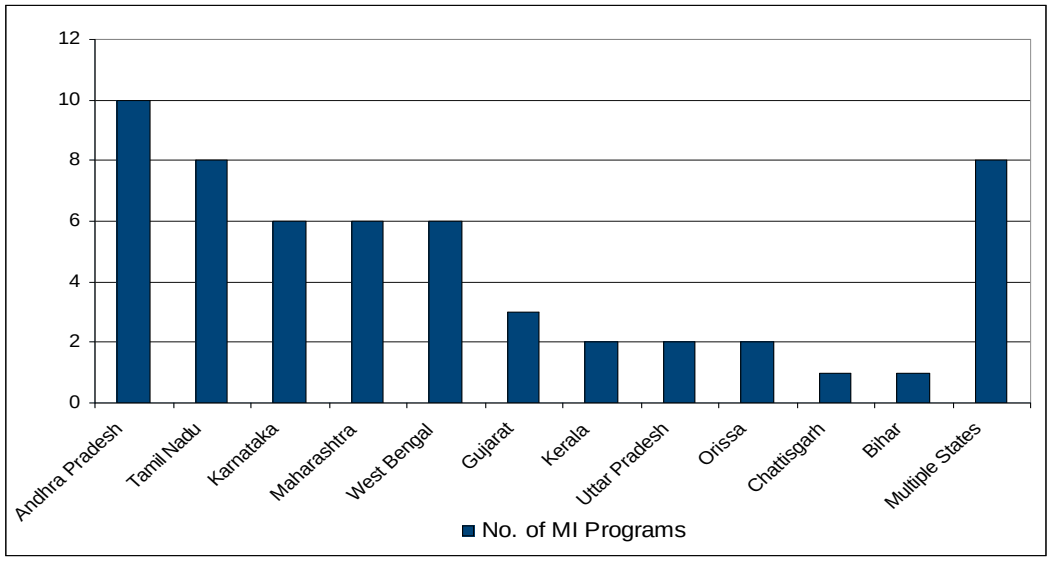
[7] Parera, Russel. "Health Insurance in India- Devising an Appropriate Model." KPMG.

Despite the mediocre success of these public-initiated schemes, there are numerous community-based organizations (CBOs) engaged in providing financial access to healthcare services for the poor, some of which offer worthy examples for both government and other CBOs in India. One example is CINI ASHA,[8] which is the urban unit of the large NGO Child in Need Institute (CINI). CINI ASHA was initiated in the outskirts of Kolkata with the objective of meeting the nutritional and health needs of neonates and mothers. A maternal health voucher scheme was designed to address preventive and curative elements of pregnancy, ensuring continuous access to health care services. Vouchers were given to pregnant women at a nominal cost, which they could use to access antenatal care and delivery care without any cash transaction, thereby eliminating the financial barrier to some essential healthcare services.

Several community-based and non-governmental organizations are also engaging in health microinsurance (HMI) activities in efforts to reduce financial barriers to healthcare. Microinsurance (MI) refers to insurance for low-income people and while there is no rigorous definition, it differs from commercial insurance in that it is a lower-valued product with modest benefits, modest premium amounts, and simpler documentation requirements. Microinsurance requires customized design and distribution strategies for different target beneficiary groups as well as flexible and frequent premium payments to match the cash flow patterns of the poor. It is usually priced on a community risk-rating basis and requires the involvement of an intermediate implementing agency that represents the beneficiary group.

The International Labor Organization (ILO) estimated in 2005 that there were 51 micro-insurance schemes operating in India covering approximately 5.1 million lives.[9, 10] ILO further estimated that approximately one-third of the microinsurance schemes are implemented by organizations that are also providing microfinance services to the poor.[11] Another third are implemented by NGOs supporting a wide range of development activities at the community level. Of the remaining, 23 percent are being implemented by community-based organizations, i.e., member-owned, mutual organizations, and the rest are implemented by health care providers. Approximately 60 percent of all the microinsurance schemes offer protection for health risks as

Figure 4.1: Number of MI Programs by State



Source: International Labour Organization, 2005

[8] Iyer, Lalitha. *West Bengal: CINI ASHA Maternity Voucher Scheme Case Study*. International Labour Organization. New Delhi, India: ILO, 2006.
[9] International Labour Organization. 2005. *India: An inventory of microinsurance schemes.* Strategies and Tools aga nst Social Exclusion and Poverty (STEP) Programme, Geneva. ILO 2006 (Op. Cit) nformally updates the number of micro nsurance activities to 58, but the number is not confirmed.
[10] International Labour Organization. 2006. Workshop Report: "Answer ng the Health Insurance Needs of the Poor: Building up Tools for Awareness, Education and Participation". New De hi, May 29-31, 2006.
[11] International Labour Organization. 2005. Op. Cit.

part of the benefit package. The existence of more MI schemes in south India appears to be correlated with the growth of the microfinance sector which is mostly concentrated in three southern states: Karnataka, Tamil Nadu, and Andhra Pradesh. Of these schemes, 61 percent are based in rural areas, 8 percent in urban areas, and 31 percent operate in both urban and rural areas.

Microinsurance schemes in India vary with respect to bearing the insurance risk. The majority of them operate within a partner-agent model in which an insurance company is the "partner" insuring the risk of the group, and with a second organization such as an NGO acting as implementer or "agent" marketing and administering the microinsurance scheme. There are also several self-insured schemes in operation and some are offering health insurance as part of a wider array of services to their members. In this model a nodal organization such as an NGO plays all the roles of an agent but also bears the insurance risk. A third model is a combination of the first two—the central organization partners with an insurance company to take on a portion of the risk through a health policy containing standard limitations and exclusions, with the scheme assuming additional risk aimed at enhancing coverage limits and exclusions that fall outside of the insurance company's policy. Some of these schemes have characteristics of mutual benefit associations to a degree in that they are driven by member participation and are responsive to their expressed needs, but unlike a true mutual they are not governed by the members.

The government of India appears to have recognized the critical importance of micro-insurers in providing coverage to the 93 percent of Indians who work in the unorganized sector as well as the failure of current public insurers' efforts to cover the BPL population.[12] The National Commission for Enterprises in the Unorganized Sector (NCEUS) prepared a Social Security for the Unorganized Workers (SSUW) Bill that was recently presented to the GOI. The SSUW Bill is expected to go before the Indian Parliament in August 2007, where it is likely to be adopted. This legislation would gradually extend coverage to 300 million unorganized workers over the period 2007 through 2011. The Government would subsidize the premiums of households below a defined income (6,500 Rs.) for a set of benefits including health coverage.[13] The program would involve partnerships among government, NGOs, and public insurers. The NGOs would assume the role of agent/administrator common to most micro-insurers. The insurance risk would be assumed by the public insurance companies. While public hospitals are explicitly mentioned as providers, neither private insurers nor private providers are explicitly named in the ILO summary of the legislation. It is not the purpose of this Chapter to provide a critique of the proposed legislation, but the challenges are significant. They include ongoing funding, National, State and District level organization and implementation, cost containment and quality control. For much of the implementation and oversight the plan would rely on a major increase in the scope and number of microinsurance type organizations.

There are several major constraints to achieving a wide outreach with microinsurance. On the demand side, lack awareness of risk pooling poses one of the most significant barriers to health microinsurance penetration. Although many communities are familiar with very simple types of informal risk pooling which they have practiced for generations, there is a general lack of knowledge about the concepts of health insurance as well as the benefits of larger scale formal risk pooling. This is particularly true for poorer households. Insurance agents do not see them as a worthwhile beneficiary group for their products and therefore do not exert a lot of effort to educate them. It is also costly to conduct awareness activities, particularly in rural areas where many of the poor live. To compound the challenge, the poor are often functionally illiterate and therefore the traditional consumer awareness strategies that are used by insurance agents need to be specially adapted to the information sources of their BPL audience.

Consumer confidence in the health service delivery system and the organizations implementing insurance activities is also a demand-side constraint. There is generally a shortage of good quality healthcare providers, particularly in rural India where most of the population lives. If people feel that there is already a barrier to accessing a healthcare provider, then there is little motivation to pre-pay for services that they cannot readily access geographically or otherwise. A third constraint is financial access—even if insurance has been

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[12] ILO, Extension of Social Protection n India: Social Security for Unorganized Workers. NCEUS Report, June 2006.

[13] The health benefit would provide for hospitalization (maximum per annum of 15,000 Rs.), maternity (l mit of 1,000 Rs.) and a sickness cover at 50 Rs. (maximum 15 days).

purchased, the poor often forgo seeking treatment because they cannot afford the transportation costs to provider facilities nor to lose their daily income while undergoing treatment. Additionally, the poor are often deterred from seeking treatment since they do not have available cash required to settle the bills upfront as required by reimbursement systems. With poverty rates as high as they are, cash flow is almost always an issue within the BPL households. There is barely enough to meet basic everyday necessities without the additional challenge of financing an annual premium for an intangible benefit that may or may not be realized. In most cases insurance companies require an annual premium and the lack of available cash at the time of collection prevents many families from enrolling.

A recently conducted study[14] looked at the willingness to pay (WTP) for health insurance among rural and poor persons in India. The findings showed that insured persons reported higher WTP values than uninsured—about two-thirds of the sample said they would pay one percent of household income; about half would pay up to 1.35 percent of household income; and 3 out of 10 were willing to pay as much as 2 percent of household income on a health insurance premium. The observed levels of willingness to pay were significantly higher than had been previously estimated. While these observations are very interesting for HMI implementers, they must be considered in light of an important caveat: the experience of some microinsurers in various parts of the world is that WTP estimates ascertained from surveys are usually higher than the amounts their clientele/members are actually willing to pay at the time of enrollment and collection.

A major supply-side constraint that inhibits the success of HMI relates to internal management capacities of microinsurance implementers. The majority of HMI schemes in India are built on a trial-and-error basis and often with minimal regard for insurance principles. They were initiated because there was a need in the community in which the development organizations were working. Very few of the HMI implementers actually possess the skills necessary for managing an insurance scheme such as developing effective management information systems, designing appropriate databases and systematic data collection, designing and pricing products using actuarial methods, managing risk, investing reserves, and developing efficient administrative processes. These skills are especially important for self-insured schemes. Lack of management capacity affects the long term viability and growth of HMI schemes.

There are other supply side constraints: while some HMI schemes successfully utilize the public sector provider network (such as Karuna Trust, Karnataka), most other HMI schemes in India must partner with private sector providers in order to deliver services. While private providers in India are generally regarded as better quality, accessibility of private providers presents a constraint for many of the poor in India. A facility survey[15] was conducted in eight middle-ranging districts of India,[16] which rendered important characteristics of accessibility of healthcare providers, particularly in respect to the rural poor:

- Distribution of facilities is skewed: 88 percent of towns have a private health facility compared to just 24 percent in more rural areas;
- 75 percent of specialists and 85 percent of technology are in the private sector;
- There is an acute shortage of human resources: in the districts that were surveyed, there were 0.4 doctors per 1000 and 0.32 nurses per 1000 population, against the national average of 0.59 for doctors and 0.79 for nurses. Exacerbating the situation, nearly two-thirds of the doctors and nurses are concentrated in the urban areas;
- 35 out of the 80 blocks surveyed had negligible to no nurses or doctors at all in either the public or private facilities;
- Only two health centers per district had emergency obstetric care facilities;

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[14] Dror, David., et al. "Willingness to pay for health insurance among rural and poor persons: Field evidence from seven micro health nsurance units in India." *Health Policy*. 2006.

[15] Government of India. Ministry of Health and Family We fare. *Report of the National Commission on Macroeconomics and Health.* Delhi, 2005.

[16] Khammam (Andhra Pradesh), Nadia (West Bengal), Jalna (Maharashtra), Koxhikode (Kerala), Ujain (Madhya Pradesh), Udaipur (Rajasthan), Vaishali (Bihar), and Varnasi (Uttar Pradesh).

- 75 percent of service delivery for orthopedics, vascular and cancer diseases, dental health and mental health were being provided in the private sector; 40 percent of communicable diseases and deliveries were also being provided in the private sector.

The striking findings from this survey underline the constraints experienced by the rural population with regards to accessing healthcare services. If participating providers in a health insurance scheme are neither geographically accessible to the beneficiaries, nor have the right skills mix to deliver services needed by the community, health insurance is not going to "improve access" to health care services and there exists little incentive to subscribe to a health insurance scheme.

There are also regulatory issues that inhibit the growth of the microinsurance sector. For example, although there are some provisions in the Insurance Act for registering self-insured schemes, these provisions limit coverage amounts for participating members to very low, outdated values that were set decades ago. On the other hand, setting up an insurance company specifically for microinsurance is prohibitive since this requires capitalization of at least 100 crores. The relatively new Microinsurance Regulations define microinsurance in more modern terms but require that all microinsurance schemes be set up as a partner-agent arrangement.

These policy limitations limit the proliferation of microinsurance since the only legal option available is to partner with insurers, even though insurers are often reluctant to insure programs that have been designed for and cater to the poorest of the poor. Insurers are required by IRDA to carry a minimum amount of their business in the social sector (which includes BPL) and for this they offer products that are often not suitable in terms of premium amounts, benefits, exclusions, and documentation requirements. In general, a top-down approach to development of microinsurance does not work as well since solutions are driven by the insurer's interests rather than by those of participating members. This is not surprising since insurers are subject to the forces of the Indian free-market economy which requires them to seek the best returns on their invested capital and other resources.

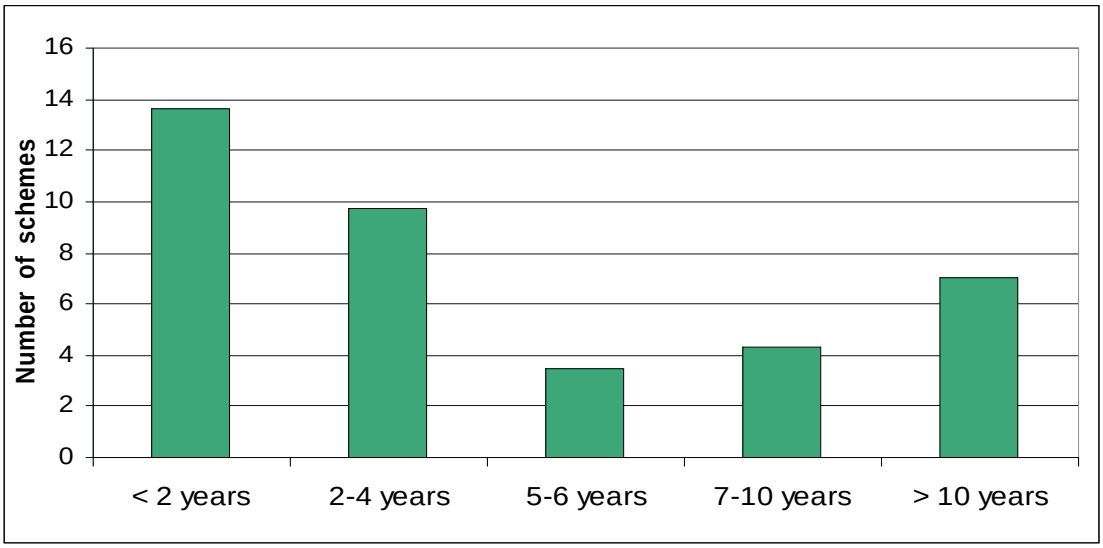
There are other challenges, not least the diversity and size of the BPL market. The Indian population was estimated to have reached almost 1.1 billion people by mid-2006, with approximately 16% of the planet's population living on just 2.4% of its land mass. The population is incredibly diverse with over 2,000 ethnic groups representing every major religion and speaking four major families of languages (Indo-European, Dravidian, Austro-Asiatic and Tibeto-Burman, as well as several other distinct languages spoken in Jammu & Kashmir). This racial and cultural diversity is a product of invasions and migrations over thousands of years from the Middle East, Central Asia and the West, as well as migrations from Tibet and southern China.[17]

The mix of peoples and cultures is further complicated by the caste system which reflects India's hierarchical stratification along occupational and socio-religious lines. Traditionally, there are four broad categories of castes which include a category of outcastes (untouchables, or dalits, of which there are approximately 175 million). These broad categories are further subdivided into thousands of castes and sub-castes whose relative status varies from region to region. Many of India's 275 million poor are among the lower strata of this caste system. Despite the modern laws designed to counter discrimination, the caste system remains as the main reference for social identification and is an important determinant with regards to political and economic status within Indian society.[18]

Such a vast and varied BPL population, beset with a wide range of problems in addition to a lack of basic human rights and unmet common needs, requires innovative policies and solutions to address these problems. Similarly and more specifically, the approach to health microinsurance also requires a broad range of adaptive tailor-made solutions to risk management, service delivery, awareness building, marketing, administrative structures, and financing. Each target population has its own attitudes and cultural values as well as its own inherent set of characteristics, such as demographic profile, state of health and disease prevalence, geographical distance from providers, risk pooling awareness and willingness to pay, occupations and livelihoods, language, and so on. A scheme that has been designed in one locale and situation and then

[17] *Wikipedia*. Jan. 2007 http://www.w k pedia.com.
[18] bid.

Figure 4.2: Years of Experience of Microinsurance Schemes in India



Source: International Labour Organization, 2005

evolved from its experiences cannot be readily transplanted and replicated elsewhere without extensive experimentation and adaptation.

There is very limited experience of microinsurance schemes in India, as shown in Figure 4.2. Because the sector is so diverse and still in very early stages of development (60% of schemes studied by ILO were established in the last 5 years), it is difficult to characterize it in general terms and to reliably predict where it is heading. The approach taken in the rest of the chapter is to describe extensively a few select and interesting examples. The geographic and operational scopes of the selected schemes are illustrated in Figure 4.3. To understand these cases better it is necessary to begin each with a brief context and chronology of its evolution.

ACCORD/ASHWINI Community Health Insurance Scheme

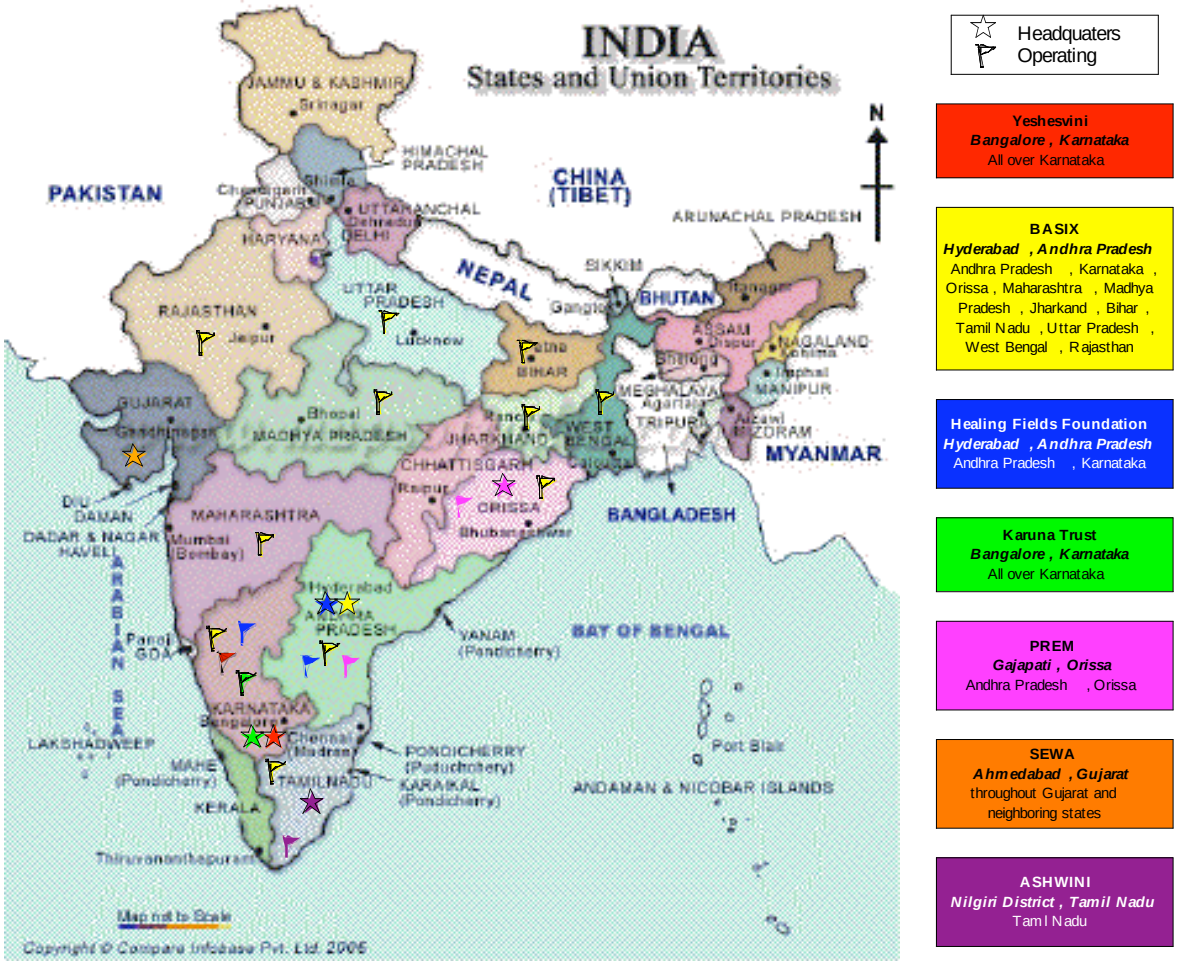
ACCORD is a local NGO founded in 1986 by husband and wife Stan and Marie Thekaekara who wanted to improve the conditions in which the adivasi (tribal) community of Gudalur Taluk in Nilgiris district[19] lived. Their main objective was to transform the adivasis (whose social status is even lower than the average scheduled tribes) into an organized, self-reliant, empowered and dignified ethnic group that could stand up for their land and forest rights.

ACCORD's many areas of intervention are developed and managed with the participation of the community through the Adivasi Munnetra Sangam (AMS), a federation of more than 200 village-level unions (sangams) whose organization was facilitated by ACCORD. These sangams work to defend the rights of the adivasi communities. The broad array of programs includes education, economic development, housing, and collective-wealth activities.

In 1987 ACCORD launched a community health program in the adivasi villages to train village health workers selected from the community to identify and prevent illnesses, provide immunizations and nutrition counseling, and improve health awareness of the community members. Encouraged by the success of the health program and spurred on because existing public and private providers in the area were not fulfilling their needs, the adivasi community urged ACCORD to set up their own community-owned hospital.

[19] Nilgiris district is located at the tri-junction of three southern Indian states: Tamil Nadu, Kerala and Karnataka.

Figure 4.3: Map of India Showing Locations of Selected MHI Schemes as of January 2007



In 1992 ACCORD initiated a health insurance scheme for members of the AMS which was to be managed by the Association for Health Welfare in the Nilgiris (ASHWINI), the sister NGO which had grown out of the health program. Enrolled members could access health services within the network of seven health sub-centers and the 20-bed Gudalur Adivasi Hospital, which by then was functioning well with all the basic facilities including obstetrics and surgery. The objectives of this scheme were to improve dignified access to health services for the adivasi community through self-reliance; to encourage health-seeking behavior through readily accessible comprehensive healthcare facilities; to continue the advancement of solidarity amongst AMS members through a participatory health program; to protect AMS households from catastrophic health expenditure; and to create a stable income stream for the Gudalur Adivasi Hospital.

Risk pooling was not an entirely new concept for the adivasis. When someone in an adivasi village needs to be hospitalized, a collection from households in the village is undertaken and the funds are used to rent a vehicle for transporting the patient with required accompaniment to the hospital. Similar types of risk-pooling had been practiced for generations.

Box 4.1: Genesis of ASHWINI and the Community Hospital

Quite encouraged by the success of the community health programme and the role played by the adivasi health workers, the adivasi community felt that the next logical step would be to start a hospital of our own. There was a heavy demand from the village sangams to start a hospital. But the doctors were reluctant, saying that Hospital is a permanent institution which needs to be run 24 hours a day, all through the year - and for many years. The health team at that time was not equipped to handle such an institution. Moreover, the ACCORD team strongly felt that their intervention had to be time-bound and they will withdraw after a few years when the AMS can take over the initiative of protecting the rights of the adivasis. But, hospital is a permanent form of intervention which cannot be withdrawn. And, in any case, where are the nurses in the adivasi community? Another basic philosophy of ACCORD was to identify youth from the community itself to deliver all the services to the people and to train them! And, Doctors??

However, the community was strong in its demand and felt that the community health programme needed a hospital of its own to make it much more effective and acceptable to the people. So, they started a search for suitable people. Again as a curious coincidence, there landed up a doctor couple, Shyla and Nandakumar, willing to be part of the health programme. Having the ideal combination of skills as Gynecologist and Surgeon, they were what the "doctor ordered" and the people were looking for! Young adivasi girls were identified by the sangams and the new doctors started training them as nurses. Thus was born the "Gudalur Adivasi Hospital" [GAH]. In 1990.

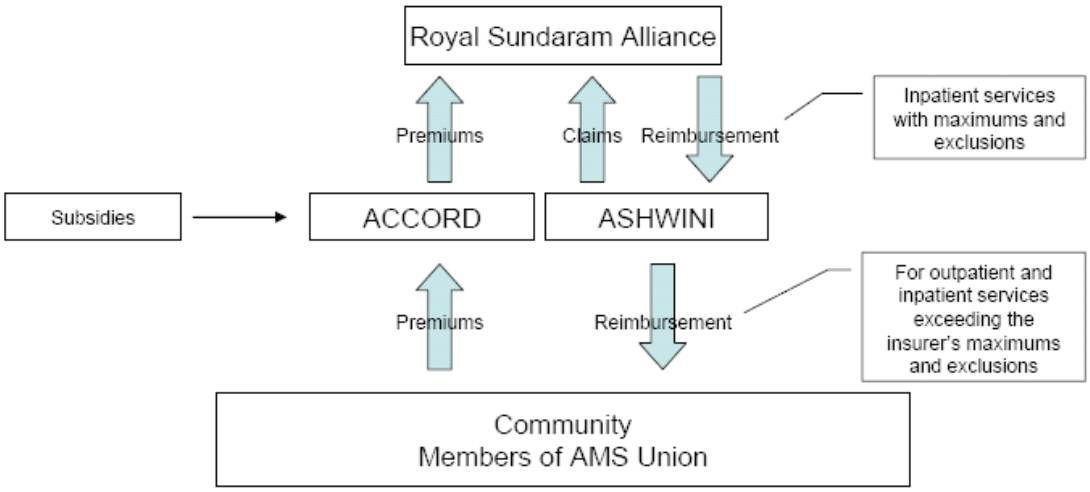
With the establishment of the Hospital, we realized that this intervention is going to continue for a many years, and structurally it has to be different from that of ACCORD or AMS. So, the health programme, activities and the staff were hived off from ACCORD and a separate legal entity called ASHWINI was registered. From then onwards, ASHWINI took care of the health issues concerning the adivasis and poor people of this area. While Deva and Roopa continued their focus on the community health programme, Shyla and Nandakumar started training tribal girls as Nurses. It was a major cultural change for the girls —from innocent village life to a three-shifts-a-day routine in the hospital. Training had to start from elementary Maths and English.

These adivasi nurses have come a long way in the next 18 years. They have become experts in conducting deliveries, in assisting the doctors in surgeries, in the general administration of the hospital, in ordering and managing the drug stocks, in designing systems to monitor the performance of the hospital (All the patient details have been computerized after 1996) and in analyzing the financial aspects of the hospital management. They are constantly trained and their skills are upgraded to keep up with the growth of the programme.

Today, the Adivasi Hospital is one of the most sought after hospital in the Gudalur valley, not only by the tribals but also by the non-tribals of the local area. Patients are brought from distant villages by ambulance and good quality care is given. As all the staff are from the community and can talk the tribal languages, the tribal patients feel at home. Efforts were constantly made to keep the place culturally acceptably to them and the community gradually adjusted to the change. Today, there are cots in the hospital, they come forward for surgeries and many of them regularly show up for antenatal checkups etc. Some more young doctors came and worked in the hospital for brief periods - the health team getting enriched by the interaction with each of these doctors..."

Source: www.ASHWINI.org

Figure 4.4: Two-level Risk Pooling Structure of ASHWINI CBHI



Source: Adapted from Devadsan, N., et al, 2004.

Table 4.1: Overview of the current ASHWINI Health Insurance Scheme

Characteristic	Description
Owner and manager of the scheme	ACCORD, a non-governmental organization, set up by the Association for Health Welfare in the Nilgiris (ASWHINI)
Administration of health insurance scheme	ACCORD manages premiums; ASHWINI manages claims.
Distribution and marketing	ACCORD, ASHWINI and the Adivasi Munnetra Sangam (AMS) field staff all collect enroll, renew, and collect premiums.
Service providers	Three-tier delivery system which begins at the village level with trained tribal health workers. ASHWINI has a network of seven regional health sub-centers manned by adivasi nursing assistants and the Gudalur Adivasi Hospital which also serves as the main ASHWINI administrative center. Referrals are made to tertiary centers at Kozhikode or Coimbatore as needed.
Role of state government	Government of Tamil Nadu provides some assistance for certain programs: immunization (free vaccinations), family planning (incentives for sterilization), TB program (testing kits and medicines), and sickle cell program (supplies for testing)
Starting date	1992
Insurance term	Annual term beginning April 15th of every year.
Participation	Voluntary enrolment of individuals and families.
Insured unit	Annual coverage on an individual basis
Risk pooling	ASHWINI/ACCORD informally assumes part of the risk; partnered with Royal Sundaram Alliance (RSA); originally with New India Assurance Corporation (NIAC) 1992 – 2002 (see below).
Target market	Adivasis (tribal people) residing in Gudalur taluk in Nilgiri District, Tamil Nadu
Eligibility requirements	Ages 0-60; must be member of AMS
Annual premium rates	Rs 40 per person per year (2006)
Benefits*	Royal Sundaram Alliance Insurance Company (RSA): • Coverage of Rs 2500 per person per year • All deliveries and pregnancy related admissions are allowed. • For delivery related admissions a ceiling of Rs.1000 per case. ASHWINI insurance program: • All hospitalization costs above Rs 2500, with no limits • Outpatient care • Drug costs • Public health/preventative services • Maternity beyond RSA benefit
Exclusions	RSA: • Psychiatric conditions • Self-inflicted injuries
Claims settlement	15-20 days under RSA; it was 3-9 months under NIAC
Waiting period	None
Co-payment	Everyone pays a Rs 10 administration fee upon hospitalization; AMS members who have not paid the premium to ACCORD pay Rs 100 per hospitalization; non-AMS members pay Rs 150 per hospitalization plus other fees.
Availing benefits	Cashless system, but varies as follows: • AMS members who have not paid premium can access services at ASHWINI hospital and sub-centers by paying user fees/co-payments. • AMS member who have paid annual premium are enrolled in ASHWINI insurance scheme and receive free care at the health facilities. • Non-AMS members can also use services in the ASHWINI health facilities, but pay higher user fees.

Characteristic	Description
Financing	Participants' premiums Reimbursements from RSA User fees charged at the hospital Donor and philanthropist financing

*These benefits are for those who have paid the premium; for all others, the same benefits are allowed but they need to pay for cost of out-patient medicines, Rs 100 for every hospitalization, and Rs 10 per health center visit.

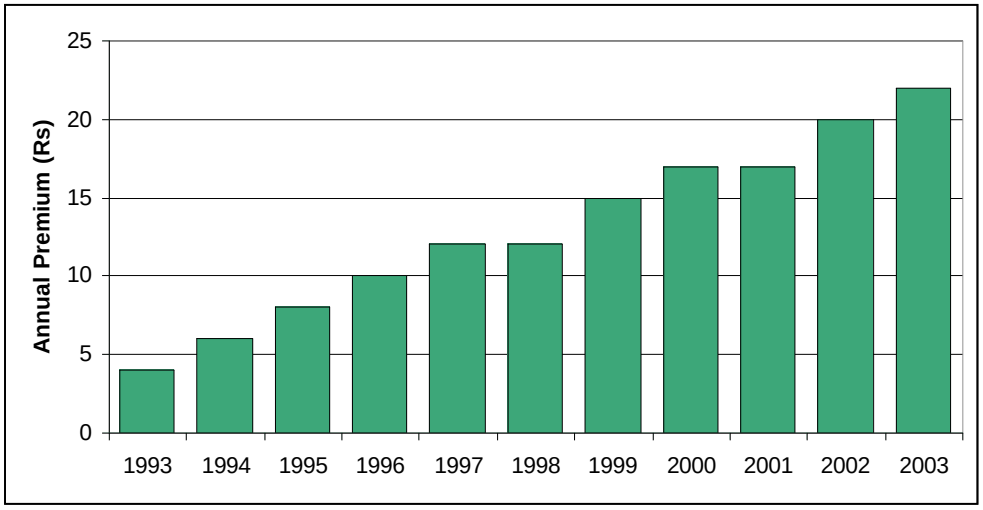
Financing the Community Health Insurance Scheme

The community health insurance scheme can be described best as a two-tier risk-pooling mechanism. At the upper level ACCORD/ASHWINI has a "reinsurance" arrangement with the insurer which covers some of the inpatient costs. At the lower level is the informal ASHWINI risk pool which is more comprehensive and covers without limit inpatient costs exceeding the insurer's individual annual maximums and specific benefit maximums, inpatient costs arising from events excluded by the insurer, preventative care, out-patient care, and drug costs. At the community level, there is an ancillary informal "risk pool" that has existed for generations and today helps the patient by providing transportation costs if needed.

Families join AMS on a voluntary basis but once they enrol they are automatically insured with the insurance company, with ACCORD prepaying their premiums. In the first ten years ACCORD negotiated a five-year contract with New India Assurance Corporation (NIAC) in which ACCORD pre-paid the premium for AMS members for a five-year period. This was financially possible for ACCORD because of donor funding. At present the benefit structure, experience, and premium of a specially designed Shakthi Shield policy is reviewed annually with the new insurer, Royal Sundaram Alliance Insurance Company.

The ASHWINI accountant processes all claims and submits these to the insurer who requires 15-20 days to review and reimburse (previously with NIAC, claims processing took 3-9 months to process). Strict accounting and a system of receipts limits fraud. A copy of the hospital bill is also given to the insured patient; however this is only for reference as the system is cashless. Any hospitalization due to an excluded illness is not claimed by ASHWINI from the insurance company.

Figure 4.5: Annual Premium Increase Since 1993

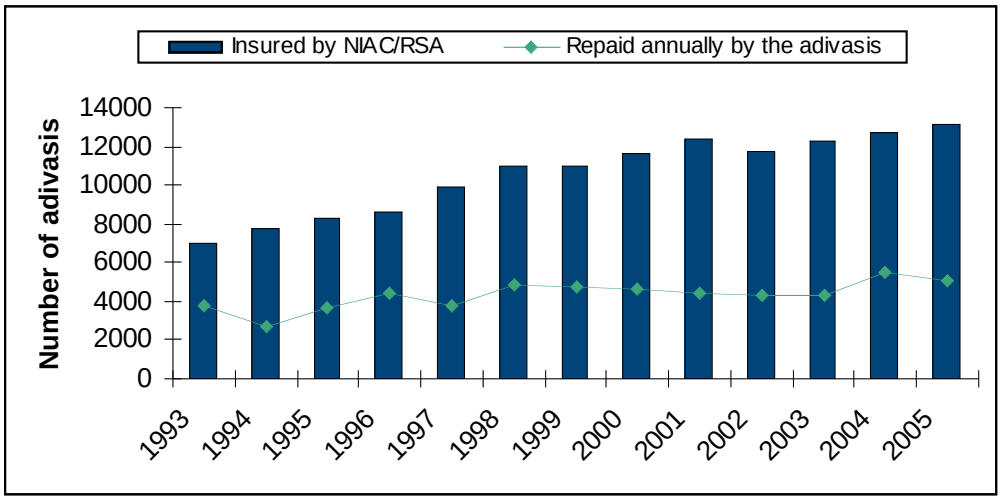


Source: Kanathigoda, Saliya, 2005

The adivasi community has agreed to repay the premium advances made on their behalf in the form of annual installments to ACCORD.[20] This premium repayment amount is determined by indicators of the adivasi community's willingness-to-pay. ACCORD, with the help of ASHWINI and AMS, collects premiums annually during the coffee harvesting season (December 5 – April 15) as this is when demand for labor is high, cash flow is greatest within the adivasi community, and people are more likely to afford the annual premium. Premiums are collected at central collection points where an insurance enrolment card is issued to those who repay. The card indicates that insurance is valid from April 15th to April 14th of the next year. Adverse selection is reduced by encouraging the family as a unit to enroll in the scheme and by having a definite collection period.

If the premium is repaid to ACCORD, the enrollee can utilize services within the benefit plan free of charge, with the exception of an Rs 10 administration fee upon hospitalization. If the premium is not repaid by the member then (s)he is subject to the Rs 10 administrative fee at health sub-centers, Rs 100 for each hospitalization, and all expenses for medicines and procedures. Non-AMS members (non-adivasis) pay Rs 150 for the hospitalization plus all other fees. This user-fee helps to cross-subsidize the services for the main beneficiary group, the adivasis. In 2005 there were approximately 13,000 AMS members, but just 5,058 repaid the premium advances made by ACCORD.

Figure 4.6: Number of AMS Members Insured with Insurance Company vs. Members who Repay the Premium



Source: Kanathigoda, Saliya, 2005

As noted, the initial insurer was the New India Assurance Company. In 2002, NIAC wanted to increase premiums to a level that was unaffordable to the AMS members, so ACCORD/ASHWINI contracted with Royal Sundaram Alliance. Today RSA inpatient coverage is for hospitalizations due to common illnesses up to Rs 2500[21] annually but this excludes psychiatric conditions, self-inflicted illnesses, and diseases associated with substance abuse. All admissions must be for at least 24 hours and in the ASHWINI hospital to qualify for coverage.

Benefit Package

ASHWINI provides a more comprehensive benefit package that works in tandem with the RSA policy. For those who repay the premium, outpatient services at the ASHWINI hospital are covered for a small co-

[20] The introduction of the prem um was done not only to recover some of the costs but to also create a sense of ownership amongst the beneficiaries. Further, because they are pre-paying for a service, the members are more vocal about dissatisfaction in the health facilities, which helps in quality control.

[21] Under NIAC, the same coverage was allowed but with an upper l mit of Rs 1500.

Table 4.2: Functions within the Health Scheme by Organization

Function	AMS Leaders	ACCORD staff	ASHWINI Staff
Creating awareness about insurance	X	X	X
Setting annual premium	X		X
Collecting annual premium	X	X	X
Monitoring premium collection			X
Providing benefits			X
Submitting claims			X
Monitoring reimbursements			X
Negotiating with insurance companies		X	X

Source: Adapted from Devadasan, N., et al. 2004

payment of Rs 10 (administrative fee). This also includes medicines and diagnostics as needed during the consultation. The ASHWINI health insurance scheme has no exclusions and there are no upper limits.

In addition to this insurance scheme, ASHWINI provides preventative care services to all the adivasis regardless of their insurance status. Services are provided through the network of village health workers and health sub-centers, and include nutrition counseling, antenatal care, health education, growth monitoring, immunizations, family planning, and chronic disease monitoring. Members of the insurance scheme can use services from the ASHWINI health facilities, which include the adivasi hospital and seven sub-centers. The facilities also refer patients to Kozhikode or Coimbatore tertiary centers when necessary. The providers in the ASHWINI system are paid a fixed salary, and use essential drugs and standard treatment guidelines to keep costs down.

ASHWINI also supports village level health workers who have been selected from the community to be trained in health education, identification and prevention of illnesses, and nutrition. Village health workers go from village to village to educate communities about health issues and discuss the insurance scheme, participate in sangam meetings and regularly monitor progress of pregnant women and children.

Limited financial information about the scheme is available for 1997-2002 when the contract was between ACCORD/ASHWINI and NIAC. For that period the claims ratio was very high and it is not surprising that NIAC wanted to drastically increase premiums in 2003.

Table 4.3: Financial Highlights of 2nd NIAC Policy, 1997-2002 and 2004-05 Policy Years

Description	1997-2002	PY 2004-05
1) Total premium paid	Rs 5,94,566	Rs 3,92,610
2) Total claim amount	Rs 13,63,373	Rs 3,75,875
3) Rejected claims	95,321	
4) % rejected claims	7%	
5) Total reimbursements	Rs 12,68,052	Rs 3,68,007
6) Claims ratio (reimburse)	213%	93.7%
7) Premium less reimbursements	Rs (6,73,486)	Rs 24,603

Source: Kanathigoda, Saliya, 2005

In 2004-05, 12 years after launch, the premium paid to the insurer exceeded reimbursements by the insurer for the first time. In that year, with premiums at Rs 30 and the annual maximum set at Rs 1500, just 43.7 percent of the total claims costs were reimbursed by the insurer. This prompted a renegotiation and revision of the insurance policy for 2005-06:

- Annual maximum was increased from Rs 1500 to Rs 2500 per year.
- Claim limit for delivery was increased from Rs 500 to 1000.

- An additional claim for referral expenses of Rs 2000 per claim to a policy maximum of Rs 30,000 a year was added (approximately Rs 40,000 had been spent on referrals in 2004-05).
- The premium was raised from Rs 30 to Rs 40 per person per year.

Table 4.4: Expense Details for 2004-05 Policy Year (Rs 1500 Annual Max and Rs 30 Premium)

Category of Patients	No. of Patients	Total Bill Amount	Paid by Patients	Insurer Reimbursed	Met from ASHWINI Funds	% Self Funded
Insured, Premium Paid	612	5,41,487	11,368	3,11,174	2,18,945	40.4%
Insured, Premium Not Paid	65	53,758	8,875	35,263	9,620	17.9%
Non-insured, Premium Paid	16	8,253	6,316	0	1,937	23.5%
Non-insured, Premium Not Paid	151	1,40,130	26,510	0	1,13,620	81.1%
Total Tribals	844	7,43,628	53,069	3,46,437	3,44,122	46.3%
Total Non-tribals	62	91,338	85,537	0	5,801	6.4%
Total Patients	906	8,34,966	1,38,606	3,46,437	3,49,923	41.9%

Source: ASHWINI Annual Report 2005

Summary and Conclusions

In summary, ASHWINI health insurance scheme is an essential service to the adivasi community in Gudalur taluk, providing improved access to quality healthcare at affordable rates. As is common in the development of other CBHIs there have been numerous innovations throughout its history that were motivated by efforts to tailor-fit the scheme to the community's needs. One of the early innovations was the prepayment of premiums to the insurer and locking in rates for a 5-year period, thus protecting the poor from inflationary costs. This was deemed too risky and tossed out by the current insurer who now reviews premiums annually. Pre-payment of premiums to the insurer on an annual basis is still a very important financing mechanism that overcomes the problem of adivasis' irregular cash-flows. ACCORD partnering with ASHWINI appears to have been a judicious move as well, as the NGO has the important characteristics of stability and trust which are needed for administering and promoting the program.

It is not entirely clear why so few adivasis repay the premium to ASHWINI and this is a significant problem that requires further study as the program advances. One factor of late is economic: the area has experienced economic depression in recent years due to low prices of crops such as tea, coffee and pepper. These are the main cash crops on which the entire local economy depends. As a result, plantations have experienced financial difficulties and drastically reduced employment. Tribals who are dependent on local employment were unable to find sufficient work and their income levels have dropped. Experiments with linking premium collection to other economic activities are underway;t for example, a donor recently donated 5 chickens to more than 1000 families on the condition that the income from the birds will be used to finance the annual health premiums of the family.

Aside from the usual challenges experienced by MHI schemes such as seasonal cash flows, lapses in member education, selling intangible services through risk-pooling, etc., there appears to be too little emphasis on promoting the concept of and building management capacity towards a viable community health insurance scheme. This may be largely due to the organizations' culture and orientation; there was perhaps a realization from the start that such a scheme could never be viable. Ongoing generous subsidies from insurers, donors, governments and philanthropic foundations also have the negative effect of creating dependency and may de-emphasize the goal of becoming viable in the long term. It is unlikely that such subsidies will continue in perpetuity and if there is too little progress towards viability, there will be limited long term impact and replication to other Indian communities.

BASIX

BASIX, founded in 1996, is a livelihood promotion institution working with more than 190,000 poor households in eleven states in India.[22] It offers three main categories of services: institutional development services, livelihood financial services (credit, savings and insurance) and agricultural/business development services (productivity enhancement and market linkages). BASIX represents a group of five entities to carry out these functions: Bhartiya Samruddhi Investments and Consulting Services, Ltd, a holding company; Bhartiya Samruddhi Finance Limited (Samruddhi), a non-banking finance company; Indian Grameen Services (IGS), a section 25 non-profit company; Krishna Bhima Samruddhi Local Area Bank Limited (KBSLAB), a local area bank; and Sarvodaya Nano Finance Ltd (Sarvodaya), registered by the Reserve Bank of India, a Non-Banking Finance Company, owned by women's self-help groups, and managed by BASICS Ltd.

BASIX began working in the life insurance sector in 2002, about the time that the insurance market in India was liberalized to allow private insurance companies to operate. The objectives were to provide risk management services to those rural clients who use some of the other services offered by BASIX. Its vision when entering this market was that "all poor households, especially those served by BASIX, will have access to risk-management services covering their lives and livelihoods, and insurance companies will provide these services willingly on a financially sustainable basis."[23]

In May 2005, BASIX collaborated with Royal Sundaram Alliance (RSA) to expand into the health insurance business, offering risk coverage for total and permanent disability, critical illness, and hospitalization. In March, 2006, BASIX also launched a health product specifically for Self-Help Group (SHG) members within the BASIX network. Operating within a partner-agent model, BASIX now has five insurance products: life, livestock, health, micro-enterprise, and rainfall. Currently, Samruddhi and IGS (two of the subsidiary companies) are selling the insurance products to the BASIX clientele through the sale of their credit and savings accounts. Their target market for credit and savings activities and subsequently the insurance products are the borrowers of productive BPL households aged between 18 and 54 years.

Health Insurance Products

BASIX offers two health products, both of which are reimbursement policies: Grameen Arogya Raksha and Self-Help Group Parivaar Beema. Both products are linked to credit and savings activities and are compulsory for the borrower but voluntary for the borrower's spouse.

Grameen Arogya Raksha provides coverage for three categories of risks: critical illness, total and permanent disability due to accident, and hospital cash to cover expenses related to hospitalization. It is sold by the micro-credit lender, Bhartiya Samruddhi Finance Ltd (BSFL, or Samruddhi), one of the subsidiary companies of BASIX.

Originally the annual premium amount was Rs 136 for the borrower alone without an option to cover to the spouse. After one year of implementation the favorable experience suggested a reduction of the premium to half but instead a decision was made to cover both the borrower and the spouse for the same premium amount. Currently, the premium for the health insurance policy remains at Rs 68 per person or 136 for a couple. There is no coverage for other family members.

People are covered for as long as they are borrowing from BASIX and are not delinquent on their loan repayments. There is no waiting period, no deductible, and no co-payment at the time of hospitalization. The benefits offered through the insurance scheme are: hospitalization cash benefit of Rs 300 per day up to 5 days, critical illness benefit of Rs 10,000, and Rs 25,000 total and permanent disability due to accident. There has been an expression of interest from insured clients for higher hospitalization benefits, for outpatient benefits, and for surgery benefits up to Rs 15,000.

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[22] The states: Andhra Pradesh, Karnataka, Orissa, Maharashtra, Madhya Pradesh, Jharkhand, Bihar, Tamil Nadu, Uttar Pradesh, West Bengal and Rajasthan.

[23] BASIX. "Insurance Services At BASIX: Reference Manual for the Period of Jan 1 2007 to March 31 2007". Hyderabad, 2006.

Table 4.5: Features of the Current BASIX Health Insurance Program

Characteristic	Description
Owner and manager of the scheme	BASIX, a for-profit, non-governmental organization.
Administrator and TPA	BASIX manages claims processing but out-sources to a company (BPO) to verify documents submitted to support claims.
Distribution and marketing	Consumers are educated at the point of borrowing; field staff also go to households which have experienced an insured event to discuss the claims process in the vicinity of family and other potential clients.
Service providers	Beneficiaries can use health services at any public or private facility.
Role of the state government	NA
Starting date	2005 (for health; 2002 for life insurance products)
Insurance term	Duration of the loan repayment; if client is delinquent on repayment of loan for 180 days, insurance is cancelled.
Scope of operation	Eleven states
Participation	All those who use BASIX credit services are allowed to participate for a nominal monthly premium rate and receive benefits immediately.
Insured unit	Coverage for borrower and spouse.
Risk pooling	Risk is borne by the insurance company, Royal Sundaram Alliance.
Target market	Productive BPL borrowers of BASIX.
Eligibility requirements	Qualification for getting a loan from BASIX, limited to age 18-54.
Annual premium rates	Rs 68 per person per month (136 per couple).
Premium collection	Monthly when loan repayment is made at specified community locations.
Benefits	*Grameen Arogya Rakesh* Critical illness: Rs 10,000 Permanent total disability: Rs 25,000 Hospital cash: Rs 300 per day up to Rs 1,500 (5 days per annum) *SHG Parivaar Beema* Life: Rs 20,000 PTD: Rs 20,000 Hospital cash: Rs 1,500
Exclusions	None
Claims settlement	Done at BASIX; approximately 50-60 days for reimbursement to the insured.
Waiting period	No waiting period.
Co-payment and user fees	None
Availing benefits	No pre-authorization necessary; beneficiaries can use services at any health facility (public or private) and apply for reimbursement.
Financing	Premiums to the insurance company; beneficiaries are also charged Rs 10 per person, which covers the cost of administration of the schemes.

Premiums are paid on a monthly basis along with the loan repayments. If the premium is not paid, it is deducted from the payment made by the borrowers before accounting for interest on the principal payment. Once the loan is overdue by 180 days, coverage is terminated. There is also an annual fee of Rs 10 per person which is used to support the operational expenses.

Table 4.6: Overview of the Grameen Arogya Raksha Component of BASIX

Target clients	Rural credit customers of BASIX and their spouses
Insurer	Royal Sundaram
Group or individual?	Group
Policy holder	BSFL
Minimum entry age	18 years last birthday
Maximum age	54 years last birthday; exit age is 55
Policy benefits and sum insured	Critical illness: Rs 10,000 PTD: Rs 25,000 Hospital cash: Rs 300 per day up to Rs 1,500 (5 days per annum)
Exclusions and waiting period	30 days waiting period for claiming hospital cash
Premium rate	Rs 68 per year, per person. Premium is paid monthly.
Frequency of premium payment to insurance company	Monthly, with loan installment.
Coverage period	From disbursement date to last date of the month in which loan is closed. Coverage stops when loan repayment is overdue by 180 days from the last payment schedule date
Medical check-up	Not required

In March 2006, BASIX began offering a health insurance benefit for the Self Health Group Parivaar Beema, which is a combination product and covers risks for: life, total and permanent disability due to accident, and hospital cash to cover expenses for hospitalization. It is offered through the Indian Grameen Services, which is one of the subsidiary companies offering credit and savings options for SHGs. Royal Sundaram Alliance is providing the coverage for the health portion of the product while AVIVA covers the life portion. The premium for this product is Rs 372 per year per member and it covers both the member and the spouse. Details are summarized below.

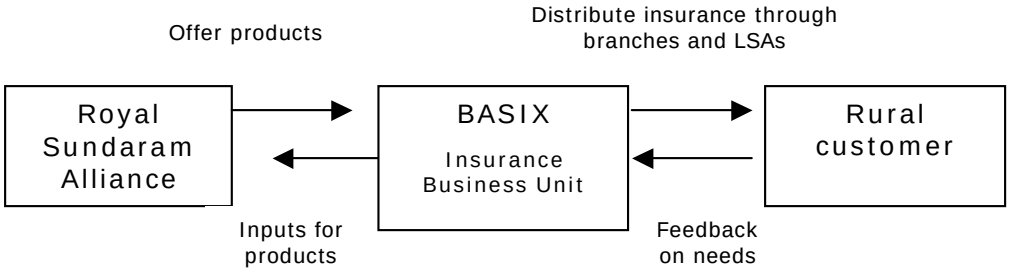
Table 4.7: Overview of the Self-Health Group Parivaar Beema of BASIX

Target clients	SHG which are institutional clients of BASIX
Insurer	AVIVA for life and Royal Sundaram for health
Group or individual?	Group
Policy holder	Indian Grameen Services (IGS)
Minimum entry age	18 years last birthday
Maximum age	54 years last birthday; exit age is 55
Policy benefits and sum insured	Life: Rs 20,000 PTD: Rs 20,000 Hospital cash: Rs 1,500
Exclusions and waiting period	30-day waiting period for claiming hospital cash; first year suicide exclusion: no claim for life in the first three months except in the case of accidental death
Premium rate	Rs 372 per year per member, or Rs 31 per month per person (this rate contains the premium for the SHG member and spouse)
Frequency of premium payment to insurance company	Monthly or yearly option is available depending on the MIS systems available within the local institution
Coverage period	12 months from date of application
Medical check-up	Not required

The insurance schemes are administered by BASIX through the Insurance Business Unit (IBU), which manages Insurance Business Relationship Development, Product and Process Innovation, and Systems Development. The IBU, which has a team of about 10 who work full time on insurance activities, provides assistance in the processing of proposals, premium accounting, claims facilitation, and reporting of the overall insurance business. The IBU works with the assistance of its branches, field-based Executive Staff and Livelihood Service Advisors (LSAs) to disburse the health insurance products to its borrowers. Each branch covers approximately 200 villages and employs 3-4 field executives. For each field executive there are about three LSAs each of whom operates in 15-20 villages to provide assistance to the beneficiaries. Health policies are sold through the subsidiary companies when clients take out a loan or open a savings account. LSAs visit

each of the villages once per week, going house-to-house to collect health claims from the beneficiaries of the insurance scheme, at which point the LSAs submit the claims documentation to BASIX headquarters. BASIX contracts out to a BPO to verify that the insurance claims documents submitted are complete. If the documents are not complete, they are sent back to the field office. BASIX maintains a sophisticated database to monitor the claims process.

Figure 4.7: Organizational Structure of BASIX's Health Insurance Programs: Partner-Agent Model



The IBU staff has on-the-job training and classroom training on the subject of insurance, which occurs upon hiring and as new insurance products are launched. All the sales staff in the field are trained online and are certified by IRDA as agents. LSAs, who are out in the field managing the whole BASIX portfolio and facilitating claims collection, are also trained on the products and services, but are not licensed. The insurance program is reviewed quarterly and operations manuals for the core and field staff are revised based on the quarterly reviews.

BASIX reaches approximately 10 to 15 percent of the households in the villages in which they work. As of November 30, 2006, there were approximately 311,492 insured lives under BASIX credit- and savings-linked health insurance scheme; just over 51 percent were male borrowers and their covered spouses. Although there were significantly fewer female borrowers, women were more likely to cover their spouses.

Table 4.8: Number of BASIX Health Insurance Clients by Gender as of November 30, 2006

Age Bracket	Female Borrowers	Male Spouses	Male Borrowers	Female Spouses	TOTAL M & F
18-25	13,119	5,311	15,842	10,124	44,396
25-35	32,475	26,631	40,678	23,984	123,768
35-45	29,679	22,746	30,453	20,093	102,971
45-54	10,658	10,744	13,868	5,087	40,357
TOTAL	85,931	65,432	100,841	59,288	311,492

Source: BASIX 10th Annual Report, 2006.

Once the claims have been verified, BASIX submits the information to Royal Sundaram Alliance for reimbursement. The insurance company reviews the claims and reimburses BASIX, at which point reimbursements are sent to the branch offices and paid to the client. The whole process takes approximately 50-60 days. The goal for BASIX is 27 days.

Table 4.9: Performance in Claims Servicing as of December 26, 2006

Insurance Products	Claims reported	Claims settled	% of Claims settled	Claims in Process	% of claims in process	Claims rejected	% of claims rejected	Claims amount paid (Rs in million)
Life	1073	1010	94%	56	5%	7	1%	14.6
Health	**2399**	**1951**	**81%**	**138**	**6%**	**310**	**13%**	**2.62**
Livestock	899	802	89%	39	4%	58	6%	6.18
Micro enterprise shield	1	1	100%	0	0%	0	0%	0.02
TOTAL	**4372**	**3764**	**86%**	**233**	**5%**	**375**	**9%**	**23.42**

Source: BASIX 10th Annual Report, 2006.

As shown in Table 4.10, settled claims of males were numerically (and proportionally) greater than for females, as was the average amount claimed. BASIX insurance staff members do not have formal actuarial training but provide statistics and calculations such as expected claims incidence and actual-to-expected claims to the insurance company. A lot of data are collected and extensive analysis is conducted, which helps in projecting costs and risks of the insurance pool at a basic level.

Table 4.10: Performance of Health Claims in past 12 months

Indicator	Group Health
Total number of claims (female)	1086
Total number of claims (male)	1362
Total claims settled	2448
Sum of claim amount	27,10,050
Average claims amount	1107
Average claim amount (female)	1080
Average claim amount (male)	1129

Source: BASIX 10th Annual Report, 2006.

The organizational structure of BASIX allows for direct presence in the villages in which staff members work. The LSAs who are responsible for activities other than insurance deliver the whole package (i.e. credit/savings and insurance) at the doorstep of the clients. This direct interaction has resulted in an increased awareness and understanding of the benefits. BASIX has also found that people are educated and motivated to participate after having seen it "work" for other people in the community.

Cost containment is inherent to the health insurance policy, as there are fixed benefit amounts paid to the beneficiary. Adverse selection is somewhat limited in this insurance scheme, as the scheme is compulsory for borrowers although elective for spouses. Further, credit and savings accounts are only allowed after an appraisal of the ability to repay the loan amount and to engage in economic activity have been established. This includes a rudimentary assessment of the borrowers' health. From the point of view of the insurer, this functions as basic underwriting of the borrowers in terms of their health and productivity status. Furthermore, field staff are close to the clients and are able to assess whether someone is suffering from a pre-existing disease prior to signing up for the health insurance cover. Those in bad health or pre-existing diseases prior to enrollment are not allowed to become borrowers, and thus become insured.

There is some suspicion of fraud and abuse but the extent to which people are abusing the system is not known. There have been instances when people have gone for out-patient treatment and claimed the expense as an inpatient treatment; people have also exaggerated the number of hospital days in order to receive higher benefit amounts. To reduce the potential for fraud and abuse, field staff is trained to monitor the insured closely. For instance, in many cases, a BASIX representative will visit the client in the hospital to certify that a

hospitalization is indeed taking place and also return to the hospital on subsequent days to ensure that the number of hospital days claimed are accurate.

BASIX has applied to the IRDA for recognition as a Micro Insurance Agent, as it falls under the criteria for eligibility per the microinsurance regulations. As of the interview for this report BASIX had not heard from the IRDA on this matter.

Summary and Conclusions

In summary, the scheme is a good example of a microfinance institution (MFI)-based microinsurance program (although BASIX is much more than an MFI). These types of programs, similar to others in several countries, are characterized in part by their inherent strengths: very efficient distribution of insurance services since it is integrated into an already-existing microfinance delivery infrastructure, near 100 percent participation due to a compulsory participation requirement of all borrowers, state-of-the-art computer systems, and affordable monthly premium installments added to the micro-loan repayments.

The target market is the "productive BPL population", which has a number of implications for cost containment and thus the financial viability of the health insurance scheme. For one, the "productive" population is generally a healthier segment of the BPL population. This reduces the overall risk of the population pool, which helps to reduce claims and ultimately costs of claims administration borne by BASIX and cost of healthcare borne by the insurer. After a year or so, good experience would open an opportunity for BASIX to negotiate with the insurer to expand coverage.

While the insurance scheme does not operate within a cashless system (an appealing feature for BPLs who struggle with cash-flow(, the reimbursable scheme allows the beneficiaries to use any service provider they like and increases the accessibility to healthcare providers considerably. It is unclear how many healthcare providers are in the geographic area of the beneficiaries, but having a choice at least provides options for the borrower. This choice can also help to ensure quality, as it is assumed that providers will choose the highest-quality of care for the price.

BASIX management is process-oriented and focused on the incremental costs and marginal revenues of its microfinance distribution channel. Management is aware that although microinsurance is itself a profit center it also has a positive synergistic effect on the company's other focus areas within a broad strategy of providing sustainable livelihood promotion and financial services. For example, although microinsurance protects the borrowers and their spouses, it also protects the quality of the institution's credit portfolio: if the borrower is protected then the repayment rate will be not be diminished in the event of sickness and untimely death. In essence, in providing microinsurance services, the institution has passed on the risk of protecting the portfolio to the borrower. This is an important point since this and the fact that the institution is for-profit affects the nature of the microinsurance product offerings, another characteristic of most MFI-based microinsurance programs.

From the point of view of the poor, the for-profit orientation is a weakness of the model since microinsurance services are influenced by forces other than the expressed needs of the population served. Another weakness is that only the "enterprising poor" BPL segment is targeted; "non-productive poor" are excluded. Hence, from the perspective of the BASIX borrowers, the health microinsurance product is inadequate, and this has been expressed through feedback surveys. The institution may be reluctant to offer a more comprehensive HMI product soon since it may be difficult to find an insurer to carry it, and it may also be a drain on institutional resources to implement it.

An important strategic consideration for organizations such as BASIX is whether to set up an independent member-owned microinsurance organization under the BASIX umbrella. Such an organization could develop member-driven services without directly affecting the profitability of the for-profit enterprise. In fact, it could have greater positive effects on protecting the credit portfolio since it could offer more comprehensive and relevant health insurance and other insurance products as well. This has been successfully carried out by the Center for Agricultural Research and Development (CARD) in the Philippines. Under the CARD umbrella there is a member-owned mutual benefit association (MBA) with separate professional management but the

Board is made up of members themselves. CARD has reported that aside from protecting their borrowers better, the existence of the MBA has given them a competitive edge over other MFIs. In fact, CARD MFI has stated in public forums that approximately 30-35 percent of borrowers joined the MFI for the purpose of accessing the services of the MBA.

To conclude, organizations such as BASIX are a very important channel for delivering essential health insurance services to a broad segment of the BPL population. The weaknesses of for-profit organizations could be compensated by sponsoring and facilitating the development of affiliated but independent member-owned microinsurance programs.

Karuna Trust Community Health Insurance

Karuna Trust was established in 1986 by Dr H. Sudarshan as a public charitable trust. Today it is focused on a holistic, integrated, needs-based, participatory, and bottom-up approach to development. The NGO works primarily with tribal, rural, and urban poor (both Scheduled Castes / Scheduled Tribes (SC/ST) and non SC/ST BPL) taking into account cultural and regional differences and with emphasis on building skills, self-reliance and empowerment that enables communities to solve their own health problems. The main focus areas are its numerous health projects and programmes, community development (including SHG development, microfinance, organic farming and vocational training), education, and advocacy.[24]

Karuna Trust was founded specifically to respond to the high prevalence of leprosy in Yelandur taluk[25] of the Chamarajanagar district in Karnataka in 1986. After successful completion of the initial but limited leprosy eradication program, the state government put Karuna Trust in charge of running its entire leprosy program for Yelandur taluk. This was followed by several other partnerships in which the NGO was charged with state responsibilities in exchange for a portion of the government budgets allocated to these areas.

This collaborative trend evolved further over the years until the establishment of a unique and innovative public-private partnership in 1996. At this stage Dr Sudarshan had concluded that the limited but successful micro-level interventions in community health were not sufficient to solve the large-scale problems still prevalent in the target populations. What was needed was a scaling up of successful programs within the bounds of limited resources available, and without a duplication of government services and facilities. The solution lay in building on the existing government capacities by taking over and running key primary health centres (PHCs) in Karnataka.[26] Beginning with the first PHC and its five sub-centers at Gumbali in Yelandur taluk in Karnataka in 1996, the Trust today manages 34 PHCs across two states (Karnataka and Arunachal Pradesh) which provide health services to a population of approximately 800,000. The PHCs are staffed by the NGO with the state government providing approximately 75 percent of the cost. The government also provides funds for medicines and other costs such as fuel for ambulances, electricity and water, etc., but this is inadequate and covers only 70-80 percent of the actual costs incurred of running a PHC. Moreover, the improved management of PHCs has increased the utilization and hence the financial burden of each PHC.

For each PHC that it manages, Karuna Trust seeks to transform it from being largely a curative solutions provider to one that also implements preventative health measures, promotes healthy lifestyles, and broadens its scope to sustainable community development. Community participation and empowerment is the emphasis as its citizens are equipped with basic but essential knowledge, such as the importance of safe drinking water, sanitation, immunization and other vital aspects of nutrition and health. "The PHC in many

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[24] Rademacher, Ralf, van Putten-Rademacher, Olga, Müller, Verena, Wig, Natasha, Dror, David, "Karuna Trust, Karnataka, India, *Good and Bad Practices Case Study No. 19*", CGAP Work ng Group on Microinsurance, 2005.

[25] *Taluk* refers to a unit of government that consists of a city or town serving as a headquarters and additional towns and villages. It is part of the local government and exercises fiscal and adm nistrative authority over the villages and munic palities within its jurisdiction. (W k pedia, 2007)

[26] Das Gupta, Shangon, and Ganshyam Bharati. *Anubhav, Experiences in Health and Community Development, Karuna Trust*. Voluntary Health Association of India, 2006.

ways is the portal to development as we have access to the entire community through it," says Dr Sudarshan.[27]

Community Health Insurance Pilot

The community health insurance scheme (CHI), one of two pilot projects of UNDP and the Indian Ministry of Health, was conceived in 2001 as an experiment in community health financing. One pilot scheme was set up in West Bengal. The second pilot, selected because of a desire to work only with well-established and successful NGOs resulted in partnering with Karuna Trust and the Center for Population Dynamics (CPD), a Bangalore-based research institution.

The Karuna Trust CHI experiment was unique and innovative in several ways:

- It augmented and built on the existing government infrastructure and to some degree compensated for its deficiencies;
- Benefits did not include the cost of provider services since these were supposed to be free at government facilities—instead, a daily cash benefit was paid during inpatient stays which was meant to lighten the burden of lost livelihood income while hospitalized; as such the benefit improved financial access and encouraged the insured to seek earlier, more timely treatment;
- A drug fund was set up at each accredited facility and was used to purchase required drugs needed over and above the basic drugs regularly stocked at each facility. A benefit of Rs 50 per inpatient day was allocated towards purchasing drugs needed for the patient's treatment and not normally stocked in the PHC;
- Drug costs were lowered when Karuna Trust acquired quality generic drugs from reliable suppliers and supplied these in bulk to providers;
- The SHGs that Karuna Trust had helped to establish were each provided with a seed fund to be used for providing emergency loans to outpatients;
- Karuna Trust managed some of the public PHCs directly, thus ensuring quality care at these facilities; and
- As part of a wider preventative health program that complemented the scheme, herbal gardens and ayurvedic practices were promoted to preserve traditional and well-accepted treatments for minor ailments and prevention.

The objectives of the CHI pilot included the following:

- Improve awareness and access to services through prepaid insurance;
- Enhance awareness and utilization of government medical facilities;
- Motivate primary and secondary health care in a timely fashion;
- Develop and demonstrate working models of CHI for possible replication;
- Develop partnership experiences with the organized insurance sector; and
- Develop CHI through local government structures, SHGs and co-operative societies.

The pilot scheme was initially limited to T. Narsipur taluk in Mysore district and Bailhongal taluk in Belgaum district. The target populations within these pilot areas were BPL SC/ST and non SC/ST; more specifically these groups included landless labourers, rural self-employed, small and marginal farmers, unorganized agricultural seasonal labourers, construction labourers, and forest dwelling tribes.

Dr Sudarshan explains, "Through Karuna Trust we had made considerable inroads in the health sector in the [CHI project] area. We were aware of the health problems that the local population was facing as well as their inability to pay for curative services. We had also learnt in the course of working with them that the government health infrastructure was largely underutilized due to the negative perceptions about its quality. On the one hand, we saw a demand for low-cost health services, on the other an infrastructure that was

[27] bid.

equipped to, but for various reasons, was not able to satisfy the demand. In order to ensure that the infrastructure was used and to avoid duplication of facilities, it was evident that it could, and in fact, should be integrated into the implementation of a successful CHI program".

Before launch, a baseline survey covering 4000 households was designed and conducted by CPD in order to document the basic features of these communities, their utilization of public and private medical facilities and to gauge their acceptance and awareness of health insurance. The study showed that while knowledge of health insurance was very limited, the target population recognized its value and indicated a willingness to participate. The study further revealed that the affordability of the annual premium would be a crucial limiting factor, that the services of public medical facilities were negatively perceived and underutilized, and that children's health in the focal areas was often neglected due to parents' financial difficulty in accessing services.

Two approaches to management were undertaken in the two areas. In T Narsipur, Karuna Trust was responsible for the entire program while in Bailhongal taluk the project was implemented by the local government of Balgaum district (i.e., the Zilla Panchayat of Balgaum), with Karuna Trust restricted to monitoring in this area to ensure a smooth flow of funds. The purpose was to establish two working models for possible replication in other areas that may or may not have a credible NGO presence. It was recognized early on that both of these models had their respective strengths and weaknesses.

Implementing agencies in both areas worked closely with village and taluk level local governments to spread awareness and to influence the community to participate in the CHI. In T. Narasipura, Karuna Trust promoted the awareness of the scheme using street plays, video shows, public announcements, one-to-one interactions, posters, and community platforms such as SHGs, Village Development Committees (VDCs), and Village Health Committees (VHCs). In Bailhongal taluk the consumer awareness campaign focused on activities and promotion through the hospitals and PHCs in the area. After three to four months of promotion the pilot schemes were launched.

Soon after the initial launch the project was further expanded to two other areas—Yelandur taluk in the Chamarajanagar district with Karuna Trust responsible for implementation, and to Balgaum taluk in Balgaum district with Zilla Panchayat as implementer.

After completion of the first phase of the project, a second phase was launched following a consolidation period to ponder the lessons learned. In the first phase premiums for the BPL population were fully subsidized to ensure wider and smoother implementation but all premium subsidies were dropped in the second phase.

Table 4.11: Scope and Phases of the Pilot CHI Project

Name of Area	Phases and Periods of Coverage	Scope of Coverage	Implementing Agency	Monitoring Agency
T Narasipura, Mysore district	Phase 1: Sep 02-Aug 03 Phase 2: Jun 04–May 05	210 villages	Karuna Trust	None
Bailhongal taluk, Belgaum district	Phase 1: Oct 02-Sep 03 Phase 2: Jan - Dec 05	112 villages	Zilla Panchayat, Balgaum district	Karuna Trust
Yelandur taluk, Chamarajanagar district	Phase 1: Apr 03-Mar 04 Phase 2: Jan- Dec 05	40 villages 57 podus in BR Hills	Karuna Trust	None
Balgaum taluk, Balgaum district	Phase 1: 16 Jun 03-15 Jun 04 Phase 2: Jan- Dec 05	133 villages	Zilla Panchayat, Balgaum district	Karuna Trust

Sources: Compiled from various sources, includ ng CPD End-L ne Evaluation Report, 2005; Management nterviews and internal documents; Communication for Development and Learn ng, 2005; MIRC Institutional Self-Assessment for Micro nsurers, 2007.

To underwrite the insurance risk, a Memorandum of Understanding (MoU) was signed by National Insurance Company (NIC) and Karuna Trust which limited the maximum claims ratio to 150 percent. Claims above this limit would have to be retained by Karuna Trust. Without conducting an actuarial study, the annual premium rate was set at Rs 30 per person.

The organizational partners and their various roles in the scheme are summarized in Table 4.12.

Table 4.12: CHI Organizational Partners

Partner	Role
UNDP	Funding agency
Karuna Trust	Implementing agency in two areas, monitoring agency in two areas
Zilla Panchayat, Belgaum district	Implementing agency in two areas
Government of Karnataka (Directorate of Health and Family Welfare)	Service provider through PHCs and government hospitals. All public facilities are eligible, within or outside of the project areas. In some cases the PHCs are managed by Karuna Trust.
Community- Gram Panchayats, SHGs, Village Development Committees, Village Health Committees	Promote CHI awareness and enroll participants.
National Insurance Company (NIC)	Insurance carrier, up to 150% claims ratio.
Centre for Population Dynamics	Baseline and end-line surveys, monitoring and evaluation.

Sources: Compiled from various sources, including CPD End-Line Evaluation Report, 2005; Management nterviews and internal documents; Communication for Development and Learn ng, 2005; MIRC Institutional Self-Assessment for Micro nsurers, 2007.

To ensure more effective implementation and cooperation of the major stakeholders, a project implementation committee was set up at each of the four participating taluks and at their respective district levels. The committees were responsible for monitoring the various aspects of the program including identity cards, claims settlement issues, participation levels, and so on. The main features of the pilot CHI are summarized in Table 4.14.

Table 4.13: Structure of Project Committees

District Level Committees	Taluk Level Committees
Chairman: Chief Executive Officer, Zilla Panchayat *Members:* • Deputy Secretary of Administration, Zilla Panchayat • District Surgeon • Deputy Director, Child Development Project • Executive Officer, Taluk Panchayat • NIC representative • Karuna Trust representative • Member Secretary, District Health and Family Welfare Office	*Chairman:* Executive Officer, Taluk Panchayat *Members:* • Administrative Medical Officer, General Hospital • Administrative Medical Officers of the participating CHCs • Medical Officers of the participating PHCs • Child Development Project Officer • NIC representative • Karuna Trust project officer • Member Secretary, Taluk Health and Family Welfare Office

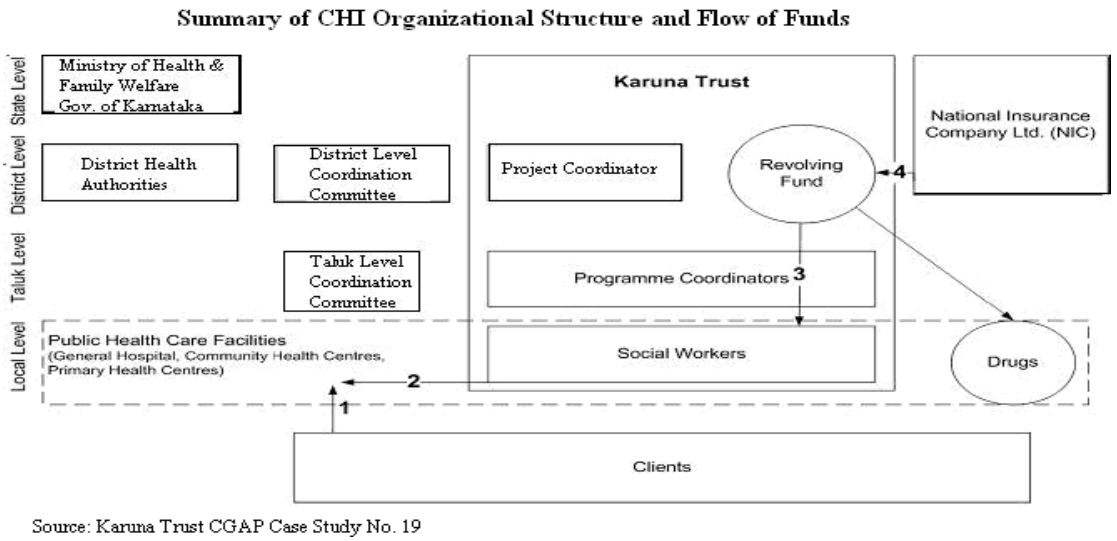
Source: Management nterviews and internal documents; Communication for Development and Learn ng, 2005

Table 4.14: Summary Features of the Pilot CHI

Characteristic	Description
Eligibility	No restrictions on age or pre-existing conditions for target population.
Underwriting and renewal requirements	• Voluntary participation • Payment of annual premium • Enrolment of the entire family- selective enrolment of only some family members not permitted
Annual premium	Rs 30 per person in phase I, Rs 20.52 in phase 2.
Premium subsidies	*Phase 1* • BPL SC/ST premiums were fully subsidized by UNDP in the first phase • BPL but non-SC/ST premiums were fully subsidized in the first phase with Rs 20 coming from UNDP and Rs 10 from Karuna Trust • No subsidies for non-BPL *Phase 2* • No premium subsidies
Benefits (phase 1)	Rs 2500 annual benefit as follows: • Rs 50/day wage loss compensation in case of hospitalisation; maximum 25 days per annum. • Rs 50/day in case of hospitalisation paid for drugs not stocked at the hospital, with remainder going to a special drug fund at each facility; maximum 25 days per annum.
Benefits (phase 2)	Rs 4000 annual benefit as follows: • Rs 50/day wage loss compensation in case of hospitalisation. Maximum 30 days per annum. • Rs 50/day in case of hospitalisation paid to a special drug fund at each facility. Maximum 30 days per annum. • In case of surgery, Rs 500 for compensation of loss of Income, Rs 500 for drugs not stocked at the hospital, with remainder going to a special drug fund at each facility; maximum one surgery per person per year.
Exclusions and restrictions	• No pre-existing exclusions • Services must be availed at public PHC and hospitals, except in areas with no public facilities such as in BR Hills • No outpatient coverage
Reimbursement type	Revolving fund set up to enable cashless settlement upon discharge. A social worker is deployed with Rs 5000 at each provider to settle claims on a daily basis or upon discharge.
Drug Fund	Drug fund set up at each accredited provider, to be used for purchasing drugs as needed for the patient and if not part of the basic drug stocks at the facility.
Claims settlement with insurer	Karuna Trust settles claims weekly at NIC's divisional office to replenish the revolving fund.

The provider network consisted almost entirely of designated secondary health centers or general hospitals. Upon admission the insured presented his identity card for verification, but this requirement was revised in the second phase and the numbered premium receipt and a photo ID, such as a ration or election card, were then used. A Karuna Trust social worker qualified the admission against the master list of insured clients. The treating doctor's discharge summary was used to determine the number of hospitalized days and the type of treatment as a basis to settle the wage compensation and surgery benefit claims on the spot. Drug benefits were paid directly to the facilities' drug fund. Each social worker generally carried an Rs 5,000 emergency fund for this purpose. The social worker used the discharge summary to replenish his/her emergency fund. On a weekly basis, Karuna Trust prepared a summary of claims with documentation for replenishment of the main revolving fund through the insurer's regional office.

Figure 4.8: Karuna Trust Organizational Structure

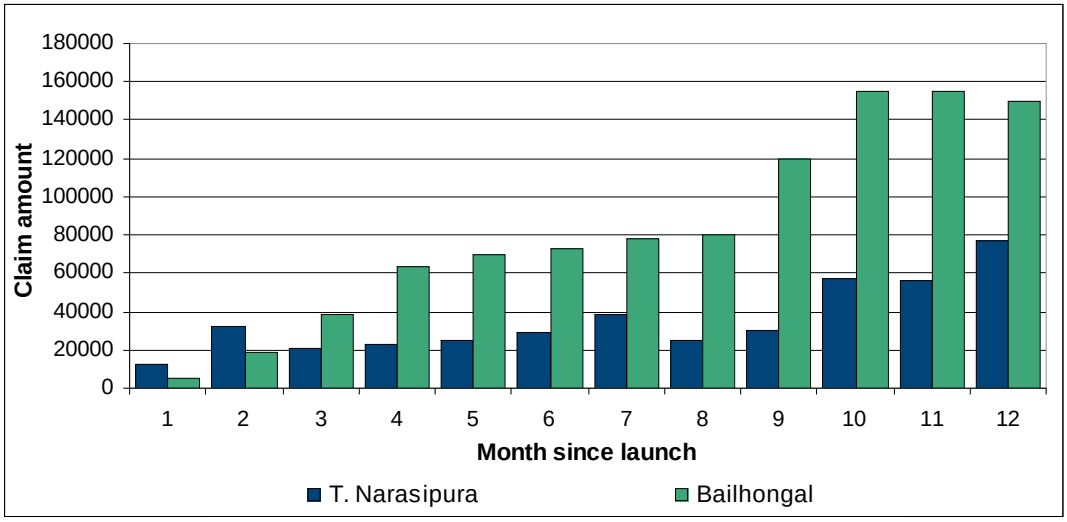


Source: Karuna Trust CGAP Case Study No. 19

Results of the Pilot

In the initial phase 231,054 participants were enrolled and Rs 6,931,620 was paid for premium subsidies. This resulted in 3,115 claims amounting to Rs 2,216,300 for an overall paid claims ratio of just 32%. The utilization varied markedly between the four project areas, ranging from a low of 7 percent in Balgaum taluk to 77 percent in Bailhongal taluk; both of these schemes were managed by the Zilla Panchayat of Balgaum. This wide range in utilization is not likely to reflect differences in health in these areas but rather factors such as awareness and access.

Figure 4.9: Trends in Monthly Claims in Two Pilot Areas



Source: Compiled from *Communication for Development and Learning*, 2005.

Table 4.15: Coverage and Experience in Phases I and II

Area	BPL SC/ST	Non SC/ST	No. of Participants	No. of Claims	Total Bed Days	Paid Claims	Premiums (rate@30)	Paid Claims Ratio
T Narasipura taluk	82,546	2,546	**85,092**	655	5,490	549,000	2,552,760	22%
Bailhongal taluk	32,428	20,322	**52,750**	1,719	12,241	1,224,100	1,582,500	77%
Chamarajanagar district	33,716	-	**33,716**	402	3,187	318,700	1,011,480	32%
Balgaum taluk	59,496	-	**59,496**	339	1,245	124,500	1,784,880	7%
TOTALS	**208,186**	**2,546**	**231,054**	**3,115**	**22,163**	**2,216,300**	**6,931,620**	**32%**

Source: Compiled from Management interviews and internal documents; Communication for Development and Learning, 2005; MIRC Institutional Self-Assessment for Microinsurers, 2007.

The more limited data for the second phase in T Narasipura taluk showed a marked deterioration in the experience as summarized in Table 4.16.

Specifically,

- The number of participants decreased by 22 percent, probably because premium subsidies had been removed.
- The claims incidence increased by 244 percent, probably resulting from both an increased awareness and reduced participation by lower risk members.[28] There were no data available to determine the actual renewal rate.

Table 4.16: Experience of T Narasipura in Phases I & II

Experience Indicator	Phase 1	Phase 2	Change
Number of participants	85,092	65,769	-23%
Avg. claims per participant*	7.7 per 1000	18.75 per 1000	+244%
Premium rate	30	20.52	-32%
Premium total	2,552,760	1,349,580	-47%
Claims amount	549,000	1,640,100	+199%
Average length of stay	8.4 days	9.6 days	+14%
Average claim amount	838	1,330	+59%
Paid claims / collected premium	22%	122%	+465%

* This is simply number of claims divided by number of participants and is not a true incidence rate since a person can claim more than once in a year.
Source: Compiled from Management interviews and internal documents; Communication for Development and Learning, 2005; MIRC Institutional Self-Assessment for Microinsurers, 2007.

[28] In theory, reduced participation normally results in higher utilization incidence since the participants that do remain are likely those who are in a poorer state of health while the healthier participants have a higher dropout rate.

- The average claim increased by 59 percent, due in part to the increase in benefits in Phase 2.
- A reduction of the premium rate and the reduced number of participants in combination reduced the collected premium by 47 percent.
- Claims amount increased by 199 percent due to the increase in utilization and the increased average claim amount.
- Claims severity increased moderately, with the average length of a hospital stay increasing by 14 percent.
- The combined deterioration of increased incidence, increased average claim, and reduced premium resulted in an increase in the paid claims ratio by 465 percent.

Summary and Conclusions

In 2006 Karuna Trust continued to operate the CHI in at least four areas of Karnataka. One of these programs covers all the 23 government PHCs under Karuna Trust management in 24 districts of Karnataka. The mobilization for the scheme was done by training the health workers (ANMs, male health workers and doctors) of the participating PHCs. Annual premium was kept at just Rs 22 per participant.

As of this writing, sufficient data were not available to analyze the results of these later programs but even without this information, some important lessons have emerged from the two-year pilot CHI experience—perhaps some are not unique to this experiment while others are. They include:

- For health microinsurance schemes to work well they must be kept as simple as possible in terms of benefits design, eligibility requirements, accessing services, etc. Maximum inclusion is all-important.
- Immediate claims settlement is necessary because the poor do not have available cash resources to settle bills upon discharge and will often delay treatment because of this.
- Active community participation is an essential condition for success in implementing microinsurance. Involvement of community-based organizations and SHGs was particularly productive in terms of enrolment, collecting premiums, and disseminating information.
- The replacement of daily income, which is not in itself health insurance, is an important supplementary benefit which encourages the poor to seek early treatment. Without it, treatment is often delayed until the condition becomes much worse or even fatal.
- Wide participation requires premiums that are kept as low as possible. The idea of prepayment for services is a difficult concept to sell and, initially, programs must be designed with modest benefits in order to keep premiums low. It takes time to build insurance awareness within a community and promoting the idea of expanding coverage and raising premiums becomes easier after participants have realized the utility of the program.
- Insuring against hospitalization is an alien concept to most of the poor and promoting it is further hampered by their superstitious beliefs. In many cultures, prepayment of services is akin to inviting bad health. In the first year of the program's operation premiums were subsidized and the community was automatically enrolled. This provided an opportunity to demonstrate that the general health of the community was not adversely affected due to their participation and that risk-pooling schemes can work. On the other hand, because the premium was fully subsidized, many participants were not aware that they had been enrolled. Furthermore, full subsidies more than likely had a negative effect on willingness to pay due to the expectations of future subsidies.
- The most important lesson that has been demonstrated is that utilizing the public health infrastructure can work provided that the facilities are privately managed. This is an innovative and unique aspect of this scheme. By utilizing a public health delivery system that actually works the insured poor can leverage their very low premium payments since services are free. The majority of the costs of running the government facilities are paid for by more affluent Indian taxpayers. If private facilities were used, the same level of services would require much higher annual premiums.

From an organizational standpoint, Karuna Trust learned much about the challenges of implementing microinsurance. Management realized that running an insurance scheme requires different technical skills and capacities, and that these will have to be developed if the program is to expand.

More generally, the project also proved that it is possible to have positive experiences and working models where government, community, and the private sector (both NGOs and commercial insurers) can devise productive partnerships. In terms of increasing access to public hospitals, the scheme demonstrated in TN Pura that early medical attention, as facilitated by the scheme, could decrease the overall economic burden of disease in the community.

Healing Fields Foundation

Healing Fields Foundation (HFF) is a non-profit registered society in Andhra Pradesh that evolved from a desire to make healthcare more affordable and accessible to people in India. It began in 2000 when a select few individuals in the healthcare industry combined their talents to develop a mechanism that would reduce the financial barriers to healthcare for the poor. Their mission was: to improve access to basic healthcare services; use innovative financing mechanisms to increase affordability of healthcare services to the population; and improve the quality of healthcare delivery using health management tools.

To achieve this mission, extensive research was carried out for two years to determine the health needs and health service utilization of rural people. Their survey showed that people wanted health insurance coverage for common critical illnesses and hospitalization. It also showed that people were willing to pay up to 25 percent of the hospitalization costs as a co-payment. The culmination of this research eventually led to the development of "Pariwar Suraksha Bima", HFF's flagship health insurance product.

The foundation works with other NGOs, the private sector, the government and semi-government sectors by leveraging its extensive domain knowledge of healthcare management and administration. For distribution it partners mainly with community-based NGOs that work with BPL members of Self Help Groups (SHGs). HFF acts as a channel, or "agent"[29], offering the health insurance product to the beneficiaries of the NGOs. The partner NGOs are responsible for some of the administrative duties such as enrolling, renewing, and collecting premiums from their members. Partners are chosen based on the following criteria: a minimum three years experience in microfinance activities; partners with well-established agencies and foundations; high-functioning internal processes; and strong bonds with SHGs.[30] Insurance risk is borne by HDFC CHUBB General Insurance Company.

Table 4.17: Overview of the Current Healing Fields Foundation Health Insurance Program

Characteristic	Description
Owner and manager of the scheme	Healing Fields Foundation (HFF)
Administrator and TPA	HFF and Parekh Healthcare Management Pvt share activities
Distribution and marketing	Through the partner NGOs; HFF staff also go to the field to educate, market and distribute the health insurance product
Service providers	Networked private providers within 52 km of beneficiaries
Role of the state government	NA
Starting date	Rolling; coverage is one year from enrollment
Insurance term	Annual
Scope of operation	Andhra Pradesh and Karnataka. Expanding to other areas.
Participation	Over 14,000 lives covered
Insured unit	Family floater: SHG member plus spouse & 3 children are covered
Risk pooling	Partner-agent model – risk is borne by HDFC CHUBB GIC

[29] HFF is not formally recognized by IRDA as an agent, TPA, insurer or broker.

[30] The target market is the BPL population of the SHG members who are in the working area of the NGOs. The NGOs need to have strong relationships with the SHGs to be effective at distributing and market ng.

Characteristic	Description
Target market	BPLs that are members of SHGs in areas where partner NGOs operate
Eligibility requirements	BPL SGH members between 18-65 years of age
Annual premium rates	Members pay 363/- per annum to cover entire family of five. – Rs 285 for Health Insurance – Rs 35 for Personal Accident Benefit – Rs 33 for Service Tax to GOI – Rs 10 to Healing Fields as registration fee
Premium collection	Partner NGOs collect premiums from their SHG members annually. If premium is not paid upon renewal, insurance policy is terminated.
Benefits	Rs 20,000 hospitalization coverage for a family of five: • Pregnancy cover • Coverage for listed 39 illnesses only • 25% co-payment by patient at time of discharge. • Wage compensation for a maximum of 15 days per year at Rs 100/- per day starting from the 3rd day (for the insured only) • Post hospitalization medicines at time of discharge • Costs of investigations are covered under insurance if admitted within 10 days. Rs 25,000 Personal Accident Benefit coverage for the insured & spouse • On death of the insured, additional Rs 5000 to each surviving child towards education. • On death of the insured, additional Rs 5000 to each surviving girl child towards marriage.
Exclusions	No exclusions
Claims settlement	HFF facilitator submits documents to HFF to process; these are then submitted to TPA for submission to insurance company which pays directly to the health facility. HFF facilitators all carry some cash to reimburse beneficiaries for lost wages due to hospitalization.
Waiting period	30 day waiting period in first year of membership
Co-payment and user fees	Beneficiaries must pay 25% of hospitalization costs; the insurance company covers the rest up to benefit limit
Availing benefits	Pre-authorization is given immediately by HFF facilitator; a second medical opinion is also sometimes given. Patient then seeks services, paying 25% co-payment
Financing	Premiums finance the program. There is also some donor assistance, particularly from USAID to finance administration of the program. If a beneficiary is unable to pay the premium or the hospital expenses, micro-credit is sometimes offered by the partner NGO.

A single health insurance product was designed with multiple benefits and is available to the SHG members between the ages of 18 and 65 years of age as a family floater. After a 30-day waiting period, newly enrolled families can use services.

The insurance product covers families of five and offers access to treatment at a quality, networked accredited nursing home or hospital for care up to Rs 20,000 per annum and compensation for lost wages of Rs 100 per day up to 15 days. Beneficiaries are subject to a co-payment of 25 percent of the hospitalization cost. The benefit also offers post-hospitalization medicines at the time of discharge, costs of investigations and consultations if admitted within 10 days. Upon discharge from the hospital, the health insurance policy will

not cover hospital admission for the same illness for the next six weeks. While the benefit package does not include out-patient services, rates for out-patient care were negotiated with the providers and beneficiaries receive at least a 50 percent discount on out-patient care.

Healing Fields operates on a cashless admission system to lower the financial barrier to health services. Members also receive personal guidance during hospitalization, as there are Healing Fields Facilitators who rotate through the hospitals to ensure compliance with the system, authorize hospitalizations, and ensure proper documentation for claims processing. Further, if a diagnosis is made, members can call the Healing Fields doctors for a second opinion free of charge.

The premium for the health insurance scheme is Rs 363 per family per year, which includes the service fee and administrative costs. The premium is estimated to be about 14 percent of total income of the target population group. This is quite high and cash flow amongst the beneficiaries is often a challenge, prompting some of the partner NGOs to offer low interest micro-credit premium loans to the families to finance the premium.

The premium rate was determined through extensive research on disease profiles in the target population group, hospital interviews to estimate utilization rates, and research on tariffs. It was designed to be self-sustaining with no reliance on subsidies from outside sources or substantial losses for the insurance company. In addition to health insurance, the package includes an accidental death and a total and permanent disability cover of Rs 25,000 for both the SHG member and his/her spouse.[31]

Organizational Structure of the HFF and Administration of the Scheme

HFF is a unique value-added health management service provider that supports organizations and people involved in the development of healthcare in India. Its approach is focused on preventative, promotional, curative and rehabilitative approaches to healthcare and is led by a Board composed of eminent stakeholders from the healthcare management, insurance, medical, community health, and social services fields.

There are currently 30 Healing Field Staff engaged fulltime in microinsurance activities. Immediately under the Director of Operations and NGO Network are the NGO Network Team and the Medical Management Team.

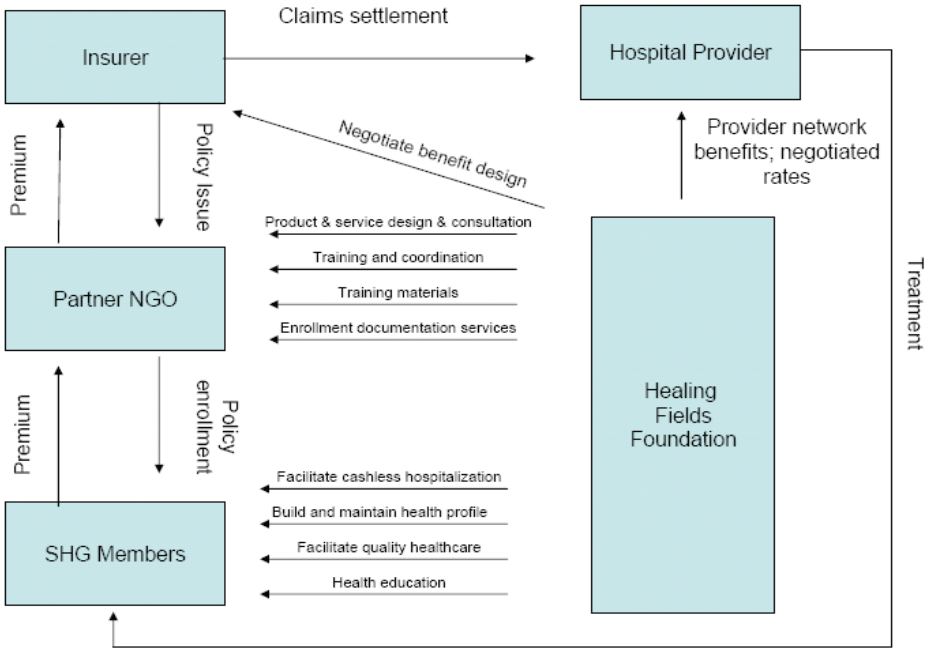
The overall responsibilities of the NGO Network Team include educating the NGOs and their members on health insurance concepts and the product. They consist of: a director, who is responsible for establishing high-level partnerships with NGOs across the country; manager and assistant manager, who are responsible for establishing and maintaining partnerships with district-level NGOs for enrollments; program officers, who are responsible for coordinating and guiding SHG participation in the health insurance program and training partner NGO workers; and field officers, who assist the program officer and managers in all duties.

The Medical Management team is responsible for managing the health facility-side of the insurance scheme and consists of a manager, who empanels hospitals, provides second opinions on medical issues and treatment protocols; an executive, who is responsible for pre-authorizations and claims verification; and hospital facilitators, who help the insured member through the pre-authorization process, hospitalizations, second medical opinion, collection of necessary documentation, and follow-up post-discharge, such as ensuring that the patient has taken the full course of medication upon discharge. The facilitators also do some public health education to the beneficiary. There is generally one facilitator for one to two hospitals.

Finally, there is the Transaction Processing Team, which has the responsibility of enrolling members, issuing ID cards, processing claims, data management, and claim verification.

[31] For partial disability only Rs 12,500 is received and in case of accidental death of the insured member an additional benefit of Rs 5,000 is paid to each unmarried girl child below age 21 to be used towards funding a future marriage. Similarly, Rs 5,000 is paid to each child under 21 years for funding future education expenses (maximum three children).

Figure 4.10: Organizational Structure of HFF

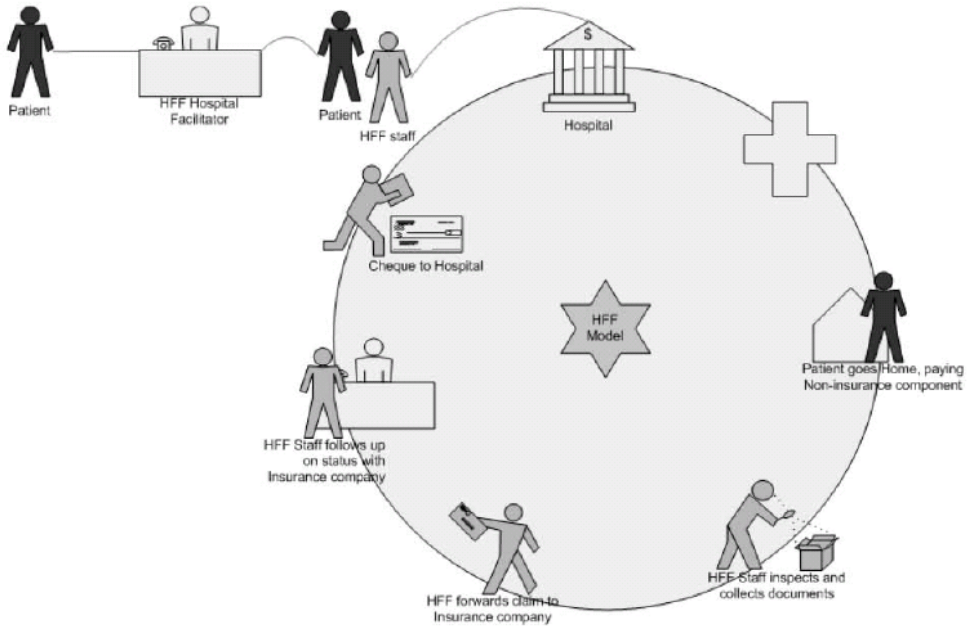


Once it has been determined that hospitalization is required, the member can walk into the designated network facility and produce the photo ID card to receive services. Upon admission, the hospital personnel and the Healing Fields facilitator collect the co-payment from the patient's family, which is 25 percent of the total bill to be paid. The rates for the services covered are predetermined and are clearly stated in the Memorandum of Understanding between HFF and the hospital. The rates are also communicated to the beneficiaries so that the cost of services and their portion of the cost is clearly understood. Upon discharge, the facilitator collects the documentation and submits the claim to Healing Fields, which submits the claim to the insurance company. The hospital is then paid directly by the insurance company (the remaining 75% of the total bill cost). The facilitators also have a certain amount of cash to reimburse the patient for lost wages due to hospitalization.

Claims processing is managed by Healing Fields. Staff based at the health facilities collect the proper documents and forward these to the medical management team at HFF headquarters in Hyderabad where a medical management team scrutinizes the claims and then passes them to the transaction processing department for verification against the database. Submitted claims are processed by the insurer who reimburses the providers through Healing Fields.

Healing Fields does a good job of making sure that staff at the management level and above are adequately trained and have a strong command of the insurance industry. All the management staff is trained in insurance regulations, rules, products, claims processing, and underwriting. Further, all Board Members and the Executive Leadership have a significant amount of prior experience in the health insurance industry, so the concepts of micro health insurance are not new. Finally, Healing Fields has received technical assistance and training from United Healthcare India and USAID to build the capacity of staff and transfer technology knowledge.

Figure 4.11: Claims Processing in HFF



Source: HFF, 2007

Enrollment

Members are enrolled by the NGO partners or directly from Healing Field staff in the field. Enrollment forms are submitted to Healing Fields for scrutiny, such as eligibility and validity of proposal forms. A personal identification number is then assigned to the enrollee and an ID card is prepared and sent to the members, along with the policy parameters.

The target market for the health insurance product is the BPL category of Self-Help Groups who are operating within the geographic area of the partner NGOs. These BPLs are predominantly daily wage laborers and agriculture laborers; 50-60 percent operate within the informal economy. However, there have been challenges in distributing this product to the target market for several reasons. First, the BPL population finds it difficult to finance the annual premium in one lump-sum, which reduces the appeal of health insurance. Second, there is a lack of education of the market about the concepts and benefits of health insurance by the partner NGOs—many are too busy with their own organizational goals and health insurance is often not among these. There is still a perception of 'fatalism' amongst the BPL community, rather than risk management, as it relates to health care and health outcomes. HFF staff is, however, becoming more proactive in educating beneficiaries and enrolling new members alongside the partner NGOs. Finally, the 25 percent co-payment requirement may also tarnish the appeal of the product.

Accessibility

Healing Fields members are able to obtain required services within 50 km of their homes at networked local hospitals and health providers. The providers are rated by Healing Fields based on utilization and structural review, quality of services provided (based on observation), qualifications of the staff and sophistication of their information systems. Of the 75 providers that were reviewed by Healing Fields, 25 were chosen to be a part of the network because they met the criteria.

Consumer Awareness

A key component of the Healing Fields model is training and consumer awareness. Healing Fields is engaged in numerous consumer awareness activities aimed at increasing the understanding of the health insurance product offered. They participate in various meetings at the community level and conduct health camps where they disseminate knowledge on health insurance for the poor. HFF conducts intensive training for the SHG members and the NGO staff with whom they work to clarify the concept of insurance and the process for utilizing the benefits. NGOs are also trained on the life-cycle model, which focuses on promotional, preventative and curative care for people throughout the duration of their life.

Training modules contain topics such as nutrition, water and sanitation, malaria/dengue, communicable diseases, HIV/AIDS, reproductive health and immunizations. Healing Fields also distributes posters and pamphlets in the local language that were developed by UNICEF and WHO, among other prominent international organizations.

Focus group discussions are conducted to measure consumer awareness and satisfaction. Discussions have revealed that 95 percent of respondents (out of 245) had a clear understanding of the product and its limitations; only five percent had minor misunderstandings. Zero reported not having a clear understanding of the product. The facilitators also regularly monitor the hospitals and field coordination weekly and fill out feed back forms. This information is entered into the management information system to permit constant monitoring.

Healing Fields also has strong partnerships with external entities that facilitate a smooth and efficient delivery of health insurance to the NGO members. For instance, Healing Fields partners with Parekh Healthcare Management Pvt Ltd, which provides TPA guidance and services; with HDFC CHUBB General Insurance Company to bear the risk of the insured and adjudicate the claims; and with 31 hospitals, selected because of their geographic location (near the partner NGOs) and the quality of care offered. Healing Fields health insurance scheme is registered with IRDA under HDFC-CHUBB GIC.

Performance and Sustainability

In summary, the Healing Fields Foundation is an interesting and unique microinsurance model, initiated by health industry professionals who felt strongly about using their expertise to advance financial intermediation among those less fortunate. They have set up an organization that fulfills practically all the functions of a TPA, agent, and insurer although the risk is ceded to an insurer.

The multi-pronged marketing approach that Healing Fields has employed does have the potential for significant health insurance penetration but with just 14,000 individuals enrolled after 3 years of operation it is clear that some major challenges have yet to be recognized and overcome. Healing Fields struggles from low enrollment rates and renewals, which could reflect levels of consumer awareness and satisfaction. While the decentralized model of marketing, distribution and enrollment looks good on paper, implementation has been challenging for several reasons. First, the partner NGOs are not insurance-oriented organizations, and are not necessarily convinced of the benefits of health insurance, which results in poor outreach and education to the community members. Second, the arguments made to the target market are unconvincing given the NGOs' priorities. And third, enrolling new members is a low priority. Healing Fields has tried to counter these problems by being more visible at the community level and taking on enrollment to complement the work of the partner NGOs. While this has made a difference to the education of the community, it may not be the most cost-effective mechanism to employ.

Perhaps most importantly, the premium amount is higher than some of the beneficiaries are able to pay on an annual basis and the co-payment can sometimes exceed the amount of cash available to the patient. This has led to the NGOs offering microcredit loans to cover the cost of the premium or the co-payment cost.

One solution undoubtedly lies in identifying and partnering with organizations that could effectively implement mandatory participation of all its clients or members. Such organizations could be well established and credible NGOs engaged in microfinance and working with SHGs. To implement the product on a compulsory basis would require intensive and ongoing education on behalf of both partners, flexible

premium financing to overcome the challenge of collecting an annual premium, and the ability to customize products for each NGO. The BPL market is very diverse in terms of perceived health insurance needs and capacity to pay and it is unlikely that the HFF "one size fits all" approach in terms of product and solutions offering will work very well.

As stated above, the benefit package was developed based on two years of research looking at the needs of the rural poor and what they were willing to pay for services. However, this research should be repeated for every new market and periodically for renewing partners as beneficiaries become more sophisticated about health insurance. Administratively this is not difficult; the organization has designed a very comprehensive system that will be capable of handling varied customized products based on expressed needs and capacity to pay for each group of potential members.

People's Rural Health Promotion Scheme

The People's Rural Health Promotion Scheme (PRHPS) grew out of the People's Rural Education Movement (PREM), a non-profit, humanitarian, secular and non-political voluntary organization founded in 1980 by social activists Jacob Thundiyil and Chacko Paruvanany. PREM was built on a vision of poverty eradication and empowerment of the poor through a rural development approach centered on increasing functional literacy, raising political awareness, improving healthcare and promoting livelihood. The initial activity was to establish an adult education centre in each of 15 villages of Mohana block situated in the hilly tribal areas of Gajapati district in south Orissa. The success of this project encouraged its expansion to the fisher-folk and Dalit people living in the underdeveloped areas of Gajapati and Ganjam districts of Orissa.

Today PREM is supported by Plan International (an international development agency) and works directly with four diverse groups of people: the Adivasis (tribal groups) living deep within the forests of Orissa, the Dalits (Scheduled Castes) traditionally repressed to the fringes of caste-ridden Indian society, small and landless marginal farmers exploited by landowners through perpetual indebtedness, and the marine and inland fishermen of Chilika Lake whose livelihoods are threatened by marine pollution and by unscrupulous fishing practices of modern mechanized trawlers that encroach their traditional fishing areas.

To avoid creating a dependency syndrome and to work more effectively with these groups PREM-Plan organized community based organizations (CBOs) at each village, sector and block level and then federated them into four organizations at the state level: Orissa Adivasi Manch which is concerned with issues affecting the Adivasis; Kalinga Fisher Peoples Union which works with fishermen and women; Orissa Dalit Manch addressing the issues concerning Scheduled Castes; and Utkal Mahila Sanchay Bikas (UMSB), a federation of

Box 4.2: PRHPS Vision and Objectives

PRHPS VISION

'One for all & all for one' is the philosophy behind the People's Rural Health Promotion Scheme. This is based on a community feeling of sharing and caring that is a part of the culture of both the community and the PREM-Plan project people. Solidarity among people is seen in every village. In almost all the villages there is strong SHG hence it is easier for the project to initiate a "Health Promotion Scheme" in every village. This scheme makes available health care facilities from the village level up to the hospitals at district level for all the participating members.

PRHPS OBJECTIVES

To strengthen the solidarity of all the marginalized in the focal villages.

To make health care affordable, available, accessible, and acceptable (4As).

To empower women to take decisions affecting the health of the family members.

To enable everyone, even every child, to contribute towards protection of the health of a member in crisis situations.

To make healthcare a people's movement led by the network of women's SHGs, Village committees, Panchayats, NGOs and People's Organizations.

To enable people to have full control of their health instead of being exploited by the "health business" nexus, i.e., pharmaceutical companies, doctors, pharmacies & hospitals.

Source: MIRC Institutional Self-Assessment for Micro nsurers, 2007.

SHGs. These grassroot networks ensure sustainable development through direct community participation and independent collective decision-making with regard to the numerous important issues and PREM-Plan programmes affecting them.

PREM was formally registered in 1984 as a non-profit organization under Societies ACT XXI of 1860, GJM No. 425-31 of 1984-1985. The scope of its operations over the years has evolved in three directions. In some areas PREM-Plan implements programmes directly, in other areas programmes are implemented in co-operation with the four state level federations, and on a much wider scale advocacy and other campaigns are undertaken through a network comprised of 172 independent voluntary and community-based organizations. By 2006, the PREM-Plan direct outreach had been extended to approximately 6,000 villages benefiting approximately 10 lakhs people, while through its network partners PREM-Plan affected approximately 50 lakhs people in 22 districts of Orissa. PREM also leads two national forums: the National Advocacy Council for Development of Indigenous People, a national forum representing 48 tribal communities from 18 states, and the East Coast Fisher People Forum representing 23 fishermen groups in 5 states.

The socially excluded people in Orissa are the focal population of PREM-Plan. Poverty, lack of awareness and lack of facilities makes healthcare inaccessible for these marginalized communities and in some areas infant mortality rates as high as 110 per thousand and maternity mortality rates of 8 per thousand have been recorded.

From its beginning the founders of PREM understood the link between the poverty cycle and poor health of men, women, and children and over the years launched several important health intervention programmes to

Table 4.18: Some of PREM-Plan's Health Intervention Programmes

Health Program	Description and objectives
Malaria Control and Prevention	Eradication of malaria through: • Promoting awareness and health-seeking behavior with regards to malaria • Effective mosquito management • Lobbying government to provide free chloroquine for malaria treatment
Child survival and safe motherhood	Goal to reduce infant and maternal mortality rates through: • Establishing links with public PHCs, auxiliary nurse midwives, etc. • Regular health checkups and government health centers • Training traditional birth attendants to deliver in hygienic manner • Promoting health awareness among children through peer-to-peer learning
Child Centered Health & Development	Reducing infant and maternal mortality, improving literacy levels, improving learning environments, reducing school dropout rates, reducing child labor, and increasing marriage age of girls.
Say "no to tobacco" campaign	A programme focused on increasing awareness about the dangers of tobacco use, discouraging tobacco consumption, and organizing diagnostic camps to detect oral and other cancers.
HIV / AIDS & other STDs	HIV / AIDS awareness and prevention, promotion of safe sex and monogamous relationships.
Eye Care Program	• Holistic approach to eye care, including promotion of good hygiene and regular eye checkups as well as identifying and treating cataracts and glaucoma. • Rehabilitation and reintegration of the visually impaired into the community.
Nutrition	Early childhood care and development centres are running in each village.
Clean water	Siphon water system and water harvesting structures are constructed wherever necessary.
Communicable diseases	Awareness and prevention.
Family planning	A program on natural family planning methods
Immunizations	Routine immunization programs are carried out in all operational villages with support of Government health department.

Table 4.19: Main features of the Current PRHPS Microinsurance Programme

Characteristic	Description
Owner and manager of the scheme	People's Rural Education Movement (PREM), with support from Plan International. UMSB is gradually taking over the management of the scheme.
Administrator	UMSB
Distribution and marketing	Marketing is achieved through the SHG network of UMSB since there is usually at least one strong SHG in each selected village. Promotion is built on a "one for all & all for one" motto and the inherent community spirit of solidarity.
Product type	Health microinsurance integrated into numerous health programmes and grassroot community structures.
Service providers	Village level medical depots with referrals to public health providers
Starting date	January 2002
Term of coverage	Annual coverage beginning January.
Scope of operation	Within the operational areas of PREM-Plan in Orissa and Andrah Pradesh.
Participation requirement	Voluntary participation.
Insured unit	All individuals in a family must enroll.
Risk pooling method	Self-insured (initially insured with NIC).
Target market	Families living in the 2 PRHPS project areas: • 333 selected villages in the district of Gajapathi in Koraput project area • 144 selected villages in the district of Puri in Chilika project area Expansion to other areas is being planned.
Eligibility requirements	Everyone in the target market is eligible.
Annual premium rates Premium financing Premium collection	Rs 20 per person Premium collection is January to March of every year through the SHG network of UMSB, in coordination with the Village Committees.
Benefits and services	Three-tier level of services that begins with VMDs where most cases are treated. Cases that do not respond are referred as required to sectoral treatment level (PHC/CHC/ or Area Hospital) or to third level (district hospital or Berhampur Medical Collage).
Exclusions and waiting period	None
Availing services	Except for serious cases, treatment begins at VMDs which are run by trained locals. If the condition does not improve satisfactorily over three days the patient is referred to a second or third level facility.
Claims settlement	Mixture of cashless and reimbursement.
Ancillary costs, eg. travel, wage loss compensation	Not covered, although village SHGs give loans for transport costs.
Co-payment and user fees	None
Financing of the scheme	Direct financing through member premiums, interest income, and subsidies from Plan International which decline over 6 years.

address the specific health problems of its target communities. One such health-related project was a malaria prevention and control programme. Orissa is known to have the highest malaria incidence in India and according to a government survey in 1999 as many as 37 percent of the inhabitants were infected. These staggering figures prompted PREM-Plan to initiate a campaign in about 1000 villages in the Gajapati district that were especially prone to malaria with the ambitious goal of eradicating the disease. At the community level, efforts were made at increasing awareness and health-seeking behavior such as improving general hygiene, effective mosquito management through spraying and elimination of stagnant water pools, encouraging the use of mosquito nets and repellents such as neem oil, and recognizing malaria symptoms in order to seek more timely treatment. At the policy level, PREM lobbied with government health authorities to increase the number of free chloroquine tablets available to infected patients from just four tablets to the

entire required treatment of 10 tablets. The majority of poor patients could not afford the remaining six tablets which forced them to give up treatment prematurely.

Aside from malaria, other major health hazards in the district include tuberculosis, sickle cell and water borne diseases such as diarrhoea and typhoid. Over the years PREM-Plan undertook several other health interventions in efforts to address these risks and to improve overall health.

Prior to 2004, major efforts of PREM-Plan health programmes were to provide medical care in inaccessible areas and raise funds to support the treatments. Over the years PREM-Plan realized that this approach to its interventions was not sustainable because it was entirely service-oriented. Aside from PREM-Plan, other organizations and the government had been working over the years on health promotion and disease prevention in these target areas without realizing the expected long term results.

In addition, when government-managed health centres were privatized in 2000, they began charging user fees, which the majority of the population in the project areas could not afford. In the months that followed, PREM-Plan faced ever escalating costs since it was now reimbursing the user fees charged to its referral cases.

These experiences, developments, and the realization that 14-20 percent of its target populations sought medical treatment every year prompted PREM-Plan to conclude that an alternative approach centered on active community participation was needed. In 2004 a health microinsurance scheme called People's Rural Health Promotion Scheme (PRHPS) under the banner of the UMSB federation was launched. The scheme is built on the intrinsic community culture of "sharing and caring" with a motto of "one for all and all for one" used to enroll families into the scheme. As the name indicates, PRHPS is a comprehensive programme covering preventative and curative healthcare while functioning as a health microinsurance scheme. It is firmly embedded into the various health and development activities of PREM-Plan as well as all levels of the network structure of the community based organizations.

Services

Access to treatment usually begins at Village Medical Depots (VMDs) which are peripheral care units set up in each village and run by local volunteer persons trained to diagnose and treat the most common diseases and ailments, provide first aid, and assess whether or not a referral for more advanced treatment is required. A detailed Village Pharmacy Dosage Chart guides the local volunteer which describes the procedure and dosages at each stage based on the observed symptoms, diagnosed disease and ailment, age of the patient, and date since diagnosis.

Table 4.20: Common Diseases and Treatment in VMD

Diseases	Prescribed treatment
Fever Cases	Paracetamol
Malaria	Chloroquine
Lose Motion	Metronidazole / Furazolidin
Dehydration	ORS Packet
Minor Injuries	Tincture Iodine, Plaster, Spirit, Band aid, Gauge, Cotton and Dressing set
Cough	Herbal Remedy
Scabies	Benzin Chloride Solution
Safe Delivery	Safe Delivery Kits (Disposable)
Immunisation	Card and Weighing machine

Source: MIRC Institutional Self-Assessment for Microinsurers, 2007.

PRPHS estimates that 75 percent of the communities' ailments can be cured with 15-20 types of medicines stocked at these VMDs. If there is unsatisfactory improvement in a patient's condition after three days he/she is referred to the nearest public PHC, CHC or Area Hospital through one of the sector PREM-Plan offices; here another 15-20 percent of patients are cured. A referral letter from the Village Committee is required. Alternative arrangements are sometimes made with a local nurse or pharmacist in areas where there is no PHC.

If the required treatment is beyond the capacity of this second level then the referral is elevated to the MKCG medical college in Berhampur through the PREM-Plan head office (about 5-10 percent of all cases). Serious diseases and emergencies, such as fractures, tuberculosis, advanced stage of cerebral malaria, surgical cases including cesareans, ENT and dental cases are immediately and automatically referred to the third level.

Table 4.21: Benefits of the current PRHPS microinsurance programme

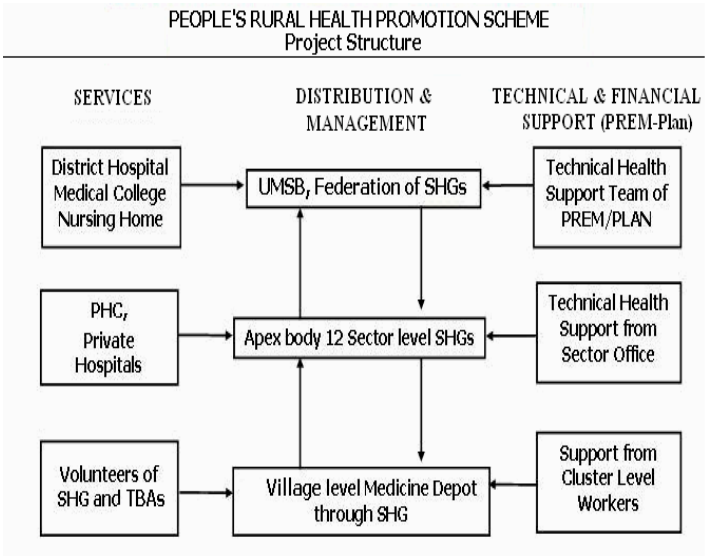
Level of Treatment		Services offered	Coverage
Level 1	Village Medical Depot (VMD)	Specific common diseases such as malaria, other fevers. Referral to higher level if insignificant improvement in 3 days	Drugs as needed, charged at cost.
Level 2	Sectoral Level Referrals to PHCs, CHCs, Area Hospitals.	Diseases within the capacity of the facilities	Max Rs 3600 for medicines, diagnostics, and surgical supplies. Services are free. Special cases up to Rs 20,000 max at PRHPS management discretion.
Level 3	District Hospitals, Berhampur Medical College, hospitals in Visakhapatanam, private hospitals if no public providers		

Source: Adapted from George, Alex, 2006.

Organizational Structure and Management

The scheme was set up as a five-year trial project of PREM-Plan. It is divided into two sub-project operational areas, one in the Gajapati district in Koraput area and a second in the Puri district of Chilika area, with a project point person responsible for the day-to-day monitoring in each area. Both areas have been further sub-divided into sectors (seven in Koraput and four in Chilika), and in each of these a sector-in-charge is responsible for looking after the day-to-day affairs of the PRHPS.

Figure 4.12 PREM-Plan Structure



Source: MIRC Institutional Self-Assessment for Microinsurers, 2007.

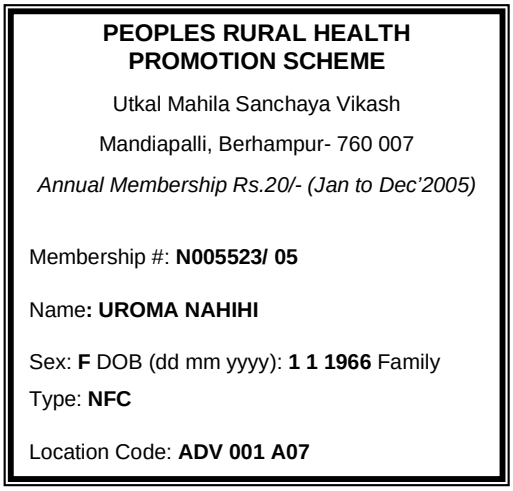
The scheme is supervised by the President of PREM, the Secretary of PREM, and the President of UMSB. The project is managed by a professional core team of eight full-time personnel consisting of an overall project coordinator and from each of the two project areas a project point person, a communication and information technology officer, and a project level referrals contact person. In addition 53 cluster level volunteers are engaged for the annual membership and premium collection drive and almost 1000 volunteers manage the VMDs at the village level and support the scheme.

VMDs are managed by a carefully selected SHG in each village from which two literate volunteers undergo intensive training on human physiology, disease recognition and administration of medicines. The training sessions are conducted by qualified medical professionals with a planned curriculum. The volunteers are also responsible for maintaining a daily patient register and inventory of drug stocks, and enrolling members.

Although staff and volunteers are trained on the various aspects of their operational responsibilities there is no formal training on risk management principles. Information management systems are in place for tracking membership and demographic information, referral information such as diseases and conditions, and expenditures incurred for each case. Accounting and investment details are also electronically maintained.

The enrolment and premiums collection process is an annual community activity coordinated by Village Committees who take the responsibility to renew all existing members and to enrol new village residents not in the scheme. This activity takes place from January to March since most members have the cash during those months due to harvest. PREM-Plan's sector-in-charge passes the premiums on to UMSB which issues the membership cards as shown below.

Figure 4.13 PREM-Plan Membership Card

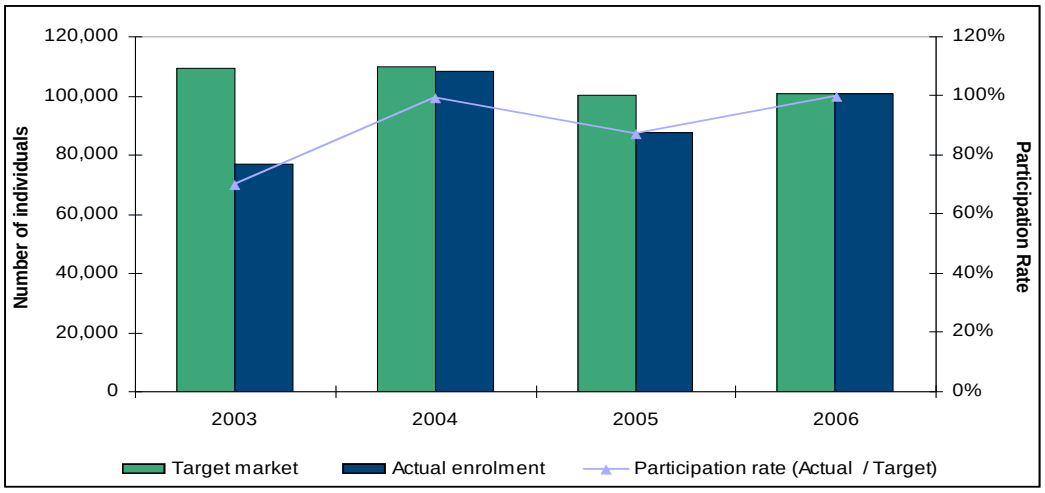


In 2004, the second year of the project, almost 99 percent of village residents were enrolled. This stellar result came from utilizing the village committees to ensure effective premium collection, requiring family enrolment, working with UMSB and the SHGs to provide financing for travel costs and premium, support from the four CBO structures, and the spirit of solidarity that glues the scheme together. In 2005, a project decision was made to exclude the higher-income families of Chilika project area to focus on the most needy, which reduced the target population to 1,00,300.

Claims

In its first year PRHPS partnered with National Insurance Company but, because of the length of time taken to reimburse claims and the exclusion of pre-existing conditions and deliveries, PRHPS severed the relationship and decided to self-insure.

Figure 4.14: Growth of PRHPS Microinsurance Programme



Source: Graph compiled from data in MIRC Institutional Se f-Assessment for Micro nsurers, 2007.

At the village, level generic drugs are provided at cost with the Village Committee acting as gatekeeper. A sense of ownership of the program among the members limits the risk of major fraud. Costs are also lowered since PRHPS sources high quality generic drugs in bulk from reliable suppliers. A revolving fund is managed at the village level for purchasing these medicines.

At the second and third level of claims payment is a mixture of both cashless services and reimbursement. Only medicines, diagnostics and surgical supplies which are prescribed by the health providers for outside purchase need to be covered by PRHPS since services in the public health system are free. In Berhampur, drugs prescribed by doctors are purchased from two accredited pharmacies without any cash outlay by members as PRHPS settles the accounts with these pharmacies on a periodic basis. This arrangement also controls fraud and inflation of drug costs. Although this appears to be working well, there are no similar arrangements in other areas and hence all other claims are settled on a reimbursement basis.

Financial Performance and Sustainability

The experience for 2004 showed a lower incidence rate and higher average claim in Koraput. Overall, the incidence seems to have stabilized; however the average claim amount kept rising until aggregate claims exceeded collected premiums for the first time in 2005. Preliminary data for 2006 indicate tightened control of referrals; nonetheless a premium increase will be needed soon if the goal to become independent of subsidies is to be realized.

Summary and Conclusions

In summary, the PHRPS project has shown very promising results. It has consistently enrolled close to its entire target population by building the scheme on a foundation of solidarity and community participation. The three levels of service with referrals to higher levels as needed appear to be a very effective cost-containment mechanism. Although heavily subsidized on a declining basis, PRHPS has built a solid foundation with the characteristics and potential of becoming a sustainable and viable microinsurance scheme. Indeed, the expressed goal of PREM-Plan founders is to grow the PHRPS into a professionally-managed mutual with proper technical support. This could well be achieved.

Table 4.22: Referral costs 2004 – 2006 (paid claim basis, in Rs)

Area	No. of Diseases/ Conditions	No. of Referrals	Total Claims Cost	Avg. Claim	No. of Members	Referral Incidence	Referral Cost per Member
2004							
Koraput	228	987	11,21,528	1136	69,899	1.4%	16.04
Chilika	70	2,404	6,11,818	255	38,690	6.2%	15.81
Combined	Not additive	3,391	17,33,344	511	1,08,589	3.1%	15.96
2005							
Koraput	221	1,538	14,50,628	943	58,800	2.6%	24.67
Chilika	354	1,483	6,18,017	416	40,099	3.7%	15.41
Combined	Not additive	3,021	20,68,645	685	98,899	3.05%	20.92
2006							
Koraput	195	1,087	13,02,908	1,199	59,260	1.8%	21.99
Chilika	315	1,214	538,162	416	41,395	2.9%	13.00
Combined	Not additive	2,301	18,41,070	800	1,00,655	2.3%	18.29

Source: 2004: Adapted from George, Alex, 2006; Compiled from PREM-Plan database, Management nterviews 2007, MIRC Institutional Self-Assessment for Microinsurers, 2007

Table 4.23: Selected Financial Indicators 2003-2--6 (2003 and 2006 partial)

	2006	2005	2004	2003
Premium collected	20,06,000	19,77,980	21,71,780	15,39,598
Interest income	N/A	493,776	52,473	N/A
Plan International grants	80,00,000	100,00,000	120,00,000	150,00,000
Other income	N/A	313,338	94,576	N/A
TOTAL INCOME	**100,06,000**	**127,85,094**	**143,18,829**	N/A
Referral Costs (Claims)	18,41,070	2,068,645	1,733,344	N/A
Administration expenses	5,00,000	5,00,000	5,00,000	5,00,000
Depreciation costs	-	-	-	N/A
Other costs	-	-	-	N/A
TOTAL Costs	**23,41,070**	**25,68,645**	**22,33,344**	N/A
NET INCOME	N/A	**10,216,449**	**12,085,485**	N/A
PREMIUM – CLAIMS - ADMIN	**(335,070)**	**(590,665)**	**(61,564)**	N/A

N/A data not available at time of interview

Source: Compiled from PREM-Plan database; Management interviews 2007; MIRC Institutional Se f-Assessment for Micro nsurers, 2007; George, Alex 2006

Vimo SEWA[32]

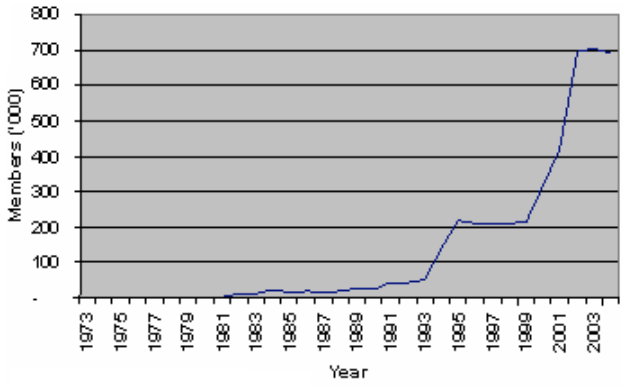
Self Employed Women's Association (SEWA) was established by Elaben Bhatt in 1972 as one of the first self-employed workers' trade unions in the world. Based in Ahmedabad in Gujarat, it grew out of India's oldest and largest union of textile workers, Textile Labor Association, and sought to organize urban and rural women earning a living in the informal sector. SEWA's objectives were to improve the economic and social security of its members and to develop a culture of individual and collective self-reliance. In 1977 SEWA gained international recognition when its founder and General Secretary, Elaben Bhatt, won the prestigious Ramon Magsaysay award for her courageous and selfless public service and leadership.

Today SEWA is a large organization and a women's movement comprised of 7 lakhs informal workers (mostly self-employed and/ or small businesses owners) spread over several states. Approximately two thirds of SEWA members are in Gujarat where they belong to more than 2000 SHGs engaged in savings and credit, 90 cooperatives (dairy, artisan, trading, child care, etc.), and almost 200 producers' collectives (crafts, forestry, etc.).

Figure 4.15: SEWA Union members - characteristic profiles as of 2004, growth 1973-2004

Profile	Breakdown
Geographical dispersion	Gujarat - 68% Madhya Pradesh - 24% Uttar Pradesh - 7% Bihar, Delhi, Rajasthan, and Kerala – 1%
Urban - Rural (Gujarat)	33% urban, 67% rural
Livelihoods (Gujarat only)	Manual labourers & service providers – 67% Home based workers – 18% Producers – 9% Hawkers and vendors – 6%

Source: www.SEWA.org



In 1974 SEWA Bank was established to provide SEWA members with access to banking services such as savings and credit as an alternative to exploitative moneylenders. The co-operative bank is owned and governed by SEWA members and by 2006 it had almost 50,000 shareholders (mostly SEWA members), almost 300,000 depositors, 25,000 pension accounts, had issued 28 crores in loans and accumulated almost 94 crores of working capital.

Over the years SEWA observed that numerous borrowing members delayed repayment or defaulted on their loans and concluded that the main cause was a lack of access to social security systems. During emergencies such as sickness or death of a family member borrowers were forced to resort to moneylenders, use up their savings, or mortgage their productive assets, which then often sent them on a downward spiral into abject poverty. Many others were obtaining loans for the stated purpose of productive business development but were actually using the funds to seek relief by paying off their oppressive debts to moneylenders.

In 1992 Vimo SEWA was launched as a fund offering a life insurance product open to all SEWA members on a voluntary basis. In 1994 the insurance program was broadened to include asset protection and health insurance, and a few months later accidental death insurance for the member's spouse was also added. The life risk was ceded to Life Insurance Corporation of India (LIC) while the remaining risks were carried by United India Insurance Company (UIIC). When the relationship with UIIC deteriorated in 1994 due to high rejection rates of health insurance claims by the insurer and due to overly complicated procedures for claiming, SEWA decided to continue the health insurance program on a self-insured basis. Later in 1998, when member dissatisfaction with the low reimbursements for asset loss claims became widespread, SEWA

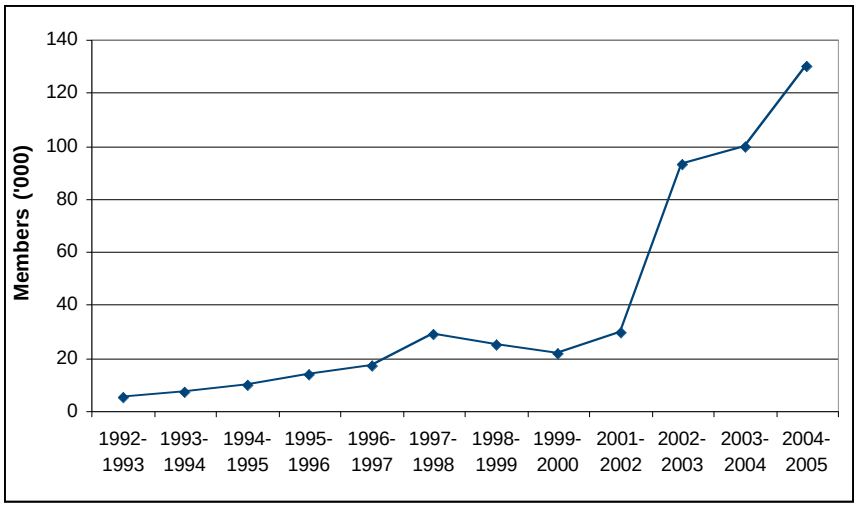
[32] V mo is the term used to designate the nsurance program of SEWA.

completely severed the relationship with UIIC and brought the asset protection insurance in-house as well. A claims committee was subsequently formed which developed and followed clear adjudication protocols to ensure fairness, efficiency and consistency in claims settlement.

Self-insurance without reinsurance proved to be a painful lesson in risk management. In January 2001 a major earthquake struck Gujarat that resulted in a Rs 34 lakhs claims shock on the Vimo SEWA self insurance scheme, far higher than the expected annual claims of Rs 30,000 at the time. This created a severe financial strain on the program and prompted Vimo SEWA to once again seek insurance partners for all its products since reinsurers could not legally reinsure informal schemes. A partner was found in National Insurance Company (NIC), and to avoid a repeat of the bad servicing experiences with UIIC, SEWA successfully negotiated to retain the claims adjudication function in-house. Negotiating with insurers had now become much easier since the large number of insured members had become a more attractive block of business for insurance companies eager to fulfill their social obligations set out by IRDA.

Although the earthquake presented a difficult challenge for Vimo SEWA it also had a very positive marketing impact on the program. In the year following the earthquake membership tripled from 29,140 to 90,259 when almost 1500 asset claims were paid to victims of the quake. The increase was mostly due to enrolment of members from rural Gujarat since the quake had the greatest damaging effects there. Insurance awareness grew even more a year later when 1135 asset claims were paid in the dark days following the communal violence in Gujarat.

Figure 4.16: Vimo SEWA Enrollment 1992-2005 (members only)



Source: S nha, Shal ni, 2006

Over the years the relationships with various insurers did not improve. In October 2001 in the wake of the earthquake and the resulting spike in membership, spurred on by cumulative dissatisfaction with the various insurance company partnerships to date and in the context of the new liberalized insurance regulatory environment, Vimo SEWA developed a business plan that aimed for viability and surplus buildup, with the ultimate goal of eventually transforming itself into a member-owned SEWA insurance company (by then Vimo SEWA had already become a separate business unit of SEWA). The plan focused on professional management based on sound insurance principles, a seven year growth plan targeting 3 lakhs insured, attaining financial viability, and a policy intervention plan that would actively lobby for a favorable regulatory environment in which microinsurance could flourish.

The chronology of the insurance scheme's evolution is characterized by numerous product revisions and insurance carriers. These changes were driven by members' feedback and the organization's own marketing experiences. From the beginning, products and servicing has been gender-sensitive and built on members' needs, in contrast to schemes designed using the usual top-down approach of insurance companies and governments.

Table 4.24: Evolution of Vimo SEWA insurance program

Year	Significant developments
1992	*Product and insurer:* life (LIC) Target market: SEWA members only. Life premium rate set to Rs 30 per member with Rs 15 automatic deduction from member's accounts and Rs 15 as a SEWA subsidy. 50,000 enrolled but most unaware that they are insured.
1993	Backlash from members due to automatic deduction leads to policy of voluntary participation and a drop from 50,000 to 7,000 insured.
1994 - 1995	*Product and insurer:* life (LIC), health, accidental death, asset protection (UIIC) Coverage extended in 1995 to cover gynecological problems and occupational health-related illnesses.
1996-1997	*Product and insurer:* life (LIC), health (self-insured), accidental death, asset protection (UIIC) Poor servicing and high rejection rate by UIC prompted Vimo SEWA to self-insure health. Claims committee formed, with established protocols for adjudicating claims.
1998 - 2000	*Product and insurer:* life (LIC), health & asset protection (self-insured), accid. death (NIAC) *Target market:* expanded to SEWA members and their spouses. Widespread dissatisfaction with reimbursements for asset protection claims prompts SEWA to cancel UIIC relationship and move the asset protection in house. Accidental death risk was ceded to New India Assurance Company. Health insurance expanded to include spouse. Hearing aid benefit extended to fixed deposit members. Vimo SEWA set up as a separate business unit.
2001 - 2002	*Product and insurer:* life (LIC), health and asset protection and accidental. death (NIC) Jan 2001: the Gujarat earthquake resulting in 34 lakhs claims prompts Vimo SEWA return.to partner–agent approach with NIC taking over health, asset protection, and accidental death but with SEWA retaining the claims committee and adjudicating the claims. As a result of the earthquake, membership jumped from 29,140 to over 90,259 due to increased awareness. Vimo SEWA introduced a package called Scheme III for the more well to do members as a strategy towards sustainability, but having more than one package confused the market. Vimo SEWA developed business plan to scale up operations and move towards becoming an insurance company. Period of communal violence resulting in 1135 asset claims which further increased insurance awareness but also increased dissatisfaction with NIC.
2003	*Product and insurer:* Life (LIC & OM Kotak Life Co Ltd), health & assets (NIC & ICICI Lombard General Co), accidental death (LIC & ICICI Lombard General) *Target market:* expanded to SEWA members, spouses and children. Child health insurance introduced. Coverage for cataract operations extended to members.
2004	*Product and insurer:* Life (LIC & AVIVA), health and assets (ICICI Lombard General), accidental death (LIC & ICICI Lombard General)
2005	*Product and insurer:* Life (LIC and AVIVA), health, acc death, and assets (ICICI Lombard General) Scheme III package dropped due to confusion and ineffective marketing. Pre-existing conditions now covered after 6 month waiting period.

Sources: Compiled from: Garand, Denis, 2005; Sinha, Shalini, 2006; SEWA website

Table 4.25: Summary features of the current Vimo SEWA insurance program

Characteristic	Description
Owner and manager of the scheme	Vimo SEWA
Administrator	Vimo SEWA is the administrator. Technically, Vimo SEWA also fulfills the functions of a TPA but is not registered as such.
Distribution and marketing	The distribution system is a network of local community leaders called Vimo Aagewans who are trained in insurance and responsible for marketing and servicing of the insurance program. Outside Gujarat, distribution is accomplished also by partnering with NGOs.
Product type	Integrated product which includes life insurance, health, accidental death, and asset protection.
Service providers	Members choose the service providers. Providers are not accredited, audited, or contracted. Recently some health service providers were selected for a pilot cashless claims payment.
Starting date	1992, although some life insurance had been offered by SEWA since 1978.
Term of coverage	Initially, annual term beginning January 1st, now with quarterly starting dates.
Scope of operation	Vimo SEWA is open to SEWA Union members, and SEWA operates in rural and urban areas of Gujarat and in 7 other states.
Participation requirement	Voluntary participation
Insured unit	Members can enroll themselves, spouses, or children on an individual basis or they can buy family coverage. Members themselves must be enrolled before enrolling their spouses and / or children.
Risk pooling method	Partner – agent model; risk is ceded to commercial insurers.
Target market	• Main market is SEWA Union membership and their families but it is also open to the BPL public, on the condition that non-members become SEWA members upon enrolment in Vimo SEWA. Membership fees to SEWA are Rs 5 per annum. • SEWA membership is all women employed in the informal economy and without access to statutory social protection.
Eligibility requirements	SEWA members and their families are eligible, with entry age limited to 18-55 for new members and their spouse, but once enrolled the exit age is 60 for life and 70 for other products.
Annual premium rates Premium financing Premium collection	**Scheme 1** / **Member** / **Spouse** / **All Children** / **Family** Premium: Annual Pay: 100 / 70 / 100 / 250 Premium: Fixed Deposit: 2,100 / 1,500 **Scheme 2** / **Member** / **Spouse** / **All Children** / **Family** Premium: Annual Pay: 225 / 175 / 100 / 480 Premium: Fixed Deposit: 5,000 / 4,000 Two options to pay premium for member and spouse: annual cash premium collected by Vimo Aagewan from September to December or interest from a fixed deposit in SEWA Bank is used to finance the premium. Child and family coverage can only be purchased by paying annual premium. Roughly 30% of adults pay using the fixed deposit method. SEWA Bank also offers a 3 year loan to urban members for the fixed deposit.

Characteristic	Description			
Benefits Scheme 1 (approx 94% of members)	**Scheme 1**	**Member**	**Spouse**	**Children**
	Non-accidental death	5,000	5,000	
	Health (in-patient)	2,000	2,000	2,000
	House & other asset loss	10,000		
	Accidental death	40,000	25,000	
	Spouse accidental death	15,000		
Benefits Scheme 2 (approx 6% of members)	**Scheme 2**	**Member**	**Spouse**	**Children**
	Non-accidental death	20,000	20,000	
	Health (in-patient)	6,000	6,000	2,000
	House & other asset loss	20,000		
	Accidental death	65,000	50,000	
	Spouse accidental death	15,000		
Special Benefits	Additional benefits **for fixed deposit members only**: • Maternity benefits, 300/birth • One time dentures benefit of 600 • One time hearing aid benefit of 1000			
Exclusions and waiting period	• Pre-existing diseases such as hypertension, high blood pressure, gynecological problems, cancer etc were not covered prior to 2005 but are now covered after a 6 month waiting period. • The waiting period for maternity benefits and hysterectomies is 1 year.			
Claims settlement (2 methods)	1) Asset and health claims are processed by the Vimo SEWA Claims Committee on a reimbursement basis. Claims committee is composed of 6 Aagewans from various trades and 2 Vimo SEWA managers. Turnaround time is 10-20 days. 2) Cashless health claims in some areas in Ahmedabad on a trial basis.			
Co-payment and user fees	No direct co-payment, although inpatients incur other costs and opportunity losses.			
Financing of the scheme	• Member premiums and interest income on these • Direct donor subsidization of operations • Donor funding of capacity building and technical assistance • Interest income on grants			

Sources: Garand, Denis, 2005; Sinha, Shalini. 2006; SEWA website; and personal communication

SEWA Health

SEWA became involved in the public health field in the early 1970s through health education and provision of maternity benefits with government programs. Today, SEWA Health provides a wide range of primary health care services, but the main focus is on providing basic health information, such as disease prevention and promotion of well-being. SEWA builds capacity among local women, especially traditional midwives (dais), who are also the "barefoot doctors" of their communities. SEWA also provides health services to the very poor, especially those living in remote areas with little access to services.

This health service is an important complement to the health insurance program since it has a direct impact on improving health as well as reducing maternal and infant mortality. In some districts a pharmacy service provides low-cost generic drugs to members. The health promotion and education activities are an effective risk mitigation strategy from which Vimo SEWA has directly benefited. The health services program also aides in detecting fraud committed by both members and providers and it directs members away from inappropriate and expensive treatments.

Box 4.3: SEWA's Approach to Health

SEWA believes that its members cannot have full employment without health security. From its early years, SEWA has been trying to devise ways to reach affordable, appropriate and sustainable health services to its members and their families. In 1984, a more structured community-based primary healthcare programme was started which is being implemented under the aegis of "Lok Swasthya Mandali" meaning People's Health Co-operative.

The Lok Swasthya team is comprised of 400 local dais called 'swasthya sathis' trained in primary health care and midwifery, 60 community health workers (local leaders who have been provided with training by SEWA Health), and 100 full-time health organizers (or staff). This team works directly in Ahmedabad, Surat and Baroda cities and also in fourteen districts of Gujarat state through SEWA's District Associations. Services are provided through 400 stationary health centres, 4 medicine shops, mobile health camps as well as home visits.

The activities of the Lok Swasthya Mandali include:

1. Provision of preventive health services, including:

- Health information and education, including information on HIV/AIDS;
- Immunization, iron and folic acid supplementation, and Vitamin A:
- Supplementation, in collaboration with government services;
- Ante-natal care (ANC), including weighing, screening for anemia, and nutrition:
- Counseling;
- Skills up-gradation (of all SEWA Health functionaries) and training of midwives;
- Contraceptives – both by providing information and making supplies available by coordinating with government services;
- Screening for reproductive tract infections (RTIs) and cancer through diagnostic 'camps'.

2. Promotion of health and well being. Health education is delivered through a six-module training program for SEWA members, and slightly modified programs for their husbands, adolescent girls and boys and traditional midwives.

3. Provision of curative health services, including:

- Low cost medicines production and marketing;
- Treatment of tuberculosis through DOTS method and screening and treating diagnosed persons;
- Mobile clinics called 'camps' for reproductive health problems, children's andgeneral health problems;
- Acupressure therapy;
- Ayurvedic (traditional medicine) treatment.

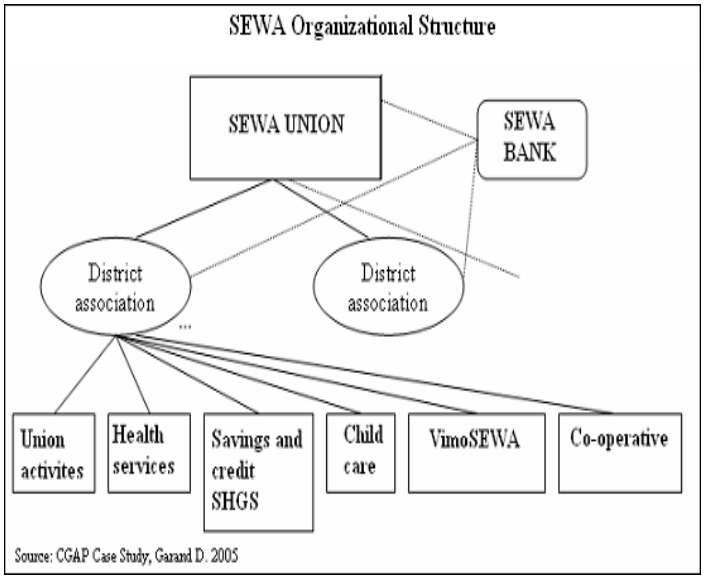
Adapted from *www.sewainsurance.org*

Organizational Structure and Governance

Within the SEWA union there are several divisions that provide various services through a network of district associations. The district associations appoint Aagewans, who are local community leaders directly responsible for implementing the various services of SEWA. By 2005 there were approximately 1000 Aagewans of which 120 were Vimo Aagewans.

Vimo SEWA is governed by SEWA Board and headed by a CEO. It is integrated into the SEWA structure and as such it benefits from the preventative services of SEWA health services, the financial services of SEWA Bank, the distribution through the union structure and the SEWA brand name. The disadvantage of this integration is being saddled with the additional bureaucracy that comes with a larger organization.

Figure 4.17



The Vimo Aagewans, trained in insurance, are taught how to sell and service the insurance product. They are paid a fixed salary and although it is comparable to the income of other SEWA members it is quite low, perhaps contributing to a high turnover. Experiments are underway with performance-based compensation. In Ahmedabad and in the four decentralized districts (Anand, Boroda, Sabarkantha and Ahmedabad District) Vimo SEWA has direct control of Vimo Aagewans but everywhere else the district associations direct the Vimo Aagewans. This distribution network is split into three areas headed by a coordinator—rural Gujarat, urban Gujarat, and SEWA Bharat (for marketing outside Gujarat). Outside of Gujarat, distribution is also accomplished through NGO partners.

Membership Composition and Enrolment Growth

The geographical scope of SEWA Union membership was primarily based in urban Ahmedabad in the early years but this has now expanded to rural Gujarat and to seven other states. Today the Vimo SEWA member composition reflects a similar 2:1 proportion of rural to urban members. These expansions to rural areas required decentralization of Vimo SEWA distribution and servicing systems and creation of four branch offices in rural Gujarat.

In 2005 the fixed deposit required for financing annual premiums increased due to the lower interest earnings by SEWA Bank and due to an increase in premium rates. This caused many unhappy members to drop out. The consulting actuary estimated that over 150,000 insured members were lost due to non-renewal in the 2003-2005 campaigns and if a renewal rate of 80 percent had been achieved as planned, the actual enrolment figures would have exceeded the business plan targets. Overall actual enrolment rates as a percentage of previous enrolment increased impressively in 2006 as shown in Table 4.29.

Initially the program was marketed by the SEWA Union Aagewans providing the general services. When dedicated Vimo Aagewans were introduced in 2002 distribution costs rose from Rs 11 to Rs 28 per insured adult. The payoff from the new marketing strategy should have been increased growth, higher renewal rates, and increased awareness and satisfaction. It appears to have worked to some degree—in 2002 the renewal rate was just 15 percent and by 2005 it had increased to 41 percent for those paying annual premium, although this is still far short of the estimated minimum 80 percent requirement for viability.

Table 4.26: Coverage and Distribution Performance of Vimo SEWA

Indicator	CY 2006	CY 2005	CY 2004	CY 2003
Target enrolment in business plan: 1) Women 2) Men 3) Families with all children enrolled (avg. # of children 2.7 per family)	1) 1,69,440 (+20%) 2) 62,501 (+25%) 3) 34,861 (+33%)	1) 1,41,200 (+33%) 2) 50,000 (+25%) 3) 26,240 (+73%)	1) 1,06,000 (+25%) 2) 40,000 (+33%) 3) 15,150 (+52%)	1) 85,000 2) 30,000 3) 9,960
Actual enrolment performance 1) Women 2) Men 3) Families with all children enrolled (avg. # of children 2.7 per family)	1) 1,04,903 (+25%) 2) 46,516 (+22%) 3) 11,369 (+66%)	1) 84,189 (+17%) 2) 38,253 (+17%) 3) 6,837 (+250%)	1) 72,206 (-15%) 2) 32,588 (+32%) 3) 1,954 (+177%)	1) 85,042 2) 24,716 3) 706
Actual enrolled / target enrolment 1) Women 2) Men 3) Families with all children enrolled	1) 62% 2) 74% 3) 73%	1) 60% 2) 77% 3) 26%	1) 68% 2) 81% 3) 13%	n/a
SEWA Union membership (women only)	Estimated 7,00,000	Estimated 7,00,00	6,88,743	7,04,166
Estimated coverage rates, members only	15.0%	12.0%	10.5%	12.1%

Source: Compiled from various sources nclud ng an nterview with Garand, Denis, 2007; Garand, Denis, 2005

A 2005 SEWA study showed that the main reasons for non-renewal were the ineffectiveness of the marketing system. The most common reasons for non-renewal were because the Vimo Aagewan did not show up during the renewal period or did not collect the money when the cash was available. Other significant reasons for dropping out were dissatisfaction, lack of product knowledge, or unavailability of alternate premium financing options.

Table 4.27: Vimo SEWA Renewal Rates

Effective Date	Premium paying method		
	Annual Premium	Fixed Deposit	Total
1-Jan-03	22%	100%	48%
1-Jan-04	30%	100%	51%
1-Jan-05	41%	100%	59%

Source: Garand, Denis, 2005.

Coverage, Premiums and Claims

Packaging health insurance with other coverages such as asset loss insurance has had mixed effects on consumer awareness and participation. On the one hand it boosted overall participation tremendously when the earthquake, communal violence, and numerous floods in 2000, 2003, 2004, and 2005 in Gujarat reinforced the importance of asset insurance; on the other, the misunderstanding and dissatisfaction with asset loss compensation had a very negative impact on many members. Many members had considered insurance to be a welfare benefit and a relief fund and as such were unhappy when compensation was not in

relation to their actual asset losses. Other members misunderstood the limitations of the coverage, had lost their proof of coverage when they lost their house or had failed to document their assets properly.

Table 4.28: Health Premiums and Benefits per Participant

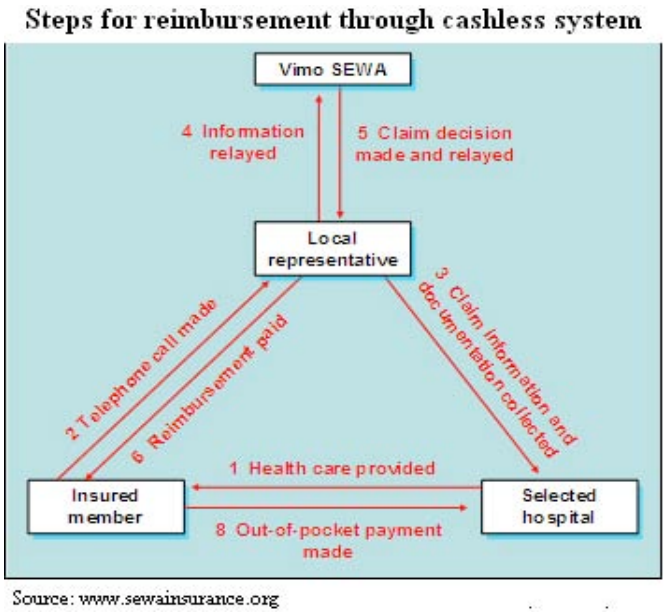
Period	Health Insurance Premium	Health Claims Cost
CY 2002	Rs 12	Rs 14
CY 2003 (Benefits increased 50%)	Rs 18	Rs 40
CY 2004	Rs 18	Rs 59
CY 2005	Rs 39	Rs 77 est

Source: Garand, Denis, 2005

In recent years health claims have increased significantly for several reasons. In 2003 benefits were increased by 50 percent followed by extensive efforts in 2004 to increase awareness of the health benefits and reimbursement procedures. In 2005 the average health claim per participant had become twice as much as the collected premium for health.

The dissatisfaction with insurers' claims servicing in 1998 led to the establishment of the claims committee which today meets thrice weekly to evaluate asset and health claims. The committee is comprised of six Aagewans from various trades within SEWA and one or two Vimo SEWA managers. Claims are evaluated according to a detailed and documented protocol for consistency and fairness. Claims servicing is carefully monitored, tracking the times taken to settle claims and the disease patterns by district and by Aagewan.

Figure 4.18



Aside from buying health insurance there may be other significant constraints to accessing healthcare even after insurance is bought, especially for poorer SEWA members and those living in rural areas. In 2004 Elsevier conducted a study[33] that showed that the poorer members in rural areas were significantly less likely

[33] Ranson Kent M, S nha Tara, Chatterjee Mirai, Acharya Akash, Bhavsar Ami, Morris Saul S, Mills Anne J, "Making health microinsurance work for the poor: Learn ng from the Self-Employed Women's Association (SEWA) community-based health nsurance scheme in India", *Elsevier Ltd. Social Science and Medicine* 2005.

to submit claims than better-off rural members, and those living in more remote areas were also less likely to claim than those nearer to provider facilities. No significant differences were found in urban based member samples. Reasons cited by members for not seeking treatment included transportation costs to the nearest provider, lack of access to cash at the time of hospitalization, and loss of income while hospitalized. Once discharged, illiterate members faced difficulties with completing claims documents and determining the required documentation, as well as travelling to the nearest Vimo SEWA claims office to submit the claim.

In 2004 Vimo SEWA experimented with cashless hospitalization claims payment in several districts of Gujarat. This worked out well and a similar system has now been set up in Ahmedabad. Under this program, Vimo SEWA selects multi-specialty private or public hospitals. Private hospitals are included only after careful evaluation of the quality of services. Vimo SEWA enters into an agreement with each partner hospital which includes negotiated reduced rates for its members. Members who use the selected facilities are reimbursed while still in the hospital but if they seek treatment in other hospitals they must then go through the regular claims reimbursement system.

Recent Financial Performance

Table 4.29: Vimo SEWA Income Statements 2003 to 2005

Income and Expense Item	2005	2004	2003
Earned Premium	111,47,928	80,96,037	76,30,688
Earned Service fee [1]	9,27,498	2,91,010	2,98,874
Investment income [2]	55,04,568	43,63,588	49,24,803
A) Total Revenue	175,79,994	127,50,635	128,54,365
Claims paid [3]	2,91,954	57,530	3,00,790
Change in IBNR [4]		0	-
Cost of insurance [5]	90,95,645	57,32,036	58,66,406
Total claim cost	93,87,599	57,89,566	61,67,196
Administration expenses [6]	137,14,399	110,85,310	73,99,021
B) Total Expense	231,01,998	168,74,876	135,66,217
C) Net Income (A-B)	-55,22,004	-41,24,241	-7,11,852
D) Donor Grants / Subsidies	105,14,573	9,301,280	7,399,021
E) Bottom line(C+D)	49,92,569	5,177,039	6,687,169
Viability test [7]	-110,26,572	-84,87,829	-56,36,655
Expense ratio = Admin expenses / earned premium	123%	137%	97%
Net Income ratio = Net income / earned premium	-50%	-51%	-9%
Subsidies ratio = Subsidies / earned premium	94%	115%	97%

Notes to Financial statement
–Service fees are reimbursements provided by the insurance companies to cover claims adm nistration cost. ICICI Lombard provides 7.5% of premium for Vimo SEWA distribution cost and 15% of premium for claims adm nistration cost.
–Investments are placed in term deposits with varying interest rates and term to maturity. Real estate rental income is also included.
–Benefits not covered by insurer and thus appear as an expense to Vimo SEWA.
–IBNR is the Incurred But Not Reported Reserve, an est mate of the change n outstand ng cla ms liabilities to Vimo SEWA.
–Cost of insurance is the prem um paid to nsurance companies to cover benefits. Most of these prem ums are subject to a service tax which the 2005 Indian Government Budget proposed to reduce or remove.
–All expenses of running Vimo SEWA are included; n 2004 amortization of equ pment was ncluded for the f rst t me.
–The viability test reflects results excluding investment ncome and donor support, and indicates the gap to achieve viability.
Source: Compiled from various sources ncluding an nterview with Garand, Denis, 2007; Garand, Denis, 2005.

Table 4.30: Vimo SEWA Balance Sheet as of December 31, 2003, 2004 and 2005

	31-Dec-05	31-Dec-04	31-Dec-03
Real estate (Vimo SEWA bldg) [1]	189,79,506	192,69,740	32,06,110
Other equipments [2]	39,82,247	24,19,514	32,94,872
Investments	484,47,421	434,55,246	504,39,839
Bank Balance	75,90,854	166,45,012	144,95,841
Due from insurance companies [3]	2,82,671	14,752	16,42,762
Receivable	13,04,491	7,77,034	5,78,107
Refund due from insurance co's	1,68,705	5,00,000	9,82,950
Prepaid insurance [4]	96,77,520	86,32,743	55,17,050
Interest accrued but not due	24,10,228	17,83,320	25,37,398
Total Assets	**928,43,643**	**934,97,361**	**826,94,929**
Current liabilities [5]	111,90,938	85,66,143	60,03,241
Grant fund [6]	314,60,850	409,40,044	419,05,569
Capital and retained earnings [7]	498,48,825	436,45,944	344,56,119
Members capital	3,43,030	3,45,230	3,30,000
Total Liabilities	**928,43,643**	**934,97,361**	**826,94,929**

The first Balance sheet was produced for the end of 2003. Notes to Balance Sheet:

1. V mo SEWA constructed a build ng n 2004 for its own use and for rental income.
2. Equipment was depreciated for the f rst t me n 2004 and included n income statement.
3. Amount owed by insurance companies for cla ms settlement.
4. V mo SEWA pays the nsurance companies in December to cover beneficiaries n the following year.
5. Includes unearned prem um reserves reflect premium collected at one year end that will be recorded in ncome in following year.
6. The Grant fund includes Rs 19,000,000 from a Ford Foundation Endowment that is permanently restricted.
7. Capital and retained earn ngs represents previous and current unrestricted grants provided to Vimo SEWA as well as the accumulation of reta ned earnings.

Source: Compiled from various sources including an nterview with Garand, Denis, 2007; Garand, Denis, 2005.

The administration expense ratio in 2005 reached an incredible 123 percent. In that year SEWA spent an average of Rs 105 per member but collected just Rs 100 annual gross premium from participants in Scheme 1, for example. To become viable, the expense ratio will have to be drastically reduced to at most 35 percent in the medium term and to 15-20 percent in the longer term. This will require rapid growth in the number of participants, which in turn can only be achieved by improving the participation rate to at least 50% of SEWA Union members in the near term and to 75% in the longer term. Even more importantly, a minimum renewal rate of at least 80% must be achieved soon. The consulting actuary has demonstrated that by doubling the current participation rate and by making it mandatory to cover families Vimo SEWA would increase revenue by 400% while only marginally increasing expenses.

Table 4.31: Vimo SEWA Expenses per Participant

Period	Admin Expenses	Distribution Expenses	Total Expenses
CY 2002	Rs 46	Rs 11	Rs 57
CY 2003	Rs 52	Rs 15	Rs 67
CY 2004	Rs 78	Rs 28	Rs 106
CY 2005	Rs 75	Rs 30	Rs 105

Source: Garand, Denis, 2005

Summary and Conclusions

In summary, the Vimo SEWA is an interesting microinsurance model established in response to a felt need of SEWA members. It has remained member-driven over its life of 15 years, rising above major challenges such as the severe claims shocks in the aftermath of natural disasters and ethnic rioting in its areas of operations. On behalf of its members' interests Vimo SEWA also locked horns with insurers and with policymakers but over time has earned their respect. It learned well from its experiences and innovated as a result to become a better provider of insurance services. Throughout Vimo SEWA has relied heavily on financial and technical support from donors and perhaps could not have survived otherwise. The main aim of Vimo SEWA remains, which is to grow into a viable and licensed mutual insurer. For this it has a blueprint in its business plan and although significant gains have been made recently, such as improved technical capacity and a more sophisticated MIS, there is still much more to be done before the organization becomes viable.

Increasing distribution performance will remain challenging with Vimo SEWA's current distribution system because members participate voluntarily. Since the initial backlash from members in its first year when SEWA enrolled them all on a compulsory basis without extensive pre-membership education, SEWA has tried to build the insurance business on a voluntary participation model but this has proven to be very difficult.

One of the answers to the distribution problem lies in reintroducing compulsory participation, perhaps by beginning on a pilot basis. There are numerous examples of MFIs in India and in other countries that have successfully implemented this and some, such as CARD Mutual Benefit Association in the Philippines, learned over time that it works best in tandem with ongoing member education and awareness-building, member-driven product design and through superior servicing.

Yeshasvini Trust Co-operative Farmers Health Insurance

The Yeshasvini insurance program was conceived in 2002 by Dr. Devi Shetty, a prominent cardiac surgeon and chairman of Narayana Hrudayalaya Hospital in Bangalore. Prior to 2002, in an effort to improve access to healthcare by the rural population, Dr. Shetty and his team initiated a telemedicine program in co-operation with the Indian Space Research Organization (ISRO). The aim of this program was to bring modern surgical methods to the remotest hospitals of Karnataka by connecting rural doctors to the amenities of key urban hospitals using satellite communications.

The experience of the telemedicine program and several concurrent field studies revealed that the services of many private and public hospitals in Karnataka state were greatly underutilized, some with prevailing occupancy rates as low as 35%. These findings prompted Dr. Shetty and his colleagues to realize that the problem of access, contrary to widely held beliefs, was not a result of poor infrastructure or a lack of professional staff, but primarily due to the insurmountable financial barriers that prevented the poor from utilizing medical services.

To address the problem, the idea of a health insurance plan for the poor that would cover major surgeries emerged. This unique concept was somewhat modified and then implemented by Sri A. Ramaswamy IAS, then Principal Secretary of the Department of Cooperation in Karnataka and in close collaboration with the government of Karnataka. On June 1, 2003, the scheme became operational as the Yeshasvini Farmers Co-operative Health Care Scheme (YCFHS).

The mission of the Yeshasvini program is to bring quality healthcare of within reach of farmers and their families through a wide network of accredited hospitals across Karnataka. The target market of the scheme is

the farmers and their families in all 26 districts of Karnataka, estimated at roughly 2.5 crores in 2005.34 Eligibility is restricted to farmers below 75 years old and provided that they have been members of a co-operative society for at least six months.The benefits package was originally designed to cover low-frequency high-cost surgical procedures on a cashless basis that were unaffordable by the majority of farmers. The plan pays participating network hospitals pre-negotiated fixed tariffs for each procedure which have been discounted by 40-50% from the usual rates charged by these hospitals.

Table 4.32: Features of the Current Yeshasvini Health Insurance Program

Characteristic	Description
Owner & manager of scheme	Yeshasvini Co-operative Farmers Health Care Trust, a private charitable trust
Administrator and TPA	Family Health Plan Limited (FHPL)
Distribution and marketing	Karnataka Department of Co-operation and the co-operative system. Primary co-op societies enroll, renew, collect premium, and disseminate information to the insureds.
Service providers	Network of accredited hospitals all over Karnataka, mostly private.
Role of the state government	Free distribution through The Department of Co-operation as well as significant annual direct subsidies.
Starting date	June 1, 2003
Insurance term	Annual term beginning on June 1st of every year
Scope of operation	All 26 districts of Karnataka
Participation	Voluntary, however in some cases automatic enrolment by co-operative societies
Insured unit	Annual coverage on an individual basis
Risk pooling	Self-insured, without reinsurance
Target market	All farmers and their families in state of Karnataka, regardless of their socio-economic status which ranges from middle income to low income.
Eligibility requirements	Ages 0-75, at least 6 months membership in a co-operative society, with no medical checkup or health declaration requirement
Annual premium rates	Rs 60/person first 2 years; Rs 120/adult & Rs 90/child (under 18) in years 3 & 4
Premium collection	Cash up front or financed by co-operative society

[34] Socquet Marc, *Yeshasvini Co-operative Farmers Health Scheme*, International Labour Office, Sub-regional Office for South Asia, New Delhi and Center for Health & Social Sector Studies (CHSSS), 2006.

Characteristic	Description
Benefits	*Inpatient* • *Surgical procedures* per a predefined list of 1600 surgeries, subject to exclusions, at pre-negotiated tariffs at participating hospitals, maximum Rs 2,00,000 per annum, Rs 1,00,000 per incidence. All expenses for the surgery are covered, including bed charges (general ward), operation theatre, drugs, ICU/CCU, anesthesia, consumables, surgeon, etc. • *Stabilization of defined medical emergencies*, limited to 2 days hospitalization and Rs 1500 per annum. Examples of emergencies include snake bites, electrical shocks, traffic accidents, poisoning, etc. (added in 4th year). • *Maternity care* limited to Rs 600 per birth, maximum one birth per annum and two births per lifetime (added in 4th year). • *Neonatal care* for children born prematurely or with low birth weight and requiring special care during the first 7 days, with a maximum Rs 700 per day for NICU charges, maximum Rs 5000 per incidence and one incidence per annum (added in 4th year). • *Outpatient and other benefits* • Free out-patient consultation at participating hospitals • Discounts for all investigations, and some hospitals provide discounts for inpatient treatments that are not covered
Exclusions	• Pre-existing conditions are covered • Surgical procedures not on list of 1600 procedures are excluded • Most non-surgical procedures
Claims settlement	Cashless to the insured; hospitals submit claim directly to TPA
Waiting period	None
Co-payment and user fees	No co-payment or user fees for covered procedures
Availing benefits	Pre-authorization requirement from TPA
Financing	• Participants' premiums • Subsidies from private sector and state government • Donor financing of some T/A

Membership Composition and Enrolment Growth

In 2005 The National Co-operative Union of India (NCUI) reported that 13,711 primary rural co-operatives were registered in Karnataka with a membership of approximately 85 lakhs.[35] Within this spectrum of the co-operative sector, the scheme targets primarily the members of dairy and credit and savings societies, but many of the farmer-members of these societies are not the poorest segments of the population and may even be regarded as middle class. Furthermore, many of the poorer farmers of Karnataka are not members of these co-operative societies. Nevertheless, remarkable success was achieved early on with the enrolment of over 16 lakhs co-operators in the first year, 22 lakhs in the second year but then reducing to less than 15 lakhs in the third year when a premium increase became necessary. In year four there was some recovery as 18 lakhs were enrolled.

The 2001 Indian Census estimated the Karnataka population at 5.27 crores. Projecting this number at 1.4 percent per annum (i.e., at the 2006 Indian national average population growth rate), the schemes outreach rates hovered around 3-4 percent for all of Karnataka, and around 6-8 percent of the target market.

Table 4.33: Membership of Karnataka Primary Rural Co-operatives by Type

[35] Socquet, 2006. Op. Cit.

Type of co-operative	No Co-op Societies	%	Members	%
Primary Agricultural Co-operative Societies	4,267	31.1%	53,87,299	63.7%
Dairy Co-operatives	8,516	62.1%	18,61,000	22.0%
PAC Rural Development Banks	177	1.3%	10,32,852	12.2%
Fisheries Co-operatives	363	2.6%	1,36,000	1.6%
Irrigation Co-operatives	388	2.8%	42,000	0.5%
Totals	**13,711**	**100%**	**84,59,151**	**100%**

Source: Socquet, Marc, 2006.

Table 4.34: Evolution of Outreach and Participation Performance of the Yeshasvini CHI, 2003-04 to 2006-07

Indicator	Year 4 (1) 06 – 07	Year 3(1) 05 - 06	Year 2(1) 04 - 05	Year 1(1) 03 - 04
Target number of enrolments	35,00,000	35,00,000	35,00,000	31,00,000
Actual enrolment (individuals for which annual premium was paid)	18,55,000 39% female 1,23,000 children	14,73,576 38% Female	20,21,661 40% Female	16,01,152
Growth trend of participants (2,3)	+ 26%	-27%	+26%	n/a
1) Total farm population 2) Rural co-operators population 3) Est. Karnataka population	1) 2.57 crores 2) 0.87 crores 3) 5.65 crores	1) 2.54 crores 2) 0.86 crores 3) 5.57 crores	1) 2.50 crores 2) 0.85 crores 3) 5.49 crores	1) 2.47 crores 2) 0.83 crores 3) 5.42 crores
Estimated coverage rates 1) All farm population 2) Rural co-operators population 3) Est. Karnataka population	1) 7.2% 2) 21.3% 3) 3.3%	1) 5.8% 2) 17.2% 3) 2.6%	1) 6.4% 2) 18.9% 3) 2.9%	1) 8.2% 2) 24.2% 3) 3.7%

NOTES:

1. Each coverage term beg ns on June 1 and ends May 31.
2. In year 2 FHPL received info for only 17,27,226 members of the 2,021,661 for which premium was paid, hence only those received ID cards and were effectively covered. In year 3, only 13,75,174 received the r ID cards.
3. The most likely reason for the decline n enrolment in year 3 is because annual prem um was ncreased from Rs 60 per annum to Rs 120 for adults and Rs 90 for children below age 18.

Source: Compiled from interview with Garand, Denis, 2007; Socquet, Marc, 2006.

Organizational Structure and Governance

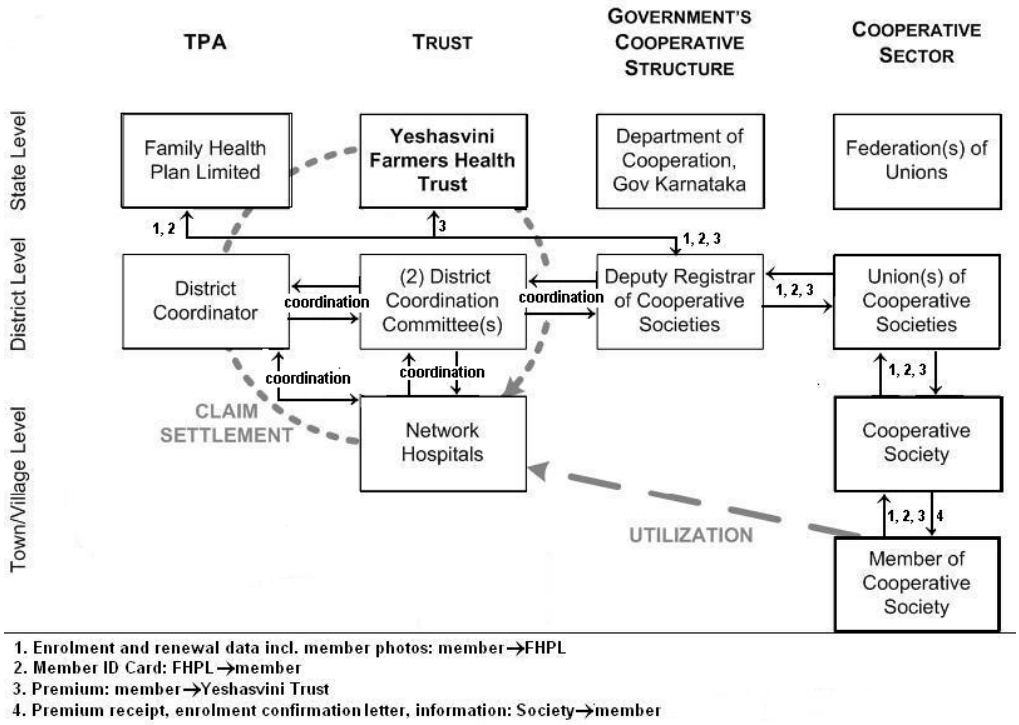
The scheme is owned and managed by the Yeshasvini Co-operative Farmers Health Care Trust, which is incorporated as a private charitable trust under the India Trust Act of 1851 and governed by a board of twelve trustees—six from the Department of Co-operation including its Principal Secretary who acts as chair of the Trust, the Director of the Karnataka Health Department, and five additional appointed trustees who usually hail from the medical profession. The board of trustees governs the scheme and approves claims, charts the development of the scheme, sets growth targets, and approves inclusion of new hospitals. A chief executive is responsible for executing the board's decisions.Marketing is achieved through the Karnataka Department of Co-operation and the co-operative infrastructure. The Principal Secretary of the Department

is the Chairman of the Trust and is actively involved with setting target participation and renewal rates for each co-operative union and district in each coverage period.

Figure 4.15 summarizes the organizational structure of the scheme, showing the various representative bodies of each organization at each level of the distribution system. Enormous outreach is efficiently achieved due to the extensive and well-organized co-operative system in the state. Premium, enrolment data, and client photos collected by co-operative societies percolate upwards through the hierarchical co-operative structures such as co-operative unions and the Deputy Registrar of the Department of Co-operation at the district level and eventually reach FHPL and the Trust. The Trust's two district-level coordination committees play an integral coordination role to ensure that the distribution system functions smoothly.

Participation is on an individual basis and is a mixture of both voluntary and automatic enrolment. While there is no stated penalty there does appear to be significant pressure for meeting targets, likely resulting in automatic enrolment of members by some co-operative societies. In some cases societies may even be using their own resources to pay for premiums which may result in some members not being aware that they have been enrolled. In other cases, societies may be using their clout as financial service providers or purchasers of farm products to pressure enrolment.

Figure 4.19: Summary of Organizational Structure of Yeshasvini CHI



Source: Adapted from Radermacher, Ra f, et al. 2005.

Administrative Role of the TPA

The scheme is administered by Family Health Plan Limited (FHPL), one of the first and largest TPAs in India with experience in administering two other self-insured schemes.[36] FHPL provides several important ancillary administrative services that ensure that the scheme functions smoothly. One of the most important of these services is to ensure that the databases of insured clients and their claims histories are kept current, complete,

[36] Rademacher, Ralf, van Putten-Rademacher, Olga, Müller, Verena, Wig, Natasha, Dror, David,"Yeshasvini Trust, Karnataka, India, Good and Bad Practices Case Study No. 20", CGAP Working Group on Microinsurance, 2005.

and accurate. These databases enable FHPL to validate clients' coverage as they are hospitalized and to monitor individual utilization so that it does not exceed plan limits for the coverage term. The databases are equally useful for analytical purposes, such as the annual actuarial review of the plan's experience and premium rates, and for claims management such as monitoring utilization patterns by provider. On at least two occasions the databases enabled FHPL to detect significant provider irregularities that eventually led to their removal from the network.

FHPL issues photo identification cards which are sent downstream through the distribution system. Cards are valid for three years but must be renewed annually. On average it takes three months for clients to receive their ID cards but if hospitalization occurs within that period a premium receipt and acknowledgment letter from the District Co-operative Registrar is sufficient evidence for admission.

FHPL selects providers to include in the network. The accreditation process includes an evaluation of the infrastructure, quality of care, the number of physicians on staff, the hours of operation, availability of ambulance services, etc. FHPL aims to accredit a sufficient number of hospitals so that all insured clients are within 50 km from accessing services but this criterion is not always attainable in very remote areas or when insured clients are too sparse to guarantee a minimum number of patients for a candidate provider.

Table 4.35: Access to Accredited Providers and Corresponding Utilization by District in Year Three[1]

District	Clients	# of Claims (Partial) (3)	Claims Incidence	# of Hosp	# of Beds	Beds per Client
1. Bagalkot	52,566	550	1.05%	7	327	6/1000
2. Bangalore	182,280	747	0.41%	15	5,387	29/1000
3. Belgaum	126,918	429	0.34%	6	2,000	15/1000
4. Bellary	36,617	183	0.50%	3	57	2/1000
5. Bidar	75,170	261	0.35%	4	285	4/1000
6. Bijapur	66,814	373	0.56%	8	1,523	23/1000
7. Chamarajanagar	22,828	265	1.16%	2	235	10/1000
8. Chikmagalur	29,963	454	1.52%	4	370	12/1000
9. Chitradurga	40,549	593	1.46%	5	705	17/1000
10. Davangere	42,937	1,018	2.37%	9	1,890	44/1000
11. Dharwad	5,700	60	1.05%	6	343	60/1000
12. Dakshira Kannada	46,153	321	0.70%	10	2,870	62/1000
13. Gadag	14,100	117	0.83%	2	115	8/1000
14. Gulbarga	45,081	178	0.39%	2	550	12/1000
15. Hassan	74,750	1,167	1.56%	11	764	10/1000
16. Haveri	32,863	296	0.90%	3	135	4/1000
17. Kodagu	27,823	172	0.62%	2	100	3/1000
18. Kolar	141,418	1,104	0.78%	15	1,207	8/1000
19. Koppal	21,482	159	0.74%	2	50	2/1000
20. Mandya	26,201	1,820	6.95%	9	474	18/1000
21. Mysore	58,100	567	0.98%	6	2,055	35/1000
22. Raichur	29,750	249	0.84%	3	500	17/1000
23. Shimoga	50,008	434	0.87%	7	882	17/1000
24. Tumkur	51,195	773	1.51%	7	1,802	35/1000
25. Udupi	37,855	649	1.71%	11	760	20/1000

District	Clients	# of Claims (Partial) (3)	Claims Incidence	# of Hosp	# of Beds	Beds per Client
26. Uttara Kannada	35,956	240	0.67%	10	619	17/1000
Totals	1,375,077 (2)	13,719(3)	1.00%(4)	169	26,005	19/1000

NOTES: 1. Table was adapted and modified from Socquet, 2006.
2. Number of clients enrolled in year 3 was 14,73,576 but only 13,75,174 were encoded n the FHPL databases.
3. Total number of claims for year three was.19,439; a detailed breakdown was not available at the time of this study.
4. Overall cla ms ncidence.

Provider contracts are extensive and describe the general protocols for patient admission, preauthorization requirements, services covered with tariffs for each covered procedure, discounted rates for investigations, requirements and formats for claiming, etc.

FHPL pre-authorizes all surgical treatments. Requirements include proof of the insured's cooperative society membership, premium receipt, photo ID card, and a completed pre-admission form completed by the surgeon. FHPL responds within three–five days and the authorization is valid for 30 days. Pre-authorizations are still centralized and are also often delayed due to incomplete documentation. For treatments costing Rs 30,000 or more on the tariff schedule FHPL investigates independently to determine if treatment is appropriate and necessary.

Table 4.36: Summary of Administrative Responsibilities of FHPL

Administrative Responsibility	Description
Database and information management	Data coding and database management Report claims and enrolment statistics to the Trust
Accreditation criteria	Determine criteria for accrediting providers
Hospital accreditation and contracting	Determine and select sufficient number of providers in each area to meet geographic access criteria.
Setting tariffs	Research the total cost of providing service packages and use as a basis for setting tariffs for each procedure
Recruitment	Recruit personnel to manage, monitor, and coordinate
Pre-authorization	Pre-authorize all surgical services, investigate services exceeding Rs 30,000
Audit	Audit providers
Claims	Verify and process claims
Client feedback	Interact with clients availing services and record feedback

Source: Socquet, Marc, 2006.

Financial Performance

The scheme spends very little money on raising awareness, and this, together with the enrolment pressures on co-operative societies to enroll and renew as many of their members as possible, results in inadequately informed insureds. In some areas there appears to be limited knowledge about where and how to seek treatment.

Yeshasvini has invested very little on research to gauge client satisfaction. A small survey undertaken by ILO and other sources showed mixed results. Some clients complained about the distances to access accredited hospitals, about the length of time taken for pre-authorizations, about the unfriendliness of hospital staff, and about overcharging for services not covered such as investigations. Some clients in the past forgot to show their ID card before seeking treatment and therefore did not receive any benefits. On the other hand there appears to be broad support for health insurance schemes in which members could participate in its design and management. One very important and generally accepted indicator of customer satisfaction is the renewal

rate but this was very low in year three at around 43 percent. However it appears to be heading towards 62% in year four.

The Indian Insurance Act requires all organizations engaged in risk pooling to register with the IRDA and to capitalize the scheme to a level of 100 crores. The organization operates a risk pool in the sense that it collects an annual premium and guarantees a benefit. The Trust attempted to develop a partner-agent arrangement with a public insurer at least once but there was very little interest on the part of the insurer, who even encouraged the Trust to continue operating as a self-funded scheme.

Lacking IRDA registration, Yeshasvini is not subject to rigorous financial and risk management standards aimed at promoting solvency. The scheme is not reinsured and is unlikely to attract a reinsurer as long as it remains a non-registered risk pool due to legal and prudent risk management reasons on the part of the reinsurer. Furthermore the Trust lacks professional managerial capacity and does not adhere to the required risk management standards and practices of a formal insurance company, making it unattractive to reinsurers. The state government currently provides large subsidies and reinsurance will not be needed as long as such subsidies continue, but to assume unlimited future subsidies may be unrealistic.

Table 4.37: Key Financial Indicators

Indicator	Year 4 06 – 07	Year 3 05 - 06	Year 2 04 - 05	Year 1 03 - 04	TOTAL Years 1-3
Participants	18,55,000	14,73,576	20,21,661	16,01,152	
Premiums Collected	N/A	1629,00,000	1197,55,440	969,09,491	3795,64,931
Subsidies	N/A	1102,10,000	423,84,117	451,37,021	1980,31,138
Interest	N/A	17,96,000	48,80,368	37,43,622	104,19,990
Total Income	N/A	2749,06,000	1670,19,985	1457,90,134	5880,16,059
Incurred Claims	N/A	2562,52,499	1802,21,408	1054,82,417	5419,56,324
TPA Fees	N/A	40,00,000	40,00,000	59,00,000	139,00,000
Other Expenses	N/A	21,57,785	21,58,999	17,45,470	60,61,255
Net Income before subsidies	**N/A**	**-977,14,284**	**-617,44,539**	**-124,74,774**	**-1719,32,658**
Net Income after subsidies	**N/A**	**124,95,716**	**-193,60,422**	**326,62,247**	**260,98,480**
Premiums / (Claims + Expenses)		62.1%	64.3%	85.7%	67.5%
Subsidies / (Claims + Expenses)	N/A	42.0%	22.7%	39.9%	35.2%
Claims ratio = Claims / Premiums	N/A	157%	150%	109%	143%
Claims / Total Income	N/A	93%	108%	72%	92%
Expense ratio = Expenses / Premiums	N/A	3.8%	5.1%	7.9%	5.3%
Expenses / Total Income	N/A	2.2%	3.7%	5.2%	3.4%

NOTES:

1. Each coverage term beg ns on June 1 and ends May 31.
2. For year 3, actual claims received up to March 31 were projected to derive an estimate of total claims for year 3.

3. Year 3 adm nistration expenses are est mated.

Source: Compiled from interview with Garand, Denis, 2007; Socquet, Marc, 2006.

Claims cost has been trending upwards in the first three years. For health insurance plans it is not unusual for the claims incidence to rise in the first two to three years due to increased awareness and then stabilize after the pent-up demand for healthcare services has been reduced. With Yeshasvini however, the incidence is still increasing very rapidly and it may be due in part to adverse selection. The clues for adverse selection lie in the low renewal rate (participants may be enrolling for one year to obtain surgery and then drop out), in the overall incidence rate which was much too high in year three for a plan offering just major surgeries, and in the incidence pattern by age—for infants aged 0-2 the incidence in year three rose 59 percent over year two to an abnormally high 4.23 percent of all enrolled infants using services. The average claim amount has also risen every year, with children having a much higher average claim than adults. The indicator that captures it all is the claims cost per participant, which after being adjusted for those who were effectively enrolled (i.e., they were issued ID cards by FHPL) rose by 81 percent from Rs 104 to Rs 188 per participant in year three.

Table 4.38: Evolution of the Yeshasvini Experience in the First Three Years

Indicator	Year Three 05 - 06	Year Two 04 - 05	Year One 03 - 04
1) Actual enrolment (individuals for which annual premium was paid)	14,73,576	20,21,661	16,01,152
2) Effectively covered members (individuals for which info was sent to FHPL, and were issued ID cards)	13,75,174	17,27,226	16,01,152
3) # of claims incurred (year three is ILO est.)	Rs 19,439	Rs 14,963	Rs 9,008
4) Incurred claims incidence = (3) / (2)	1.41% +64% over yr 2 +152% over yr 1	0.86% +53% over yr 1	0.56%
5) Average claim amount	13,538	12,044	11,750
6) Annual claims cost per participant (year three is ILO est.)	Rs 175 + 97% over yr 2 + 165% over yr 1	Rs 89 +35% over yr 1	Rs 66
7) Annual premium per participant	Rs 120 per adult Rs 90 per child	Rs 60	Rs 60

Source: Compiled from nterview with Garand, Denis, 2007; Socquet, Marc, 2006.

Summary and Conclusions

In summary, the Yeshasvini scheme has been very successful in terms of achieving very large numbers of covered individuals quickly and efficiently. In the first three years of its existence it annually covered an average of 17 lakhs mostly poor people, providing them with over 1,50,000 free outpatient diagnostic services and 42,000 surgeries. All this was accomplished with just 5.3 percent of premium spent on administration and other expenses, and this would have been even lower if adequate premium had been collected to cover claims and expenses.

In the first three years the collected premiums financed just two-thirds of the requirement for claims and expenses. For such a large scheme the degree of subsidization is still much too high and brings into focus the question of long-term viability, especially with the worsening trend in the claims experience. Even though the scheme is probably one of the largest in the world, much wider participation within the targeted population is

required to reduce adverse selection and improve the financial results, but this can only be accomplished with effective member education, which is an area in which the scheme has invested insignificantly so far. Mandatory enrollment of all co-operative farmers and their families would be the best solution by far but this would require an intensive educational campaign in advance of implementation. In the immediate term, the scheme would benefit greatly by requiring family coverage instead of allowing members to selectively enroll their children as they anticipate the need for services in the upcoming year.

HMI Evaluation and Recommendations

The HMI cases discussed above are diverse in terms of their targeted outreach, the health plans they offer, and their manner of implementation. Each evolved under different circumstances and all of them continue to experiment, work to improve their services, and struggle to reach viability.

By themselves these cases do not depict the entire sector but some of their common experiences shed light on the challenges that are prevalent in developing health microinsurance in India. For example, even though access to health services is vitally needed by the entire BPL population it is difficult for many programs to achieve sustainable levels of insurance penetration within their target populations due to common problems such as low level of awareness about risk-pooling, difficulties in accessing quality health providers in rural areas, small economies of scale, the inefficiencies of product distribution infrastructures and a lack of alternate premium financing options. Some of the schemes have overcome one or more of these obstacles. Self-insured plans struggle to design and manage their programs without having the professional capacity of insurers while those sourcing products find it difficult to find insurance partners offering appropriate HMI products with minimal exclusions and with good quality servicing.

Evaluation of Micro Health Insurance

As shown in **Table 4.39** following this concluding section, the Framework introduced in Chapter Two has been applied to these seven plans both to recognize their many achievements and to illustrate those areas where progress is needed. Micro health insurance in India has made significant advances in the last decade, bringing financial protection for health to over five million people. The seven HMI Schemes described extensively in this text were chosen because they provide valuable lessons learned and interesting examples of the micro health insurance activities that are ongoing in India. The Framework identifies 13 characteristics of health coverage and provides benchmarks for each characteristic against which to measure the performance of the schemes. In the interest of highlighting some of the positive lessons learned, a specific positive finding associated with each scheme is illustrated below.

ACCORD through ASHWINI covers out-patient services, public health interventions, and health education. The insurance partner provides partial coverage for the insurable, higher cost hospitalizations; and ASHWINI provides coverage for services outside of the scope of the insurance company.

BASIX is compulsory for all credit customers thereby reducing its vulnerability to adverse selection associated with voluntary enrollment.

Healing Fields has spent significant time and resources raising awareness of health insurance in the communities in which it is working and designing a benefit package based on extensive research on the health needs and willingness to pay of the target population.

Karuna Trust benefits include wage loss while hospitalized, enhancing financial access to services, and has successfully partnered with the government to improve quality at the public facilities, thereby reducing the cost of the premium.

PRHPS is an innovative model providing comprehensive primary care at each village and two other service levels to which referrals are required; nonetheless consumer satisfaction has resulted in high enrollee retention levels.

Vimo SEWA, which is governed by its membership, provides a comprehensive package of primary health services for the whole family, reflecting the community's burden of disease.

Yeshasvini CHI has effectively utilized the Karnataka co-operative system for very wide, low cost distribution and, given its large membership, has been able to set tariffs for procedures which hospitals have accepted as fixed.

As described earlier in this chapter, a Bill on Social Security for Unorganized Workers (SSUW)[37] is expected to be voted on by the Indian Parliament as early as August 2007. CBOs, SHGs, and other NGOs at the national, state, and local levels working as partners to government are central to the envisioned plan for implementing this social safety net which would include health coverage. The strengths of these schemes reside in their membership/volunteers and the willingness of their leaders to request and use feedback from members to improve services and resolve problems. However, inefficiency as measured by administration costs is either high or not documented. Their coverage is either heavily subsidized or very inadequate. Most, though not all, lack emphasis on health education, prevention and primary care. As most currently receive subsidies either from government, donors or both, the SSUW legislation represents an opportunity to achieve sustainability through a continuing partnership with government. If the program is sufficiently funded and well-implemented, the government's effort on behalf of the unorganized poor of India will be most commendable.

Recommendations

The growth of this sector to include widespread BPL coverage will require much more time, more experimentation and innovation, and very importantly, a favorable and flexible policy environment. A number of policies, based on the results of this study that would favorably affect microinsurance development are as follows:

1. Permit micro-insurance products and services to be tax free in all aspects including investment taxes of reserves, service taxes, and income taxes. Taxation of the industry creates a drag on its growth, is a burden on the poor and encourages the proliferation of informal schemes. Furthermore, it is inconsistent to ponder development of policies aimed at promoting insurance for the poor and at the same time stifle growth of that sector through taxation. The SSUW bill provides for tax exempt contributions by both individuals and institutions.

2. Encourage public-private partnerships. As has been demonstrated by the Yeshasvini and Karuna Trust programs, such partnerships can work well. The SSUW legislation, as currently drafted, would require partnerships among local groups, public insurers and state governments. While details are lacking, those drafting the bill envision use of public facilities by the insured, which could greatly reduce cost of health microinsurance. However, this can only work if the public system is functional. Without greater public and private oversight it is not at all clear that more resources would be used effectively.

3. Provide Incentives within the legislation or its implementing requirements to give microinsurers and, where relevant, their insurance company partners, the ability to reward improved performance by public sector facilities through their contracts with government. Karuna Trust has pioneered an interesting approach to remedy this problem by negotiating with the Karnataka state government to manage the PHCs in some districts in Karnataka in return for the lion's share of the state budget allocated for those PHCs that it manages. Clearly, not all microinsurers are qualified to do this and some never will be since this is not their orientation; however for other organizations donors should seek opportunities to build capacity in this area.

[37] Op. Cit., ILO, June 2006. FIX CITATION

4. Promote and legally recognize self-insured schemes. This could be achieved by amending the relevant sections of the current Insurance Act so that mutual insurance programs can be registered, or by creating a special microinsurance law. Mutuals should not be required to put up significant capital since they carry low risk products which are sold only to their own member publics (i.e., they do not sell insurance to the general public). These programs should be required to build up a surplus and guarantee funds at prescribed rates, and they should be also required to follow prudential risk management practices to ensure their viability. At present the Insurance ACT "Section 2 (f) reduces NGOs, SHGs and MFIs, currently working in health insurance independently, into agents of the "insurers", i.e., for profit insurance. The regulations see NGOs, SHGs and MFIs only as marketing links to the people, to canvass policies, and as an aid in administration." [38]

5. Constitute a separate regulatory framework for microinsurance (see Chapter Five) enabling management participation of informal sector trade unions, cooperatives, women's organizations, SHGs, NGOs, CBOs, etc., who are better informed and sensitive to the needs of the microinsurance sector. This will enhance the development of this sector. For the existing regulator, a mushrooming of mutuals as is likely under SSUW will require greater effort and resources. One solution for this is to permit self-regulation of the industry through a federation of mutuals or a trade association. For example, the IRDA could "deputize" a national federation or regional federations in different parts of the country to annually audit and accredit each mutual based on a common set of performance indicators and benchmarks. Failure to meet performance standards would result in varying degrees of disciplinary action by the regulator.

6. Require that self-insured programs be not-for-profit. This advantage, together with tax exemption and increased operational efficiencies, would contribute highly towards reducing costs of delivering services. This translates directly to lower premium or equivalently, to higher benefits. Indeed a 2001 study conducted by ACME [39] found that claims ratios for mutuals were significantly higher than for stock companies, and in spite of this the business performance of mutuals was better than their stock competitors. The significance of these findings meant that mutuals were returning a higher portion of the premium in the form of benefits and hence were a much better value for their member-policyholders.

7. Experiment with approaches that combine service delivery with coverage by creating an enabling policy framework. As noted above, Karuna Trust, with its direct management of PHCs for the benefit of its members and the broader community, is an example of an MHI that is moving in the direction of a comprehensive health plan. Schemes that include coverage and delivery of comprehensive health services can be very effective in utilizing each level of service appropriately. The best of such plans have demonstrated the cost savings and gains in health status when prevention is emphasized because there is no financial incentive to increase the volume of curative services, as is true of fee-for-service payments. The creation of comprehensive plans is not without precedent since there is a rich tradition of such activity in Europe and the United States and today in Africa. Religious groups, farmer's cooperatives, social workers, unions, hospitals and doctors, and workingmen's groups often created these plans. There are several structures already in existence that combined with appropriate leadership could facilitate the development of these plans.

See the Appendices on Cost Containment and Quality Improvement for more complete explanations of these essential areas for innovation and experimentation in coverage and delivery of services.

Additional Recommendations

Improve micro-insurers management skills. There are some distinct advantages of member-owned self-insured programs, or mutuals. These programs are usually more efficient than partner-agent programs for a number of reasons as demonstrated by the ACME study, a comprehensive study of 97 insurance companies in 11 countries in Western Europe; these companies represented a quarter of the total premium volume in

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[38] As an example of exist ng asymmetry: "Accord ng to Section 5 (4), a micro- nsurance agent can be terminated without notice f the agent engages in misconduct/ ndiscipline or fraud. On the contrary the agent has to give a notice of three months to the insurer before cancelling his contract." "Critical Appraisal of Micro Health Insurance Laws", *Economic and Political Weekly*, February 10, 2007, pp. 476-480.

[39] Association of European Cooperative and Mutual Insurers, or in French, Association des Assureurs Coopératifs et Mutuels Européens (ACME) which is a regional association of International Co-operative and Mutual Insurance Federation (ICMIF) based in Manchester, UK *Valuing Our Mutuality*, a study published for members of ACME and ICMIF 2001. FIX THIS FOOTNOTE!

those countries. The study found that mutuals were significantly more efficient than stock companies, even in these highly developed and mature insurance markets. While no such similar studies have been conducted for microinsurance there are some real experiences such as CARD Mutual Benefit Association in Philippines which is providing insurance services to its members at much lower costs than is possible by commercial life companies through a partner-agent arrangement. However, a disadvantage of member-owned mutuals is their *limited management capacity*. The business of insurance is highly technical and complex and programs generally are set up and run by non-professionals as a complementary service. This problem could be addressed if the federation or trade association could also act as a resource center that would provide technical assistance and capacity-building services to mutuals. Services could include actuarial assistance with product design, insurance accounting, microinsurance operations systems, general operations and risk-management training, and investment management among others. The developing Micro-Insurance Resource Center (MIRC)[40] will be an important source of such technical advice and training and its services will become even more critical if the government's SSUW becomes law.

Provide assistance in and access to reinsurance. Smaller risk pools are more vulnerable to ruin and as such, mutuals would need technical assistance with setting up reinsurance programs and getting access to reinsurers. This would only be possible if they were legally recognized and managed according to prudential standards- commercial insurers would readily "risk share" and reinsurers would reinsure a "profitable" microinsurance portfolio. Alternatively, a microinsurance industry secondary risk pool could be set up once the base of insured BPL population is sufficiently large enough, but this may be something for the more distant future.

However, there are some additional advantages of member-owned self-insured schemes. One is *lower risk of moral hazard* since the membership has an economic stake and a sense of ownership in the risk pool. There also tends to be a "one for all and all for one" solidarity spirit which is very conducive to marketing and which in turn improves participation. Self-governed schemes can readily create tailor-made policies and *better product design specific to membership needs*. This is very important. As was pointed out at the beginning of the chapter, the BPL sector is highly varied hence risk management solutions need to be flexible and adaptive in order to be relevant to the various BPL market segments. In addition, local knowledge and administration of self-insured schemes results in *better servicing quality* such as reduced time required to process claims. Finally, all *profits and surplus gains remain with the members* and can be used to build up additional reserves or to increase benefits in the future.

[40] Micro nsurance Resource Center in India: *Preliminary Inputs and Concept Notes*, http://www.karmayog.org/redirect/strred.asp?docId=2508

Table 4.39: Overall Performance of HMI Schemes by Characteristic and Scheme

Characteristic of Health Plan	Benchmark	ACCORD	BASIX	Healing Fields	Karuna Trust	PRHPS	Vimo SEWA	Yeshasvini CHI
Population coverage: 1. Scope	Target population clearly defined.	Approximately 13,000 AMS members covered by RSA, 39% repay the premium	Approximately 311,400 lives covered in 11 states--borrower & spouse only.	Largest population is BLPs where partner NGOs are operating.	Select communities--in first phase > 2 lakh people covered.	Marginalized communities in Orissa, approx. 1,00,000.	Membership is 1,40,000 mostly BPL families from informal sector.	Probably the largest CBHI in existence—almost 20 lakhs members.
2. Growth trend	Growth exceeding 20% until close to saturation	Growth trend: not available	Growth trend: not available	Slightly negative data available for 2 years of operation	Scheme experienced negative growth after first phase mainly because year 1 premiums were subsidized.	Penetration rate stabilized at near 100%	Positive but performance is well below the targets set in the Vimo SEWA business plan	Erratic but strong growth: +26% in yr 4, -27% yr 3, +26% yr 2
3. Coverage rates	For large groups, exceeding 50% by year 5	39% in 2005 repaid premium (year 13)	Health insurance is linked to credit and is compulsory	Participation rate: 2005: 13% of target market; 2006: only 7.6% (target market nearly doubled, skewing this figure)	NA		SEWA union participation rate is estimated at around 15% in 2006 which is still much too low for viability.	7.2% of the target market, 3.3% of the population
Covered Services	Essential basic services including education, prevention, disease management, etc.	RSA: hospitalizations up to Rs 2500/yr including maternal benefits up to Rs 1000. ASHWINI: other medical costs including out-patient, public health interventions, and education.	Includes reimburse-ment for critical illness, daily cash for hospitalizations, total & permanent disability due to accident. No health education component or health services.	Hospitalization & compensation for lost wages limited to 39 diseases Significant community public health education Negotiated reduced rates for outpatient consultations.	Inpatient services free in select public providers; drugs benefit; lost wage compensation. No health education and prevention.	Complete health coverage: numerous health education and health intervention programmes.	Comprehensive family package for life, acc. death, basic health, and asset loss. Health coverage is very low at Rs 2,000/yr. Some additional benefits to members paying through fixed deposit method.	Inadequate coverage. Complete package only for most major surgeries, limited maternal & neonatal care, stabilization of emergencies. No health education, prevention, or disease management.
Access to care 1. Geographical	Within 20km from a PHC, within 50km from hospital	One hospital is in Gudalur taluk; a health sub-center in each administrative zone.	Beneficiaries can go to any health facility (public or private). Accessibility to service providers is not monitored.	HFF networks with providers within 50 km of beneficiaries	Pilot limited to a few selected government PHCs. .	First level of treatment at village level, higher levels at nearest appropriate public facility.	Members can go to any private or public providers nearest to them. In some areas accredited providers offer cashless service..	Within 50km of hospital for most clients
2. Financial	Benefits include wage loss and travel costs	No coverage for transport, lost wages, lodging costs, etc. but community risk pool assists with transportation costs.	No benefits for wage loss or transportation costs	Include wage loss	Includes wage loss enhancing financial access	Accessible at village level, SHGs lend money for travel to nearest public health facility	Financial constraints, e.g. transportation costs, lack of cash for hospitalization, loss of income, etc., affected utilization.	No reimbursement for lost wages or opportunity costs, travel costs, misc. expenses, or lodging costs for family members

Characteristic of Health Plan	Benchmark	ACCORD	BASIX	Healing Fields	Karuna Trust	PRHPS	Vimo SEWA	Yeshasvini CHI
Efficiency	Admin costs < 20%	NA	Estimated administrative costs Rs 10/ person/yr, i.e. 14.7% of premium costs.	NA Administrative expenses covered by USAID for initial 5 years of operation.	NA	Now viable due to integration with other Plan activities & community structures. Currently expenses charged is arbitrary Rs 5,00,00 (about 25% gross premium).	Admin costs > 100%, i.e. greater than earned premium, an unsustainable situation.	Administrative costs are very low and still dropping: Year 1- 7.9%, year 2- 5.1%, year 3- 3.8%, of premium.
Affordability, including subsidies	Less than 3% of income	Adivasi community is involved in setting premium, rate should be affordable, but even at Rs 20/yr premium appears to be unaffordable for many families, perhaps only due to limited cash at collection time, not non-cash income.	Estimate is that a household's disposable income is Rs 2000-10,000/yr so health insurance premium is therefore 1.36% - 6.80% of disposable income, but coverage is not adequate.	Members pay Rs 363/yr to cover entire family of five. (estimated as about 14% of total income).	Rs 22/yr: less than 3% of income for those earning > Rs 73/yr..	Package subsidized on a declining basis. Affordable at an premium of Rs 20/ person/ yr, by using public health system. Premium increase necessary, probably Rs 25 sufficient for now.	Composite package heavily subsidized. Health portion of package had a claims ratio of 200% in 2005 after investments made to increase awareness. There are two schemes to choose from.	Premium is less than 3% of income but buys an inadequate package. *Proxy estimate example for poor family:* Assume Rs 18,000 annual income; Premium= (2 adults x Rs 120) + (3 children x Rs 90) = Rs 510 (i.e. 2.8% of annual income).
Cost containment	Strong case/disease management programs; effective preauthorization and utilization review, strong provider contracts for quality/cost expectations and incentives	Providers are salaried Co-payments for non members but little control of waiting periods, pre-authorization; pre-existing conditions, etc.	None Basic monitoring, policy limits	HFF facilitators manage pre-authorizations and necessary second medical opinions 25% co-payment paid by beneficiary, which helps reduce moral hazard	Emphasis is to promote rather than control use of government facilities without concern for over-utilization.	Solidarity of members & use of community structures limits fraud & abuse. Public health system used. Generic drugs negotiated on a bulk basis from supplier. Cash-less drugs in Berhampur. VMDs at village level can handle 75% of cases. Claim costs rising but have stabilized; 2 referral levels work very well.	Negotiated rates and MOU & selected accredited hospitals that are part of cashless system. 6-month waiting period for pre-existing illnesses, 12-month waiting period for benefits such as hearing aids & hysterectomies.	FHPL controls service agree-ments, pre-authorizes all surgical treat-ments, negotiates fixed tariffs, invest-igates procedures above Rs 30,000, monitors utilization carefully using an extensive database. Little is done on demand side--no waiting period, no pre-existing exclusions, & elective enrolment is allowed within family. Adverse selection becoming a major factor.

Characteristic of Health Plan	Benchmark	ACCORD	BASIX	Healing Fields	Karuna Trust	PRHPS	Vimo SEWA	Yeshasvini CHI
Consumer satisfaction	Tracked & actions taken to resolve complaints & improve services. High and/ or increasing renewal rates.	No formal surveys completed, no information on renewal rates. Percentage of members who repaid premium has been 35-40% without much growth for last 10 years.	Ad hoc surveys. Some feedback indicates that consumers want greater cover-age for out-patient services & increased cash limit on surgeries.	Focus group discussions held.	In phase I >95% members found scheme useful, (it was still free in Phase 1) & >90% non- insured had positive percept-ion of scheme. Compensation for wage loss & providing costs of medicines perceived very useful benefits.	Overall high satisfaction; members will-ing to continue scheme after project phase, & seem willing to raise prem-iums to Rs 30/ year to keep the program going.	Claims are regularly monitored to ensure good satisfactory service. Claims rejection rate is too high at 15%. Low renewal rates indicate dissatis-faction but renewal rates are increasing.	FHPL tracks surgery clients but does not monitor the 99% who have not availed services. Sample surveys by ILO show mixed results. Renewal rate 43% in year 3, be around 62% in year 4 (a strong indicator of awareness and satisfaction).
Consumer awareness and understanding	Member education through community structures in the local language.	Village health workers & AMS leaders educate people about scheme & try to increase solidarity in the community. Low literacy rates limits understand-ing of brochures, so personal contact is crucial.	Staff training is provided on educating consumers, but no consumer awareness studies have been conducted.	95% of beneficiaries have a clear understanding of the product and its limitations; 5% had minor misconceptions.	Limited awareness but growing. Consumer aware-ness was built by automatic enroll-ment through subsidized premiums in year 1 providing an opportunity to demonstrate benefits of participating.	High degree of awareness; almost all seem to understand the scheme.	Both negative and positive: dissatisfaction with asset protection portion hurt perc-eption of the entire product in some years but helped in other years. Vimo Aagewan distribution is still weak & needs more experimentation; training consumer aware-ness is quite low & is a major reason for non-renewal. Claims rejection rate is 15% and indicates poor awareness.	Very little money and effort spent on awareness and education. Automatic enrolment by some co-operative also results in significant information gaps.
Innovation	Consumer feedback, lessons learnt, challenges, etc. translated into innovations that improve effectiveness.	Consistent tweaks in scheme, based on consumer interests and to make it more appealing to adivasi community.	Little innovation; no evidence of beneficiaries' needs for a health insurance scheme.	Significant research to develop a program responsive to needs of target group. Innovative organizational structure, lever-aging contact of community-based organizations with SHG community.	Most significant innovation is partnership with state government to manage public health facilities. This lowers cost for poor & provides an opportunity for better-off population to finance health care needs of the poor.	Innovative design with 3 service levels. Other innovations include: solidarity–members own scheme and hold others accountable; benefit package--subsidized on a declining basis; members can access the public system and receive benefits; drugs bought in bulk and good rate negotiated.	Premium financing through fixed deposit in SEWA bank. Urban members can also get 3-year loan from SEWA Bank for the fixed deposit. Holistic & integrated approach to microinsurance. Claims committee processes claims, not insurer.	Uses cooperative structure for effective, low cost distribution, setting tariffs for proced-ures and getting hospitals to accept fixed tariffs.

Characteristic of Health Plan	Benchmark	ACCORD	BASIX	Healing Fields	Karuna Trust	PRHPS	Vimo SEWA	Yeshasvini CHI
Management attributes	HR plans and continuing skill improvement programs in place for all staff.	Risk management seems be understood by managers. Strict accounting practices & system of receipts. Executive Committee members are all adivasis.	Risk management principles are understood by managers. Accounting practices are sound & robust information management systems are in place. Dedicated group (Insurance Business Unit) within BASIX manages program	Considerable amount of training & understanding of insurance by the HFF staff. Decentralized operation with a clear line of accountability. MIS in develop-ment to improve level of risk analysis. Relying on NGOs for enrollment not as successful as anticipated, so stronger mechanism of distribution is being developed.	Little if any insurance training.	Good MIS developed but is perhaps not fully utilized. Operations training but no risk manage-ment training. Management orientation is towards becoming a professional mutual.	Management and staff: Generally excellent training based on assessed individual capacity gaps but Vimo Aagewan used for marketing seem inadequately trained and compensated. MIS developed.	Risk management skills & knowledge of the Trust is poor. FHPL is an experienced TPA with good systems. Donors are funding micro-insurance experts & an actuary to assist with analysis & advise the Board of Trustees.
Organizational structure	High functioning Board of Directors provides transparent and sustainable financial and beneficiary results	Clear lines of authority, but not a functioning Board of Trustees	Very efficient decentralized system, particularly for distribution of health insurance products. Use of Livelihood Services Advisors at village level ensures consistent information distribution & program monitoring.	Board of Directors manages a highly decentralized organization, apparently efficiently and effectively. Field staff trained to manage beneficiaries & health insurance product. No indication of an inefficient process.	Development-oriented transparent NGO manages scheme.	See above; appears to be precursor for a mutual.	Governed by its membership, i.e., democratically elected SEWA Union BoD. Staff & some Vimo Aagewans are trained well but compensation is low. Donors have funded operations, capacity building & MIS, & a consulting actuary.	Trust is governed by a transparent Board of Trustees.
Regulatory compliance	Regulator requires all risk-pooling activities to be registered & to meet regulatory requirements.	Registered charitable organization; not registered with IRDA as an agent or a risk-bearer.	Has applied to the IRDA for Micro Insurance Agent status.	Health insurance policy offered through HFF by HDFC CHUBB is registered with IRDA.	Partner-agent model although claims ratio is capped at 150%, thus the scheme has not fully ceded all insurance risk.	Risk pooling activity not registered.	Experimented with self-insurance in the past, but now a fully compliant partner–agent scheme. Some issues because it performs some TPA functions but is not registered as such.	Registered charitable trust engaged in risk-pooling, an activity that is not registered with the IRDA.

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Sustainability	Long term sustainability: buildup of resources & reserves, positive net income after year 3, indep-endent of sub-sidies except where state is directly support-ing premium payments of eligible BPL population &/or through tax exemption.	ASHWINI is heavily subsidized & according to an ILO case study, it was never anticipated that the scheme would be financially self-sustainable.	Too early to tell; it is unclear what the claims ratios are for either of the health products. No outside funding is solicited.	Slow growth due to NGOs not prioritizing the education or enrollment of members into the insurance scheme offered by HFF Partnering with several NGOs increases the chance of having critical mass needed to sustain a group micro insurance product.	Although this is only a pilot, scaling up seems possible to a point where the CHI could be sustainable.	Appears to be sustainable. With some technical assistance it could become a sustainable self-insured CBHI. Reinsurance needs to be part of the solution.	Slow growth due to: voluntary enrolment and inadequate participation; low renewal rates (should reach minimum 80%); individual distrib-ution system results in low participation; high expense ratio.	Heavily subsidized & subsidy require-ments increasing. 4 types of subsidies: 1. direct cash subsidies (35% in years 1-3); 2. subsidized services (by providers); 3. marketing & distribution (free through co-op sector); 4. donor subsidies (annual T/A such as actuarial review).

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Consumer awareness and understanding	Member education through community structures in the local language.	Village health workers & AMS leaders educate people about scheme & try to increase solidarity in the community. Low literacy rates limits understand-ing of brochures, so personal contact is crucial.	Staff training is provided on educating consumers, but no consumer awareness studies have been conducted.	95% of beneficiaries have a clear understanding of the product and its limitations; 5% had minor misconceptions.	Limited awareness but growing. Consumer aware-ness was built by automatic enroll-ment through subsidized premiums in year 1 providing an opportunity to demonstrate benefits of participating.	High degree of awareness; almost all seem to understand the scheme.	Both negative and positive: dissatisfaction with asset protection portion hurt perc-eption of the entire product in some years but helped in other years. Vimo Aagewan distribution is still weak & needs more experimentation; training consumer aware-ness is quite low & is a major reason for non-renewal. Claims rejection rate is 15% and indicates poor awareness.	Very little money and effort spent on awareness and education. Automatic enrolment by some co-operative also results in significant information gaps.
Innovation	Consumer feedback, lessons learnt, challenges, etc. translated into innovations that improve effectiveness.	Consistent tweaks in scheme, based on consumer interests and to make it more appealing to adivasi community.	Little innovation; no evidence of beneficiaries' needs for a health insurance scheme.	Significant research to develop a program responsive to needs of target group. Innovative organizational structure, lever-aging contact of community-based organizations with SHG community.	Most significant innovation is partnership with state government to manage public health facilities. This lowers cost for poor & provides an opportunity for better-off population to finance health care needs of the poor.	Innovative design with 3 service levels. Other innovations include: solidarity–members own scheme and hold others accountable; benefit package--subsidized on a declining basis; members can access the public system and receive benefits; drugs bought in bulk and good rate negotiated.	Premium financing through fixed deposit in SEWA bank. Urban members can also get 3-year loan from SEWA Bank for the fixed deposit. Holistic & integrated approach to microinsurance. Claims committee processes claims, not insurer.	Uses cooperative structure for effective, low cost distribution, setting tariffs for proced-ures and getting hospitals to accept fixed tariffs.

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Management attributes	HR plans and continuing skill improvement programs in place for all staff.	Risk management seems be understood by managers. Strict accounting practices & system of receipts. Executive Committee members are all adivasis.	Risk management principles are understood by managers. Accounting practices are sound & robust information management systems are in place. Dedicated group (Insurance Business Unit) within BASIX manages program	Considerable amount of training & understanding of insurance by the HFF staff. Decentralized operation with a clear line of accountability. MIS in develop-ment to improve level of risk analysis. Relying on NGOs for enrollment not as successful as anticipated, so stronger mechanism of distribution is being developed.	Little if any insurance training.	Good MIS developed but is perhaps not fully utilized. Operations training but no risk manage-ment training. Management orientation is towards becoming a professional mutual.	Management and staff: Generally excellent training based on assessed individual capacity gaps but Vimo Aagewan used for marketing seem inadequately trained and compensated. MIS developed.	Risk management skills & knowledge of the Trust is poor. FHPL is an experienced TPA with good systems. Donors are funding micro-insurance experts & an actuary to assist with analysis & advise the Board of Trustees.
Organizational structure	High functioning Board of Directors provides transparent and sustainable financial and beneficiary results	Clear lines of authority, but not a functioning Board of Trustees	Very efficient decentralized system, particularly for distribution of health insurance products. Use of Livelihood Services Advisors at village level ensures consistent information distribution & program monitoring.	Board of Directors manages a highly decentralized organization, apparently efficiently and effectively. Field staff trained to manage beneficiaries & health insurance product. No indication of an inefficient process.	Development-oriented transparent NGO manages scheme.	See above; appears to be precursor for a mutual.	Governed by its membership, i.e., democratically elected SEWA Union BoD. Staff & some Vimo Aagewans are trained well but compensation is low. Donors have funded operations, capacity building & MIS, & a consulting actuary.	Trust is governed by a transparent Board of Trustees.
Regulatory compliance	Regulator requires all risk-pooling activities to be registered & to meet regulatory requirements.	Registered charitable organization; not registered with IRDA as an agent or a risk-bearer.	Has applied to the IRDA for Micro Insurance Agent status.	Health insurance policy offered through HFF by HDFC CHUBB is registered with IRDA.	Partner-agent model although claims ratio is capped at 150%, thus the scheme has not fully ceded all insurance risk.	Risk pooling activity not registered.	Experimented with self-insurance in the past, but now a fully compliant partner–agent scheme. Some issues because it performs some TPA functions but is not registered as such.	Registered charitable trust engaged in risk-pooling, an activity that is not registered with the IRDA.

Characteristic of Health Plan	Benchmark	ACCORD	BASIX	Healing Fields	Karuna Trust	PRHPS	Vimo SEWA	Yeshasvini CHI
Sustainability	Long term sustainability: buildup of resources & reserves, positive net income after year 3, indep-endent of sub-sidies except where state is directly support-ing premium payments of eligible BPL population &/or through tax exemption.	ASHWINI is heavily subsidized & according to an ILO case study, it was never anticipated that the scheme would be financially self-sustainable.	Too early to tell; it is unclear what the claims ratios are for either of the health products. No outside funding is solicited.	Slow growth due to NGOs not prioritizing the education or enrollment of members into the insurance scheme offered by HFF Partnering with several NGOs increases the chance of having critical mass needed to sustain a group micro insurance product.	Although this is only a pilot, scaling up seems possible to a point where the CHI could be sustainable.	Appears to be sustainable. With some technical assistance it could become a sustainable self-insured CBHI. Reinsurance needs to be part of the solution.	Slow growth due to: voluntary enrolment and inadequate participation; low renewal rates (should reach minimum 80%); individual distrib-ution system results in low participation; high expense ratio.	Heavily subsidized & subsidy require-ments increasing. 4 types of subsidies: 1. direct cash subsidies (35% in years 1-3); 2. subsidized services (by providers); 3. marketing & distribution (free through co-op sector); 4. donor subsidies (annual T/A such as actuarial review).

5 REGULATION OF PRIVATE HEALTH INSURANCE

Governments, particularly in countries where pubic health systems are considered inadequate, look upon private health insurers as partners in achieving health policy goals. Private health insurance is an alternative source of health financing offered in the voluntary market and geared towards providing health coverage with customized benefits to a large portion of the population. While private health insurance is a potent tool to increase the capacity of a country's health system, government intervention is necessary to prevent market failures. This chapter discusses the legal and regulatory framework of private insurance in India, presenting the adequacy and efficacy of its insurance laws and regulations and their implementation in providing protection to consumers of health insurance products. In India development and promotion of health insurance is an additional legal mandate imposed on the regulator. The performance of IRDA in this respect is also evaluated. A brief history of insurance and its regulation in India is provided in Appendix V.

Rationale for Private Health Insurance Regulation

In order for private health insurance to achieve its objectives and fulfill its functions, effective regulation and supervision of both the carriers of risks (insurers) and the providers of health care are imperative for reasons of public safety and because health care services have aspects of public goods.[1] This requirement is particularly critical in India as private health insurance is emerging as an important source of health care financing.

A Discussion Paper published by the WHO[2] offers a comprehensive rationale for, and the objectives of, private health insurance regulation in developing countries, as summarized below:

1. Health insurance is more complex than other types of insurance. The exposures to health risks and the consequential costs of covering those risks are very difficult to assess due to the following factors:

    a. Health risks are not static; they change over a period of time and, in the long term, every one requires health services.

    b. An individual has more control of his/her health risks compared to other types of insurance risks.

    c. The definition, nature and extent of insurable health risks keep changing due to medical advances.

2. Health insurance markets are particularly subject to a number of market failures preventing or hindering their effective functioning. Some of these failures stem from information asymmetry about health risks and costs. These lead to moral hazard and anti-selection on the part of insured, adverse risk selection on the part of the insurers and potentially poor choice of health care providers for both.

3. To be effective, regulation and supervision of health insurance must encompass the following objectives:

[1] A healthy population confers benefits on all those with n the population group such as immunity from infectious disease and greater productivity; therefore public promotion and provision of access to health services, just as with public education, is deemed desirable.

[2] WHO. "Regulation of Private Health Insurance to Serve Public Interest—Policy Issues for Develop ng Countries" Discussion Paper No 3. Geneva. 2005.

a. Promoting public interest of ensuring equitable, affordable and accessible healthcare to the people at large.

b. Establishing requisite procedures for intervention that safeguard the solvency and financial soundness of health insurers so that they are in a position to fulfill the promises they made to the insured and providing an environment to allow health insurers to continuously offer health insurance products and carry health risks on sustainable bases.

c. Establishing and promoting a level playing field among the carriers of health risk so as to encourage participation of an optimal number of health insurers in order to provide most consumers with a variety of products at reasonable benefits for affordable premiums.

d. Ensuring order in the market through the promulgation and enforcement of laws and regulations that address issues such as, the type or types of health policies or covers that insurers can sell, the manner and methodology of arriving at equitable product pricing, the prompt and orderly payment of claims, the contract terms and conditions including the specification of standardized definition of certain policy terms, mandatory minimum policy stipulations and setting market standards for transacting the business of health insurance.

e. Establishing similar safeguards and/or standards for the orderly functioning and financial soundness of other programs that assume health expenditure risks, such as subscription plans, HMOs, health plans of mutual benefit associations, cooperatives, and other community plans. Prescribing appropriate authorization (registration) and oversight of entities that carry and manage these plans in order that public policy objectives of health insurance are realized and specific market failures are corrected. It is noteworthy that these entities operate in the same market as duly registered, and thus regulated, health insurers. We will visit this issue again in more detail in the later part of this Chapter.

Legal and Regulatory Framework of Private Health Insurance in India

As in most jurisdictions, the legal and regulatory framework of insurance in India is shaped and influenced by the actions of the legislative, executive and judicial functionaries of the Government of India (GOI). We briefly visit each of these functions.[3]

Legislative Branch

The Parliament (legislative branch) consisting of two houses, namely, Lok Sabha (Lower House), and Rajya Sabha (Upper House) enacts laws (Acts). An Act passed by the parliament requires the assent of the President of India and such Act comes into full force following its notification in the Official Gazette. Acts are referred to as "primary legislations". For insurance, the broad legal framework is the Insurance Act, 1938, as amended (Act).

Executive Branch

The Executive Branch, comprising the various ministries and governmental entities under it, enforces compliance with the Act. The Act, as recently amended by the Insurance Regulatory and Development Authority Act, 1999 (IRDA Act) created the Insurance Regulatory and Development Authority (IRDA) and constituted it as the entity or body (executive) to enforce the provisions of the Act. The executive (IRDA) is looked upon as possessing the technical expertise on insurance matters within the GOI to discharge its powers and obligations for the prudential oversight of the business of insurance.

▪ Rules

Before the IRDA Act took effect, the Act authorized the concerned Ministry (executive) to frame insurance rules and, on the basis of that legislative authority, the Controller of Insurance, then under the Ministry of

[3] Communication with Mr. K Subrahmanyam, Executive Director of the IRDA.

Commerce until it was transferred to Ministry of Finance, promulgated the Insurance Rules 1939. These Rules were the principal secondary legislation governing the conduct of insurance. The authority of the "executive" to make Rules is specified and limited to areas mentioned in the Act. No Rule may override the provisions of the Act. For example, if the Act gives power to the executive to impose a penalty for violations of the provisions of the Act but limits the amount of penalty, say, to Rs 100,000 for each act of violation, the executive cannot impose a higher amount of penalty, say, Rs 100,001.

- Regulations

The regulatory body (executive), created and empowered by the Act to do so, frames and promulgates regulations. For insurance matters, the regulatory body is the IRDA. The Act specifies the areas where regulations can be made. For instance, where the Act grants power to the IRDA to make regulations on licensing of agents, such regulations would describe the qualifications and practical training required of an agent and specify the corresponding fee, etc., for a license to be granted. No Regulation may override the provisions of the Act.

Rules and Regulations are made, usually after discussions/consultations with various groups who are likely to be most affected. They come into effect after their notification in the Official Gazette with the additional requirement that they are presented (tabled) before the Parliament following their due notification.

Rules and Regulations are referred to as 'secondary legislation'. They are dynamic, and can be modified, revised or supplemented as exigencies arise through time and are therefore pro-active as they fill in the details of primary legislations. They are most used and effective in providing quick help and guidance to the public. For this reason, secondary legislation is a favored route to regulation because bringing in primary legislation is not only time consuming but also a tedious process. Parenthetically, legislative reforms are taking place internationally, granting more powers, including quasi-judicial (adjudicatory), to the executive branch of government.

Additionally, IRDA has also the power to issue directions in the public interest or to prevent the affairs of any insurer from being conducted in a manner detrimental to the interest of policy holders or, in general, to secure proper management of any insurer and, in which case, insurers, or insurer as the case may be, shall be bound to comply with such directions.[4]

Judicial Branch

The judiciary interprets the law, both primary and secondary legislation. It hears and decides disputes between insurers and the policyholders, protects the insuring public by imposing civil fines or criminal penalties for violation of the insurance laws and protects insurers, their agents and intermediaries by overturning arbitrary or unconstitutional legislation, rules, regulations or orders promulgated by the insurance regulator.[5]

The Supreme Court is the highest court in India, and its judgment is final in all respects. Every state has a High Court. High Court is below the Supreme Court. Other lower courts are District Court, Taluq Kachery, and Village Munsiff. Every state has districts, every district is divided into taluqs, and each taluq has villages. Thus, each geographic region is represented by a specific court.

To facilitate dispute resolution, India has also Consumer Courts (Fora), Insurance Ombudsmen, Lok Adalats, etc., that address consumer grievances in summary proceedings. Policyholder complaints against insurers are mostly dealt with at the Insurance Ombudsmen and Consumer Courts. There are also various tribunals dealing generally with industrial or sector-specific matters as appellate authorities exercising specific adjudicatory powers. While these entities do not fall under the judiciary branch, they are considered a part of the court system.

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[4] Insurance Act, 1938. Section 34.

[5] Adapted from Kenneth black Jr and Harold D. Sk pper Jr., *Life and Health Insurance*, Thirteenth Edition, Chapter 35, "Regulation and Taxation of L fe and Health Insurance", p. 946. Prentice Hall, 1999.

In summary, the legal framework upon which insurance business in India operates consists of the following: the Insurance Act, 1938, as amended; the Insurance Rules, 1939; the Regulations made by the IRDA and, as applicable under the doctrine of "res judicata", the final decisions of the judiciary (case laws). Thus, insurance laws comprise the primary legislation, secondary legislations and case laws.

Insurance Sector Reforms and Health Insurance in India

The IRDA Act heralded the privatization of the insurance sector in India and ended the monopoly by public sector companies. Unique to India is the dual mandate of the IRDA both as a regulator and a developer of insurance. In this context BearingPoint has analyzed important provisions of the IRDA Act and the regulatory steps it envisaged. Our analyses has focused on the broad policy objective of "creating a health care system that is not too costly, of good quality and with equitably distributed burden of health care spending".[6] Apart from the insurance laws, the analysis also briefly addresses the efficacy of other important legislation in promoting the development and facilitating the growth of health insurance in India.

Ideally, an environment that promotes growth of health insurance is one where consumers are well enough informed to evaluate alternative benefits and costs of health insurance products and health care services along with appropriate legal protection available to them.[7] Typically, areas for government intervention that provide such an environment for private health insurance include the following:

1. Safeguarding the financial stability of insurers.
2. Ensuring or strengthening consumer protection.
3. Controlling risk selection by insurers and adverse selection by insured.
4. Enabling the participation of and establishing oversight over health risks carriers, such as managed care organizations (including HMOs), subscription plans as well as self-insured plans and community based health plans of mutual benefit associations and/or cooperatives.
5. Facilitating complementary legislation to health insurance such as provider regulation, provider accreditation and medical malpractice laws, to mention a few.

The legal and regulatory framework for private health insurance in India is analyzed in the above context, consistent with the primary objectives of the IRDA Act to "protect the interest of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry"[8] and take into account IRDA's dual mandate as a regulator and promoter/developer of insurance.

Areas of Regulation of Private Health Insurance

To predicate discussion of the areas of regulation, it is worth considering whether health insurance is a line of business included in both life and non-life business. BearingPoint considers health insurance a separate category, the third major branch of insurance business (life and non-life being the other two). The major lines of health insurance include medical expense, disability income protection, and long-term care. All of these products are included in the current regulatory definition of health insurance business.[9]

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[6] Mahal, Ajay. "Assessing Private Health Insurance n India: Potential Impacts and Regulatory Issues." *Economic and Political Weekly*, 37 (February): 559-71, 2002.
[7] Ibid.
[8] Introductory statement (preamble) of the IRDA Act; The IRDA Act took effect on April 19, 2000 via Notification No. SO 397 (E) dated 19-4-2000
[9] See Sec. 2 (f) of IRDA Registration of Indian Insurance Companies Regulations, 2000

Under the Insurance Act, 1938, insurance business is divided into two classes: (a) life insurance business and (b) general insurance business. Health insurance is common to both. Thus:

1. Section 3(2AA) of the Act states that: "The Authority shall give preference to register the applicant and grant him a certificate of registration if such applicant agrees, in the form and manner as may be specified by the regulation made by the Authority, to carry on the *life insurance business or general insurance business for providing health cover to individuals or group of individuals*".[10] This provision traces its roots to the recommendations of the Malhotra Committee[11] and it is included in the Act to recognize the public policy objective of developing and promoting the growth of private health insurance.

2. Health insurance business or health cover is defined as "the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient on an indemnity, reimbursement, service, prepaid, hospital or other plan basis, including assured benefits and long term care".[12]

3. However, Section 4, (2) of IRDA Regulations 2002, Registration of Indian Insurance Companies creates some ambiguity where it prescribes that "The classes of business of insurance for which a requisition for registration application may be made are: (a) life insurance business consisting of linked business, non-linked business or both; or (b) general insurance business including health insurance business." The mention of health insurance as included in the general insurance business, while silent as to life insurance business, is an ambiguity that needs to be clarified by the IRDA, particularly in light of Section 3(2AA) of the Act, cited above.

Consumer Protection

For insurance matters, India has broad laws on consumer protection including, but not limited to, those enunciated in the Insurance Act 1938, Consumer Protection Act 1986, Arbitration and Conciliation Act 1996 and, to a certain extent, the Indian Contracts Act 1872. Secondary legislation, particularly the Insurance Rules 1939, the Ombudsman Rules 1998 and regulations issued by the IRDA provide detailed guidelines that further strengthen consumer protection. Broadly, consumer protection is provided through sound and prudential regulatory oversight of market conduct; solvency of insurers in establishing fair and transparent business practices in the solicitation, servicing and claims settlement and in providing assurance that health insurers are able to fulfill their contractual promises; and effective functioning of adequate mechanisms for handling and resolving consumer grievances, complaints and industry related disputes.

We shall focus this subchapter on certain regulations and guidelines promulgated by the IRDA, particularly as they apply to health insurance.

▪ Regulations 2000 on Licensing of Insurance Agents

Section 43 of the Act ensures that agents possess legal competence and trustworthiness by requiring that they have capacity to contract, are free of any criminal conviction with respect to misappropriation, breach of trust or cheating, forgery or abatement or attempt to commit any such offense and have not knowingly participated or connived at any fraud, dishonesty or misrepresentation against any insurer or insured, etc. Regulation 2000 on Licensing of Insurance Agents reinforces Section 43 by prescribing, among others, minimum educational attainment, number of hours of practical training, successful passing of the licensing examination and adherence to a set code of conduct, all of which strengthen market confidence and consumer protection. In similar fashion, such requirements and codes of conduct are also prescribed specifically for brokers and corporate agents. Compared with the other insurance lines, health insurance is

[10] Italization, ours.

[11] In 1993, the Government of India set up an eight-member committee called the Committee for Reforms n the Insurance Sector (CRIS) cha red by Mr. R. N. Ma hotra, a former Governor of the Reserve Bank of India, with the primary mandate to make recommendations for changing the structure of the insurance ndustry and for changing the general policy framework relating to regulation and supervision of the nsurance companies as well other matters which are relevant for the development of the nsurance industry in India. The committee rendered its report in 1994, recommending among others (a) allow ng the entry of private insurers, (b) the establishment of an independent nsurance regulator, and (c) giv ng health insurers preferential treatment n the registration and licensing of insurance companies.

[12] IRDA Regulations, 2000 on Registration of Indian Insurance Companies, Sec. 2 (f).

clothed with a higher degree of public interest because of its characteristics of a public good. Moreover, as insurers attempt to balance the varying needs of consumers with accessible, affordable and quality health care, health insurance products may be highly diversified. For these reasons, public protection related to the solicitation, offer and sale of health insurance needs to be further enhanced. For example, additional and separate educational and practical training requirements and licensing examinations that are specific to health insurance may be necessary for agents and intermediaries in soliciting or offering medical expense cover, disability income protection and long-term care policies to enable them to appropriately explain to their customers the varying objectives of these policies and the nature of benefits covered.

- Regulations 2000 on Advertisements and Disclosure

This regulation requires certain disclosures to be included in every advertisement to further inform consumers of the insurance product. It also requires every insurer and intermediary to designate its compliance officer as well as the filing and retention of advertising materials. However, while defining "unfair or misleading advertisement" with specificity and clarity, the regulation does not include a provision specifically prohibiting the use of "unfair or misleading advertisement". Further, it states that (unspecified) penalties may be imposed only when the advertiser "fails to comply with the directions of the Authority," thus leaving the initial violation that led to the issuance of the regulatory directive unsanctioned. On the matter of advertisements, this regulation applies also to health insurance.[13] However, the regulation should be amended to rectify the omissions observed above.

- Regulations 2001 on Third Party Administrators – Health Services.

To date, this is the only IRDA regulation specific to health insurance. This regulation established third party administrators (TPA) and the rules for their licensing as intermediaries in rendering healthcare for insured beneficiaries and promoting a "cashless system" with easier access to and faster settlement of covered benefits of medical expense covers. The regulation prescribes high educational and practice standards of individuals operating and managing a TPA and requires adherence to a prescribed Code of Conduct. While this regulation has prompted expanded consumer interest and confidence in medical expenses insurance, many believe that the regulation needs to be revisited and updated considering the changes occurring in the industry and the imperatives to provide quality healthcare. Moreover, there is growing evidence that the TPA system has not been effective in promoting quality of healthcare and in containing healthcare costs. TPA business practices are quite often cited as one of the causes of the very high loss ratios in the current health insurance business. Chapter Three discusses in more detail the current state, requirements and future directions of TPAs in light of the overall objective of developing and promoting health insurance in India.

- Regulations 2002 on Protection of Policyholders' Interests

This regulation provides comprehensive standards on consumer protection describing materials (including product prospectus) and explanatory statements that are to be provided at the point of sale, the necessity and importance of the proposal form, matters to be stated in a life or general insurance policy, claims procedures in respect to life and general policies, and certain standards for the proper discharge of policyholder services. Except for the absence of a 15-day period within which a general insurance policyholder may obtain a return of premium (as required for life insurance policies), this regulation may be deemed complete as to life and general insurance. However, we feel that the regulation was framed without considering matters that are particular to health insurance business. For example, provisions on accessibility or availability of coverage, transferability (portability) of previous coverage, renewability, pre-existing conditions (and other benefit exclusions) and policy stipulations common to all health insurance cover and specific to the type of health cover, were not taken into account. These subjects are presented and discussed separately in this chapter. It is envisaged that a separate IRDA regulation specific to health insurance will cover these issues.

[13] It would be ideal to enhance this regulation with prescribed "Standards on Disclosures and Marketing Practices for Health Insurance" which is also presented n this chapter.

▪ "File and Use" Guidelines

The IRDA issued Guidelines on "File and Use" for General Insurance effective as of 1st November 2006. The guidelines are salutary for property and casualty (non life) insurance in that they clearly define and prescribe the requirements and procedures for the regulatory filing and approval of general insurance rates and forms, including emphasis on corporate governance relating to underwriting, product design and rating, among others.[14,15] However, to ensure fulfillment of the broad policy objectives of "creating a health care system that is not too costly, of good quality and with equitably distributed burden of health care spending,"[16] intervention through heightened regulation is both justified and necessary for health insurance. The most important standard for approval of health insurance policy forms is to ensure that premium charged under the policy is reasonable in relation to the benefit provided. This standard is often implemented by requiring a minimum loss ratio under a particular policy form. "Rate to loss ratio" guidelines could be prescribed as a regulatory means of monitoring and controlling pricing activities of health insurance.[17]

Solvency of Health Insurers

In the European Union there has been a move towards solvency regulation and less emphasis on policy terms, conditions and prices. This philosophy looks more to ensuring that there is adequate capital measured against risk underwritten and the presence of strong management control of risk, appropriate board oversight and transparency. Ensuring the solvency of health insurers is an indispensable requirement to adequate protection of policyholders. However, regulations that are designed to prevent insurer insolvencies must be balanced with public policy goals of providing accessible and affordable health care. This is a challenge for regulators the world over and particularly in India where IRDA is both the regulator and developer of insurance.

▪ Minimum Capital and Surplus

The Act prescribes minimum paid up equity capital for insurers,[18] the maintenance of required solvency margin (RSM),[19] and the detailed manner by which RSM is determined under IRDA regulation.[20]

Margin of solvency is the excess of an insurer's assets over its liabilities. In some jurisdictions this is referred to as "surplus". However, the amount of the required margin of solvency is restricted (appropriated) surplus, thus not available for policyholders' dividends or profit distribution. As an added "control" (intervention level), "IRDA has set a working Solvency Margin Ratio (ratio of actual solvency margin to the required

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[14] With respect of policy forms the guidelines requ re that:
- Products are designed and rated based on sound and prudent underwrit ng.
- The cont ngencies insured should be clearly described so as to provide transparent cover which is of value to the nsured.
- All literature relat ng to the product should be in s mple language, easily understandable to the public at large. All technical terms should be clarified in s mple language for the benefit of the insured.
- The product should cover insurable risks and risk transfer is real.
- The nsurance product should comply with all the requirements of the Protection of Policyholders' Interests Regulations 2002.
- Insurers should use as far as possible, s milar wording for describing the same cover or the same requirement across all their products. For example clauses on renewal of nsurance, basis of insurance, due diligence, cancellation, arbitration etc., should have s milar wording across all products.
- The rates, terms and conditions of cover should be fair between the nsurer and the insured.

[15] With respect to rates, the guidel nes requ re that:
- Pric ng should be based on appropriate data and with technical justification.
- Marg ns built nto rates should be consistent with insurer's experiences with respect to commission, management expenses, contingencies and profit.
- Insurers shall ensure that rate competition will not lead to unprincipled rate cutt ng and mproper underwrit ng practices.
- Products may either be class rated or individually rated.

[16] Mahal, Ajay, Op.Cit.

[17] See also Kenneth Black Jr and Harold D. Skipper Jr *Life and Health Insurance,* page 953.

[18] Section 6 of the Insurance Act requ res a m nimum paid up capital of INR 100 crores for either l fe or non- l fe insurers. On the recommendation of Stand Alone Health Insurance Subgroup, IRDA has forwarded its recommendation to the GOI to reduce this m nimum equity capital to INR 50 crores for companies that would only transact health insurance.

[19] Section 64V, et seq, Part IIC of the Act.

[20] IRDA Regulation, 2000 on Assets, Liabilities and Requ red Margin of Solvency.

solvency margin) of 1.5 for all insurers.[21] The above provisions of the Act and the implementing IRDA regulations are conservative measures to make sure that no insurer operating in the market is financially distressed. It is a wholesome assurance of public protection. However, the RSM relates directly to the policy liabilities of an insurer and as its business grows its policy liabilities grow. So also does the corresponding RSM, which may ultimately strain the financial resources of the insurer and its shareholders, leading to inefficient use and/or immobilization of capital. It may be advisable for IRDA to review the current margin of solvency requirements to enable more effective use of capital and at the same time enhance competition in product costs and benefits, especially for health insurance.

- Loss Reserving

For health insurance business, the determination of policy liabilities (reserves) follows the systematic formulae prescribed under IRDA Regulations, 2000 on Assets, Liabilities and Solvency Margin of Insurers.[22] As noted earlier, standards could be implemented that require a minimum loss ratio under the policy form and loss ratio guidelines could be prescribed as a means of monitoring and controlling the pricing activities of health insurers. However, since loss experiences are factored into the determination of fair, reasonable and adequate premium rates applicable to the various types of health insurance products, a regulation prescribing different reserving rules to apply to specific categories of health insurance may be necessary. In addition, claims characteristics and loss development of different health insurance products vary. For example, the determination of adequate reserves for policy liabilities for the short-term but renewable nature of medical expense covers differ from those of the long-term and permanent nature of contracts for disability income protection and long-term care.

- Filing and Independent Audit of Financial Statement

Prudential insurance oversight requires that all insurers file financial reports reflecting their financial condition and results of operations at least annually or as frequently as necessary when an insurer is deemed to have a financial problem. The filing of financial reports is primarily to determine that the reporting insurer is at all times maintaining assets that are enough to cover its current and estimated prospective liabilities plus the required solvency margin. These areas are adequately covered under the current legal and regulatory framework.[23] In addition, the IRDA regulations on Appointed Actuaries further strengthens credibility of the insurer's financial statements.[24]

Redress of Grievance and Dispute Resolution

Laws relating to the handling, resolution and settlement of disputes and the machinery through which complaints and disputes can be addressed are plentiful in India. These are summarized below.

- Judicial system

Recourse to the courts is a guaranteed right of every citizen and for insurance matters, this right is further emphasized in the Act by giving policyholders the right to sue for any relief in respect to his or her policy in any court of competent jurisdiction.[25] However, judicial proceedings are normally cumbersome, expensive and time consuming.

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[21] IRDA *Annual Report 2005-06*, p.36.

[22] See Regulation 6, IRDA Regulation 2000 on Assets, Liabilities and Solvency Marg n of Insurers.

[23] See Sec. 12 of the Insurance Act requ r ng annual independent audit; IRDA Regulation 2002 on Preparation of F nancial Statements and Auditor's Report of Insurance Companies; IRDA Regulation 2000 on Appo nted Actuary (L fe Insurers) and IRDA is currently tak ng a view of the Appo nted Actuary Regulation for General Insurance proposed by the Actuarial Society of India. All these enhance the cred bility of the f nancial reports of Indian nsurance companies.

[24] We learned that the IRDA is also taking the view of the Appointed Actuaries regulations for general insurance proposed by the Institute of Actuaries of India.

[25] See Section 46 of the Insurance Act 1938.

▪ Arbitration

The Directive Principle of State Policy of the Indian constitution lays down the principle that the state should encourage settlement of disputes by arbitration. Thus the Arbitration and Conciliation Act 1996 established the process of arbitration through which parties to a dispute present their cases at a hearing before a mutually agreed upon panel of disinterested persons (arbitrators) to render decision. Arbitration provision in insurance policies typically stipulates that any dispute with regard to the quantum of claim, liability having been admitted, shall be referred to arbitration conducted in accordance with the provisions of the Arbitration and Conciliation Act 1996. Decisions arrived through arbitration can be challenged, by way of appeal, by either or both parties in a proper civil court based on (limited) grounds specified under the Act.

▪ Consumer Protection Act, Consumer Courts

The Consumer Protection Act created the consumer commissions comprised of consumer courts as accessible forums for inexpensive and speedy redress of consumer grievances. It is a comprehensive legislation containing, among others, the definition and meaning of terms such as "consumer", "complainant", "deficiency in service", "negligence" and "unfair and restrictive trade practices" that apply to all goods and services of all types of companies and organizations. Insurance is a type of service that falls under the jurisdiction of the consumer courts. The consumer protection machinery consists of a three-tiered jurisdictional system comprised of District Commission, State Commission and National Commission. Their jurisdictional competencies are set in relation to the amount of claim. District forums take cognizance of disputes involving amounts that are not more than twenty lakhs; State Commissions for claims that are not more than one crore; and the National Commission for amounts involving more than a crore. The consumer courts are quasi-judicial bodies under the Ministry of Law of the GOI.

The consumer commissions (courts) play a key role in the resolution of the disputes between insurers and insured, including a number of health insurance related claims. However, "Recent evidence suggests that problems with backlogs have begun to occur in the consumer courts as well, due to an inadequate number of 'judges' and to the increase in the burden of cases. According to one recent study of medical cases in consumer forums, more than 90 per cent took one year or longer for completion, compared to the mandated 90 days!".[26]

▪ Insurance Ombudsman System

Because the (overwhelming) majority of insurance disputes are handled and resolved through the ombudsman system, this section focuses on the ombudsman system and the Rules promulgated in 1998 on grievance redressal and dispute resolution[27] and suggests certain measures to further strengthen it.

Regulation 5 of IRDA Regulations 2002 on Consumer Protection, dated 26 April 2002, strengthens the 1998 rules when it provides that:

> Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed and the same along with the information in respect of Insurance Ombudsman shall be communicated to the policyholder along with the policy document and as may be found necessary.

With respect to issues pertaining to customer protection, the IRDA in its 2nd Annual Report dated October 31, 2002 stated that:

> Having settled the mechanism of a regulatory environment to convert a wholly regulated and controlled sector into one that is market-driven, it is the concern of the regulator to ensure that the systems and mechanisms in position enable the customer to get the best in terms of packages offered to meet his needs, speedy settlement of claims, and protection of his interest. While the insurers have in place in-

[26] Mahal, Ajay. *Op. Cit.*

[27] Sources consulted include applicable rules and regulations, annual reports of the offices of insurance ombudsmen, and discussions with IRDA officials and the Office of the Ombudsman of Hyderabad.

house customer grievance cells, the regulations pertaining to protection of policyholders' interests along with the existing institution of Ombudsman should go a long way in the adoption of healthy market practices alert to the knowledge that a fall-back is available through the grievance settlement machinery fully backed by adequate penal provisions.[28]

Rules of Ombudsman System. The insurance ombudsman system was established by Redressal of Public Grievance Rules ("RPG Rules") effective November 11, 1998 issued by the Department of Economic Affairs (Insurance Division) of the Ministry of Finance of the GOI. Institution of this system followed growing recognition that both the civil courts and the consumer fora were too afflicted with delay and expense to be effective grievance redressal mechanisms for insurance matters. Twelve insurance ombudsmen offices functioning in metropolitan areas covering all the states of India were established and clothed with jurisdiction to hear complaints against insurance companies relating to personal (but not commercial) lines of insurance. The ombudsmen act as both mediators and adjudicators. If the mediation process overseen by the ombudsman fails to produce agreement, the ombudsman will resolve the dispute and issue an award. This award is binding on the insurer giving the complainant the choice to reject it and pursue available remedies in the courts.[29]

The RPG Rules establish a "governing body of insurance council" which shall appoint ombudsmen. This council is composed of representatives of insurance companies. An ombudsman is appointed by the governing body from a panel prepared by an advisory committee of eminent persons consisting of the Chairman of the IRDA, two representatives of the council (one from the life insurance business and one from the general insurance business), and one representative of the Central Government. An ombudsman shall be appointed for a term of three years but may not serve after attaining age 65; removal is permitted only for gross misconduct.

The Ombudsmen may entertain written complaints[30] where (1) the complainant had previously made a written representation to the insurer and the insurer had either rejected it or not replied within one month, or the complainant had not been satisfied with the insurer's response; (2) the complaint is made within one year after the insurer had rejected the complaint or sent its final reply; and (3) the complaint is not on the same subject matter for which any proceedings before any court or consumer forum or arbitrator is pending or was earlier. "The ombudsman acts as counsellor and mediator in matters which are within his terms of reference and, if requested to do so in writing by mutual agreement by the insured person and insurance company."[31] The ombudsman is to act fairly and equitably.[32] Within one month of the filing of the complaint, the Ombudsman shall make a recommendation for settlement in terms he thinks are fair in the circumstances. If the mediation process fails, the Ombudsman shall grant an award.[33] The complainant is allowed one month from the date of receipt of the award to send a letter accepting it. If he does so, the award is final and the Ombudsman accordingly notifies the insurer which must comply with the award within fifteen days.

Annual Reports of Ombudsmen. Under the RPG rules, each ombudsman is required to submit an annual report to the government concerning his activities during the preceding year. This report is to include a review of the quality of services rendered by insurers and recommendations to improve them. The reports[34] are impressive for their thoughtfulness and thoroughness and provide valuable guidance for the reform of insurance forms as well as sales and claim settlement practices in India.

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[28] Cha rman's Statement by Shri N. Rangachary, then IRDA chairman.

[29] See Sam ran Bhattacharya, "How the Ombudsman Works", *IRDA Journal*, April, 2003, p.11, for an explanation and discussion of the ombudsman system.

[30] Compla nts must arise out of partial or total repudiation of cla ms by an insurer, disputes concerning premiums payable, disputes concerning legal construction of policies as they relate to delay in the settlement of claims, and non-issuance of insurance documents to customers after receipt of prem um.

[31] Rule 12 of the Redresal of Public Grievance (RPG) Rules.

[32] Rule 14 of the RPG Rules.

[33] The award is to be made with n three months from the date of rece pt of the compla nt and it must be in writing, stat ng the amount awarded to the complainant. The award is limited to the lesser of the amount to cover the loss suffered by the complainant as a d rect consequence of the insured risk or twenty lakhs (approx mately $45,000).

[34] While each ombudsman files a report for his own district and thus the reports vary n content, details and scope, they are a valuable source of both data and commentary concerning the operations of the ombudsmen.

Box 5.1: Observations from Ombudsmen's Annual Reports

1. General Apathy – Insurance companies do not respond to the insureds/claimants' letters/queries or are extremely slow in responding.
2. Non-Application of Mind – A sizeable percentage of decided cases have gone against insurers on account of mechanical approach, i.e., non-application of mind and lack of sensitivity.
3. Carelessness and Negligence – Loss of documents and other important papers in the custody of insurance offices. Premium cheques or bank drafts received were misplaced. Records in some cases were not kept up to date. In some offices no proper record was kept of important documents received from customers.
4. Bureaucratic Approach – Where simple mutual consultation over intercom or across the table could do, departments in the same office, e.g. Legal and Claim, are fond of exchanging letters/notes on the same subject causing avoidable delays.
5. Lack of Transparency – In disputes relating to non-life cases, including health insurance, claims were rejected without citing any reasons. Claims were also found simply filed away as "no claim". This caused avoidable irritation to the customers.
6. Lack of Customer Education – Many complaints arose because product features/policy terms were not made known to the customers. For instance, exclusion clauses in various policies are mostly not known to the insured.
7. Underwriting Lapses v Vital information was not sought at the time of underwriting. Uncompleted proposals (with some blank columns and spaces) were accepted and cover issued. For example, Mediclaim policies were renewed with the same existing diseases for which a claim had been rejected in the previous year and no endorsements as to exclusion of that disease were placed on the policy.
8. Customer Identity – A customer is taken for granted; he is no more than a policy number. Transactions with him do not reflect any sensitivity in dealing with his problems.
9. Impractical policy provisions – Mediclaim policy provisions need to be updated periodically, taking into consideration the technological advancement and resultant changes in the modes of treatment, such as relaxing the "24 hours stay" requirement as a practical measure to provide treatment of diseases like cancer, kidney failure, etc., where because of changes in the modes of treatment, these conditions often do not even require hospitalization.
10. Lack of minimum definition of pre-existing disease or condition – Mediclaim policies exclude claims for pre-existing diseases. The misinterpretation of what constitute exclusion continues to be the major cause for disputes. There is a tendency on the part of insurers to exclude cases where the disease does not afflict overnight but progresses gradually even though the patient would not have been aware of it when taking the insurance. Despite several consumer protection judgments on this issue, insurers continue to repudiate a claim without establishing the insured's awareness of the disease prior to taking the policy.
11. Materiality of information – Claims are at times rejected on the basis of alleged suppression of material facts. The insurers, however, fail to look into the materiality of the fact, analyzing the nexus between the facts suppressed and illness for which treatment is taken.

Not surprisingly, the overwhelming majority of complaints that are filed with and entertained by the ombudsmen result in awards in favor of complainants. The reports reveal systematic problems of unjustified delay, unreasonable policy interpretations, unreasonable application of pre-existing conditions, exclusions and unjustified denial of claims. As illustrated in Box 5.1, important observations are often included in the reports.

The Ombudsmen system appears to be working quite well despite its newness and limitations. The Ombudsmen appear to be both dedicated and effective in resolving consumer complaints and in inducing insurers to directly resolve them without external intervention.

Monitoring and Enforcement of Insurance Laws by IRDA

IRDA implements the insurance laws[35] and monitors and enforces compliance thereof. Applications for registration of insurance companies are verified thoroughly by IRDA, ensuring that all requirements prescribed by the insurance laws are fulfilled. In performing due diligence IRDA ascertains that owners and certain top officials proposed for applicant insurers satisfy certain "fit-and-proper" tests. Consistent with the provisions of the Insurance Act, 1938, IRDA has promulgated, thus far, twenty-two sets of regulations and issued several directives and guidelines that further prescribe standards on market conduct and solvency

[35] In this context, insurance laws consist of the Insurance Act, 1938, as amended, the Insurance Rules, 1939, and the Regulations, Directives and Guidelines issued by the IRDA.

requirements. Approval of policy forms and rates under IRDA's "file and use" guidelines, use and application of "early warning ratios" following desk analysis of quarterly and annual reports of insurance companies and intermediaries, conducting target on-site inspections with respect to market practices and performing continuing off-site and on-site audit of their financials, including a compliance audit of company investments, are important tasks undertaken by the IRDA to monitor and enforce compliance with the insurance laws. With respect to health insurance, during the fiscal year 2005-2006, IRDA canceled the license of a TPA for failing to comply with the requirements of the TPA regulations in the performance of its duties and for want of professionalism in conducting its affairs and for similar reasons, the licenses of two other TPAs were put into inquiry during the same fiscal year.[36]

IRDA also adjudicates disputes between and among insurers and intermediaries in a process that calls contending parties for explanations regarding the dispute and conducts due verification and on those bases adjudicates the dispute on its merits. In support of consumer grievance handling IRDA has established its public grievance cell. While IRDA does not, as a matter of policy, adjudicate claims, its grievance cell ensures that consumer complaints and disputes are addressed expeditiously and meritoriously, first within the internal grievance mechanism of insurers or, failing which, by giving advise to complainants with respect to their right of recourse in the offices of the Insurance Ombudsmen, Consumers Courts and, if needed, in the regular courts.

BearingPoint recommendations for further improvement in the system are presented in the conclusion of this chapter.

Development and Promotion of Health Insurance

The IRDA objective of promoting and developing health insurance is further emphasized in Section 3(2AA) of the Act by giving preferential status to the registration of insurers proposing to provide health cover. These extremely supportive provisions of law and regulations and mechanisms to resolve policyholders' grievances notwithstanding, the types of health cover currently being offered in India remain very limited and restrictive.[37] The IRDA recognizes this problem and, within its purview, has taken the lead to develop and promote health insurance in several areas.

However, the development of health insurance requires the collective effort and will of the Central and State governments, the medical profession and the IRDA at a minimum. Health insurance cannot work in isolation from the providers of healthcare and services, whose existence and operations fall outside the jurisdiction of the IRDA. The sections that follow describe IRDA initiatives to date, recommendations for further steps that IRDA should take and initiatives that fall outside the purview of IRDA.

IRDA Initiatives to Develop and Promote Health Insurance

Consistent with its "development" mandate, the IRDA is carrying out several initiatives to develop and promote the healthy and robust growth of health insurance. Over the last six years, these IRDA initiatives include the following:

1. Broad definition of health insurance. The regulatory definition of health insurance business or health cover[38] is broad and comprehensive as it includes most health insurance or health care benefit coverage or plans available in almost all jurisdictions.

2. Regulations 2001 on Third Party Administrators (TPA)–Health Services created TPAs which, by virtue of their service agreements with insurance companies, facilitate the delivery of healthcare services to covered beneficiaries of health insurance for fee or other forms of remuneration. The advent of TPAs prompted

[36] See Part III, *IRDA Annual Report, 2005-06*

[37] As reported in Chapter Three of this study, health nsurance has not developed much and, as reported by the IRDA, "hardly one percent of the country's population is covered under health insurance". *IRDA Annual Report, 2005-06*, p.43.

[38] IRDA Regulation 2000 on Registration of Indian Insurance Companies.

the so-called "cashless system" for easier access to healthcare services covered by insurance and thus contributed to increased consumer awareness and public confidence in the health insurance sector.

3. The Microinsurance Regulation in 2005, though needing refinements is a pioneering initiative of the IRDA in promoting insurance, especially health, to the poorer segments of the population by stipulating that microinsurance business counts towards the industry's obligations of providing insurance to the social and rural sectors.[39] See Chapter Four of this study for a comprehensive discussion of recommended changes in these regulations.

4. The Health Insurance Working Group (HIWG) organized and convened by IRDA in 2003 included a broad cross-section of representatives of the government, healthcare providers, regulator, insurance companies, NGOs and consumers, to assess the then current state of the health insurance market, identify growth barriers and recommend steps to achieving its robust growth. The HIWG advocated broad objectives in promoting growth and expanding the reach of health insurance and expressed concerns regarding the overall development of health Insurance in India. The concerns should be addressed by an IRDA regulation on health insurance or the enactment of further enabling legislation. Their recommendations are summarized below:

    - Creation of an effective legal and regulatory framework for health insurers so that they can plan their operations on a long-term basis and enable them to cover a larger portion of the population with appropriate products and services.
    - Review of the various stipulations in health insurance policies and prescribe a minimum standard definition of pre-existing disease or condition in order to provide clarity if a benefit is in fact excluded, thereby curbing the practice of "underwriting at the time of claim" and to encourage the development of products that may cover pre-existing diseases or conditions subject to definitive policy terms.
    - Prescribe minimum policy standards applicable to renewals, cancellations, conversions and other mandatory clauses for health covers, including terms or clauses often employed by insurers in designing their health insurance policy forms and rates, in order to ensure or, at a minimum, clarify the insured's right to portability of health insurance cover.
    - Study the feasibility of, and identity steps to, providing health insurance for people in rural areas and the poor.
    - Develop and create risk pools to provide basic health covers to those who are unable to access health insurance in the normal channels, including the most vulnerable populations.
    - Enable legislation to authorize and regulate stand-alone health insurance companies and other entities providing contemporary health insurance products and schemes such as provider-based subscription plans, managed care and HMOs, including self-insured health plans.
    - Enact law or issue regulations that prescribe standards in licensing of health care providers, appropriate credentialing of physicians and provider accreditation to ensure quality of healthcare.
    - Encourage the Medical Council of India and other trade associations of hospitals and professional health care providers to self-regulate and enforce their rules with appropriate sanctions in cases of non compliance thereto.

    5. The HIWG set up three subgroups: Data Subgroup, the Registration of Stand Alone Health Insurance Subgroup and the Product Innovation and Definition of "Pre-existing Condition" Subgroup. On the recommendation of the Product Innovation Subgroup, a fourth Subgroup on Rural Health Insurance was also organized and convened by the IRDA with a "view to giving a

[39] However, it is felt that exclusivity and restrictiveness of the partner-agent model, which is not cost efficient in terms of distr bution, claims servic ng and plan administration, is also barrier to spread ng the reach and depth of health nsurance, particularly to the poor.

special thrust to rural health insurance."[40] The HIWG and the four subgroups have submitted their reports, with a long list of "looking forward" suggestions, to the IRDA. However, IRDA has been extremely slow in addressing, much less implementing, most of their. A complete listing of the group's and sub-groups' recommendations is provided in Appendix VI.

Areas for IRDA Action to Strengthen Development of Health Insurance

▪ Regulations Specific to Health Insurance

One perceived reason for the slow development of health insurance is the absence of regulations specific to health insurance. IRDA also recognizes this need and is "giving special focus to this area (health insurance) and is in the process of setting up a separate Health insurance department. The Authority is also planning to bring out separate regulations/guidelines for health insurance."[41] Such regulation, if promulgated would enhance the interest of health insurers because it will give them firm guidance to plan and design products based on a more stable vision of the long term.

The three broad categories of health insurance are medical expense, disability income protection and long-term care policies. The common purpose of all products belonging to these categories is to provide protection against financial loss to the insured in meeting expenses for the treatment of a covered sickness, ailment, injury or medical conditions. However, specific products have specific objectives and their variation should be considered in framing regulations specific to health insurance with an overall objective of achieving the goals of accessibility, affordability and quality of care.

To assist the IRDA in considering regulations on health insurance, the following guidance is provided.

Regulatory Areas Common to All Health Insurance

1. Policy Provisions

▪ Pre-existing disease, illness or condition (Pre-existing condition)

"Pre-existing illness or condition" should be made to conform to a minimum definition because this is the issue where most disputes in health insurance arise. For this purpose, we suggest the "prudent man rule" definition because it is less prone to adverse selection. Consistent with the "prudent man rule," a pre-existing illness or condition may be defined in terms that are not more restrictive than "a condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the period of 24 months immediately preceding the inception date of coverage and the burden of proof lies with the insurer".[42]

▪ Time limit on certain defenses

As in the case of the "incontestability" clause of life insurance policies, insurers should not be allowed to rescind (void) a policy, deny a claim or defend a claim denial by reason of a statement, information or representation contained in the application/proposal form after coverage has remained in force for a specified period of time (two years is customary) from policy inception date, except for fraudulent statements and misrepresentations made by the applicant/proposer when the coverage was obtained.

In addition, in order to limit the exclusionary period of pre-existing illness or condition, regulations should require that no claim for loss incurred or benefit payment covered under the policy, commencing after two

[40] *IRDA Annual Report 2005-2006*, p. 43.

[41] *IRDA Annual Report 2005-2006*, p. 43.

[42] The 24 months "count back" period is only a suggested period. It is not to be viewed as a substitute for nsurers' due diligence n risk selection, underwrit ng and proper rat ng. However, to protect policyholders, it is also mportant to prescribe a reasonable cap on "counting back".

(2) years[43] of continuous coverage, shall be reduced or denied on the ground that a disease, sickness or physical condition had existed prior to the inception date of the health cover.

- **Prohibition of post-claims underwriting**

This practice is often referred to as "underwriting at the time of claim". Insurers have resorted to a meticulous review of the underlying application or proposal form when claim arises rather than exercising due diligence before issuing the policy, resulting in unfair settlements to the detriment of policyholders. A regulation should be prescribed such that, except for guaranteed issue cover, insurers must use proposal forms that contain adequate, clear and unambiguous questions designed to elicit and ascertain the health condition and other particulars of the proposed insured so these are not at issue at the time of claim. For example, a question that asks whether the proposed insured has had medication prescribed by a physician, must also ask the proposer to list the medication that has been prescribed. If the medications so listed were known or should have been known by the insurer at the time of proposal to be directly related to a medical condition for which coverage would otherwise be subject to additional premium, denied or excluded or limited in terms of benefits, then the insurer shall not rescind the policy or certificate for that condition or use that condition to decline or reduce a claim.

- **Group health insurers to offer individual cover**

A very important stipulation in a group health cover is the right of conversion so that any individual covered under the group health contract is given the right to convert his group coverage to an individual health insurance when he or she ceases to be eligible for continued coverage under the group plan. Conversion is further discussed under transferability or portability of coverage.

- **Post sales disclosure**

Health insurance is highly sensitive to changes relating to health risks, vis-à-vis cost of care. For example, benefits and rates change as they respond to changes in the cost of health care services, age of the insured, duration of coverage, and other risk factors. At a minimum, circumstances that would require continual disclosure include modifications of: premium rates or premium rates table; policy benefits or coverage, exclusion clauses and the definition of certain terms and clauses used in the contract. Policy modifications should require service of written notification to the policyholder describing the changes made and the options available to the policyholder.

2. Reserves – Technical Provisions

"Reserves" are the amount of policy liability that includes all items of benefit liability, whether in the nature of incurred claim or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. The IRDA should consider rules to determine the adequacy of policy reserves specific to health insurance, taking into account that health insurance claims and claims costs development differ from life or non-life products. For example, health insurance claims are more frequent, easier to predict and very, very seldom catastrophic.[44]

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[43] The 2 years "count forward" period is aga n only a suggested period. What is important is to prescribe a reasonable t me limit of "count ng forward". Of course insurers can stipulate a period shorter than what is prescribed by regulation. In the US, n the case of ndividual health policies, pre-existing conditions are rated and, except for certain conditions specifically excluded in the policy, immediate coverage is provided; and in the case of group health plans where enrollment periods are fixed and observed, all pre-exist ng conditions are covered once the certificate of insurance is delivered.

[44] With respect to any block of contracts, or with respect to an nsurer's health bus ness as a whole, prospective gross premium valuation should be the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take nto account, on the valuation date, the present value of all unpaid expected benefits, all unpaid expected expenses, and all unearned or expected premiums. In the event inadequacy is found to exist, mmediate loss recognition should be made to restore adequacy of the reserves. In addition, an actuarial cert fication to support the gross prem um valuation including all the documents and exh bits should be requ red to be filed with the IRDA. In the development and calculation of reserves for health insurance policies and riders, due regard should be given to the applicable policy provisions, market ng methods, adm nistrative procedures and all other considerations which have an mpact on projected cla m costs, including, but not l mited to, all benefits and coverage including m nimums/maximums, and any other limitations and exclusions; barriers to eligibility, f any; prem um waiver provision; renewability; ability to raise premiums; marketing method; underwriting procedures; claims adjustment procedures; exclusionary and elim nation periods; and max mum benefit payable.

3. *Standards of Disclosure and Marketing Practices*

Insurance business is solicited and offered in several ways, the most common of which is face-to-face contact with the prospect through agents and intermediaries. Products are also marketed online (via internet), through call centers and telemarketers.[45] Because health insurance consists of a large variety of products with varying objectives and benefit features, potential customers are easily misled. For this reason, in the earlier part of this chapter, we espoused the need to prescribe additional education, training and separate testing for the licensing of health insurance agents and intermediaries.[46] To further strengthen consumer protection in health insurance, special standards of disclosure and marketing practices are exigencies that curb or, at least mitigate, the incidence of unfair marketing practices. Exemplary standards include:

- Standards to assure fair marketing and sales practices may include the following:

- An application or proposal for health insurance should not be declined because of the health status or claims experience of proposed insured if the proposer agrees to the terms and conditions of the policy and is able and willing to pay the required premium.
- On written request of the proposed insured, any denial of a proposal or application shall be made in writing specifying the reasons therefore, unless the insurer is prevented to do so by law or court order.
- No health insurer/agent/intermediary shall direct or encourage any individual to refrain from completing a proposal for health cover with an insurer or direct or encourage any individual to seek coverage from another insurer, because of the health status, claims experience, industry, occupation or geographical location of the individual or dependents.
- No health insurer shall directly or indirectly contract for the payment of commission or other forms of compensation where the percentage of commission or compensation varies because of the health status, claims experience, industry, occupation or geographical location of the covered individual or dependent.

- Disclosure Requirements for Insurers may include the following:

- Every health insurer must prepare a benefit illustration or a product summary for the policies it underwrites pursuant to industry standards, if any, to be furnished to the prospect at the point of sale. The product summary should provide prospective buyers with details on key product information and features, policy provisions, terms and conditions, and other relevant information that may affect their decision to purchase the policy.
- Where the policy gives a right to the insurer to vary or amend the terms of the policy, the insurer must provide advance written notification to the policyholder before any variation or amendment takes effect, disclosing: the existing terms of the policy; the new terms of the policy with sufficient explanation for the change; and the manner in which the insured may accept the new terms or the circumstances under which the insured will be deemed to have accepted the new terms.

- Standards on direct marketing and telemarketing may include

- Where an insurer/intermediary engages in the marketing of health insurance products using direct response advertising through any medium, including mail, print, TV, radio and other electronic media, designed to solicit and complete a sale, all its marketing materials shall include a prominent caveat that any prospective buyer may wish to seek advice from an agent/intermediary before making a commitment to purchase the product and in the event that such advice is not taken he/she is solely responsible to determine whether the product in question is suitable for him/her.
- Where an agent/intermediary carries on the business of arranging contracts of health insurance over the telephone (commonly known as telemarketing) in a manner designed to solicit a proposal and close a sale, he/she shall remind the prospect of his right and benefit to seek advice from an agent/intermediary

[45] See also the recommendations of the HIWG on alternative channels of distribution.
[46] See also similar recommendations of the HIWG.

before making a commitment to purchase the policy and in the event that the prospect chooses not to seek such advice he/she should consider whether the policy in question is suitable for him/her.

- Post-sales disclosure requirements

When there are modifications to the product information or key policy provisions following the issue and delivery of a health policy, insurers should be required to make continual disclosures to policyholders. Circumstances that would require continual disclosure include, but are not limited to, modifications of policy provisions in the following areas: premium rates or premium rates table; policy benefits or coverage; exclusion clauses; and definition of terms and/or clauses. Both the existing and the modified benefits/terms and the effective date of such changes must be disclosed to the policyholders in advance written notice and obtain their written acceptances of the modified terms and describing their options, if any, with respect to the modified terms.

Regulatory Areas Specific to Medical Expense Coverage

- Availability of Coverage

Availability of medical expense insurance means that fairly priced products providing reasonably meaningful health care benefits are on offer such that no applicant for such cover is denied the opportunity to obtain coverage. Regulation should require that every health insurer should actively offer at least three medical expense plans comprising:

(a) a low cost hospital/medical expense cover for the treatment of specified or unspecified illness, sickness or injury, for limited benefit amounts, intended primarily to provide basic cover for individuals or groups in the poor and economically disadvantaged sectors;

(b) a standard medical expense cover that pays for certain costs for the treatment of a wider variety of specified or unspecified illnesses, sickness or injury whether incurred as in-patient or out-patient care or both, intended to provide health cover for the general public;

(c) a catastrophic medical expense cover that provides for benefits to pay for medical expenses relating to specified illnesses, sickness or injury requiring prolonged or recurring medical treatment or care, intended to provide health cover for the general public.

An insurer for individual medical expense cover must not refuse to issue either a low-cost, standard or catastrophic medical expense cover, or a combination thereof, to any eligible individual who proposes to buy such cover, satisfies all requirements for obtaining the cover, agrees to all provisions of the policy and pays the premium corresponding to the coverage.

- Transferability/Portability of Coverage and Conversion in Group Contracts

Transferability or portability is the ability of an insured to transfer the period of qualifying previous coverage for pre-existing condition, disease or illness from one individual or group policy to another individual or group policy. Qualifying previous coverage could be defined to include any individual or group medical expense cover provided by an authorized health insurer, the central or state governments of India or any publicly sponsored medical benefit program. Such policy provision further ensures availability of coverage that waives all or a portion of the exclusionary period applicable to a pre-existing condition to the extent of the period of time a person was previously covered by a qualifying coverage. Typically, a regulation allowing transferability/portability also safeguards the interest of the insurer by requiring that the new cover is similar or reasonably similar to the previous cover and by prescribing the minimum period of coverage under the previous policy in order to be "qualifying". In like manner, group contracts should also be required to provide for the right to conversion such that a covered person under a group medical expense certificate has the ability to obtain individual covers for the same or similar benefits from the same insurer in the event that his/her coverage in the group terminates.

▪ Renewability of Coverage

Renewability is another area where intervention is needed, particularly in the case of medical expense covers where insurers, at their discretion, find it easy to non-renew coverage because of the adverse claim experience of an insured. To address this issue, regulations should require that medical expense covers shall be renewable at the option of the covered individual or policyholder except for valid reasons such as:

(a) nonpayment of the required premiums,

(b) fraud or intentional misrepresentation, or

(c) in certain (specified) cases allowed, and subject to regulatory terms and conditions prescribed, by the regulator.[47]

For group medical expense contracts, the group policyholder and the insurer should be allowed to determine the terms of renewal but such terms and conditions must be clearly specified in the master policy.

▪ Cancellation of Coverage

Corollary to the issue of renewability are policy provisions defining the right to cancel a medical expense cover. Cancellation usually occurs during the term of the cover.

Best practice allows the insured (policyholder) to cancel at any time for any reason while the insurer is given the right to cancel only in cases of fraud or intentional misrepresentation or in certain (specified) cases allowed and subject to regulatory terms and conditions prescribed by the regulator.[48]

As with renewability, the group policyholder and the insurer should be allowed to determine provisions in respect to cancellation of coverage for group medical expense contracts but such terms and conditions should be clearly spelled out in the master policy.

▪ Claim Provisions

Claims or requested authorizations for medical expense need prompt attention by insurers because delays may result in delayed care or non-provision of care. It is thus necessary, notwithstanding the operation of the "cashless" system administered through TPAs, for regulations to require that every medical expense policy shall define and describe the manner and specified period of time in which the obligations of the claimant to provide timely notification to the insurer and the obligations of the insurer to make speedy investigation of the claim and prompt payments of covered benefits are to be performed.

▪ Over Insurance Provision (Individual Medical Expense Covers)

It is a regulatory objective, consistent with public policy, to prevent a person from financially benefiting from a sickness or injury when multiple covers pay for the same benefits on an expense-incurred basis. With respect to an individual medical expense policy, where there are two or more policies covering the same benefits, loss, costs and expenses, the liability of the insurer should not be more than the ratable proportion of its coverage that the total claim bears to the total benefits provided by all policies.

▪ Coordination of Benefits (COB) (Group Medical Expense Covers)

To achieve a similar regulatory objective as in over-insurance, coordination of benefit (COB) provisions in group plans establishes the order in which two or more medical expense health covers pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits do not exceed the total allowable and covered expenses of the policy/contract that provides the highest benefit coverage.

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[47] Examples: when the regulator grants permission upon request of an insurer: (1) for the insurer to withdraw from a certain geographical area where it cannot continue providing equitable service to its policyholders, or (2) for an insurer to cease from further transacting medical insurance in order to preserve its financial solvency. It may also be a case that the regulator directs the insurer to cease and desist from further transacting (health) insurance business.

[48] See footnote explanations above.

COB provisions are meant to: (a) establish orderly transfer of information needed to pay claims promptly; (b) reduce duplication of benefits payments; (c) ensure fair and equitable payment of benefits and forestall undue outflow of benefit payments by insurers covering the same benefits; (d) reduce claims payment delays; and (e) establish uniformity of stipulations in group policies or contracts that contain COB provisions. While a COB regulation offers protection to the insurers, as an alternative to a regulation, IRDA may require the Life Insurance Council and the General Insurance Council to adopt and enforce a COB rule for the industry.

▪ Regulatory Considerations Relating to Premium Rates

Rates should be both fair in that they are reasonable with respect to the benefits provided and adequate so as not too impair the solvency of the insurer. For group covers, rates and benefits are typically negotiated between the group policyholder and the insurer who are both adequately knowledgeable of the relationship between cost and benefit with respect to their needs and interests. This is not so, in the case of individual medical expense covers where policies are contracts of adhesion,[49] thus requiring heightened consumer protection. To ensure efficiency and fairness of individual medical expense insurance business, we offer the following guiding principles on rate making and regulation as a supplement to the IRDA guidelines on "file and use".

- Equity is maintained in the premium rates charged during a rating period to individuals with similar case characteristics for the same or similar coverage.
- Case characteristics are consistently used with respect to all individuals. Rating factors may produce different premiums for individuals with similar case characteristics and benefit coverage but with different risk propensities.
- Without prior authority from the IRDA, case characteristics other than the individual's age, tobacco use, geography, gender, claims history, health status and duration of coverage should not be used.
- Rate filings shall specify the rating periods for which the proposed premium rates shall apply.
- Any percentage increase in the premium rates for individuals with similar case characteristics for the same or similar coverage, or the rates that could be charged for such individual under the rating system, should be capped to a fixed percentage based on an average (index) rate.
- The increase in the premium rate for a new rating period may include a capped adjustment due to claims experience, health status or duration of coverage of the covered individual or dependents.
- Any adjustment due to change in benefit coverage or change in the case characteristics of the individual shall be consistent with in the insurer's rating system or rating manual filed with the IRDA.

▪ Rate Disclosure

Since rates vary according to individuals case characteristics, rating factors, claims experience, health status and duration of coverage, insurers must be transparent and inform their policyholders when and how changes in their premium rates occur. It would be ideal for a regulation to prescribe that insurers of individual medical expense cover shall make reasonable disclosures in their offer, solicitation and sales materials of the following:

- The extent to which premium rates are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the insured, if any.
- The extent to which premium rates vary depending on the amount of deductibles and/or percentages of co-insurance, if any.

[49] A contract drafted by one party and offered on a take-it-or-leave-it basis or with little opportunity for the offeree to bargain or alter the provisions. Contracts of adhesion typically conta n long boilerplate provisions n small type, written in language d fficult for ordinary consumers to understand. Insurance policies are usually considered contracts of adhesion because they are drafted by the insurer and offered without the consumer being able to make material changes. As a result, courts generally rule in favor of an nsured f there is an ambiguity in policy provisions. http://insurance.cch.com/Rupps/contract-of-adhesion.htm.

- The nature and extent of the insurer's right, if any, to change premium rates and/or rating factors, other than claim experience.
- The stipulations relating to any pre-existing condition provision, the exclusionary period thereof and the corresponding premium charge if such condition is or is not a covered benefit.

Refinement of the Microinsurance Regulations

The IRDA has taken steps towards the development and promotion of insurance for the economically disadvantaged and underserved people through Regulations on the Obligations of Insurers to Rural and Social Sectors, 2000, and Microinsurance Regulations, 2005. Complementary to these efforts, IRDA convened the subgroup or Committee on Rural Health Insurance focused on identifying feasible ways and means of developing and promoting health insurance in the rural areas. We learned that the recommendations in the committee's report which was recently submitted to the IRDA are under serious consideration.[50]

The IRDA Obligations of Insurers to Rural and Social Sectors Regulations, 2000 prescribed annual minimum insurance business, in terms of number of policies and premium required of insurers to write in the rural and social sectors.

The second regulation that was promulgated by the IRDA in November 2005 is the "Micro Insurance Regulation", 2005. The IRDA recognized the significant role being played by community-based health insurance organizations and, through the "partner-agent" model, authorized the participation of NGOs, SHGs, and other community-based organizations as microinsurance agents to facilitate distribution and servicing of microinsurance products. Nonetheless, there are a number of areas where regulatory limitations should be relaxed (or an entirely new microinsurance regulation adopted as recommended in Chapter Four.)

Overly restrictive requirements include:

1. The requirement of minimum and maximum sums that insured needs to be rationalized in order that insurers and their microinsurance partner-agents are not unduly restricted in devising covers suitable to the needs of their insured members consistent with their ability to pay.
2. It may be prudent for IRDA to consider the application of "use and file" or a more simplified "file and use" regime for microinsurance, particularly health covers because these products involve low insured sums and where risk acceptances, benefits and pricing may be entrusted to the fair determination of insurers who, at the end of the day, are financially responsible.
3. The regulation does not permit a microinsurance agent (NGOs/MFIs, etc) to partner with more than one life insurer and/or one general insurer. It is felt that this rule unduly restricts the agents, mostly NGOs and MFIs who are the prime movers of microinsurance, in securing best possible covers for their members.
4. The limit set on commissions for servicing life policies is 20 percent while the limit set on servicing health insurance, which is much more expensive to service, is set at 15 percent. This capping of commissions needs to be relaxed.
5. Organizers of microinsurance, such as NGOs, MFIs and SHGs, have very close relationships with their members and are very effective in providing guidance and counsel to them with respect to insurance covers, in addition to efficient member enrollment, collection and remittance of premium and post sales servicing. It is suggested that these organizers be accredited as providers of health insurance and given more power than mere agents of insurers.[51]

[50] See the general recommendations for promot ng micro-insurance n Chapter Four and also recommendations of the Subgroup on Rural Health Insurance n Appendix VI.
[51] See also s milar recommendations of the Committee of Rural Health Insurance. Where?

6. The officers and staff of the Panchayats, rural health care practitioners and postmen are centers of influence in the rural areas and are effective channels of product distribution. IRDA may consider a special agent and relaxed licensing rules for them to market micro health insurance in their areas of operation.[52]

Institutional Capacity Building

As was noted in Chapter Three, to improve the functioning of the market, more specialized expertise in health care and health insurance is needed at the IRDA. It is envisaged that this relatively new and untested market will continue to grow and new products will emerge increasing the reach and depth of private health insurance as a major source of health care financing. Already, one stand-alone health insurer[53] has been registered and authorized by the IRDA. Other entities are about to seek registration and will also focus on health insurance.

Responsive to the GOI policy objective, enabling laws to allow market participation of other health risks carriers, such as managed care organizations (including HMOs), subscription plans, and other self-insured and self-administered health care schemes, some of which already exist in India, require the attention of the GOI and IRDA so that their operations, market conduct and solvency are brought to appropriate oversight.[54]

Although BearingPoint in the implementation of the USAID technical assistance program in support of the Indian insurance sector reform, has focused assistance to the IRDA in building specialized expertise, there still exists enormous room for strengthening IRDA's specialized expertise in health insurance. IRDA leadership must remain committed to reach that desired level of expertise. Towards this objective, it is salutary that a separate health insurance department is being set up and the IRDA health insurance library is being enhanced.

Similarly, there is also a need for IRDA to promote and encourage technical capacity in health insurance by requiring the Institute of Actuaries of India, Insurance Institute of India, insurance educational institutions and other professional and certification bodies to develop appropriate course curricula for health actuaries and health insurance underwriters, claims processors, agents and intermediaries.

Enabling Legislation and/or Actions Outside the Purview of IRDA

The development and promotion of private health insurance will require legislative actions to remove barriers, some of which will require the will of the medical profession and other healthcare stakeholders to support the broad policy objective of creating a health care system that is "not too costly, of good quality and with equitably distributed burden of health care spending."[55] Recognizing that these are matters outside the exclusive purview of IRDA, we recommend that IRDA initiate actions towards building a consensus to resolve the following critical issues.

Quality of Care-Provider Regulation, Licensing and Accreditation

The quality of care in both the public and private sectors is poor in India. One of the major reasons is the near absence of self-regulation by providers and no government regulation of quality. Private insurance could play an important role in improving quality but many others need to participate. A large base of small physician practices and the increasing number of private health care facilities has worsened the already poor

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[52] bid.
[53] Star Health and Allied Services Insurance Company.
[54] See also the recommendation of the sub-group on Stand Alone Health Insurance Companies. WHERE/
[55] Mahal, Ajay, *Op.Cit.*

record of health care professional associations and academies in establishing, monitoring and enforcing standards for quality of health care services.[56]

For this purpose, three institutions must work together. First, the Union Health Ministry must be the leader in promoting quality of care by establishing and enforcing standards. Second, the Ministry must work hand in hand with the Medical Council of India to require responsible self-regulation of its members and of the facilities in which they are providing care to ensure, at least, that a credible process of accrediting healthcare establishments, regular accreditation reviews, and public disclosure of current accreditation status are in place and that every individual healthcare provider at work in the facility can demonstrate their credentials for providing specific kinds of care. Third, the State Health Ministries must become actively involved not only in granting licenses to both providers and facilities, but also in providing mechanisms for updating and monitoring those that are licensed. These mechanisms include the establishment of (Medical) Review Boards with the capacity and the will to remove the licenses of those that are shown to be unqualified, requirement of annual continuing medical education (CME) to retain a license and significant remedial medical education to regain a license. Resources must be made available to enforce these requirements. Lastly, it is again the responsibility of the various medical disciplines to determine the requirements for their members' credentials, the content of CME, and the treatment protocols appropriate to the illnesses and disabilities that fall within their purview. If these principal bodies do not perform their roles effectively, health insurers cannot develop the networks of qualified providers they will require to meet the demands of those purchasing and others wishing to purchase health insurance.[57]

For a start, it is laudable that the Quality Council of India through the National Accreditation Board for Hospitals and Health Care Providers (NABH) recently took the initiative of establishing quality of care standards and is now in the process of accepting applications for provider accreditation. The standards are expected to result in "high quality of care and patient safety" provided by "credentialed medical staff" where "rights of patients are respected and protected and patients' satisfaction is regularly evaluated."[58] The NABH released the first set of standards covering functional areas of hospitals and validated the quality of care through the level of compliance to about 500 criteria benchmarked with best international standards and a strong focus on patient rights and benefits, patient safety, control and prevention of infections in hospitals, practicing good patient care protocols and better/controlled clinical outcomes.[59] The efforts of the NABH, to be successful, deserve the fullest support and cooperation from the Union Ministry of Health, the Medical

Box 5.2: Consumer Information and Activism

The fulfillment of consumers' reasonable expectations for care, personal safety and treatment outcomes, including information sharing, patient's education and definition of patient's rights are integral to developing standards on the quality of healthcare. An effective provider internal mechanism for collecting consumer feedback, particularly complaints and the prompt resolution of such complaints, provide performance indicators on the quality of healthcare.

As noted in a recent World Bank Report, "the courts have held that health is a fundamental right, as described in the Indian Constitution, and have been active in defining the boundaries of medical negligence. The law is much stronger on paper than in practice, however, because of weak enforcement and long delays in judicial proceedings." In practice, only a small percentage of health facilities offer consumers a systematic process for gaining information and/or registering complaints. But studies measuring consumer satisfaction are becoming more common and demonstrate a preference for private care by those surveyed. A recent study (also) noted that high marketing costs for health insurance result in part from widespread ignorance of the potential benefits of health insurance and therefore make it more difficult to develop this line of business. Increasing the information available to consumers in a way that will be useful to them and will help them understand and change their behavior with respect to what is available to them and how to access it is therefore imperative. Health insurance properly developed and regulated can act as a bridge between patients and providers, balancing quality care at reasonable costs with an effective and accountable healthcare.

Source: Excerpts from Kenneth Cahill & Susan Matthies,'"Health Insurance: Global Lessons and Barriers to Development n India,' India Insurance Report: Series-I

[56] Kenneth Cahill and Susan Matthies. "Health Insurance: Global Lessons and Barriers to Development in India". *India Insurance Report: Series-I*, Birla Institute of Management Technology, p. 337. 2004.

[57] bid.

[58] Quality Council of India, NABH: http://www.qcin.org/html/nabh/nabh_ ntro.php

[59] Bus ness Wire India: http://www.businessw re ndia.com/PressRelease.asp?b2mid=11950

Council of India, the State Health Ministries, and all trade associations of hospitals and medical professionals. IRDA should strongly endorse this initiative and health insurers should also openly support such efforts, considering that good quality of healthcare results in better treatment and outcomes which, in the long run, reduce costs of health care. As noted in the boxed quotation below, so should consumers.

IRDA can support this effort by requiring insurers to adopt a formal system of accrediting providers based on set healthcare quality indicators and to submit to the IRDA an updated listing of accredited providers so that IRDA can share this information with health insurance policyholders on enquiry.

Harmonization of Existing Health Insurance Regulations and Supervision

The current health insurance market is subject to a fragmented regulatory structure as depicted in Table 5.1 below. This fragmentation has created a playing field that is perceived as inequitable, particularly by potential private commercial health insurance organizations.[60]

Table 5.1: India: Regulatory Status of Selecteced Health Care Financing Schemes

HEALTH FINANCING SCHEMES	LEGAL REGIME	REGULATOR
Private Commercial Health Insurance	Commercial law, Insurance Act 1938 and IRDA Act 1999 and related regulations	IRDA
Public sector insurance companies: (a) Commercial competitive; (b) Subsidized non-competitive.	Own Acts; and Insurance Act 1938	(a) IRDA (b) Central Government, Ministry of Finance (subsidies).
ESIS (social security schemes that include finance and provision of health care).	Own Act	Ministry of Labor
Corporate self health insurance	Commercial law	*Unregulated*
Community-based health insurance	Associations law, Cooperatives law	Unregulated. Subsidies by the Ministry of Finance entail hidden regulation.
Exempted schemes (Calcutta Hospital and Nursing Home Benefit Association)	Own legal status not affected by the Insurance Nationalization Act.	IRDA
Managed care type organizations and subscription plans		*Unregulated*

Enabling Other Health Risk Carriers

An important policy consideration for the GOI is to address the boundaries of private health insurance. Should it be restricted only to indemnity schemes or should it also encompass carriers of various health plans that likewise assume health care risks such as subscription plans, prepaid plans, self-insured plans, community-based insurance schemes, and other forms of managed care? These entities insure individuals and/or groups against health expenditure risks in exchange for premiums or subscription fees and operate in the same market with registered insurers. A regulatory arbitrage occurs if public policy fails to prescribe a similar regulatory framework over these entities. For example, the provision of health cover flows to the unregulated or lightly regulated entities, exposing the private health insurance market to serious inequities. Moreover, because the carriers of these risks are not subject to prudential standards of market conduct and solvency norms, their business operations could lead to unfair marketing and claims practices, rising costs of

[60] Adapted from: Cahill, Kenneth and Matthies, Susan. *Op. Cit.* p. 337.

insurance and healthcare and/or poor quality of healthcare to the prejudice and detriment of the insuring public who also are not adequately protected against insolvency of their risk carriers. If not so regulated, this practice has the potential of erupting into crises that damage public confidence in health insurance.[61]

Government intervention may recognize certain differences between insurance companies and other carriers of health risks, as well as among the other carriers themselves. Reasonable regulatory differentiations applicable to different risk carriers are justifiable, particularly as they transition in the market. For example, differentiated laws and regulations may relate to the following:

- 1. Market Conduct

In the transaction of health insurance business, compliance with standards of market conduct similar to those prescribed for insurance companies should also be required from health risk carriers other than insurance companies. While specific requirements and procedures may also be necessary, these carriers, for instance, should be duly registered and authorized as mono-line health insurance specialty companies. Agents and intermediaries soliciting and offering their products need to satisfy age and minimum educational qualifications and be duly trained and licensed as well. The policy or contract forms and the rates they use for their products must also be regulated in similar fashion following the IRDA guidelines on file and use adjusted appropriately to correspond with the nature and type of their products. They must also conform to standards of disclosure, fair advertising and post sale contract servicing as insurers are bound to; they must also be required to observe similar corporate governance standards. Their contract holders or beneficiaries should be given access to an internal dispute resolution process, recourse to the Ombudsmen, and similar grievance redress mechanisms available to policyholders and insureds of insurance companies.

- 2. Lower Minimum Capital and Solvency Requirement

Health insurance has special features compared to other forms of insurance that justify lower requirements for capital and solvency margins on the premise that their contracts have different risk profiles. For example, they do not generally face the huge liabilities that confront general insurers when a catastrophic natural disaster (e.g., earthquake) occurs. Also, health insurance claims tend to be more frequent, smoother and predictable than some other forms of insurance (though health risks can increase dramatically as a result of epidemics and other occurrences). To the extent that health insurance is less risky than some other forms of insurance, capital and solvency requirements should reflect this and should be risk-based.[62] Another argument for lower capital and financial solvency requirements is that some insurance schemes are also providers of health care and therefore some of their risk is business or service risk. For example, a company offering health coverage that contracts with members to provide health services using its staff and facilities, has a relatively lower insurance risk (only for the payments they must make to others when they cannot provide the service internally). The capital requirement should reflect this lower level of insurance risk.[63] Additionally, they may have significant capital invested in infrastructure that can be used to deliver services, the value of which is normally not counted towards meeting capital or solvency requirements because of its lack of liquidity. This is an argument favoring a determination of the fair market value of such company infrastructure as capital. This can be the case either when health care provider organizations form subsidiaries that provide health insurance and when the parent organization is obligated to provide the services even if the subsidiary goes out of business, or under forms of health care service delivery and financing commonly called managed care in the U.S. [64] In the U.S., for example, there are differences in supervisory requirements between managed care organizations and indemnity insurance, as can be seen in the National Association of Insurance Commissioner's Model HMO Act.[65]

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[61] See also recommendations of the HIWG Subgroup on Stand Alone Health Insurance Companies. WHERE?

[62] See also: Cahill, Kenneth and Matthies, Susan. *Op. Cit.* pages 335 & 336.

[63] However, a provider-based organization needs to establish that it has the resources to provide the services even if its insurance program seriously under prices the coverage it promises to give s nce sick insured people cannot wait for a bankrupt hospital and its equipment to be sold when they need services.

[64] While there are many forms of managed care n the US and elsewhere, a key feature is usually that the managed care organization is respons ble for the health care services of its members either through its own staff and facilities or staff and facilities under direct contract with the organization.

[65] Kenneth Cahill and Susan Matthies, *Op.Cit.*

▪ 3. Financial Surveillance and Solvency Monitoring

These other health risk carriers also should submit to the regulator independently audited financial statements, at least annually or as often as the regulator deems proper.

While rules in determining the value of their assets could follow the asset valuation and limitations applied to insurance companies, specific rules should be prescribed for the determining the adequacy of reserve liabilities as these are appropriate to the size of their business, the riskiness of their products, appropriately adjusted for the risks associated with the nature, extent and capacity of their facilities and service contracts with other health care providers, if any. Reserve requirements can be related to the scale of potential claims and the size of the risk carrier. Additionally, and as described above ("Lower Capital and Solvency Requirement"), an appropriate value of the carrier's infrastructure to deliver the promised health care and services could be determined and considered a part of the carrier's capital and surplus.

As described in detail in the Appendix on Cost Containment and briefly summarized here, other health insurance risk carriers may include the following:

Managed Care Organizations (MCO), including Health Maintenance Organizations (HMOs). A managed care health plan is a health cover of an individual, family or group of individuals pursuant to which an insured member/enrollee is entitled to receive a defined set of health care benefits (predetermined), on a pre-paid basis, through an organized system of health care providers in exchange for defined fee or premium and which requires the insured, or which gives financial incentives for the insured, to use health care providers employed by or under contract with the insurer. Emphasis is placed on preventative care and a utilization management program is implemented to review the medical necessity, appropriateness and quality of health care rendered.

Subscription Plans. A health care subscription plan is a contract or agreement providing all or part of one or more health care services for its subscribers in exchange for periodic payments in identifiable amount(s) by such subscribers. Contracted health care is also provided by entities, typically hospitals and specialist physicians individually or in groups, to individuals, family or group through their own staff and facilities and/or through the facilities of other health care providers with which they have entered into service agreements. It does not necessarily stress preventative care or the implementation of utilization management programs. Several of these health schemes, mostly carried by hospitals, are already popular in India. These schemes as well as MCOs should be regulated so as to level the playing field in which they operate along side commercial health insurance companies and because they may assume large risks with commensurate results of failure for public welfare. They are more likely to serve the interests of the population as a whole if they are not-for-profit entities.

Self-Insured Health Plans. A health plan under which an employer or other group sponsor, rather than an insurance company, is financially responsible for paying plan expenses, including claims made by group plan members, also known as a self-funded plan. The legal framework should require that self-insured health plans are carried out on a "not-for-profit" basis. The law may prescribe or empower the regulator to prescribe, among others, the separation of the plan's management from that of sponsoring employer, organization or entity so that the entire management and governance of the plan are entrusted to a board of trustees consisting of individuals who meet and continue to meet set "fit and proper" standards. The plan should be required to adopt and implement sound corporate governance and investment norms and require the board of trustees to implement an adequate funding mechanism to ensure that the plan's assets continually meet and match the plan's liabilities based on actuarial valuation. Regulations to ensure appropriate record keeping, fund custodianship and financial reporting standards should also be prescribed.

Mutual Benefit Associations and Cooperatives – Health Microinsurance and/or Rural Health Insurance

As described at length in Chapter Four, most developing countries encourage community-based health insurance schemes, especially those carried by mutual benefit associations and cooperatives. For social or political reasons these schemes are excluded from regulation or are subjected to light regulations, such as very low capital and liberal reserve requirements, simplified financial reporting, governance standards, etc. Some

are even exempt from complying with quality of health care standards. However, weak regulation can backfire if such insurers cannot fulfill their promises to pay claims or lose credibility over the kind of care they offer. Community-based health insurance schemes and health microinsurance plans are best managed and operated by mutual benefit associations and cooperatives. Their establishment, organization and operations may be subjected to reasonably different regulations in order to obtain reasonable assurance that they are financially and administratively sound and responsive to the needs of their members. These schemes are most effective for health microinsurance and/or rural health insurance because of the lower costs associated with product distribution, claims handling and administration.

Mutual Benefit Associations and Cooperatives authorized and registered as health insurers would be required to comply with the provisions and requirements prescribed by the Insurance Act and the IRDA regulations applicable to (health) insurers subject to certain differences, which we recommend to cover the following matters:

1. Enable legislation for the registration (licensing) of Mutual Benefit Association and Cooperatives as monoline health insurers strictly on a "not-for-profit" basis and solely transacting their business within their membership and members' dependents. The law should prescribe a minimum number of insured members/dependents, written premium and other operating benchmarks as requirements or conditions for the grant of a certificate of registration and the continuing validity thereof.

2. The required initial paid-in capital.should be pegged at a modest amount[66] to be adjusted yearly to an amount at least equal to its management and administrative costs in the immediately preceding fiscal year.

3. Micro-health insurance and rural health insurance products and services of these not-for-profit entities should be exempt from the service tax, tax of interest earned on investment of asset (reserves) and income tax.

4. The public health infrastructure should be upgraded and strengthened in order to allow their participation as healthcare providers to beneficiaries of health insurance and earn the corresponding fees for rendered services, including rewards or incentives usually given by insurers for good performance and high quality of service.

5. Risk pools should be established to provide health covers for senior citizens and/or persons with certain (specified) ailments, illness or medical condition who are unable to access insurance.

Summary and Conclusion

Following a long period of nationalization, the Indian insurance sector has come full circle back to its beginnings in the early 19th century as an open competitive market. During the years of monopoly, little but steady development occurred in the life and non-life (marine, fire and miscellaneous lines) sectors and health insurance was generally a neglected line of insurance.

Reforms in the Indian financial sector led to the enactment of the Insurance Regulatory and Development Authority Act (IRDA Act) in 1999.[67] The IRDA Act established the Insurance Development and Regulatory Authority (IRDA) and constituted it as the executive entity to "protect the interests of holders of insurance policies and to regulate, promote and ensure orderly growth of the insurance industry".[68] The IRDA Act allowed registration, licensing and operations of privately owned insurers and, beginning in 2002, new insurers re-entered the insurance market. The IRDA Act gave dual mandates to the IRDA: that of a regulator and that of a developer of insurance. Development and promotion of health insurance was one of the

[66] The amount should at least be equal to the applicant's work ng capital (management and administrative costs) as projected in its bus ness plan to be filed with its application for registration as requ red by regulation.
[67] The IRDA Act took effect on April 19, 2000, vide Not fication No. SO 397 (E) dated 19-4-2000.
[68] See Preamble or Introductory Statement of the IRDA Act, 1999.

principal motivations of the reform and this objective is made evident in the IRDA Act by giving "preference in the registration of life or non-life insurers providing health cover to individuals or group of individuals".[69]

The entry of privately owned insurers in the market initiated the development of a competitive insurance environment and prompted technical capacity building across the industry. Insurance awareness campaigns of the IRDA, complemented by various company and product advertisements and active recruitment and training of agents by insurers, produced an increasing level of public awareness about insurance. The insurance sector has expanded rapidly in the open-market regime. However, there is still very little growth in health insurance, particularly in number of people insured and product variation that meet particular needs and means of the general public. Industry expertise in private health insurance, while beginning to develop, is still considered inadequate.

IRDA is faced with the huge challenge of continually balancing regulatory objectives of affording adequate protection to consumers with the public policy aims of creating and maintaining an environment that drives development, growth and expansion of accessible, efficient and cost effective health covers and good quality health care.

Development and growth of health insurance require a legal and regulatory framework that strengthens consumer protection, safeguards the financial stability of insurers, controls risk selection and allows participation of other health risk carries.[70] Growth and development of health insurance likewise require supportive regulation of healthcare providers (including the enforcement of standards of healthcare quality, provider accreditation, professional credentialing and enacting laws relating to medical malpractice).

Regulation of Health Insurance

Providing fair and adequate protection to policyholders and beneficiaries (consumers) sums up the objective of regulations. Broadly, this objective is attained through the implementation and enforcement of laws and regulations prescribing standards of market conduct and solvency norms and the effective functioning of systems for equitable and speedy redress of consumer grievances. Albeit lacking in some aspects, these requirements exist in India today. IRDA implements the insurance laws[71] and monitors and enforces compliance thereof. Applications for registration of insurance companies are verified thoroughly by IRDA ensuring that all requirements prescribed by the insurance laws are fulfilled and performing due diligence of ascertaining that owners and certain top officials proposed for applicant insurers satisfy "fit-and-proper" tests. Consistent with the provisions of the Insurance Act, 1938, IRDA has promulgated, thus far, twenty-two sets of regulations and issued several directives and guidelines that further prescribe standards of market conduct and solvency requirements. Approval of policy forms and rates under IRDA's "file and use" guidelines, use and application of "early warning ratios" following desk analysis of quarterly and annual reports of insurance companies and intermediaries, conducting target on-site inspections in respect to market practices and performing continuing off-site and on-site audit of insurers' financials are among several important tasks undertaken by the IRDA to monitor and enforce compliance with the insurance laws. For the redress of consumer grievances, IRDA regulations require that every insurer establish and properly staff its internal grievance mechanism and maintain appropriate records. Proper functioning of these internal grievance systems is being monitored by the IRDA by calling upon insurers to produce records of complaints and their dispositions on inspections conducted by IRDA at any time. In addition, insurance customers have recourse to the regular courts, consumer courts and the Insurance Ombudsmen. The Insurance Ombudsmen serve as the most effective external mechanism in handling and resolving insurance-related complaints or disputes.

Certain of the existing regulations of the IRDA and the public grievance rules (Ombudsman System) were reviewed and analyzed, and the following recommendations are offered:

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[69] See Paragraph 7 (c), Amendments to the Insurance Act, 1938, First Schedule of the IRDA Act, now Section 3 (2AA) of the Insurance Act.

[70] Such as, managed care organizations ncluding HMOs, and se f insured plans of employers, mutual benefit associations and cooperatives establishing rules to licensing (registration) and supervision.

[71] In this context, insurance laws consist of the Insurance Act, 1938, as amended, the Insurance Rules, 1939, and the Regulations, D rectives and Guidel nes issued by the IRDA.

1. Registration of Indian Insurance Companies Regulations, 2000 needs to be clarified particularly Regulation (Section) 4, (2) so that health insurance is likewise specified as included in life insurance business. In addition, we also suggest that health insurance be considered as a third class of business which may be transacted by either and both life and general insurance companies. In addition, health insurance could be the sole line of business transacted by stand-alone (mono-line) health insurers.

2. Additional and separate educational and practical training should be required in the licensing of health insurance agents and intermediaries to strengthen policyholder protection and to promote and develop industry's technical competence in health insurance. Regulations 2000 on Licensing of Insurance Agents may be amended to include this requirement or such requirement may be stipulated in a regulation specific to health insurance.

3. Third Party Administrators-Health Services Regulations, 2001 need to be revised and updated to include among others the imperative to provide quality health care and contain costs.

4. Protection of Policyholders' Interest Regulation 2002 needs to be enhanced, or separate health insurance regulations promulgated, to include matters that particularly apply to health insurance. These matters are discussed in detail below re: "Development of Health Insurance".

5. Separate "file and use" guidelines that address special features and characteristics of health insurance should also be adopted as a measure to monitor and ensure that premium charged under a health cover is reasonable in relation to benefits covered.

6. The current margin of solvency requirement for health insurance should permit better use of capital for enhanced insurers' competition in product cost and benefits.

7. Separate reserving rules should be considered for the different categories of health insurance, especially taking into account the short-term versus long-term nature of contracts, whether policies provide indemnity or assured benefits and considering the particular loss experience of varying health insurance products.

8. Grievance redress is integral to insurance and because the system proved to be the most effective mechanism for external resolution of policyholders' complaints and grievances, enhancement of the Redress of Public Grievance (RPG) Rules in the following areas should be considered:

    8.1 Require that specific notices about the local Office of the Ombudsman be made in all correspondence to policyholders not only in the policy document.

    8.2 Broaden the jurisdiction of the ombudsman system to include complaints arising under group insurance policies and complaints against agents, brokers, and insurance intermediaries.

    8.3 Eliminate or substantially increase of the jurisdictional cap of Rs 20 lakhs so as not to restrict the ability of ombudsmen in awarding full justice in cases of large claims.

    8.4 Empower Ombudsmen to impose penalties where the actions of insurers are found to have been made in bad faith or in cases where insurers fail to comply with the orders and awards of Ombudsmen.

    8.5 Require Ombudsmen to transmit to IRDA their recommendations for changes in policy forms that address issues arising from their cases.

    8.6 Increase the number of Ombudsmen to at least two in each district in order to avert backlogs when an Ombudsman retires or dies in office, and to provide greater decision-making resources.

    8.7 Extend the mandatory service cut-off to at least age 70, as in the case of judges, instead of the current age 65.

    8.8 Build institutional capacity by staffing offices of the Ombudsmen with permanent technical staff rather than deputized employees of insurance companies and by empowering them to empanel

physicians and/or other persons with expertise in health insurance, healthcare and medical treatment when needed.

8.9 As a complement to the ombudsman system, establish a similar agency for grievance redress arising out of commercial or non-personal lines of insurance business.

Development of Health Insurance

While the insurance industry as a whole continues its rapid expansion and growth, health insurance has lagged behind. While it is encouraging that the IRDA 2005-2006 Annual Report indicates that health insurance recorded a growth of 30.33 percent year to year "hardly one percent of the population is covered under health insurance".[72] As one of the mechanisms in healthcare financing, private health insurance cannot function in isolation from India's healthcare delivery system. The role of the IRDA in developing health insurance largely depends upon requisite interventions of the union and state governments as well as the medical profession and provider groups, especially in areas that ensure reasonable costs and good quality of care.

Development of health insurance is an active agenda of the IRDA. IRDA's initiatives include:

- Establishing broad regulatory definition of health insurance business of health covers.
- Establishing TPA regulations that prompt the "cashless" system in accessing insured health care benefits.
- Promoting microinsurance regulations that help to pave the way for NGOs, SHGs and MFIs and other community-based health organizations in reaching out to the poor and providing them with basic medical expense cover.
- Commissioning of the Health Insurance Working Group (HIWG) and its various subgroups (committees) that identified certain growth barriers to health insurance and recommended specific steps[73] to achieve robust growth.
- Commissioning the Committee on Health Insurance for Senior Citizens.[74]

Certain actions can be taken by the IRDA on its own authority that would further facilitate development, promotion and growth of private health insurance. These actions include the following:

1. Establish regulations for health insurance.

   A common recommendation of the subgroups/committees of the IRDA HIWG is the need for regulations specific to health insurance. Regulations are effective tools to promote access to private health insurance, improve consumer confidence and orderly growth of the health insurance industry. In addition, regulations provide definitive directions to health insurers and other industry stakeholders that would prime robust development and growth of private health insurance. It is recommended that IRDA frame and promulgate separate regulations specific to health insurance that address the following issues:

   1.1 Minimum regulatory definition of pre-existing illness or condition to provide clarity and uniformity of its interpretation, including prescribing maximum "look-back" and "look-forward" periods.

   1.2 Incontestability of a health insurance contract after it has remained in force for a specified period of time from date of inception.

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[72] See page 43 of the *IRDA Annual Report 2005-06*.

[73] The recommendations of the HIWG and its various subgroups (committees) include many priority areas where development and promotion of health insurance can be achieved. IRDA, in its 2005-2006 Annual Report, stated that the recommendations are taken one by one; however the adoption and/or implementation of the recommendations remain largely neglected.

[74] As of this writing the Committee for Health Insurance of Senior Citizens is still in deliberation and working on its Terms of Reference and expects to submit its recommendations to the IRDA by the 4th quarter of this calendar year.

1.3 Prohibition of post-claims underwriting.

1.4 Requiring insurers to offer both group and individual policies.

1.5 Prescribing standards on point-of-sale and after-sales disclosures specific to health insurance.

1.6 Adopting separate guidelines for "file and use" and, in certain (microinsurance and rural health insurance) cases, "use and file" for health insurance products.

1.7 Adopting reserving rules specific to the different types of health insurance contracts.

1.8 Particularly for medical expense covers, promulgate additional regulations that prescribe the following:

(a) Availability or accessibility

(b) Transferability or portability

(c) Continuity (renewability and cancellation)

(d) Rules on over-insurance, in the case of individual covers, and coordination of benefits, in the case of group covers.

2. Refine the Microinsurance Regulations in the following aspects:

- Elimination of the minimum and increase of the maximum sum insured;
- Elimination or relaxation of the "one-partner-one-agent rule";
- Elimination of commission caps;
- Expanding the authorities of microinsurance agents who are also organizers of health microinsurance to specifically include, among others, enrolment of members, collection of premium and post sales servicing including settlement of claims;
- Adopting special agent licensing rules to allow officers and staff of Panchayats, rural health practitioners and postmen to solicit health microinsurance.

3. Build institutional capacity. The development and growth of health insurance require technical expertise of the industry and the regulator. The market should evolve with variations of products as there is no single "one fits-all" health insurance product and thus challenges to address market complexities are inevitable. It is therefore recommended that:

- IRDA facilitate the organization and staffing of its health insurance department and implement continuing training of its staff to achieve higher level of institutional expertise in health insurance.
- IRDA promote and encourage development of health insurance technical expertise in the industry by institutions such as the Institute of Actuaries of India, Insurance Institute of India, and insurance educational institutions to adopt and implement contemporary health insurance curricula as well as organizations that offer studies and certification programs for health insurance professionals.

4. Lead in establishing contemporary healthcare financing models that provide accessible basic and primary health insurance products for the elderly and the "vulnerable" who are unable to obtain coverage in the normal channels. This can be achieved by creating risk pooling facilities among all health insurers, preferably with government participation, for basic and primary covers which could be supplemented with private health insurance obtained voluntarily.

There are certain imperatives to developing and promoting private health insurance that are outside the realm of IRDA's authority, the establishment of which require legislative actions from the union and state

governments and self-regulation of medical professionals by the Indian Medical Council and the various trade associations of healthcare providers. These actions include the following:

1. Quality of care and provider regulation, including rules respecting provider licensing and accreditation.

2. Harmonization of existing health care laws and regulations and their supervision and enforcement.

3. Legislation enabling the registration and requiring due supervision of health risks carriers other than insurance companies. Such organizations and their businesses are already gaining a foothold with growing prominence in the Indian health insurance market place. Private health insurance business is best carried out by these other health expenditure risk carriers (insurers) that are organized as "not-for-profit" entities. These health risk carriers would include:

3.1.1. Managed care organizations (MCOs) including Health Maintenance Organizations (HMOs).

3.1.2. Healthcare subscription plans of hospital and/or professional healthcare providers.

3.1.3. Self-insured health insurance plans of Mutual Benefit Associations and Cooperatives.

Conclusion

The legal and regulatory framework for private health insurance, because it operates in the voluntary market, should continually balance competing goals of access, affordability and quality of healthcare and providing health covers to a larger fraction of the population with varying risk characteristics and ability to pay. Regulations, aside from being solely aimed at providing protection of health insurance policyholders and beneficiaries, can be potent tools to promote access to healthcare, control pricing of health covers vis-à-vis healthcare providers and enhance the quality of healthcare. Allowing the participation of other entities that provide health covers, such as MCOs, HMOs, Hospital and/or Professional entities, and self-insured health insurance plans of employers, Mutual Benefit Associations and Cooperatives would further increase the reach and depth of private health insurance. Licensing standards required for compliance and enforced on health care provider facilities and self-regulation of the medical profession and provider groups would ensure continuing improvement of healthcare quality. Private health insurance cannot grow if reasonable consumer expectations relating to access, cost and quality of healthcare remain promises rather than realities.

APPENDICES

I BEST PRACTICES IN COST CONTAINMENT[1]

Introduction

Healthcare cost containment, as practiced by insurers, moderates the volume, cost, or kinds of health services provided under a health insurance plan. When effectively implemented, cost containment enables insurers to provide more extensive benefits with greater confidence that the broader services are clinically appropriate and/or reduce the premiums of its insured. It can have a positive "added value effect" on the offering of health insurance and make health insurance a more acceptable vehicle for meeting the public's need to cover the costs of medical care. Insurers may do many other things to contain their own operating costs or to control risks but unless it involves moderating medical services it does not fit into the category of heath care cost containment.

Cost containment and the quality of care

Soundly managed health care cost containment can have beneficial effects on the affected population beyond reducing its expenditure levels. Understanding the relationships between modern cost containment approaches and the quality of care received is important to the design of health insurance products. Evidence based planning of benefit programs can allow coverage for broader and more in-depth health services while at the same time helping to ensure that the quality of care received meets acceptable standards. It is often wrongly assumed that programs which constrain costs lead to substandard services and that more care leads to better outcomes.

If the cost containment program focuses on reducing use of unneeded and even harmful services, promoting the use of services known to be cost-effective and enhancing the efficiency of health care delivery, the result will be both cost savings and enhanced clinical outcomes. Quality is also not adversely affected when excessive prices are reduced through creative contractual arrangements with the care providers.

Of course, health care programs planned for low-income communities in developing countries may not initially be able to cover costly "high tech" diagnostic and treatment modalities. Rather, they must focus first on providing basic primary care and community health services which will benefit large numbers of people. While costs could be held down by denying medically necessary basic care, this will be unacceptable to most people. Programs that provide for basic needs can utilize cost containment methods which improve the quality of care without excluding medically appropriate services, just as the more comprehensive programs found in affluent economies do.

Four simple examples can help demonstrate this point. A cost containment program that prevents unnecessary admissions to hospitals or redirects care to appropriate outpatient facilities can lead to significantly reduced levels of morbidity and mortality from hospital-induced infections that are frequently prevalent in hospitals in developing countries. A program which requires proposed surgical treatments to meet accepted clinical standards will have the effect of reducing the number of risky but unnecessary operations. Internationally sanctioned TB DOTS treatments are not only less expensive than traditional medical treatments (which are more expensive and often not completed by the patient, particularly amongst the poor) but lead to comparable or improved results. Finally, utilizing the relatively inexpensive drug TPA

[1] This appendix on cost containment is the respons bility of its author, Neil Hollander. It was prepared with expert advice and suggestions from Marilyn Field, Ph. D., Senior Program Officer, Institute of Medic ne, National Academy of Sciences: Donald Sacco, former D rector of Cost Conta nment of the Blue Cross/Blue Shield Association and President of Oregon Blue Cross/Blue Shield; and Steven Henn ng Sieverts, retired senior executive of Blue Cross and Blue Shield and a former adjunct associate professor at Georgetown University's School of Medicine, now liv ng n England.

versus more recently developed drugs for stroke treatment has not only reduced costs but also increased survival rates for stroke victims. All of these approaches are directed at cost containment but also lead to higher quality of care.

Since it is well-established that providing insurance coverage will increase the utilization of medical care services and that a population with medical care deficits will always use more services after coverage is available than before, social purposes of expanding coverage are advanced when policies provide payment only for medical services known to be efficacious and cost effective.[2] A progressive cost containment program of a competently managed insurance plan can therefore reduce the costs of coverage while optimizing coverage for those services that are proven to be medically effective and quality enhancing.

Requisites for cost containment

Health insurance is particularly complex because the beneficiaries of services are dependent upon the actions of physicians, hospitals and other health providers who are uniquely empowered to make decisions about care and who practice artfully the "science of medicine." This means that most, but not all, modern cost containment techniques are dependent on the insurer or its representatives establishing business or contractual relationships with these providers to enforce reasonable standards and to set reasonable payment rates. It also requires informational databases to be developed that enable the insurer to deal effectively with health professionals and their organizations as well as having specialized staff capable of doing so. These efforts may also be strengthened by statutory and regulatory requirements that support cost containment, such as minimum standards of clinical practice that enforce hospital hygiene and cleanliness.

Cost containment programs do not automatically succeed. The competence of the management and the effectiveness of implementation are critical to success. The most effective programs change over time and adapt to changes in provider behavior and the expectations of patients. Also, approaches need to be geared to the types of provider payment and benefit packages that an insurer offers. For example, from a cost containment perspective, a payment system that reimburses hospitals on a per day basis needs to focus on the length of hospital stays whereas a system that reimburses on a per case basis needs to focus on premature discharges. Both approaches must monitor unnecessary admissions.

Cost Containment

Cost containment approaches can be broken down into three categories: those activities that are designed to affect the demand for services, those that are designed to affect the supply of services and those that affect supply and demand simultaneously. To make successful cost containment even more complex, containing health care costs is sometimes like a balloon which when pushed in at one place pops out in another. Thus, for example, if you push providers by constraining the price paid for a day of care they may attempt to respond by increasing the number of admissions or length of inpatient stays, leaving total costs unchanged or increased. Historically, and often unconsciously, providers act to insure that their incomes remain constant when cost containment programs are introduced. The challenge to the health insurance plan is to manage the programs to assure that the alterations in the patterns of clinical care will have benefit for the insured. The ideal cost containment program follows a balanced approach that includes both consumer and provider strategies using supply and demand tools with an information system that generates the data to guide the use of both.

Demand for Services

Benefit Design

Two major strategies that are often used by insurers to influence the demand for services are benefit design, and health education and promotion of healthy lifestyles. Benefit design has long been used in the health

[2] See for example Folland, Sherman, Goodman, Allan C., Stano, Miron, *The Economics of Health Care*. Prentice Hall, 1997, pp 241-243.

insurance industry as a technique to keep premiums affordable and to make benefit packages attractive to both the insured and those paying for insurance, often the employer. However, deliberately using benefit structures to achieve cost containment goals while maintaining or improving the quality of care, is relatively new. Using large co-payments and deductibles for **all** services to reduce utilization and thus cost is an approach designed to make people think carefully before they use a medical service. However, this approach does not distinguish between necessary and unnecessary medical utilization and may lead to postponing necessary care and ultimately to increased cost and poorer quality outcomes because more serious treatment becomes necessary due to neglected conditions.[3] On the other hand, research has demonstrated that the selective or targeted use of co-payments can play an important role in discouraging people from seeking services at a level of care that is not necessary. For example, in the United States individuals with minor ailments, when faced with having to pay high deductibles or co-payments for the use of hospital emergency rooms, dramatically decrease their utilization of these facilities.[4] Instead they seek care in physicians' offices or clinics or other non-hospital settings which can provide appropriate care at a lower cost and with appropriate quality. As medical evidence accumulates that less costly and less risky care is appropriate, benefit design can be used to explicitly pay only for such care except in unusual circumstances.

Co-pays and deductibles are often used when scarce resources dictate limiting the demand for even necessary services. Progressive dental care benefit design presents a clear demonstration of this approach. Preventive care, such as regular examination and teeth cleaning, can significantly reduce dental disease and cavities, which in turn can reduce the need for extractions, gum treatments, bridges, prostheses and other expensive measures. Benefits structured to provide full or minor co-payment payment for preventive services, moderate co-payments for simple treatments such as filling cavities and larger co-payments for the more complex and costly dental procedures that might be necessitated by inadequate preventive care, encourage patients to alter their behavior in ways that will actually reduce the need for the more expensive services.

Adding benefits to an insurance program can also lead to containing cost. Research and practical experience—as well as new technologies which reduce the invasiveness of many interventions—have shown that many surgical procedures can safely be done on an outpatient basis, without requiring admission to hospital.[5] If proper quality controls are put in place in outpatient facilities, the care received can actually improve on the quality of care received in more intensive settings. However, as an example of how complex cost containment programs can be, if surgeries are removed from a hospital and nothing is done to reduce capacity in that institution, the fixed costs may be passed on to other consumers, including those of the insurer adding the outpatient benefits, in the form of higher prices, negating some or all of the benefit of a more efficient level of care.[6]

Expanded benefits can also be provided for selected sub-groups of the covered population. For example, while screening programs are often unproductive for many age groups in a population, it has been found that for children in the Medicaid program (the US health insurance program for the poor) it is cost effective to add early periodic screening, diagnosis and treatment benefits to the program.[7] Thus, while not generally available to adults, the addition of these benefits for children has actually reduced the costs to the government. Similarly, there is good evidence that diabetes screening, breast cancer screening, and cervical cancer screening after certain ages and at certain intervals can be cost-effective. As can be seen from these examples, it takes good information, professional knowledge, skills and a certain amount of creative risk-taking on the part of insurers to achieve good results.

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[3] Gruber, Jonathan, *The Role of Consumer Copayments for Health Care: Lessons From the Rand Health Insurance Experiment and Beyond*, (The Kaiser Family Foundation, Menlo Park, California), October 2006. pp. 1-16; www.kff.org.

[4] Ibid. p. 4.

[5] For a full discussion of ambulatory surgery see Davis, James E, MD (ed.) *Major Ambulatory Surgery*. Baltimore, MD: Williams & Wilkins. 1986.

[6] Hollander, Neil, "Payment" in Davis, 1986. pp. 399- 312.

[7] Newman, Howard N., *Child Health Services Under Medicaid: Concentrating Efforts Where They Count*, Medical Services Administration Social and Rehabilitation Services. A report prepared for the National Health Forum, Washington D.C. 1974. pp 12-13.

Health Education & Healthy Lifestyles[8]

Promoting certain forms of health education and healthy lifestyles has only recently been seen as a cost containment tool, although some HMO health plans, such as Kaiser Health Plans in the United States, have incorporated these approaches into their health plans for many years. Broadly speaking, giving people enrolled in insurance plans information about matters such as leading healthier lifestyles (e.g., exercising regularly and eating a healthier diet) may have some long-term impacts in reducing health care costs, but this is far from certain and very difficult to quantify. Health insurers and purchasers saw its payoffs as being too obscure and uncertain, particularly since concrete benefits may occur long after a particular insurer's coverage has ceased. However, as consumer movements have progressed and as people have begun recognizing their responsibility for managing their own health care, some progressive companies have concluded that an investment in education and healthy lifestyles could pay off in better health for their insured as well as, perhaps, a long-term reduction in costs. In addition, it can be an effective marketing tool in the highly competitive health insurance market and a way to differentiate an organization from its competition. On the other hand, it is well demonstrated that health education can be significantly effective in specifically defined areas such as disease management for chronic conditions like diabetes, HIV/Aids, and TB.[9] Under appropriate guidance, patients and their families, when afforded the support of their insurance plan, can learn how to manage these conditions more effectively and safely at home, while generating real cost savings. This can have an immediate and significant effect on hospitalization, medical and drug use rates. Other areas, such as self-examination by women for breast cancer, still suffer from a lack of clear evidence as to their value.[10] Some insurers have even created health education centers or made available to their members information from leading medical schools so that they can make better choices about their own and their families' care. It has been difficult, however, to quantify the impacts of these ventures on the costs incurred by the affected populations.

Recently, insurers or employers have offered lifestyle programs such as exercise club memberships or smoking cessation programs. While these may have long-term cost-containment and quality-of-life benefits, direct and immediate impact on premiums is less certain. As economic and social development progresses, these kinds of approaches are expected to become increasingly common.

One area of controversy in cost containment is the extent to which insurers should take responsibility for education that in the past has been primarily a public health function. Examples in developing countries include information about immunizations, family planning, clean water, etc. There is no right answer to this question and depending upon an insurance company's sense of its cost containment potential, social mission, concern for its members, or marketing strategies, it may move in to these areas of education when public health fails to provide them.

Supply of Services

Cost containment programs that aim to influence and shape medical service delivery are the most complex and difficult to implement since they can directly affect the incomes and behavior of third parties, namely health providers and suppliers, yet they have the greatest potential to improve clinical outcomes while reducing costs. Health providers enjoy high prestige, income and political influence and because of their unique skills are often granted by the state extensive independence and autonomous power over medical decisions. Most actions in this area require contracts with providers and suppliers or some method of directing insurance plan members to efficient and reasonable cost organizations or individuals. At their best

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[8] Issues such as healthier l festyles are prominent in well-to-do affluent Western economies where medical problems often come, for example, from eat ng too much of the wrong kinds of foods. Ironically, in develop ng countries such as India dual medical problems occur, with too much of the wrong k nd of food for some and the traditional problems of malnutrition for the many. See, for example, "India Prosperity Creates Paradox: Many Children Are Fat Even More Are Famished," *New York Times*, December 31, 2006.

[9] For an example of how an insurance plan is foster ng diabetes education see "Blue Perks", http://www.arkbluecross.com/health_plans/diabetes.aspx

[10] Lars Holmberg Anders Ekbom, Eugenia Calle, Ali Mokdad and Tim Byers: "Breast cancer mortality in relation to self-reported use of breast self-examination. A cohort study of 450,000 women." *Breast Cancer Research and Treatment*, Vol. 43, no. 2, April 1997. pp. 137-140.

these contracts must be perceived by both parties as being in their interest, as they set terms of payment while committing the providers to conform to reasonable clinical standards and to accept a degree of professional surveillance. The *quid pro quo* for the provider is that the plan's beneficiaries are given incentives to choose contracting providers who have agreed to such contractual arrangements.

Provider Standards

One of the simplest ways to contain costs is to require licensure, certification and accreditation. Usually seen as quality tools, their major benefit for insurance cost containment is in requiring minimum standards of practice to be met. As a result, substandard practitioners are excluded from the insurance plan. However, accreditation programs are becoming more sophisticated, as the relationship between cost and quality is better understood. Today accrediting agencies have begun reviewing for good management and efficient operation as well as medical quality and adequacy.[11] Even though irregular providers might set lower fees, excluding them should result in lower costs as a consequence of not paying for unnecessary or poor quality services. In addition, the insurer who contracts can reasonably demand of its contracting providers that they use standard nomenclature and coding systems for diagnoses and treatment of their patients.

Licensure is a particularly sensitive area because it can also be used to increase costs rather than reducing them. For example, physicians have often used license restrictions to prevent other less costly providers from performing services that they can safely and effectively undertake on their own. Nurses, midwives and psychologists have often been restricted in their practices by politically powerful physician groups long after medical research has proven that they can quite safely and effectively perform a service.

Health Planning

Capacity controls also have a long history.[12] These range from controlling the number and location of hospitals to controlling the number and placement of new technologies and services in hospitals or other providers. Their goal is to control overall costs to a society by limiting facilities and services to some centrally planned need. Their success depends upon the willingness of a society to control costs through planning the latest in new approaches or the placement of facilities to serve the needs of a whole population. Private insurers can play a role in convincing providers to voluntarily implement planning programs and/or governments to pass planning laws. They can also require their contracting providers to participate after planning programs are put in place. It is important to note that planning does not always restrict growth but at its best helps insure that services and facilities are appropriately placed and consistent with good access and quality care.

A short discussion of experience in the United States and Canada is illustrative. In the United States, voluntary hospital planning began in several localities in the 1950s. All insurers were expected to receive the benefits of community planning and most of those who contracted with hospitals included a clause in their provider contracts that denied payment for services that were not approved by the voluntary health planning organization. Initial individual successes were translated into a national health-planning act in the 1970s in which the federal government funded local planning on a national level and included legal powers to control high-cost new technology, medical services and facilities. However, the process became adversarial and the funding levels, skills and political acumen of the planners never could match the forces that the medical industry mobilized to circumvent planning. In most places this meant that the process became largely a paper game. The public was mostly unaware of the program and generally did not support the planners when decisions affected them personally. Under a new conservative president the national program was abolished in the 1980s and decisions about capacity were left to market decisions. A few states continued to operate their individual programs on a limited basis.

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[11] See Appendix II, and www.jointcommission.org The Joint Commission on the Accreditation of Health Organizations (JCAHO) presently accredits programs in ambulatory care, assisted living, behavioral health care, critical access hospitals, home care, hospitals, laboratory services, long term care, networks, and office based surgery. It certifies programs in chronic kidney disease, chronic obstructive pulmonary disease, disease specific care, health care staffing services, inpatient diabetes, lung volume reduction surgery, primary stoke centers, transplant centers, and ventricular assist devices.

[12] Rorem, C.Rufus, "Standards and Priorities for Area-wide Planning" presented at the American Public Health Association meeting in 1953; *A Quest for Certainity: Essays on Health Care Economics, 1930-1970.* Ann Arbor, Michigan: Health Administration Press, 1982, pp. 138-148.

In Canada, which has a smaller and more homogenous population, the national and state governments have much more direct leverage over providers through their national health (single payer) insurance programs and planning organizations, since they control prices, etc., so their activities in capacity control are much more successful. Most importantly, the general population is more amenable to the government's playing such a role in deciding, for example, where and how new technology is introduced. A study in the 1990s by the insurer Blue Cross showed that in Western Pennsylvania, with a population of five million people, there were more MRIs in physician offices than in all of Canada.[13] The appropriate number is, of course, debatable but it is clear that planned capacity controls are limiting supply in Canada relative to market forces in the U.S.

Assessment of Medical Technology

The clinical efficacy of various medical modalities (e.g., surgical interventions, diagnostic tests, drug therapies, etc.) is another area where cost containment and quality management meet both for old and new technology. In the 1960s, American and British researchers began reporting that some of the most firmly established procedures in medical care had never been adequately assessed for efficacy. Early examples include tonsillectomies for children with recurrent throat infections, and extended bed-rest for patients with back pain. In the United States, this led to some insurers questioning payment for services which their members were receiving. In the 1970s, the Blue Shield Plans (covering the services of doctors and other medical practitioners) began to refuse to pay for old and outmoded procedures even though some physicians were still using them. Likewise, the Blue Cross Plans (hospital insurance) faced with a proliferation of newly developed CAT scanners, adopted standards for the appropriate employment of this new technology. Both approaches were based on an "elite review" approach, with Blue Shield using a national panel of distinguished medical advisors and Blue Cross commissioning a panel of the National Academy of Sciences Institute of Medicine.[14] This was followed by a governmental effort to be more systematic and all encompassing and included the establishment of a Congressional Office of Technology Assessment whose work led to the development of scientifically based treatment protocols for diseases such as pneumonia.[15] These efforts played an important early role in supporting the development of evidence-based medicine. Typically, insurance company contracts with the insured have provisions that the company will only pay for "medically necessary care". It also helps if the insurance company has an agreement with the providers to the same effect, including a defensible definition of "medically necessary."

Utilization Review and Analysis[16]

While the approaches described above mostly apply to all the insureds of a company, other cost containment methods apply to the specific medical services received by their individual beneficiaries. The most prominent of these is utilization review (UR) which looks at the kind and extent of services received by patients to see if they are medically necessary or at the appropriate level of care. Almost all utilization review is directed at hospital stays and services (including surgery) where the costs are high and the savings from the process justify the administrative costs of the review. Utilization review is often combined with other insurance administrative functions, such as determining if the claim for services provided is for a paid-up insured or if the service is a covered benefit.

Needless to say, if the utilization review shows that all or parts of the hospital stay are unnecessary, payment may be withheld. In the best cost containment programs that see it as their duty to protect their insured it is essential that the insurance plan's contract with the hospital prevents the hospital from charging the patient after the plan has declined to pay, while also giving the hospital the option of appealing the insurer's decision.

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[13] Cl ne, Kathryn, *Medical Technology in Pennsylvania*, Blue Cross of Western Pennsylvania, March 1995.

[14] United States. National Academy of Sciences, Institute of Medicine. *A Policy Statement: Computed Tomographic Scanning.* Washington D.C., April 1977.

[15] This early effort was very politically sensitive and many nterest groups and providers opposed its efforts. The United States Congress finally was convinced to terminate its efforts after a "free market" Adm nistration was elected. However, its efforts cont nue to be used and it was the precursor to the establishment of future organizations.

[16] For an excellent summary of managing the use of services in the United States, its development and the roles of private insurers, HMO's, government, providers, business, labor unions and others n this activity, see Gray, Bradford H., and Field, Marilyn J., editors, *Controlling Costs and Changing Patient Care: the Role of Utilization Management*; Wash ngton, D.C.: National Academy Press, 1989.

Focusing on how long patients are in the hospital is not just a matter of counting days. The more sophisticated UR programs look at the length of time between the admission and, for example, the surgical operation, as well as the number of post-operative days. In most cases of elective admission, the needed diagnostic studies should have been performed in advance on an outpatient basis. Initially, most forms of utilization review were retrospective (after the fact). However, other forms of utilization review have been developed that are prospective in nature. Rather than creating the risk that coverage of a particular service will be refused after the fact, the insurer establishes systems to preauthorize benefits for the use of non-emergency or elective high cost or controversial services. Depending on the contractual relationships with the providers involved and with the insured, either the provider or the patient is required to seek the insurer's prior authorization of benefits before the service (such as the hospital admission or the specified procedure) is actually rendered. If the service is provided without having been pre-authorized—i.e., either the pre-authorization had been denied or the provider or patient neglected to seek authorization—the insurer may withhold payment, subject, of course, to a fair appeals process. Often insurers also focus on the overall behavior of a provider with respect to costs and standards of care, not just on those of an individual patient. Recently, some insurers have also attempted to evaluate the outcomes of care as part of the utilization review process.

As the approaches to health care cost containment become more sophisticated and research-based, databases of high quality become necessary, capturing data on diagnosis, treatments, severity of illness, and basic demographics. For this reason, those who design claims forms and systems should be sure that those processes require the submission of these data. Computer-based methods make it much easier to operate a sophisticated utilization review system, often as part of an overall insurance claims data and processing system. Since data systems and the professional staff necessary to implement UR and other cost containment programs are expensive, it is important to make sure that the investment leads to lower premiums and improved quality of care. Most insurers monitor savings from cost containment programs to make sure that their investment is worthwhile.

Retrospective UR. Retrospective review of utilization occurs after a service is provided and is the original and simplest approach. The hospital or member submits a completed bill to the insurer for payment. The insurer then reviews the bill for "medical policy." For example, does the service fit the person, e.g. the bill for a male who was given a gynecologic exam would be denied or questioned. The service is then reviewed for appropriateness of the level of care, e.g., does the care received warrant a hospital admission? Finally, based upon some "objective" standard, the length of stay in the hospital is reviewed to make sure the patient is discharged at the appropriate time. Often this process is partially automated and administered by nurses or other qualified utilization review specialists. Doctors' decisions are usually challenged only by the insurance company's doctor. One problem with this approach is that cost and care have already taken place. Doctors and hospitals may face substantial revenue losses and may not accept responsibility for their actions even if egregious. The patients who often cannot afford to pay in the absence of a hold harmless contract with the provider must then pay themselves. Most utilization review processes provide a grievance program that allows providers or members to challenge the decision of the insurer.

Pre-admission, Concurrent & Case Management UR. Insurers have attempted to mitigate the impact of utilization review on their insureds in several ways. They may contractually hold the member harmless from any of their decisions and settle any disputes directly with the provider. They may also make agreements with providers so that if a large percentage of their medical actions fit into accepted medical practice they will not challenge the less frequent outliers. Other approaches deal with providers before or during the time the service is provided. Pre-admission review is one such approach. The insurer, through a contractual relationship with their insured members or with a provider, requires for certain elective admissions that the provider submit information before admission actually takes place. Often, if the admission is approved, the provider is guaranteed payment for an approved length of stay. If the stay will exceed the approved days the provider must gain additional approvals from the insurer. This process of review of hospitalized patients is called concurrent review. A similar approach has been applied directly to physicians by requiring approvals from the insurer before a member visits a specialist. If that approval is not sought, the member receives reduced or rejected insurance reimbursement.

More complex is the UR activity called case management; the insurance plan's professional team acts in a kind of consultative partnership with the doctors and other providers in the management of complex and costly cases. This can be done on a "win-win" basis, with the patient benefiting from more efficient and effective care, and the insurance plan enjoying lower costs.[17]

Outsourcing. Some insurance plans are either too small or feel inadequate to manage one or more of these UR activities, instead contracting with a third party to undertake them.[18] A small industry has evolved in the US specializing in utilization review management, for example, focusing on case management in concert with the patient's personal physician, or generating the prior authorizations of benefits described above. However, because of the high costs associated with the necessary professional involvement and the high overheads of these firms, it has often found to be cost effective only for very high cost cases. Moreover, providers have sometimes been offended when they have to deal with a third party agent in these matters, rather than with the insurer with which they have contracted.

Pattern analysis. Utilization can also be reviewed by using pattern analysis. The medical and payment databases of the insurer are used to review patterns of care by physicians, hospitals and other medical suppliers and to identify aberrant practice patterns. These studies can be used to educate doctors and hospitals when their practice patterns differ significantly from norms, or to identify the unintended adverse consequences of certain kinds of practice, or even to identify malpractice or fraud.

The essence of utilization review is that the insurer, using community standards, best practice standards, information culled from national data bases, etc., provides a check on what is generally the unquestioned judgment of the hospital or physician by requiring justification of their medical decisions. Needless to say, this can be a contentious process, particularly when it is first initiated, but its usual outcome of lower cost and improved quality of care conserves benefit resources and leads to better patient outcomes.

Payment Mechanisms: General Issues

An effective utilization review program without a parallel program to affect how providers are paid for services can make cost containment difficult to achieve. As already indicated, different payment systems can determine the type of utilization review that an insurer will use. All forms of payment contain incentives for the providers to adjust their clinical behavior in order to maximize revenues. In any event, it is a fundamental requirement that the payment system utilized should not undercut the effects of the changes brought about by effective UR.

Payment can be made in three basic ways although many hybrid approaches exist. Paying on a per day or per service basis, which most private insurers originally used, is still in use in many countries including India. Other approaches have been developed that include paying per case and per person. The payment per unit can also vary. In market driven health systems, providers set their own prices, constrained only by competitive pricing by their peers. In poorer communities, affordability has had a strong influence on prices but as insurance becomes available, "affordability" tends to include the insurance benefit. When the person delivering the service also sets the price, it is usually costly, and insurers, and in many cases governments, have sought to contain costs by a variety of alternative methods. Sometimes government agencies, acting as regulators, have sought to constrain costs by setting the actual rates of payment to providers, or the maximum prices which the providers may charge. This inevitably leads to strained relationships, unless fair and equitable means are employed to adjust payment rates over time, responding to inflation and to changes in clinical patterns. Partial reimbursement or small payouts on policies can contain insurance costs but usually are not effective in health care cost containment since providers pass uncontrolled costs on to the members.

UCR and cost-based payment. Two of the earliest methods designed to control the amount of provider payment include paying practitioners per service on a "usual, customary and reasonable" (UCR) basis and paying hospitals on the basis of their costs. Both approaches are much better than paying the uncontrolled

[17] For the kinds of cases best served by case management see Rosenbloom, David, and Gertman, Paul M., "An Intervention Strategy for Controll ng Costly Care," *Business and Health*, July/August 1984, pp.17-21 and for a general overall discussion of the approach see Gray & Field, pp. 119-142.
[18] These organizations often have functions s milar to the TPA's presently operat ng in India.

billed charges of providers. There is, however, a built-in bias towards increasing payment amounts to providers in both these methods. First, because there are always some providers who are able to charge more than their peers due to perceived quality or other differences, the "customary" fee gradually but continually increases because it is based on the average fee throughout a community until ultimately all providers set the same fees. Second, cost reimbursement for hospitals and other institutional providers has the effect of apparently limiting payment to actual costs and some agreed-upon surplus or profit but, as hospitals define their costs, the bias in this method without other actions is also one of steadily increasing costs and payments. For this reason cost-plus reimbursement was abandoned by the U.S. government insurance programs when diagnostic-related groups were implemented thirty years ago. As with physicians, the provider ultimately determines what will be reimbursed although alert insurers can at least try to pay only for their fair share of an institution's costs and if they are a large enough percentage of the institution's business, they can actually restrain them. There are variations on these systems, such as paying cost plus an incentive fee, to reward quality care or some other desired outcome.

The key to successful implementation of a UCR program is for the insurance plan, through its contracts with the providers, to control the aggregate rate of increase, and based on evidence, to hold down over-priced fees. UCR requires that the providers adopt a uniform set of terminology for both diagnoses and clinical procedures. The World Health Organization's standards provide an excellent basis.[19] In addition, UCR must be based on acceptance by the practitioners regarding what is to be included in the fee for each service. For example, it is customary for the surgical fee to include the entirety of the follow-up care furnished by the surgeon, and it is customary for obstetrical and midwifery fees to cover prenatal and immediate postnatal care as well as the actual labor and delivery episode.

For a cost-based hospital payment system the insurer also must place constraints on the overall rate of increase allowable by the institution and this requires each provider institution to adopt a uniform method, acceptable to the insurer, for computing the costs, employing standard accounting principles and subject to external audit. While there is a degree of complexity in establishing the uniform cost accounting methodology, this form of payment, once established, is quite simple to manage and operate. It is frequently used in Europe but referred to as "global budgeting" because the government is the most important payer of hospital services.

Per case payment. A third approach, increasingly being used, is per case or per episode payment. For years in many parts of the world obstetricians have accepted payment of a set fee for a normal delivery, including pre- and post-natal care. More recently, case payment systems have been developed to pay for acute inpatient services. Paying hospitals on a per-case basis (such as per inpatient stay and per outpatient clinic visit) has the attractive feature, from a cost containment standpoint, of creating incentives for the providers to hold down the costs, increasing the efficiency of providing each case. This can be designed to be quite simple, with only a few types of "cases", for example separating maternity cases, infectious disease cases, minor surgery cases, and major surgery cases.

Whether these systems actually contain costs depends on the amount paid and how reasonable or limited the payments are. A case-based payment system may motivate cost saving innovations because the difference between the amount paid and the actual cost of services determines whether the hospital gains or loses on a given admission, providing a powerful incentive to manage costs. The cost containment purpose of these systems is to counter the incentives associated with traditional fee-for-service systems which create a strong temptation for a provider/hospital to include more patient days and/or more diagnostic tests and physician or nursing services than are medically necessary since each hospital day, test, or service is separately billed, thus increasing total compensation for the admission.

Resource-based relative value scales and payment. A more sophisticated and complex approach to reimbursement of physician services is the resource-based relative value scale (RBRVS) which is based on an estimation of the resources required to provide a medical service. This system establishes the relationship between consultative medical visits and procedures by creating measures of complexity, required equipment

[19] See http://www.who. nt/classifications/icd/en/index.html

and skill and then assigning weights for each medical service based on its estimated relative value. This enables the insurer to pay providers on the basis of the assigned resources attributable to the medical care being given. If the weights are given the appropriate monetary value they can play a significant role in containing costs. However, if the rates are biased toward specialty care and procedures as many feel they are currently in the U.S., they will result in too few primary care providers, too little primary care and prevention services and overall higher costs.[20] RBRVS approaches can be combined with a case- or even fee-for-service system as a tool to contain costs. Relative value approaches can be used for reimbursing either professionals or institutions. For example, a normal birth delivery takes less skill and is less complex than a Caesarian section and accordingly in this system a physician would be paid a higher fee for the Caesarian than for the normal delivery.[21] In the United States, such systems of payment are used in both the public and private sectors. Likewise, a coronary bypass procedure is much more complex than a Caesarian section and the physician would receive a relatively higher reimbursement. This enables the insurer to pay on the basis of real value instead of what the provider might determine its worth to be. The Medicare Program for retirees, which is the largest payer system in the U.S., uses the RBRVS system to pay physicians and a case-based diagnosis-related group (DRG) system to pay hospitals. These systems have the advantage of being easily changed once the basic weights, etc., are established. For example, if a payer negotiates a reduction in the value of the basic unit of service of hospitals or physicians, payments will be reduced across the board for all of its cases. However, relative value systems require high maintenance since they must be modified as medical practice changes and as new technologies emerge. Some feel that this approach, by assigning value based on resource use, undervalues the services that lead to better health outcomes such as primary and preventive care and thus may actually increase costs rather than moderating them.[22] They may also undervalue cognitive medical services, leading to the same result. This potential problem underlines one of the most important points about payment systems: they often have unintended consequences which need to be identified, monitored and modified if necessary to make sure that their desired effect is not overcome by some unplanned result.

Capitation payment systems. The broadest unit used for the payment of providers is capitation, which pays a fixed amount for each person for whom the provider (or more likely, the group of providers) has accepted clinical responsibility. Capitation is based on contractual arrangements that clearly specify exactly the range of services which the provider is required to furnish. It has long been used in the United Kingdom and across Europe as the basic means of paying for primary care furnished by general or family practitioners, whether practicing in groups located in clinics or as individuals.

Capitation payment has also been adopted in the US by some health maintenance organizations (HMOs) (see below) which contract with groups of doctors (or doctors and hospitals organized as a single institution), paying the group a set amount of money for each person for which they are responsible. In this system, there must be very clear rules as to exactly what services the providers' contracts oblige them to furnish to the enrolled beneficiaries. This approach is designed to encourage providers to focus on preventative care as well as cost effective treatment since payment is fixed for a given period (usually one year). Success in preventing illness depends to a considerable degree on members staying enrolled for long periods. Containing costs within the organization means that members must also be willing to receive services only within the capitated organization's provider network. Since the amount the insurer will pay to the alternative delivery system is fixed for each insured person, insurers have to be concerned with possible denial of needed care in order to increase profits so the premium charged by the insurer must be sufficient to cover reasonable costs of medically necessary care. On the other hand, one of the difficulties of capitation as a payment method is that if the capitation is set too high then providers can make windfall profits since it is easier for an organization to attract preferred risks—those who will naturally use fewer services—than it is to do the hard work of cost

[20] Petersdorf, R.G. "The Family Medicine Imperative," *Academic Medicine* 68:12, p. 896, December, 1993. Under RBRVS, the percentage of primary care physicians in the United States has declined dramatically over the last 20 years. At present only 10 percent of train ng residency positions are for pr mary care physicians n contrast with 40 percent n Canada, a country with lower health costs and better population health statistics.

[21] This example is important because, as ndicated above, whether it leads to cost conta nment depends upon how it is implemented, particularly the effectiveness of the utilization management system. For example the first year such dist nctions were ntroduced in Hungary the ncidence of complicated deliveries increased five fold, ent rely as a result of the payment differential

[22] For a recent article on this issue see Bodenhe mer, Thomas, Berenson, Robert A., Rudolf, Paul. "The primary care-specialty ncome gap: why it matters." *Annals Internal Medicine*. 2007; 146: 301-306.

containment and managing care. The theoretical answer to this problem is risk-adjusted capitation which takes into account the likelihood of medical use of the particular individuals who are enrolled in the capitated plan. However, this is very complicated and to date is being attempted only by some of the large national insurance programs and in European countries such as the Netherlands.[23]

Negotiated prices. Private insurers who have significant market power are now turning to negotiated prices, often with large health systems. They are adopting a practice that has been used for many years by countries with single payer systems. This approach requires a knowledgeable staff with information about prices, costs and other factors in the marketplace. Since they are typically in place for long periods of time, the negotiated rates, if well done, pay providers' prices that encourage efficiency while providing stability in premiums and containing costs.

Performance-based payment systems. Insurers are increasingly using payment bonuses and other forms of inducement to reach some desired level of performance by providers. Withhold pools in which funds are accumulated over time and distributed to those providers who have met the defined and agreed upon performance objectives and grants to develop standardized electronic information systems, consistency in organizing diagnostic tests in advance of hospital admissions, or assuring that the care of chronic disease patients meets established clinical guidelines are among the kinds of incentives being used. The important point to be noted is that they are usually supplementary to a basic payment system and can be very valuable in encouraging providers to take desired actions.

Drug cost management

Physicians and hospitals are not the only areas where cost containment can work. As cost drivers, new pharmaceuticals and the volume of prescriptions per person are currently of great concern. Most insurers in Europe and North America have programs covering outpatient prescription drugs, either by reimbursing members after they buy drugs from a pharmacy or by establishing direct contractual relationships with selected vendors who accept discounted payment rates. In either approach, incentives can be created to hold down costs.

There are two main approaches to containing costs of drugs: generic substitution for patented drugs and creation of drug formularies which identify the essential drugs the insurer will cover and the percentage/flat fee of each prescription cost that must be paid out of pocket. Once a patent has expired for a brand name drug, a generic with the same or clinically equivalent therapeutic value is often available at a fraction of the cost of the brand name drug. Some plans pay only for generics, when available, or cover only the partial cost of patented drugs and pay for generics in full. There are usually appeals processes in place to take into account the rare situation where the generic drug is not appropriate and a newer patented drug has been shown to be therapeutic.

Another valuable drug cost containment tool is the establishment of a 'drug formulary' by the insurer. Many pharmaceutical manufacturers today are turning out new brands of expensive medicines similar to already existing and effective therapies which are less expensive. Insurers interested in cost containment are establishing lists of essential drugs that cover all or most medical conditions. More expensive copycat drugs are not covered and members are informed to help make sure their physician does not order them without good reason. Usually, the formulary is established and kept current through the advice of a group of professional physicians and pharmaceutical advisors which recommends which drugs to cover.[24]

Prescription drug costs, particularly for chronic conditions such as diabetes and arthritis which require long-term drug therapies, can also be moderated through the judicious use of mail-order dispensing. Insurance plans, or companies with which they contract, employ professional pharmacists to fill prescriptions for these

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[23] Van de Ven, Wynand P.M.M., van Vliet, Rene C.J.A., van Barneveld, Erik M. and Lamers, Leida M. "Risk-adjusted Capitation: Recent Experiences in the Netherlands," *Health Affairs*, W nter 1994, pp. 120-136.

[24] For a comprehensive look at the conflicted relationship between the medical profession and the pharmaceutical ndustry see Brody, Howard A, *Hooked: Ethics, the Medical Profession, and the Pharmaceutical Industry*. Roman and Littlefield, 2007.

drugs, typically sending the patient a one- or two-month supply each time. Because the drugs can be ordered in bulk, significant cost savings can be achieved.

Controlling Fraud and Abuse

An integral part of any cost containment program is preventing and dealing with fraud and abuse. This usually concerns both the insured individuals and providers and, in some cases, both, who may be colluding in fraudulent behavior. It may also include employees of the insurer or its agents. To deal with these issues, mechanisms need to be developed to identify false claims, false amounts on claims and false claimants. Traditional approaches include policing activities looking for fraud, etc., but increasingly health insurers are monitoring for abuse of their programs. Examples include systematically reviewing claims data to identify providers who are not behaving criminally but who are ordering unneeded tests or unnecessary prescriptions because they have an interest in a pharmacy at or near their office. The more sophisticated the information system the easier it is to identify patterns of abuse or fraud. However, the development of such data without follow-up action is of little value. Even if an insurer is unwilling or unable to take legal or other drastic action there are a number of intermediate steps which often bring about change. For example, providing information to providers on their behavior compared to a group of peers makes them aware that they are being watched. This can cause them to change poor medical practices, particularly if, at the same time, information on how other providers are treating patients more responsibly can be demonstrated.

Alternative Delivery Systems and Their Effect on Both Demand and Supply

Health Maintenance Organizations

Managed Care is the term used to describe organizations that directly manage demand and supply. In effect, they act as an insurance plan which enrolls members, collects premiums, and pays for care, and a provider and manager of clinical services to members. They affect demand by channeling their members to obtain virtually their entire medical care from their participating providers.

The strongest form of managed care is furnished by Health Maintenance Organizations (HMOs). HMO members follow simple rules such as obtaining elective specialist care only upon referral from their primary care doctors. HMOs also strive to hold down costs by keeping their members healthy, through health education, education in self-care, and reducing or eliminating co-pays on use of preventive care and skillful chronic disease management. By increasing utilization of these services they hope to reduce the demand/necessity for more costly hospitalizations. They affect supply through carefully drawn standards of practice designed to allow for only needed services, prudent provider selection and payment mechanisms that reward best practices. They also attempt to align the economic interests of all the parties involved so that the HMOs (including the providers) do well financially when the insured are given the best care. Except in an emergency, members can receive benefits for services only from the HMO providers. In the case of emergencies, the member must be transferred into the care of the HMO as soon as medically possible. Members who seek care from providers outside of the HMO are personally responsible for paying the costs of those services. One of the outstanding features of HMOs is that at their best they align the incentives of all parties—providers, administrators and members—towards a health system that provides quality health care at a reasonable cost. To do so those who join must be prepared to give up some of their freedom of choice about from whom and where and what services they receive and providers, both professional and institutional, must be prepared to provide care in a disciplined environment.

An important advantage of well integrated managed care plans is their use of comprehensive electronic medical records (EMR) for each enrolled person. EMRs are useful in reducing unnecessary or duplicative services, medical errors due to drug interactions, lack of information on complicating morbidities, etc. The ability to do so is both a method to contain costs and to improve the quality of care to beneficiaries.

Types of HMOs. There are three basic types of HMOs. Group Practice plans contract with formally organized independent groups of doctors who are part of a single organization and often associate with a single hospital

system or group of linked hospitals. The medical groups accept joint responsibility for serving the HMO's members, and often share profits and losses with the HMO. Typically, the HMO's members represent the total clinical activity of the group.

A second form of HMO is the Individual Practice Association (IPA) which contracts with individual doctors to serve the HMO's members, leaving them free to serve other patients as well. When taking care of HMO members, they are contractually committed to following the HMO's rules and conforming to its standards. Similarly, the members know that to receive benefits they must obtain their care from the HMO's contracting doctors, clinics, and hospitals. The primary advantage of IPAs is that their doctors can be spread over a large geographic area, matching where the HMO's members live and work. IPA doctors do not rely entirely on HMO payments in making their livings, which has the effect of weakening the IPA's ability to integrate care and contain costs than in other forms of HMOs.

The third HMO approach, less often used today, is the staff model. It is, however, the framework for several national health systems as exemplified by the United Kingdom and Sweden. In the staff model the HMO directly employs doctors and other staff to serve its members, in facilities owned by the HMO or National Health System. The doctors are usually salaried and in group practice, in most cases working full-time for the HMO. While this is the form in which the HMO would seem to have the strictest control over clinical practice, this approach has not flourished except in countries which by law have created national health services.

All three kinds of HMOs enter into direct contracts with hospitals and clinics. In some cases, the same entity may own and manage both the institutions and the medical groups. Irrespective of the exact nature of its relationships, the HMO requires conformity with its rules and standards.

Preferred Provider Organizations

It is costly, politically difficult and financially and administratively challenging to unite a group of hospitals, doctors and other providers into an efficient HMO and to share the financial risk of providing services to an enrolled population. In addition, many clinicians are reluctant to make the commitments that HMOs require. For example, the largest group practice model in the U.S., the Kaiser Health Plan, has taken over fifty years to develop on a regional basis. The IPA approach has grown more quickly. However, the benefits that can accrue from a coordinated system of care require that providers work closely together and, while various approaches to providing incentives for them to do so have been tried, IPOs require administrative actions that put burdens on both the IPO members and its providers that are costly and intrusive.

For this reason, an alternative approach to managed care has evolved called the Preferred Provider Organization (PPO). PPOs are systems established by health insurance plans (or infrequently, by a grouping of providers offering to contract with plans) as a kind of compromise between the strong controls of an HMO and relative lack of controls in ordinary health insurance. Rather than requiring members to obtain all their clinical services from a single set of doctors and hospitals, the insurance plan gives the members a choice. They can receive somewhat reduced benefits (e.g., having to pay higher co-payments) by going to any doctor or hospital, or they can receive fuller benefits by choosing a provider enrolled in the plan's PPO.

The providers who choose to join the PPO must agree to a stronger set of requirements and standards than imposed by the insurer's ordinary programs, and usually also agree to accept lower payment rates in recognition of the PPO's ability to channel more patients to them. PPOs are often more popular with subscribers than are HMOs because they are free to go to the doctors of their individual choice. They are still insured when they go outside of the network, though in practice few do so.

The extent to which both HMOs and PPOs contain costs and provide high quality care is dependent upon the capabilities and performance of the management. There are examples of HMOs which seem to be relatively ineffective as well as many that are very effective. Likewise, some insurance plans' PPOs have shown significant strength in managing care, while others have not. There are no magic bullets in cost containment!

II QUALITY ASSURANCE AND QUALITY ASSESSMENT

Introduction

Quality health care delivery has been a concern for most private health insurers in the United States since the early 1990s. Previously, quality of care was either an assumed reality based upon legal licensure or something for which health insurers (particularly in the private sector) perceived they had little responsibility. It was felt that quality could not be objectively measured and therefore judgments about quality existed between individuals and their providers. Three things have changed the way insurers are looking at this. First is the growth of alternative delivery systems which limit their members' individual freedom of choice of providers. Group purchasers and individuals want confirmation that the limited selection of providers available in their insurance programs will provide quality care to their employees and their families. In fact, organizations, such as the U.S. National Committee for Quality Assurance,[25] have now been established making it possible to measure the quality and operating performance of individual insurers or alternative delivery systems. Second, researchers and organizations have developed techniques for actually measuring differences in care and comparing them to health outcomes.[26] Finally, the relationship between quality care and the cost of care is better understood and insurers and, importantly, purchasers of care increasingly understand that good quality care is often less costly than substandard care. A simple and easily understood example of this is nosocomial infection rates in hospitals. When hospital-based infections are reduced not only are institutions safer and of higher quality but insurers do not have to pay for illnesses that are actually generated in a hospital nor for readmissions of insured patients whose illnesses are aggravated by being exposed to infections during a hospital stay.

In many countries, quality of care provided by their peers had been of concern to hospitals, physicians and nurses long before interest developed with insurers. This reflected a sense of professional responsibility by leaders to move medical practice forward, the need to protect against malpractice and other legal issues, and pressures within the medical community to insure against substandard providers and quacks. These efforts have often been supported or mandated by governmental requirements directed at protecting the public from poor quality care.[27] Since hospitals are where most serious medical problems are treated, hospital services have been the major focus of efforts to improve quality. Also, hospitals are more easily regulated than individual practices, which are numerous and less easily tracked. Recently, some countries have increased effort to measure the overall performance of physicians and other health professionals with very mixed results. In selective networks where physicians can be monitored as part of their contractual responsibilities and where they are limited in number this has proven more feasible. In open fee-for-service systems where insured individuals have the right to choose their physicians monitoring quality is both more difficult and expensive and subject to political resistance by physician organizations.

Quality Assurance versus Quality Assessment

There is an important distinction between insurers and providers in bringing about improved quality of care. Since providers actually deliver care they can put in place mechanisms to help ensure that the care being delivered is of high quality. A simple example of the difference is the creation of hospital tissue committees which review the pathology of all surgically removed tissues to make sure that the surgery was appropriate.

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[25] National Committee for Quality Assurance, www.ncqa.org. The role of this organization is discussed at length n a later section of this paper.

[26] The ability to compare care across institutions using an agreed upon methodology began with the mplementation of Diagnostic-related Groups (DRGs) by the U.S. Health Care Financing Administration n the 1980's.

[27] See, for example, sharing of best practices at the 3rd Annual World Health Care Congress in Europe 2007 at http://www.worldcongress.com/partners.cfm?confCode=NW715&level=top

The tissue committee is expected, under the authority of the hospital, to take corrective action to educate and, if necessary, it disciplines physicians who violate standards and thus ensures that unnecessary surgery does not take place. This quality control in hospitals is similar to what a manufacturer may do when it samples the quality of its products to improve and make sure they perform as expected and is called quality assurance. Insurers, on the other hand, do not perform surgery nor are they considered to have the expertise or the capacity to review all surgical pathology. However, they can contract only with institutions that have tissue committees and require that either they or accrediting bodies review the actions of these committees to make sure they do their job. This oversight role is called quality assessment. Together, quality assessment and quality assurance increase the likelihood that medical care is of the highest quality possible. The mechanics of this simple process can be more complex as more intermediating organizations, regulators and professional organizations play a role but the fundamental approach remains the same. Often the terms are used interchangeably and some organizations like HMO's may do both but in this report we will use assessment for insurers and assurance for providers.

Basic Approaches to Quality[28]

There are three inter-dependent approaches to assuring the quality of care that people receive. The first looks at structure: do the organization or practices being reviewed have the necessary capacities to provide quality care? For example, does a primary care clinic or a hospital have the proper staffing, equipment and supplies to provide care at the level for which it is being evaluated? If not, what is needed to assure that care will be delivered more safely when compared to an alternative facility or a different provider? The second approach, building on the first, looks at process: are the appropriate processes in place and being followed to insure that care delivered meets accepted standards of practice? The third approach focuses on the outcomes of care: does the care delivered produce the best results that can be expected given the present state of medical expertise? Intuitively, quality outcomes are the gold standard to be sought but they are often the most difficult to measure, the most costly to identify and the most contentious to prove to all segments of society. Historically, the accepted standards of practice of the medical profession by its members in combination with cultural practices have determined the meaning of "good medical care". However, as medical care has become more complex and determining the best medical outcomes more difficult, patients, basic scientists, epidemiologists, statisticians, health services researchers and financers of care increasingly are playing a role in defining quality care.

Quality Assessment and Quality Assurance in Developing Countries

There are many differences in medical resources, capacities and training around the world, especially between those in the richest countries compared to those in poorer countries. Assessing the quality of care must take into account the resources that are available. Since many facilities may be resource poor a first step is to make sure that the services delivered to the patients are not harmful and that the benefits provided to patients are appropriate. Many proven quality enhancing actions are not expensive and a quality assurance or assessment program can test for them. A good example of a low cost action is educating providers to reduce the spread of illness by washing their hands between seeing patients and making sure that soap and water are conveniently available to do so. This is an issue in both developing and developed countries and while actions to achieve this quality standard vary by situation, the resources available are only a small part of the solution. One difficulty in assessing care in developing countries is often the vast differences in services and facilities available to the wealthy and the poor. Often both are being served by the same institution or practitioners but with standards of care that go beyond amenities that the well-to-do may choose to purchase. Measuring quality under these circumstances can be done, but which approaches or standards are used is a matter of policy, values and culture of the countries involved. Such differences are not unknown in resource rich countries: a famous example is the difference in treatments of hip fracture in the elderly between the United States and the United Kingdom. In the UK's public health care system it is acceptable to provide painkillers and a cane whereas in the US the standard quality practice is to surgically replace a broken hip at any age so

[28] For the classic discussions of these approaches see: Donabedian, Avedis, "Evaluat ng the Quality of Medical Care," *Milbank Memorial Fund Quarterly/Health and Society*, 1966. pp.166-203.; and Donabedian, Avedis, *The Definition of Quality and Approaches to its Assessment*, Anne Arbor: Health Adm nistration Press, 1980.

long as it is medically beneficial. The UK places significant emphasis on estimated quality years of life in the definition of their standards for publicly financed care whereas in the United States these decisions about quality of life are usually made between a patient and his physician.

Further information on approaches to quality care in developing nations is provided in the cited documents.[29]

Development of Quality Assessment and Quality Assurance

In most countries organized efforts to address quality follow a similar pattern. First, the idea of specifying standards must be understood and institutionalized, followed by development of structures and processes to enforce them. However, in today's world, with the easy transfer of information and expertise, the time needed to implement programs is much shorter. It is still instructive, however, to focus on the basic approaches roughly in order of their historical development since it may be more feasible to implement programs in stages when there is no tradition of quality assessment.

Licensure, Certification and Accreditation

The most basic form of quality control is the issuance of a license by the State giving a provider or institution the right to practice medicine. Presumably the holder of a license has met the training and other requirements necessary to provide a minimum level of quality.[30] In fact this is the first level of quality that almost all people use when seeking medical care and has been universally required by insurers before they will pay providers for services. However, variations in treatment, outcome and experience by practioners have shown that licensing is a necessary but not sufficient measure of quality care. Further, medical professionals, particularly physicians, often used licensing as a vehicle to prevent other qualified practitioners from providing different kinds of care, usually in the name of quality medicine. This led to the need for certifications, which examine what actually takes place in the delivery of care.

Most of the established certification approaches trace their beginnings to voluntary efforts by the professions. The most prominent of these is the Joint Commission on the Accreditation of Health Organizations (JCAHO) in the United States. In other countries there are different histories and names but their evolution is similar. JCAHO was started at the beginning of the 20th century by physicians in the American College of Surgeons who felt it was important to follow hospital activities to make sure that medical care was effective for patients. It became a Joint Commission in the 1950's when separate organizations were incorporated into one by the College of Surgeons, the College of Physicians, the American Medical Association, the American Hospital Organization and several other professional organizations. The Joint Commission[31] was originally designed to accredit only hospitals; subsequently, as the health industry matured and other modes of care became more prominent, the organization broadened its emphasis to include other types of providers such as home health organizations. Today, JCAHO accredits ten different types of institutions and certifies nine types of care. The creators of this organization anticipated requirements by insurers and government and the belief of the founding organizations that it was better to be part of the process than have an involuntary process forced upon them. Quality and safety have always been important parts of the JCAHO review process, which also focuses on management, administration, organizational structure and other characteristics considered important for a well-run hospital. The inspection teams that evaluated hospitals were made up of representatives of other JCAHO members. Over time only the most egregious behavior was identified and acted upon. Following the implementation of large government-sponsored insurance plans for the poor and

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[29] Brown, Lois Di Prete, et al. *Quality Assurance On Health Care In Developing Countries*. Quality Assurance Project Bethesda, Maryland; Pr mary Health Care Initiatives Amman Jordan??. *Quality Assurance in the Jordan Primary Care System: Best Practices*. Bethesda Maryland, February 2004; De Geyndt, Willy. *Managing the Quality of Health Care in Developing Countries*. World Bank Technical Paper Number 258, 1995.

[30] Frequently this is supplemented by further cert fication (board certification) that a practitioner is qualified as an expert n a special field of medicine

[31] Jo nt Commission on the Accreditation of Health Organizations, www.jo ntcommission.org. The JCAHO presently accredits programs n ambulatory care, assisted liv ng, behavioral health care, critical access hospitals, home care, hospitals, laboratory services, long term care, networks, and office based surgery. They certify programs in chronic kidney disease, chronic obstructive pulmonary disease, disease spec fic care, health care staff ng services, npatient diabetes, lung volume reduction surgery, pr mary stoke centers, transplant centers, and ventricular assist devices.

the elderly and private payers' growing interest in minimum standards for their members, JCAHO accreditation became the mechanism for recognizing hospitals that had met acceptable standards. However, as financing organizations became more sophisticated, they realized that without significant outside pressure provider-dominated organizations could not be expected to examine themselves objectively and in some cases public inspections were undertaken while JCAHO was seen as only minimally effective.

JCAHO did respond to outside influence: it is now managed by a diverse board of health experts and it offers certification on quality care to institutions throughout the world. Many insurers, particularly in the United States, require this certification as part of their quality assessment program.

Other organizations, in countries as diverse as Australia,[32] Canada,[33] Denmark,[34] South Africa,[35] Malaysia,[36] and the Philippines,[37] offer programs of accreditation and certification designed to meet similar purposes to JCAHO. There are also non-profit international organizations such as the International Society for Quality in Health Care (ISQua), with members from over 70 countries, which works to improve the quality and safety of health are and which publishes the International Journal for Quality in Health Care.[38]

Another approach to accreditation that is being used in some countries and by some providers throughout the world is certification through the International Organization for Standardization (ISO).[39] This voluntary organization, which is governed by members from 130 countries, is dedicated to developing worldwide standards, including quality, for all types of organizations and industries. ISO certification is also being offered to different types of health care organizations and is used by many of the most prominent providers in developing countries. Both individual institutions and the accrediting organizations themselves not only provide information to insurers both public and private but often offer information to the general public as well.

Certification & Accreditation by Public Bodies

In many countries with national health insurance, or where the state undertakes a responsibility for maintaining the quality of care and does not want to be dependent upon voluntary bodies to provide this service, quality assessment is carried out directly by the state or through contracts with accrediting bodies. In countries like the United States, which has a mix of public and private bodies, both voluntary and public systems exist side by side, often building on each other's work.

Business-Driven Quality Assessment

One of the most important encouragements for insurers to develop quality assessment programs has been the increasing role of business in these programs, brought about by its understanding of the positive relationship between good quality care and cost. This has been particularly true for selectively contracted managed care programs which restrict the providers available to employees. The United States is the leader in this area and its most prominent efforts are the activities of the previously mentioned National Committee on Quality Assurance (NCQA). NCQA (a private group) has established nationally-based standards (Health Plan Employer Data and Information Set or HEDIS) and provides "report cards" on how health plans meet these standards. It provides information on individual plan performance and how all of its plans are progressing. Many employers will not contract with health plans that do not participate in NCQA and use its evaluations to designate plans. The items that are currently being measured nationally include how well the plans insure the immunization of children and adolescents, insure appropriate treatment for heart attacks, encourage effective diabetes treatment, and assist members to enter smoking cessation programs. Individually, NCQA

[32] The Australian Council of Healthcare Standards, www.achs.org.au
[33] Canadian Council on Health Services Accreditation, www.cchsa.ca/default.aspx
[34] Institut for Kvalitet og Akkreditering I Sundhedsvæsenet (Danish Institute for Quality and Accreditation in Healthcare), www.kvalitetsinstitut.dk
[35] Department of Health, South Africa, Directorate: Quality Assurance, www.doh.gov.za/department/dir-qassurance.html
[36] Malaysian Healthcare Accreditation Programme, www.msqh.com.my
[37] Philipp ne Council for Accreditation of Health Care Organizations (PCAHO), http://hospmgt.tripod.com/pcaho.htm
[38] The International Society for Quality in Health Care, Inc., www.isqua.org
[39] International Organization for Standardization, www.iso.org

evaluates plans on how well they provide access to care and deal with customer grievances, how they help members to maintain good health, how well-qualified their providers are, how they ensure that their medical care is the most up-to-date and will achieve the best results possible, and how they help members obtain treatment for chronic conditions. In addition to private sector plans this information is made available to individuals and members of government plans to help them choose managed care plans based on NCQA standards.

A second enterprise, the Leapfrog Project,[40] was created by a number of large national businesses and focuses directly on providers of care, especially hospitals. It now includes providers, insurers and government in its membership as well as business. It focuses at the local level on creating voluntary efforts of all stakeholders, including purchasers, insurers, hospitals, health plans, physicians, unions, consumer groups, and others to meet the quality and safety goals established by its members. These include:

- Implementation of computer physician order entry (CPOE) systems;
- Staffing ICUs with intensivists;
- Referring patients to hospitals with the best results for treating certain high risk conditions;
- Implementation of The National Quality Forum-endorsed Leapfrog Safe Practices.

The Leapfrog Group bases its actions on "purchasing principles" which it has established. They include educating and informing employees about local health care differences, using comparative provider rating systems and using incentives to drive markets towards improved health care quality and value.

While these efforts at the local area are voluntary—and there are over a thousand hospitals now participating in such efforts—it is important to note that businesses supporting these projects are often amongst the largest purchasers of care in an area and that the "voluntary" participation of providers and insurers is based upon a strong financial incentive to cooperate.

Insurance-Driven Quality Assessment Approaches

While many current private insurer approaches are being driven in part by outside organizations, some insurers and managed care plans do undertake quality assessment activities on their own. Almost all contracting plans have requirements for provider participation and increasingly many include a review of a provider's performance or qualifications. Many selective health insurers such as HMOs have also been using specialty certification as part of their quality assurance or assessment program.[41] Most plans, particularly in the developed world, have some form of grievance procedures to enable their members to raise problems with the care or coverage they receive. Customer satisfaction with the quality of care received is usually an important factor for plans, particularly where purchasers of care can offer a number of plans for their members/employees to select from. Correcting systemic problems can be part of a quality assurance and/or assessment program, including removal of aberrant providers from a plan.

Data

One of the most important questions faced by most insurers when involved in quality assessment activities is what type of data to collect. Claims are the basis for payments to most providers and in the absence of a medical record, what the insurer usually receives is a bill with little information about why or how certain things were done. This is often complicated by the fact that, unless the insured person is limited to certain providers, an individual claim may only partially explain the kind of treatments a patient received. This can be mitigated by interactive computer systems or the direct review of medical records but such records are expensive to retrieve and beyond the capabilities of many insuring organizations. Ultimately, this means that insurers have to be very selective in how they approach quality assessment, taking into account the kind of information they can develop on their own.

[40] The Leapfrog Group, www.leapfroggroup.org
[41] De Geyndt, Willy, Op. Cit.

Research-Based Quality Assurance and Assessment

Some long established health maintenance organizations which employ, own or have close relationships with their providers, such as the Kaiser Permanente health plans in the United States, have research departments that undertake studies on quality that directly affect the way medical services are provided to their members. However, such approaches by health insurance plans are the exception not the rule.

Two other approaches by insurers have had more general applicability. The first uses claims data, while recognizing the limitations of such data, as the basis for studies that a health plan can appropriately undertake. One such study looked at coronary bypass surgery to examine whether there was unusual mortality in any of the plan's hospitals.[42] To do this the insurer had to be large enough so that it covered a significant number of such procedures in its contracting hospitals and had the statistical and medical capability to isolate random differences from those that were medically significant. The study also required that claims data on deaths from surgery be sufficiently clear and that the number of claims be large enough to support the conclusion that particular providers had a potential quality problem. In fact the study did identify a single problem provider but was not able to determine the cause of the problem. The insurer then required the quality assurance committee of the hospital to isolate and correct the problem, which turned out not to be the quality of the staff or the bypass procedures but rather the extraordinarily long time involved in moving emergency patients from a helicopter through the hospital and into surgery. After correction of the problem and follow-up monitoring the hospital demonstrated that its results were consistent with its peers and national studies and was removed from a watch status. Since the insurer through its efforts was only able to identify that the number of deaths from the procedure was greater than the statistically expected mortality and did not know the reason why this occurred, it agreed with the hospital to keep the information private if the hospital acted promptly to discover if a problem actually existed and if it agreed to correct any problems that were discovered. While this example shows what can be done by an insurer and how quality assurance and quality assessment programs working together can achieve results that individually neither could, it was both expensive and time consuming and only the largest insurers have the resources and data to undertake such an effort.

A second approach used by insurers requires fewer resources and utilizes existing medical research to change provider behavior and improve quality of care. Throughout the world medicine is highly decentralized and operates through a combination of science and practical experience. Historically, it has been slow to change, with practitioners basing treatment of individuals on their education, reading and their own experience. Scientific studies of outcomes and the best practices that flow from them have not been adopted quickly, although the information age is shortening this time period dramatically. Quality assessment programs have started taking advantage of research to transfer knowledge and treatments to providers by bringing in recognized experts to explain why certain approaches are safe, effective, and often less costly, and by recruiting local providers to demonstrate to their peers that such approaches serve their patients best. Insurers can also use their own claims data to demonstrate differences among providers and ultimately identify substandard practitioners. Through a variety of mechanisms, such as sharing this information with hospital quality committees, they can require provider outliers to justify their practices. Ultimately they can use payment programs that reward best practices and penalize poor practice. These later approaches can be legally and politically difficult depending upon the laws of the insurer's jurisdiction and the quality of the analysis that demonstrates substandard practice. The gold standard of evidence to support outcome-based approaches is today being produced through evidence-based medicine.

Evidence-Based Medicine

Background

"Evidence-based medicine (EBM) is an attempt to apply more uniformly the standards of evidence gained from the scientific method to certain aspects of medical practice. Specifically, EBM seeks to apply judgments

[42] This study was undertaken in 1986 by the author when he was Vice-President of Blue Cross of Western Pennsylvania.

about the inductive quality of evidence to those aspects of medicine that depend on rational assessments of risks and benefits of treatments (including lack of treatment)."[43]

EBM has come into prominence in the past few decades although it has been a part of medical research for many years. Most people throughout the world assume that when they visit a health professional, especially a physician, the treatment they are given uses the best available scientific information. In fact, medical practitioners base their efforts on their training, experience, legal constraints, past practice and perceived patient desires, as well as scientific fact. For example, the germ theory of disease, upon which much of modern medicine is based, was an established scientific fact by the mid-19th century, yet many physicians resisted applying it in their practices until well into the 20th century because of their training and experience. Some medical practices—for example, discouraging women from attempting a vaginal birth after they have previously delivered by Cesarean section— have been traced to a statement by a single physician or a particular textbook.[44] Peer judgments made by practitioners about which treatments are best for patients, often based upon experience and teaching of the most senior physicians, have been the most accepted method of determining good quality of care. However, as medicine has become more complex and scientific understanding more thorough, it has become increasing clear that treatments can lead to better results if the results are demonstrated using controlled experiments (the scientific method) and measuring the outcomes.

While scientific research has always been incorporated into medicine, e.g. the efficacy of drugs, and physician training (which includes a great deal of basic science), in the 1980's Doctor David Eddy, a heart surgeon at Stanford University in the United States, who also was trained in mathematics and statistics, began to examine the extent to which major medical treatments were unproven. He subsequently argued that only about 15 percent of all medical treatments had been actually proven and to the embarrassment of many in the medical establishment was able to demonstrate this point.[45]

There were many things taking place at the same time that contributed to his ability to do this. The field of clinical epidemiology had come into prominence with studies that demonstrated significant regional differences in clinical practice and costs that could not be explained by any legitimate differences in the populations being served.[46] Another factor was that the understanding of physiological processes and disease mechanisms reached new highs in the last quarter of the 20th century, together with the qualitative (using randomized clinical trials) and quantitative growth in medical research. (Half of all the clinical trials between 1954 and 1995 were completed after 1990.)[47] Added to the mix was the high cost of new technologies that were coming into the market place at an accelerated pace, and financially challenged government programs and private insurers were facing new expensive approaches to care without any firm knowledge as to whether they were superior to already existing treatments. For example, the X-ray, which was the staple of radiological diagnosis for many decades, was being supplemented and often replaced by Computerized Axial Tomography (CAT Scanning) and Magnetic Resonance Imaging (MRI) and questions were raised about what worked best since the cost of these new machines was in the millions of dollars vs. thousands for conventional X-ray machines.

All of this activity, coupled with an increased interest in improving quality care by organizations, individuals, and governments, led to the acceptance of EBM as an important factor for improving medical treatment while controlling increasing costs.

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[43] Wikipedia, accessed May 1, 2007: http://en.w k pedia.org/w ki/Evidence-based_medicine: According to the Centre for Evidence-Based Medicine, "Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence n making decisions about the care of ndividual patients." (http://www.cebm.net/index.asp).

[44] Carey, John. "Medical Guesswork," *Business Week*, p. 73. May 29, 2006.

[45] bid., pp. 72-79.

[46] See for example, John E. Wennberg, Elliott Fisher, and Jonathan Sk nner, "Geography and the Debate Over Medicare Reform," *Health Affairs*, web exclusive, W96-114, February 13, 2002.

[47] For an excellent discussion of these developments see Miller, Wilhelmine. "Value-Based Coverage Policy n the United States and the United Kingdom: Different Paths to a Common Goal," *National Health Policy Forum*, The George Washington University, Washington D.C. November, 29 2006. pp. 1-33.

Health Insurance and Evidence-based Medicine

Health insurers, often with the prodding of their customers, have taken an increased interest in EBM. Efforts at cost containment by public and private insurers have been criticized by many in the medical professions as "cookbook medicine" utilized by those who are only interested in saving money and not in the quality of care. These critics argue that doctors and other health professionals are the only specialists capable of choosing the best quality care for their patients. At the same time, lax insurers, and insurance itself, are often cited as important causes of the rising costs of health care throughout the world. Given their prominent position as one of the drivers of higher medical costs and at the same time facing attacks on their containment programs by the provider community, insurers find that a focus on quality, safety and medical outcome is a more attractive way to contain costs. Even countries with national programs which budget government funding of health care or control the proliferation of new technology and services by controlling total numbers and placement, still have not been able to completely eliminate differences in medical treatment and the concerns that unnecessary care is being provided under their auspices.[48] Understanding that good quality care is usually the least expensive care and that EBM presents scientific and defensible evidence about what type of care produces the best outcomes has encouraged both insurers and governments to adopt EBM. This is done in several ways: for example, (1) by utilizing practice guidelines based upon EBM and refusing to pay for outdated, unnecessary or ineffective procedures, or (2) by rewarding providers who use EBM in their practices and by refusing to pay for tests or medical equipment that have been scientifically proven to have no medical value. EBM is being expanded into controlling payments for pharmaceuticals, dentistry, and other areas of the medical arts.

Potential problems with EBM

Using EBM as a basis for making medical payments is a powerful tool but it is not without obstacles. These can be political, legal, or rejection by an uninformed public. Providers, who may have economic or other reasons for objecting to changing long established ways of treating their patients, are often able to exercise significant political influence to restrict insurers' desires to pay only for appropriate care. Resistant providers often have legal traditions on their side since local practice or pronouncements by medical societies are considered the governing standard of care. Health providers also have significant influence over the general public and their individual patients who often respect their medical judgments above all others. Thus while it is counterintuitive to think that it would be difficult for insurers to declare they will only pay for care where efficacy has been demonstrated it can in fact be a long litigious road to travel.

It is also possible that mandating the use of a very specific evidenced-based practice may stand in the way of innovation in practice. Payment systems that bundle services for a particularly diagnosis or admission based on average costs of care, such as diagnosis-related groups (DRGs) or other types of episode groups, is the implicit incentive to reduce costs per case without compromising quality thereby motivating both innovations in care and financial rewards. Thus, U.S. Agency for Healthcare Research and Quality (AHRQ)[49] has substituted a policy of publishing externally developed guidelines based on EBM rather than developing its own. By publishing a variety of EBM guidelines, providers and/or health plans can review the experience demonstrated in the published data and choose a guideline. The users can then make their own experience with the guideline a part of the published data. Meanwhile, new treatments and care modalities will continue to be developed and their results made public through agencies such as AHRQ.

Some steps to put an EBM program in place

To have an effective program, insurers must look first to their own policies or insurance contracts with their customers. Many policies in the past and even today are obligated to make payments if the care is ordered by a licensed professional, usually a physician. This often has backing in law and the ability to refuse to pay for poor quality care under those circumstances is highly circumscribed. More progressive policies, which take

[48] Personal nterview by the author with Gordon McLochlin, Secretary to the Trustees (President) of the Nuffield Provincial Trust, one of England's lead ng health services research organization, in which he indicated that 'despite the governments efforts for over fifty years there were still sign ficant differences in how physicians practiced depending on which medical school n Great Britain they attended.'

[49] Agency for Healthcare Research and Quality, http://www.ahrq.gov/

into account the reality that not all medical personnel operate within the standards of their profession, contract to cover "medically necessary or reasonable care" but exclude coverage of experimental care as outside the standards of current medical practice.

In cases where medical professionals have been given an unchallengeable legal right to order medical services or where insurance policies agree to pay for professionally ordered services irrespective of need or medical necessity, the only way to introduce EBM is to convince the profession of its merits or to develop reward schemes that encourage adoption. In any case, as described below, education of medical personnel and the general public about the importance of EBM and its output is critical for any program. If insurance contracts have medically reasonable and necessary provisions and can legally be interpreted as providing outcome-based services and not the community standards of care, then clearly insurers have leverage to implement programs that rely on EBM. However, merely rewriting insurance contracts to pay only for care based upon EBM-developed protocols is not by itself the answer to good quality care. There are many medical procedures where results are self-evident and where evidence-based research is unnecessary, for example, resuscitation after someone has stopped breathing or where there are no or inconclusive EBM findings.[50]

Other important steps to the effective implementation of an EBM program include educating physicians and other health professionals about EBM and recruiting as many as possible forward thinking providers to support efforts. Also, informing and obtaining the support of customers and insureds in implementing programs is important to their success. Providing information to the public about their choices of care is an excellent tool to help them make important decisions about care. A good example of this is providing information to women about avoiding mastectomies in most early stage breast cancer where there is scientific evidence that a lumpectomy to remove the tumor is as effective as removing the whole breast and is much less risky and surgically invasive. This can be done by providing information directly, or through women's cooperatives, employers, unions, hospitals, etc., so when surgery is suggested women will have sources of information to help them understand that the most aggressive and disfiguring approach may not be better than the least invasive option.

It is prohibitively expensive for most individual insurers, no matter how large, to have a dedicated EBM staff with the skills necessary to undertake the studies or reviews of worldwide literature that are necessary to create their own independent program. The responsibilities to undertake these efforts, given their size and cost, are generally being shouldered by national governments, with the efforts presently being led by Great Britain and the United States.[51] The Canadian and Australian governments have also implemented programs. These public sector programs often fund efforts utilizing public and private organizations such as universities to carry out their work. There is at least one private sector insurance-run EBM program operated by the Blue Cross/Blue Shield Association of insurance plans through its Technology Evaluation Center.[52] It was put in place in 1985 in the United States by like-minded insurance plans and undertakes 20 to 25 assessments a year. It has established procedures for reviewing and making information available to its member insurance companies as well as to other organizations.[53]

While an insurer may not be able to undertake its own independent program, one of the advantages of public bodies supporting this work is that the information is generally in the public domain and available to anyone in the world via the internet.[54] Exemplary programs applied to local conditions for disseminating information can accelerate the implementation of a cost-effective EBM process. Thus even the smallest insurer or country that has the will and support of its constituencies can take advantage of this extremely costly and technically sophisticated activity with only a modest investment of its own resources.

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[50] Estimates by experts ndicate that in spite of a great deal of work be ng done only 20-25% of current medical treatments have been proven effective. Carey, John, Op. Cit. p. 73.

[51] See Miller, Wilhelmine. 2006. Op. Cit.

[52] www.bcbs.com/betterknowledge/tec/

[53] Miller, Wi helmine. 2006. Op. Cit. p. 19.

[54] For example, the American Academy of Family Physicians has a performance mprovement program known as METRIC or Measuring, Evaluat ng and Translating Research into Care. Care modules can be viewed at http://www.aafp.or/metric/

Value-Based Coverage

EBM programs are capable of identifying which medical approaches are effective and even which ones are more effective than others. In situations where multiple approaches are effective or when the differences in effectiveness are moderate but cost differences are significant, the insurer trying to contain health care costs has an opportunity to increase the value of EBM. Some insurers and health plans have been following this approach for many years as a part of their cost containment programs. These health insurers have attempted to educate their members and medical providers on the use of the least costly but effective approaches to delivering care.[55] Organized or publicly supported EBM makes this approach even more attractive, given that there is a very public scientific consensus on the results of the research and value-based EBM gains credibility from its use.

One final point about quality assessment programs and EBM: as with cost containment programs, it is important for political, legal, medical and human reasons to have in place an appeals process so that insured and their medical practitioners can challenge decisions that are made on behalf of the quality or EBM program. Medicine, despite its increasing scientific base, is also an art. There are many medical and social reasons why it may be appropriate to use a less effective method or to pay for a more expensive copycat drug. For an appeal to be successful such a process should require the provider of care to demonstrate adequate medical or other justification.

[55] See, for example, the discussion about the use of the heart drug TPA in the section on cost containment in Chapter Three.

III PRIVATE INSURANCE INTERVIEW QUESTIONNAIRE

Start with providing a short background about the healthcare financing scenario in the country and the critical need for health insurance as a financing tool.

General Information:

How long has the company been providing health-related insurance products?

What are types of health-related insurance products do you offer?

Who are your clients? Group vs. Individual? What is the customer profile?

What are the trends in your health-related insurance products?

Benefit Design:

What is the scope of benefits covered by your products? How has this scope changed over time?

Are there any exclusions to the health-related products you offer?

Do you offer any benefits for non-allopathic, traditional medical services?

Organizational Structure:

What are the underwriting practices that your company performs?

- How are premiums set?
- What are the claim payout percentages?
- What is your retention rate for the various health-related products and what are your profit margins?
- Any other medical underwriting practices?

How do you process claims and what is the relative sophistication of this process?

Do you find regional variations in both purchasing of health insurance policies as well as claims outgo?

What do you think are the motivators for buying health insurance?

Do you find any evidence of 'adverse selection' against insurers in health insurance? Please elaborate with claims experience.

What strategies do you use to market your products?

Do you conduct marketing research?

Relationships with Providers and TPAs:

How do you work with providers? What types of contracting or agreements? How do you manage providers?

Do you implement cost-containment and quality assurance approaches to address fraud and abuse, utilization and quality control, etc?

How much negotiating 'power' do you feel you have with providers?

There is a general feeling among insurers that hospitals tend to over-treat an insured patient or over-utilize an insurance policy. Do you subscribe to this view? Please elaborate.

How do you work with TPAs and what types of contracting or agreements are in place?

Human Resources:

What is the executive leadership structure of your organization?

What are the skills of your employees working on health-related insurance products?

Do you offer training to your employees to better educate them on health insurance?

Customer Services:

What services do you offer to your customers and clients for health insurance inquiries?

How do you address and control for fraud?

Directions for the future:

What direction do you see your company moving in with regard to health-related insurance products?

What is your prognosis about the future of health insurance market in India?

What products, practices and regulations should be adopted to make it a major healthcare financing vehicle in the country in view of shrinking public healthcare expenditure and a simultaneous rise in both infectious and life style diseases?

IV TPA QUESTIONNAIRE

Enrollment:

1. How do you enroll new members?

   ❒ Physical Form ❒ Online

   ❒ Both ❒ Other (please specify) _____

2. Who supplies the membership data?

   ❒ Consumer ❒Employer ❒Insurer

   ❒ All ❒ Combination_____

3. Do you conduct insurance placement for members?

   ❒Yes ❒No

Claims Settlement

4. Does your company have a document recovery department to assist claims settlement?

   ❒ Yes ❒ No

5. Do you provide a cashless service?

   ❒ Yes ❒ No

6. What kind of claims settlement systems do you have?

   ❒ Computerized ❒ Manual ❒ Both

7. If both, what percentage of the work is computerized as opposed to manual?

   Computerized_____ Manual_____

8. What is your average claims settlement period?

9. Can you describe the chain of departments through which a claim is processed?

Marketing Structures:

10. Do you have a department or personnel dedicated to researching emerging markets?

    ❒Yes ❒ No

11. What percentage of your marketing resources do you direct at the following?

    Groups _____ Insurers _____ Brokers _____

12. Can you provide us with a rough percentage of the demographic your customers belong to?

    Individuals____ Families____ Groups____

    Associations____ Government Employees____

13. Does your company undertake any complementary business ventures?

    ❒ Yes ❒ No

14. If yes, can you specify the kind of complementary businesses undertaken by your company?

    ❒ Agents ❒ Brokers ❒ HSO/TPA combination

    ❒ Hospitals ❒ Providers ❒ BPOs

    ❒ Other (please specify) _____

15. How exactly do these activities complement your TPA work?

16. What markets or geographic segments do you cover?

17. How do you brand your services?

Human Resources

18. Do you provide your employees with a specific training program? If yes, could you describe this training program?

    ❒ Yes ❒ No

19. What kind of process do you follow to hire, retain and discharge staff?

20. What qualifications does your executive leadership possess?

    ❒ Bachelors ❒ Masters ❒ PhD

21. How does your company remain in touch with technological advances? This could be through an information technology department or it could be contracted out.

Customer Service

22. What kind of infrastructure do you have set up to handle customer grievances? Please tick all that apply.

    ❒ Call Center ❒ Website FAQ ❒ Email

    ❒ Company Liaisons ❒ Other _____

23. Who is primarily responsible for the detection of frauds?

24. Do you maintain a centralized information system to which all employees have access?

    ❒ Yes ❒ No

Provider Relations

25. What kind(s) of information systems do you possess to keep track of your provider network?

26. How many providers do you have in your network? Can you categorize these by class and into categories such as Hospital, Nursing Home, and Diagnostic Center? See the table for further help.

	Super Specialty	Multi Specialty	Nursing Home	Diagnostic Center		
				Imaging	Pathology	All
Class A						
Class B						
Class C						
Class D						

27. Can you describe the kinds of contracts you have with Super Specialty Hospitals, Multi Specialty Hospitals, Nursing Homes and Diagnostic Centers?

	Super Specialty	Multi Specialty	Nursing Home	Diagnostic Center		
				Imaging	Pathology	All
Deposit Waiver	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Direct Settlement	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Credit Period	15/30/45/75	15/30/45/75	15/30/45/75	15/30/45/75	15/30/45/75	15/30/45/75
Discounts:						
Consumables	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =
Room Rent	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =
Surgeon's Fees	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =
Diagnostics	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =	Y/N % =

Direction of the Private TPA Market in India

28. Can you provide us with an insight into where you think the TPA industry is headed in the next few years? This would include future markets and potential new players.

29. Could you provide us with your company's growth statistics since its inception?

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