REPORT OF THE COMMITTEE ON HEALTH INSURANCE FOR SENIOR CITIZENS

NOVEMBER 2007

Insurance Regulatory and Development Authority

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EXECUTIVE SUMMARY

1. The National Policy on Older Persons adopted by the Government of India recognizes that only a judicious mix of public health services, health insurance, health services provided by not for profit organizations and private medical care can address the healthcare needs of the older persons.

2. Healthy ageing is a major requirement for the graying population, since prevalence rate of morbidity is higher within this population segment. Unfortunately in India, public healthcare services have not been able to live up to the expectations of the people. Private health sector has made impressive strides specially in providing tertiary healthcare, though, it remains expensive and often out of financial reach of older population. However, no attention has been paid either by Government or by healthcare providers towards preventive care, which is especially important for the senior citizens.

3. Health insurance is a vital part of health care financing, yet its penetration in India is woefully inadequate. With low public expenditure on health, households have been burdened with meeting most of their healthcare expenses out of their earnings, savings or borrowings, but often, through disposal of assets.

4. The awareness about and efforts to popularize health insurance have been inadequate. Concerted efforts would need to be made in this direction.

5. While the corporate group health insurance policies enjoy liberal coverage and subsidized pricing, the premium for the individual policy holders especially the senior citizens, are witnessing steep escalation in premium leading to declining affordability.

6. The Committee observed that though there are some insurance products that are technically 'available' for senior citizens, in practice it is not easy for them to obtain a health insurance cover. The underwriting practices of insurers are not transparent and there are several complaints of arbitrary loading, denial of renewals and cancellations without assigning reasons. All these restrict access of Senior Citizens to health insurance. Private insurers too have to really deliver. Not all private insurers offer health insurance and those who do are reluctant to cover the elderly.

7. In keeping with the philosophy of the National Policy on Older Persons, it is necessary to assure the Senior Citizens that they will be protected through health insurance with guaranteed renewal. It is also desirable that the health insurance policy is drafted in simple language with terms and conditions clearly stated for easy

understanding by the users. There is also a need for the Industry to have uniform definitions of terminology, and standard terms and conditions used in the policy. The Committee notes with satisfaction that the General Insurance Council has taken the initiative in this direction by suggesting a common definition of 'Pre-existing disease' clause. It is also necessary for insurers to have a consensus on issues such as portability of covers, sharing of information (such as creation of an information bank of rejected proposals, renewals, denied and moral hazard related claims), standard definitions of critical illnesses etc.

8. Cost control is a key issue in health insurance product design. In absence of cost control methods, continued high claims ratios would drive premium rates upwards, eventually making health insurance unaffordable. Basic cost control components include: deductibles, co-payments, co-insurance and internal benefit limits. In addition to reducing the insurance costs of the insurer, application of one or more of cost control measures results in the insured eventually taking the ownership of healthcare services to be delivered to him by weighing considerations of - when to seek care, what kind of care to seek and how much care to seek.

9. The insurance companies should endeavour to offer continuity in health insurance for applicants who were hitherto covered by corporate insurance or insurance offered by any Government or otherwise, on conditions that they deem fit, subject to observing the principles of horizontal and vertical equity, that is to say, like cases should be treated alike and the differential between any two classes should be justifiable and reasonable.

10. It is critical that health sector reforms address the issue of regulation of providers in the context of promoting sound and affordable health insurance.

11. In the long run, to ensure consistent quality of services, and also to be able to compare and benchmark the costs of services rendered by health providers, there is need to move towards accreditation and grading of providers, and also the implementation of standard treatment guidelines for managing cases of specific common conditions, particularly where there is substantial scope for standardization of diagnostic and treatment practices. This could be done through joint initiatives of Government, Regulator, Insurers (along with their Third Party Administrators) and health providers.

12. The creation of a national repository of data relating to health insurance as well as health sector is of paramount importance for the use of the industry; this should be under the aegis of IRDA.

13. The Committee recognizes that people should enter health insurance schemes as early as they could, for better distribution of risk for the insurance companies and for building up sufficient reserve to be viable in the long term. Medical profession too is emphatic that a strict regime of preventive health including proper diet, regular exercise and periodical screenings and tests must commence no later than 45 to 50 years of age.

14. Health insurance can be made viable not only by having properly designed products but also through appropriate pricing and sound underwriting. The approach suggested by the Committee is that insurers should fix a 'base' price at the age of 50 and adjust it with an age-loading for each year and a loyalty discount for each year the insured has been with the health insurance system (not necessarily the particular product). The Committee feels that the industry should aim at a 'base' price of Rs. 3000 per annum for a healthy individual at age 50 for a Sum Insured of Rs.1,00,000/-, at current levels of prices and healthcare costs.

15. As a transitional measure, since guaranteed access is being provided to the senior citizens for the first time, there should be no upper age limit for entry or renewal for a period of three years from the date IRDA issues the regulations. After the expiry of three years also, insurance companies should exercise their discretion in entertaining the first entry of senior citizens above the age of 65 years in deserving cases.

16. At any time, there will be certain individuals, particularly senior citizens whose present medical condition will not make them readily 'insurable' by normal industry standards. The needs of these 'high risk' individuals should be addressed through a pre-dominantly government funded 'pool' mechanism with participation of all stakeholders of the industry. The health insurance pool should be created under the aegis of the IRDA to take over high risk cases, for example, those who have a health status based loading of 40% or beyond.

17. The insurance companies should endeavour to offer continuity in health insurance for applicants who were hitherto covered by corporate insurance or insurance offered by any Government or otherwise, on conditions that they deem fit, subject to observing the principles of horizontal and vertical equity, that is to say, like cases should

be treated alike and the differential between any two classes should be justifiable and reasonable.

18. Traditionally, the family doctor or family practitioner played a significant role in providing healthcare. The growth in medical specialization, medical technology and greater mobility of population, have significantly reduced his role. Institutionalisation of the family doctor/general practitioner is imperative in the context of healthcare for senior citizens. But, he should have only a limited role in the health insurance system. He should become responsible for the overall care provided by the entire healthcare system and remain the 'friend, philosopher and guide' of the senior citizen seeking care.

19. The Committee has also made recommendations to further streamline the procedural and operational issues related to senior citizens, salient amongst them pertaining to: service standards of TPAs, grievance redressal mechanism, policy renewals, choice of TPAs, disclosure requirements, cashless authorisations and delays in claim reimbursements

20. At present, insurance premiums attract Service Tax of 12.36% including cess. The Committee recommends that, if health insurance premiums cannot be exempted from Service Tax altogether, at least 50% of the Service Tax on all health insurance premiums should be allowed to be credited to the Insurance Pool recommended to be created with the IRDA for dealing with high-risk health insurance cases of senior citizens.

21. The present income tax concession under Section 80 D for health insurance premiums is regressive – a taxpayer in the highest tax bracket gets a tax rebate of Rs 6,000 or so whereas a senior citizen in a lower tax bracket gets less. Tax concession for health insurance should be given 'below the line' in the form of a tax credit at a uniform rate of Rs. 6,000 (if possible, at a higher level) for each taxpayer, to transform the concession into a progressive one. Further, unabsorbed tax credit should be allowed to be carried forward.

22. Stand-alone insurance companies should be permitted to accept long-term deposits from those insured with the company. Such deposits should be made into a 'healthcare savings account' broadly patterned on the lines of Public Provident Fund accounts but without any time limit, premature deposits being permitted only for bona fide medical treatment. They should qualify for deduction under Section 80C of the Income Tax Act.

23. Senior citizen beneficiaries of CGHS, ESIS be given permitted to opt out of their respective Schemes since quite of few of them reside at places where they cannot avail of these facilities. Such optees should be given a suitable annual grant, say, equivalent to the average cost being incurred per beneficiary, to enable them to buy health insurance.

24. A substantial majority of the older persons fall below average per capita income. The Committee recommends that all senior citizens with incomes below the average per capita income but above the poverty line should be given a grant of Rs 100 per month by the Government. This should not be given in the form of cash but in the form of a voucher either for buying health insurance or for primary and preventive care services provided through institutions like the proposed family clinics.

25. Government of India has recently announced an old age pension scheme, effective from 19th November, 2007, for persons aged 65 and above if they belong to the BPL category. The Committee recommends that Rs 100 per month out of the Central Government contribution should be disbursed in the form of a voucher.

26. IRDA should play an active 'developmental' role till health insurance picks up momentum.

27. IRDA should mandate the companies carrying on health insurance business that all senior citizens should have access to health insurance regardless of age, health condition or claim history, except in cases where the person is diagnosed with selected terminal or incurable illnesses at the time of first entry.

28. To develop health insurance sector and to transact this business on more professional lines, it is desirable that IRDA promotes 'stand alone' health insurance companies. All insurance companies, both life and non-life should promote separate health insurance subsidiaries.

29. There is a definite need to undertake publicity and increase awareness of health insurance and to undertake capacity building in health insurance, in which IRDA must play a pro-active role.

30. IRDA should establish a dedicated, full-fledged Health Insurance department which should be responsible for monitoring the implementation of the Committee's recommendations.

CHAPTER 1

INTRODUCTION

1.1 The National Policy on Older Persons adopted by the Government of India has provided the beacon light for the work of this Committee. The Committee was entrusted with the task of looking into various issues in Health Insurance affecting the Senior Citizens as detailed in the Terms of Reference contained in the last chapter of this Report. The Committee, with full knowledge of the vulnerability of this category of citizens and bearing in mind the concerns voiced by them in different forums, has attempted to address the different issues involved and make specific recommendations regarding them.

1.2 The healthcare needs of the Senior Citizens cannot be considered in isolation from the healthcare needs of the total population. If we look at the wider scenario of healthcare in the country, it leaves a lot to be achieved. According to the WHO ranking of countries, India ranks 118 out of 191 countries, below even Pakistan (85) and Bangladesh (103). As a proportion of GDP, total expenditure on health in all the three countries hovers around 5%, compared to more than 10% in developed countries. About 80% of the expenditure is incurred by the citizens themselves. Hence, the effectiveness of aggregate expenditure incurred in achieving their overall well being deserves close study. Institutional arrangements like health insurance are means to that end. Sure enough, health insurance system does not augment the available resources for healthcare. What it does is create mechanisms for pooling the resources to improve their overall effectiveness. Preventive healthcare and the concept of wellness are still not common in our society where healthcare has been revolving around sickness care. It is time that health insurance graduates from sickness care and gives due recognition to preventive care.

1.3 The elderly are an important and sizeable component of our country's population and need for financing their healthcare is brought out in Chapter 2 of this Report which, among other things, deals with the National Policy for the aged, Policy framework for reforms in Health in India, Financing of Health in India etc. At this juncture, the Committee would like to state that for the purpose of health insurance, a 'Senior Citizen' should be a person aged 50 years and above. This is in line with the philosophy of planning for 'old age' from age 50 onwards. The Committee advocates that individuals join health insurance schemes while they are still young, but for the

purposes of implementation of the recommendations applicable to Senior Citizens contained in this Report, a Senior Citizen is one who is aged 50 or above.

1.4 A peek into the history of insurance in India and evolution of health insurance in particular, covered in Chapter 3 provides an insight into the backdrop in which the health insurance market works today and brings out the need for rationalization in health insurance. What logically follows is the pressing need for reforms in Health Insurance in general, and in particular from the perspective of the Senior Citizens. This is addressed in Chapter 4, which first discusses the existing regulatory provisions and then establishes the need for reforms.

1.5 One of the biggest concerns for Senior Citizens today, is the 'access' to health insurance. While the health insurance industry does have products available for Senior Citizens, very often, they are out of bounds for the Senior Citizens—either because they are unaffordable or the underwriting philosophy and practices of insurers are such that there are many barriers to get an insurer to keep a scheme for the aged going continuously. Chapter 5 covers these issues and makes out a case for innovations and improvements in not only underwriting practices but also product design and pricing with a view to making health insurance accessible to all senior citizens.

1.6 Product design is covered in Chapter 6. It deals with cost control mechanisms as well as the need for innovations in products, keeping in view the Senior Citizen segment of the population. The categorical recommendation is that every insurer should make available a product or a range of products for the Senior Citizens. This chapter is a curtain raiser for the issue of an affordable price for a product that would address the fundamental healthcare financing requirements of the Senior Citizens. The chapter that follows (Chapter 7) drives home the point that health insurance of senior citizens cannot be divorced from the steps they themselves need to take to remain healthy and from the arrangements for their healthcare. The chapter discusses the need for a balance between adequacy of and equity in pricing. Making health insurance accessible to all senior citizens at affordable prices would require bringing in elements of risk-based underwriting instead of relying solely on age-based underwriting, coupled with adequate cost-control measures.

1.7 While one often hears about how fast the health insurance sector has been growing and what tremendous potential exists for further expansion, it is a known fact that its penetration in relation to the country's population is very low. When it comes to the elderly, the penetration is even lower. Chapter 8 deals with our suggestions for

expanding the coverage of health insurance in India, especially of the elderly. The chapter brings in the concept of Family Clinics as a means of reaching out to Senior Citizens.

1.8 The Committee interacted with representatives of many stakeholders and most importantly, several Senior Citizens. The problems encountered by Senior Citizens in obtaining health insurance services at the points of sale as well as claims were discussed and possible solutions have been suggested in Chapter 9 of the Report.

1.9 Chapter 10 on Government Intervention covers promotion of stand-alone health insurance companies, creation of a health insurance pool, tax incentives and subsidies. The performance of the health sector is inextricably linked to health insurance. Streamlining of the health sector is a must, if health insurance is to be a success, has also been discussed in the Chapter.

1.10 The role envisaged for IRDA in the whole gamut of health insurance is detailed in Chapter 11. That IRDA has to be the torch bearer in the whole reform process needs no emphasis. There are a lot of developmental and structural thrusts that IRDA needs to give if it has to make a success story of health insurance. The chapter not only covers issues ranging from registration of stand-alone health insurers, health insurance regulation, health data initiatives, publicity and awareness generation, grievance redressal, micro insurance, social sector schemes etc., but also augmentation of its own resources for effective implementation and monitoring of the recommendations made in this Report.

1.11 Chapter 12 gives a summary of the recommendations contained in the various chapters of this Report.

1.12 Chapter 13 provides the terms of reference of the Committee, methodology adopted by the Committee and acknowledgements.

CHAPTER 2

FINANCING HEALTHCARE FOR THE AGED

The aged in India—National Policy for the aged--Policy framework for reforms in Health in India—Health of the ageing population in India—Provision of healthcare: Access and Service quality—Financing of Health in India: Public and Private expenditure — Need for financial protection.

The aged in India:

2.1 India's population is currently around one billion and is still experiencing high growth rates as compared to most emerging nations. By the year 2015, India's population will increase by a quarter to 1.24 billion.

2.2 The 2001 census has shown that the elderly population of India accounted for 77 million. While the elderly constituted only 24 million in 1961, it increased to 43 million in 1981 and to 57 million in 1991. The proportion of elderly persons in the population of India rose from 5.63 per cent in 1961 to 6.58 per cent in 1991 and to 7.5 per cent in 2001.

2.3 The elderly population aged 70 and above, which was only 8 million in 1961, rose to 21 million in 1991 and to 2.9 per cent in 2001.

2.4 The Indian population census reported 99,000 centenarians in 1961, their number rose to 1,38,000 in 1991.

Table 2.1: Number and proportion of Elderly in the Indian Population by Age-groups, 1961-2001

AGE	Number in millions					Percent of Elderly to the total population				
	1961	1971	1981	1991	2001	1961	1971	1981	1991	2001
60+	25	33	43	57	77	5.6	6	6.49	6.76	7.5
70+	9	11	15	21	29	2	2.1	2.33	2.51	2.9
80+	2	3	4	6	8	0.6	0.6	0.62	0.76	0.8
90+	0.5	0.7	0.7	1	n.a	0.1	0.1	0.1	0.2	n.a
100+	0.01	0.01	0.01	0.01	n.a	0.02	0.02	0.02	0.02	n.a

Note: Compiled from the last five population censuses.

Source: 'Population ageing and health in India'- Rajan Irudayam

2.5 The size of India's elderly population aged 60 and above is expected to increase from 77 million in 2001 to 112 million by the year 2015, 179 million in 2031 and further to 301 million in 2051. The proportion is likely to reach 12 per cent in 2031 and 17 per cent in 2051.

2.6 The table given below provides numbers of persons aged 60 years and above during 1901 to 2050 and the percentage of population in this age group.

Table 2.2 Number and Percentage of Persons aged 60 Years and above – 1901 to 2050

Year	No of Persons (In million)	%
1901	12.060	5.08
1911	13.169	5.24
1921	13.485	5.38
1931	14.208	5.11
1941	18.040	5.69
1951	19.612	5.50
1961	24.712	5.63
1971	32.700	5.97
1981	44.348	6.49
1991	57.554	6.80
2001	76.622	7.47
2010	101.232	8.62
2020	141.779	10.80
2030	194.795	13.75
2040	247.979	16.69
2050	308.463	20.14

Note: Figures for 2010 to 2050 from U.N., World Population Prospects

2.7 Advancement in medical care, improved housing and sanitation and higher levels of earnings has ushered in major demographic transformation—increase in life expectancy being a significant one.

2.8 India has made remarkable achievements in improving its health indices since independence. The improvement in the important health indicators are given below:

Table 2.3: Health Indicators for India

Health indicators	India Before	India After
Life Expectancy at birth	37(1951)	64 (males) 67 (females) (2006)
Infant Mortality Rate (per 1000 live births)	146(1951)	56 (2005)
Maternity Mortality Rate (per 1,00,000 live births)	750(1960s)	301 (2003)

Source: Govt of India and WHO reports

National policy for the aged:

2.9 The National Policy on Older Persons adopted by the Government of India recognizes that only a judicious mix of public health services, health insurance, health services provided by not for profit organizations and private medical care can address the healthcare needs of the older persons. The Policy goes on to say that 'development of health insurance will be given a high priority to cater to the needs of different segments of the population and have provision for varying contributions and benefits. Packages catering to the lower income groups will be entitled to state subsidy. Various reliefs and concessions will be given to health insurance to enlarge the base of coverage and make them affordable. At the same time, the Policy advocates the concept of healthy ageing. It is necessary to educate older persons and their families that diseases are not a corollary of advancing age nor is a particular chronological age the starting point for decline in health status. On the contrary, preventive healthcare and early diagnosis can keep a person in reasonably good health and prevent disability. Towards this end, the importance of balanced diet, physical exercise, regular habits, reduction of stress, regular medical check-up, allocation of time for leisure and recreation, and pursuit of hobbies will be conveyed.

Policy framework for reforms for health in India:

2.10 The state of health of citizens of a nation is a priority- it reflects the quality of life enjoyed by its people and impacts economic development. India does not have a strong health infrastructure and has several infirmities in its health system. This state of affairs portends a major handicap for India in the information era where quality of human capital of a nation determines economic development and quality of life. Thus, an improvement in health systems and infrastructure is vital to assure India's future. With the spread of communications, aspirations for a better quality of life are increasing. There is already a groundswell for better education. It is only a matter of time before similar demands arise for better quality health care. The worst possible scenario is already beginning to unfold in India. One segment of society is making the transition and has begun to require costly hospital treatment for chronic illness. On the other hand, a very significant population remains mired in an earlier communicable disease profile. It is imperative that India avoids merely investing in health care that addresses lifestyle diseases. India has to battle with life threatening diseases for a large component of its underprivileged while simultaneously caring for life style diseases for a large segment of relatively well-off people.

2.11 The Health Policy of India focuses on family planning, immunization, selected disease surveillance and medical education and research. The Union Ministry of Health and Family Welfare, Government of India is responsible for implementation of various programmes of national importance like family welfare and prevention and control of major diseases. The Ministry also assists states in preventing and controlling the spread of epidemics through technical assistance. In addition to centrally sponsored schemes, the Ministry has formulated and is implementing various World Bank assisted projects for the control of various diseases. State health projects are implemented through State Governments; however the Department of Health, Government of India, assists in availing external assistance.

2.12 Thus the National Health Policy 2002 focuses on the need for enhanced funding and organizational restructuring of the national public health initiatives in order to facilitate more equitable access to health facilities. The policy also focuses on those diseases that are principally contributing to the disease burden—TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of newly emerging diseases.

2.13 The policy sets out the basic objective of achieving an acceptable standard of good health among the general population of the country. A few focus areas of the policy are as follows:

- *Providing increased access to decentralized public health systems, enhancing public health investment, and converging public programmes*
- *Programmes to put in place a modern and scientific health statistics database and a system of national health accounts*
- *Gradual convergence of health under a single field administration and emphasis on implementation of programmes through local self-government institutions*
- *Identification of specific programmes targeted at women's health and strengthening of food and drug administration, in term of both laboratory facilities and technical expertise.*
- *Greater contribution from the Central Budget for the delivery of public health services at the state level.*

2.14 The National Health Policy (1983), in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to

provide ‘Health for All by the year 2000 AD”, through the universal provision of comprehensive primary health care services. However, the financial resources and public health administrative capacity was far short of what was necessary to achieve such an ambitious and holistic goal. The National Health Policy, 2002, therefore attempts to maximize the broad-based availability of health services to the citizens of the country, on the basis of realistic considerations of capacity and keeping in view the socio-economic circumstances currently prevailing in the country. One of the initiatives towards this end was the National Rural Health Mission (NRHM), 2005-12 launched in April 2005 by Government of India. The NRHM aims to fulfill the Government’s commitment to meet people’s aspirations for better health and access to healthcare services. Its ambitious goals include the training of 250,000 women volunteers designated as Accredited Social Health Activists (ASHAs) over the next three years across 18 states with weak rural health infrastructure

2.15 At the same time, India has the potential to be at the forefront of modern health care, given its strong base in quality health care professionals and cost effective world class drug research. India has the opportunity to harness these strengths to deliver quality health care not only for its people but to larger geographical regions as well. In such a setting, the vision for India in the area of health would be to foster a healthy society through provision of quality health care services to all citizens. To realize this vision, India has to focus on health development with the mission of creating an affordable and efficient health care system, balancing preventive and curative measures and establishing an enduring public-private partnership. India would need to follow several strategic objectives including increasing the overall Government expenditure on health care to improve equitable distribution between different segments of the population.

2.16 There is a need to ensure a health care safety net for the poor and indigent so that every citizen of India has access to affordable, appropriate health care, regardless of their socioeconomic status. It is necessary to reduce the health and health care disparities between urban and rural areas and between the States. This would require encouragement of an evolving range of health financing mechanisms that ensure financial viability of India’s health care system and supplement Government’s spending on health.

Health of the ageing population in India:

2.17 Ageing of population has wide policy implications for the Government. Older age groups cause greater demands on family, civil society and public resources. This group generates enhanced demand for primary and tertiary healthcare and welfare services and support.

2.18 Healthy ageing is a major concern among the graying population, since prevalence rate of morbidity is higher within this population segment. Developed nations make significant public fund allocations on the healthcare and welfare of the old, since this segment is disproportionately susceptible to multiple causes of morbidity, chronic ailments, longer hospitalization stays, more expensive diagnostic investigations, curative care and rehabilitation procedures.

2.19 In developed nations, the healthcare sectors, both public and private have adapted to the needs of provision of healthcare to the ageing population. Direct provision of healthcare or health insurance often subsidized by the Government, allows easy access of healthcare to this segment.

2.20 Unfortunately in India, public healthcare services have not been able to live up to the expectations of people. Private health sector has made impressive strides specially in providing tertiary healthcare, though, it remains expensive and often out of financial reach of older population.

Provision of Healthcare: Problems of access and service quality

2.21 The guide-lines for national health planning in India were provided by a number of committees dating back to the **Bhore Committee in 1946**, which laid the foundations of a comprehensive primary health care delivery system in the country, not too different from the National Health Service in UK and other such tax-funded health provision models in many countries. Over the last six decades, India did attempt to build an extensive public health infra-structure at primary, secondary and tertiary levels, but with mixed success. The public health sector continues to face problems like poorly motivated manpower, inadequacy of funding, skewed geographical distribution and other access issues. The problem of access to healthcare is even more pronounced in rural and remote areas, where qualified providers from the private sector are also conspicuous by their absence and the only qualified health provider is often a poorly motivated medical officer in the nearest government health centre. In the urban context, though private providers are available in plenty, the providers of healthcare in India

continue to be poorly regulated for pricing and quality, despite a multitude of legislations having been enacted for the health sector. The absence of any significant influence from large organized purchasers of healthcare (like insurance mechanisms or the government itself) has also contributed to the situation where there is virtually no check on what a provider can charge for healthcare services, and often no check even on the quality of services rendered. This raises serious concerns of access to healthcare, which is equally, if not more, pertinent for senior citizens.

Financing of Health in India

2.22 Financing of a health system is closely and indivisibly linked to the provisioning of services and helps define the outer boundaries of the system's capability to achieve its stated goals[1]. Based on two separate studies commissioned by the Ministry of Health and Family Welfare, Government of India (National Health Accounts Cell, 2006 and the National Commission on Macroeconomics and Health, 2005), the magnitude of health expenditure in India for the year 2001-02 was calculated as about **4.8% of the GDP** at current market prices[2,3]. On the whole, this figure compares well with other countries having a similar socio-economic and development profile, but unfortunately, it is the households or the private health spending which predominates in India, with close to four-fifths share, and we also do not favourably compare on health outcomes

Public Expenditure on Health in India

2.23 Out of the total health expenditure in the country, the share of public or government spending, i.e. that of Central, State and Local Governments taken together, is about **one-fifth of the total health expenditure** (NHA Cell, 2006). The per capita total health spending in India was about **US$23** during 1997- 2000 (World Bank 2003). This, when compared to the levels of spending by countries such as Sri Lanka (US$31) and Thailand (US$71) in the same period, is substantially lower. At about **0.9% of the GDP**, India's public health spending appears even poorer in comparison with China, Sri

[1] Rao KS, Selvaraju S, Nagpal S, Sakthivel S. Financing of Health in India. National Commission on Macroeconomics and Health, Governement of India. New Delhi, 2005.
[2] National Health Accounts Cell, Ministry of Health and Family Welfare, Govt of India. National Health Accounts-India- 2001-02. New Delhi, 2006
[3] Ministry of Health and Family Welfare, Govt of India. Report of the National Commission on Macroeconomics and Health, Governement of India. New Delhi, 2005.

Lanka and Thailand, for which this proportion was 1.95%, 1.8% and 3.06% respectively[4].

2.24 The low public investment in health and the absence of any form of national social insurance have heightened insecurities, and the senior citizens in the country also face the same, perhaps even more so, for the reasons discussed in the pages that follow. The unpredictability of illness requiring substantial amounts of money at short notice are **impoverishing an estimated 2.2%** of India's population every year[5]. Illness, thus, has the potential for catastrophic effects on individuals and their families.

Private expenditure on health in India:

2.25 Private expenditure in India is mostly on curative care, consultations, diagnostics and inpatient care. Expenditure on preventive care has been moderate. It has been pointed out that private sector has stepped in bridge the growing demand and supply gap. It is slowly and steadily increasing its dominance in health delivery, with majority of household health expenditures being channeled to it. Most of the household expenses are being met out of savings due to absence of any alternative financing. The majority of the population seeks care during their illness from private rather than public providers for out-patient care and a very thin majority of sick people seek care from public providers for in-patient care. High-income families and individuals with privileged access to other facilities avoid public health care services whenever possible. 95% of visits for treatment to private facilities are by households in the top 20% of the income distribution.

2.26 The fact that Government expenditure has not only been low but declining over the plan periods (it dropped from 3.3 percent in the First Plan to 1.7% in the Eighth plan) drew the following comment made in the Eighth plan it is time that the concept of free medical care is reviewed and people are required to pay even if partially, for the services.

2.27 In the light of the fiscal crisis facing the government at both central and state levels, in the form of shrinking public health budget, escalating health care costs coupled with health care services and lack of easy access of people from the low-income groups to quality health care, health insurance is emerging as an alternative mechanism for financing healthcare.

[4] Calculated from the World Health Report, 2005.
[5] World Bank. Raising the Sights:. Better Health Systems for India's Poor. Overview. November 3, 2001. Health, Nutrition, Population Sector Unit. World Bank, India, 2001.

Need for Financial Protection:

2.28 While there is substantial awareness of health insurance being a mechanism for financial protection of the enrollees to meet costs of healthcare, it is important to remember that health insurance also has the potential to influence provider behaviour. Presence of financial protection could itself contribute to increased access to healthcare (Kutzin, 1998) as the cost barrier is overcome by many who would not be able to afford healthcare otherwise. Further, by acting as large purchasers of healthcare, health insurance schemes could have the negotiating power which can potentially influence provider behaviour, something an individual purchaser of healthcare cannot achieve. Conversely, poorly designed health insurance systems could lead to the providers pushing up costs and actually reduce access for the uninsured, and thus, has implications on the accessibility, costs and quality of healthcare.

Importance of Financial Protection for Senior Citizens

2.29 It need not be reiterated that financial protection for health related expenses is all the more important for senior citizens. On one hand, many of the senior citizens are decreasing the level of their workforce participation and their incomes in turn are either inelastic or even declining. On the other hand, for many of them, health status also begins to decline, implying higher risk of hospitalization and need for expensive health services. And finally, these events are often interrelated, e.g., health problems could reduce a person's ability to work and consequently income declines[6].

2.30 The changes in the social milieu (e.g. disintegration of the joint family system, increasing nuclear families) coupled with increased longevity has implied that the senior citizens need to have financial protection from health related conditions for long periods of time, and the most feasible option appears to be health insurance, where pooling of risks could help protect them (and their families) from sudden or catastrophic expenditure on health events.

[6] Holahan, J. Health Insurance coverage of the near elderly. The Urban Institute, USA. July 2004.

CHAPTER 3

HEALTH INSURANCE IN INDIA

Development of Insurance in India—Evolution of Health Insurance in India— Current Perspective.

Development of Insurance in India:

3.1 The history of insurance in India could be traced to the country's deep-rooted history where insurance finds mention in the writings of Manu (*Manusmrithi*), Yagnavalkya (*Dharmasastra*) and Kautilya (*Arthasastra*). The writings refer to pooling of resources that could be re-distributed in times of calamities such as fire, floods, epidemics and famine. The tradition was preserved in the form of marine trade loans and carriers' contracts. Insurance in India has evolved over time heavily drawing from other countries, England in particular. Insurance developed in India with the establishment of life and non-life insurance companies, beginning early 19th century.

3.2 The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business. In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life business transacted in India by Indian and foreign insurers including provident insurance societies. In 1938, with a view to protecting the interest of the Insurance public, the earlier legislation was consolidated and amended by the Insurance Act, 1938 with comprehensive provisions for effective control over the activities of insurers.

3.3 There were allegations of unfair trade practices and there were apprehensions over the solvency of the insurers. The Government of India, therefore, decided to nationalize the insurance business, initially the life insurance business in 1956, and followed by the nationalization of the general insurance business in 1973. Accordingly, the Life Insurance Corporation of India, and the General Insurance Corporation of India, with its four subsidiaries, namely, the National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd.were formed.

3.4 This millennium has seen insurance come a full circle in a journey extending to nearly 200 years. The process of **re-opening of the sector** had begun in the early 1990s to increase the penetration of insurance, to improve customer service, to enhance the efficiency of the insurance industry and to bring down costs through

competition. In 1993, the Government set up a committee under the chairmanship of Shri R N Malhotra to propose recommendations for reforms in the insurance sector. The Committee submitted its report in 1994 wherein, among other things, it recommended that the private sector be permitted to enter the insurance industry. It also stated that foreign companies be allowed to enter by floating Indian companies, preferably through joint venture with Indian partners.

3.5 Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry.

3.6 The IRDA opened up the market in August 2000 and so far, 16 life insurance companies and 17 general insurance companies, including two stand alone health insurance companies, the ECGC and Agriculture Insurance Company of India, are operating in the country.

Evolution of Health Insurance in India:

3.7 Formal systems for Health Insurance in India began with the inception of the **Employees' State Insurance Scheme**, introduced vide the ESI Act, 1948. Established in 1948, the Employees State Insurance Scheme (ESIS) provides for both cash and medical benefits. It was introduced as a social security blanket for workers employed in the formal sector, in organizations which meet certain criteria for enrolment, and these criteria have been revised from time to time. ESIS provides for comprehensive health services through a network of its own dispensaries and hospitals, supplemented by Authorized Medical Attendants and private hospitals to serve needs which cannot be met by its own network. The coverage includes OPD and IPD services, and a large variety of cash benefits to compensate for loss of pay and other eventualities. The scheme is largely financed through a contribution from employers and employees, which is supplemented by the Central and State governments. The ESIS covered about 33 million beneficiaries in 2005-06.

3.8 The ESIS was soon followed by a scheme for central government employees, the **Central Government Health Scheme (CGHS)**, which was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. The list of beneficiaries includes all categories of current as well as former central government employees, members of parliament, supreme court and high court judges, and certain other categories of

beneficiaries. CGHS has over 44 lakh beneficiaries and is financed largely by the Government of India budget, while the government employees also contribute a nominal amount (ranging from Rs 15 to Rs 150 per month) from their salaries based on their scale of pay. Here also, the coverage is comprehensive and includes both outpatient care and hospitalisation. OP care is provided through CGHS dispensaries, located in major cities. It also uses the facilities of the government and approved private hospitals to provide inpatient care and reimburses the expenses to the patient or the hospital, as the case may be.

3.9 Even before nationalization, non-life insurers were providing health cover, largely on group basis, and individual health insurance schemes were few, with diverse terms and conditions. After nationalization, the four subsidiaries of GIC continued to issue health insurance policies, more as tailor-made group covers to corporates with varying terms and conditions. The first serious attempt to standardize the terms and conditions of health insurance was made by the GIC in 1986 with the launch of what is popularly known as the "**Mediclaim**" policy. Mediclaim is a voluntary health insurance scheme and covers for hospitalization and domiciliary hospitalization episodes (and certain day care procedures) with certain exclusions like pre-existing diseases, pregnancy and child birth, HIV-AIDS, etc (though maternity is covered in Group Mediclaim policies). It is an indemnity cover, where reimbursement of expenses is provided to the insured, or more recently, directly to the hospitals through the mechanism of Third Party Administrators.

3.10 Over the last two decades, the **standard Mediclaim product underwent a number of revisions and modifications**. Also, in recent years, particularly from private insurance companies, there has been the availability of newer products which have included certain innovations. Thus, the maximum sum insured available under Mediclaim, which used to be Rs 83,000 in 1986, became 1 lakh in 1996 and shortly thereafter, the sum insured was increased to Rs 3 lakhs, and finally, to Rs. 5 lakhs presently. However, still higher sum insured is now available under other products. Similarly, the concept of 'sub-limits' for room charges, OT, surgeon's fee etc. which formed part of the original mediclaim product, was done away in 1996, but has been re-introduced in newer versions of the product as a measure of cost-control. A major innovation in the post-2000 period, is the availability of 'cashless' facility through the agency of TPAs or through direct tie-ups of insurers with hospitals, where the insured need not make payments to the hospitals and the same is settled directly by the insurer (or through TPA) with the hospital. There has also been an increase in the maximum

age at which cover can be granted under mediclaim (subject to necessary medical examinations) which presently stands upto 80 years in some versions- though in practice, underwriting practices vary and acceptance rates at higher age groups are significantly lower.

3.11 The insurance industry also **innovated and launched certain other health insurance related products**, to fill in certain gaps which were not addressed by the Mediclaim policy. Even prior to the opening up of the insurance sector, a number of products like Jan Arogya, Bhavishya Arogya 1990, SCUP (UTI – Senior Citizen Unit Plan), LIC Asha Deep, Jeevan Asha and Nav Prabhat), Overseas Mediclaim Policy, Cradle Care, Long Term hospitalization, Critical Illness/ Dreaded disease cover, Cancer Insurance etc were introduced by the industry. In recent years, the availability of newer products has been still higher, and there are earmarked products for Senior Citizens, for Diabetics, against specific diseases, for lower socio-economic groups (Universal Health Insurance Scheme) and the pace of innovations is increasing with the entry of stand alone private health insurance companies in the market since 2006. Already, two stand alone private health insurance companies are operational, and health insurance is now an increasingly important portfolio of other insurance companies. As of March 31st 2007, the industry registered a premium of Rs 3209.9 crores from health insurance products and approximately 25 million insured persons were covered under Mediclaim and other health insurance policies. Further details about products currently available in the market in India and problems of accessibility are covered in Chapter 5 of the Report.

Current Perspective:

3.12 The urgent need for rationalising health insurance arises out of several factors-- Health expenditure is a major outgo from an individual's income and out-of-pocket payments may not be sufficient in the event of even minor hospitalizations. Health Insurance is an ideal mechanism for protecting an individual's earnings by transferring the risk. Health insurance can provide a better access to health care. A properly managed health insurance programme would not only protect the finances of the individual but also ensure wellness by providing access to preventive health care. It can also be used as a tool for obtaining cost effective healthcare.

3.13 Basically, a health insurance policy protects a policyholder against uncertain illness/sickness by either reimbursing the costs of medical treatment or paying a lump sum amount to the policyholder in the event of diagnosis of a specific ailment covered under the health insurance policy. The principle underlying health insurance (as in other

insurances) is from the total pool of premium contribution of the policyholders the 'fortunate' take care of the 'unfortunates'. In India, presently the health portfolio is showing a high claims ratio implying that the claims outgo is being funded from either the reserves or cross-subsidized by other classes of insurance business like fire and engineering. However, this element of cross-subsidization would not continue for long since fire, engineering and motor classes of business are witnessing drastic fall in prices in view of competition as a result of detariffing.

3.14 Hence, it is imperative that there be adequate numbers not only to sustain health insurance but also ensure affordable premium. In the case of senior citizens, with the total number of insured persons being low, both the parameters, viz. claims outgo and the number are loaded against them. It is therefore a prime requisite that the number of uninsured senior citizen population (over 80 million) is brought into the commercial health insurance fold. The Life insurers also market health insurance which is mostly in the form of riders or long term benefits policies, but the policies are directly targeted at the younger population. There are very few stand-alone health insurance products in the life sector.

3.15 That the Health Insurance sector needs reforms requires no further emphasis, and this is discussed in the next Chapter.

CHAPTER 4

NEED FOR REFORMS IN HEALTH INSURANCE

Existing Regulatory provisions- Need for Reforms from the Senior Citizens' perspective

Existing Regulatory provisions:

4.1 Already, as provided in the Insurance Act, 1938**, both Life and Non-life Companies may underwrite health insurance policies**. Section 3 (2AA) under Part II dealing with 'Provisions applicable to insurers' of the **Insurance Act, 1938 (as amended in 1999)** 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 regulations made by the Authority, to carry on the life insurance business or general insurance business for **providing health cover** to individuals or groups of individuals.'

4.2 Regulations 12(3) of **IRDA (Registration of Companies) regulations, 2000,** under 'Consideration of Application' state that 'The Authority shall give preference in grant of certificate of registration to those applicants who propose to carry on the business of providing health covers to individuals or groups of individuals.' (the regulations define 'Health Insurance Business' or 'Health Cover' as 'the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient, on indemnity, reimbursement, service, prepaid hospital or other plans basis, including assured benefits and long term care').

4.3 The various Acts, Regulations, Rules, Notifications, Guidelines etc governing the conduct of insurance business applicable for all classes of business (life or general) as the case may be would be equally applicable for Health Insurance business. These include, for example, the Protection of Policyholders Interest regulations, the File and Use guidelines, the Advertisement and Disclosure regulations, Rural and Social Sector obligations, licencing of intermediaries etc. There are also separate regulations on Micro Insurance policies which include Health Insurance.

4.4 As on date, there is/are no separate Act/s, Regulations, Rules, Notifications, Guidelines etc dealing specifically with Health Insurance, except the **'Insurance Regulatory and Development Authority(Third Party Administrators—Health Services) Regulations, 2001.** Under the IRDA (Third Party Administrators—Health

Services) Regulations, 2001, a ' TPA' means a Third Party Administrator who, for the time being is licensed by the Authority, and is engaged, for a fee or remuneration, by whatever name called as may be specified in an agreement with an insurance company, for the provision of health services. The first set of companies were given TPA licences by IRDA in March, 2002. Presently, there are 27 licensed Third Party Administrators (TPAs). The basic functions of Third Party Administrators are to provide cashless facility to the insureds and process claims on behalf of the insurers. Covered medical expenses are paid by the TPAs directly to the hospital. The TPAs serve as extended arms of the insurers and provide assistance to the insured, whenever required and/ or asked. A Third Party Administrator acts as a link between the insurer and the hospital in terms of the contract that the TPA has entered into with the insurer.

Need for Reforms from the Senior Citizens' perspective:

4.5 Health Insurance is a vital part of health care financing, and it is also a **highly specialized** class of insurance; however, it is still managed by organizations and personnel with limited specialized domain knowledge. Health insurance business is transacted by non-life insurers under 'Miscellaneous' class of insurance business which includes other forms of business like Burglary, Fidelity Insurance, Cattle, Motor, Engineering, etc, which are very different from Health Insurance. Health insurance has thus been a neglected branch of insurance.

4.6 Though Health insurance in the country can be marketed by the life and non-life insurers, apart from the stand-alone health insurers, it is the non-life insurers who have been selling most of the health insurance policies in the country. In the international context, health insurance is more often the domain of the life insurers or specialized health insurers than of non-life insurers. Until the establishment of the TPAs, not much morbidity data was available with the Indian insurance industry. Even now, though substantial amount of data is being collected, the method of collation of health insurance data and its subsequent analysis needs substantial improvement. There is therefore, definitely a case for health to be a separate line of business for insurance companies, or even to spin-off separate subsidiaries for handling health insurance business, given the tremendous potential for expansion in the years to come.

4.7 Reforms in Health Insurance are also needed to make the products **friendlier to the senior citizens**. Senior citizens will constitute an increasingly significant group of population from the ensuing decade. The process of building up numbers of insured

persons from among the future senior citizens should start now itself, so that adequate volume of premium is built by insurers and adverse selection is avoided.

4.8 In the context of the consumers' need to be able to make a comparison of the health insurance products available from different insurance companies, especially in the case of Senior Citizens, IRDA should examine to what extent the existing agency system and/or broker community can be utilized to propagate Individual Health Insurance.

4.9 There is also a necessity to specifically provide for the health insurance needs of the Senior Citizens through the micro-insurance medium and a separate schedule including the sum insured and benefits applicable for Senior Citizens may be indicated in the relevant regulations. Intermediary channels available to other micro insurance products need to be extended to the senior citizen micro insurance products.

4.10 Reforms are also needed to **facilitate innovations** in the industry and to broaden the scope of health insurance. Despite recent initiatives by the regulator and the industry, there is still a lack of innovative health insurance products in the industry. Most of the policies continue to be hospital-centric and disease-centric rather than incorporating elements of preventive health care also. There has been a steady development and increasing recognition of **other systems of medicine** that is not being adequately recognized by the insurance industry.

4.11 The **awareness and efforts to popularize health insurance** have also been sub-optimal. Concerted efforts would need to be made in this direction by the insurers and the IRDA. The low penetration of health insurance in the country is because the insurance companies have not been marketing their products enough. While the organized sectors of the economy have witnessed varied forms of health insurance being available, insurers have not yet reached out to the masses.

4.12 One-sided **terms and conditions** (especially in regard to pre-existing diseases conditions, renewals, imposed exclusions, etc.) in the health insurance policies, and poorly explained fine print of these policies, has made health insurance the product with the poorest customer satisfaction, accounting for a disproportionately high number of grievances. Adjudicating and grievance re-dressal authorities are flooded with complaints relating to health insurance claims or servicing.

4.13 The reforms in health insurance also need to address the issue of **regulation of providers**. There is no regulatory body or widely available mechanism for

standardization or accreditation of medical services and institutions. Complaints of unwarranted medical services given to insured patients are galore. There are also serious charges by the insurance industry that growth of health insurance has pushed up hospitalization bills, as rates charged by providers remain unchecked.

4.14 The Committee observes that there have been inadequate incentives to promote individual health insurance. The complex socio-economic structure of the country has its implications on the availability and affordability of insurance. On one hand, the privileged few with access to corporate group health insurance policies enjoy liberal coverage and subsidized pricing, and on the other, premium for the individual policy holders and especially senior citizens, are witnessing escalation in premium resulting in declining affordability. There is a need for reform, so that cost-control mechanisms are put in place and **premiums remain affordable**, and the pool of insured persons increases, rather than encouraging adverse selection through high priced products. At the same time, the business has to be sustainable and viable in the long run, and so premium rates cannot be artificially kept low. This is another aspect for reform which this Committee has identified.

4.15 At any time, there will be certain individuals, particularly senior citizens, whose present medical condition will not make them readily 'insurable'. This Committee believes that there is a role for the government in addressing the needs of these 'high risk' individuals through a pre-dominantly government funded **'pool' mechanism** with participation of all stakeholders of the industry. This is another area for reform which this Committee has considered and will be detailed further in the ensuing sections of this Report.

4.16 In addition to the role in awareness, the **insurance regulator has a huge and onerous task** to bring about several reforms in the manner health insurance is regulated, sold and managed in the country. These reforms within the regulator and also at the behest of the regulator will play the most important role in ensuring that health insurance in India is a success story and does not end up like many other countries where spiraling costs, high premium and other problems have resulted in a very complicated and inefficient health insurance system.

CHAPTER 5

ACCESS TO HEALTH INSURANCE FOR SENIOR CITIZENS

Products currently available for Senior Citizens—Underwriting practices of insurers—Affordability and accessibility major concerns.

Products currently available for Senior Citizens:

5.1 Prior to 1986, voluntary health insurance in India meant different types of products offered by different companies. Most of the covers were in the form of tailor-made group health covers. It was in 1986 that the **Mediclaim** policy was introduced as a standard cover, for individuals as well as groups. Since then, it has dominated the health insurance market for nearly two decades. In the last four or five years, post opening up of the insurance market to private insurers, the health insurance market has seen the introduction of benefit covers (defined benefit) such as Hospital Cash and critical illnesses . However, these are very few in number and there is not much awareness about these options.

5.2 The Mediclaim is an indemnity policy sold by the four Public Sector Insurance Companies, viz. The National Insurance Co Ltd, The New India Assurance Co Ltd, The Oriental Insurance Co Ltd and M/s United India Insurance Co Ltd. The product was developed by the holding company of these insurers, viz. M/s General Insurance Corporation of India Ltd and the companies followed identical terms, conditions and rates. The product was continued to be sold thus even after the Public Sector General Insurance Companies became independent of the General Insurance Corporation of India. However, in 2006/2007, each company modified the policy differently in its scope, eligibility norms and benefit packages.

5.3 Mediclaim had evolved based on the market needs and underwent major structural changes before each company decided to modify it differently. When it was introduced, it had the accident component and the hospitalization part had limits of expenses, referred to as Tables of Benefits for various components of hospitalization expenses. There were six defined categories of benefits and premium was independent of age. The Tables of Benefits and sub-limits were done away with effect from 1996 and reimbursement was allowed up to the sum insured without any cap or sub-limits. Different bands of sums insured were introduced and premium was determined based on the sum opted and the age of the insured. Now, the companies have revised the

Mediclaim with reintroduction of some features such as sub-limits and bringing in new features such as good health discount, loyalty discount for family, modification in the definition of pre-existing disease to incorporate waiting periods etc.

5.4 It may be observed that the policy age-band does extend upto 75 to 80 years in case of most of the indemnity policies, critical illness benefit covers are not really available to the Senior Citizens. The position with regard to Hospital Cash covers is slightly better in that such policies are available upto age 65 or 70. Similarly, it is a concern that though the Life Insurance Corporation of India (LIC) and some of the private life insurance companies offer riders as well as stand-alone covers (though very few in number) in the form of Critical Illness Benefit of Hospital Cash, the outer age limit for entry (normally at 50) leaves out the Senior Citizens from its scope. An illustrative list of such riders offered by life insurers is contained in Annexure J. It is important to realize policies like Hospital Cash and Critical Illness covers are innovations that address affordability for the insured and cost control for the insurer.

5.5 For the lower income groups, the Universal Health Insurance Scheme (UHIS), Swasthiya Bima Yojana and Jana Arogya Bima policy (on lines of 'Mediclaim' with a lower fixed Sum Insured) are policies sold by the Public Sector General Insurance companies.

5.6 Some of the companies, including all the Public Sector General Insurance companies have either already launched or are about to launch policies specifically meant for Senior Citizens. These are also contained in the appended Annexure I. The policies, however, may need to be reviewed to address the pricing as well as other concerns related to the scope and design in the context of the Committee's recommendations

Underwriting practices of insurers:

5.7 Though there are some insurance products that are technically 'available' for senior citizens, in practice it is not easy for them to obtain a health insurance cover. The underwriting practices of insurers are not transparent and there are several complaints of arbitrary loading, denial of renewals and cancellations without assigning reasons. All these restrict access of Senior Citizens to health insurance.

5.8 Private insurers too have not really delivered. Not all private insurers offer health insurance and those that do are reluctant to cover the elderly.

5.9 The Committee examined the complaints received from individuals and consumer organizations on various health insurance issues. The complaints include - Non-availability or restricted insurance coverage for persons above 55 years. Even if there are products available, the insurers either adopt underwriting practices that deter individuals from obtaining the cover or the insurers do not propagate the covers even if available on the shelf. Sometimes existing products are replaced or withdrawn without allowing an insured to continue with the pre-revised product. The exorbitant premium rates are beyond the financial capacity of an average Senior Citizen and his/her spouse. Insurers also adopt the practice of loading the premium at entry over and above the published premium in the prospectus; blanket exclusion of pre-existing diseases, etc. With these, the policy holds no value for a senior citizen. Often, insurers also deny renewal facility when an individual migrates from one scheme to another or from a group health insurance to an individual policy, following super-annuation.

5.10 Many Senior Citizens also feel that savings linked or deferred medical care health insurance covers operating on a long term (life long cover) basis is the need of the hour.

Affordability and accessibility major concerns:

5.11 The Committee has observed that affordability and accessibility stand out as the most profound problems for Senior Citizens in health insurance today. The steep upward revision in premium for age groups above 60 years by the Public sector insurance companies, has made a severe dent in their limited resources. It is noted that the recent premium revision by these insurers has been effected after nearly a decade, by which times medical costs have grown exponentially. The Committee examined the pricing methodology of the health insurance products filed by insurers with the IRDA. It has noted that past claims experience of the relevant age groups is the major determinant for pricing. In other words, it is simply the 'burning cost' which is being examined for price adjustments. While industry wide claims data—product-wise, age-wise, disease-wise etc is not readily available, the Committee had the opportunity to examine the pattern of claims data furnished by individual insurers and the TPAs. Apparently, the claims experience of the higher age segments is adverse. However, while claims cost could be directly proportionate to age, the converse is not necessarily true. There are a host of other factors including health status, sex, occupation, life-style etc that need to be considered while rating a risk.

5.12 All along, Senior Citizens have been considered as a declined/sub-standard risk category by insurers and no attempt was made to penetrate this market segment. Obviously, the numbers available for analysis were very less and experience of this limited data has been extrapolated for pricing. While the Committee understands that pricing is a complicated topic, it nevertheless draws the attention of the insurers to this game of numbers. Health insurance involves class-rating and critical mass is the key to making it commercially viable.

5.13 While there has been a tremendous growth in the health insurance business in recent years, this is mainly due to group insurance covers, and individuals in general and senior citizens in particular, have not significantly contributed to this growth. The same group insurance covers are equally responsible for the adverse experience of the health insurance portfolio, prices being low and claims cost being huge. This adverse experience has led to increase in the price of individual covers, as the claims experience gets reckoned for the portfolio as a whole, there being no separate analysis of the experience of groups/individuals. In fact, the brunt of the increase is only borne by the individuals as, Corporates do continue to get subsidies in health insurance rates, even if not as much as they did earlier, i.e. prior to de-tariffing. The Committee is of the view that pricing of health insurance policies ought to be done separately for group and individual policies, factoring the distinct experience each has.

5.14 The Committee recommends that the industry graduates to Risk-based Underwriting, covered elsewhere in detail in this Report. While a small step has been taken by some of the insurers in the form of loadings for smokers, discounts for individuals going regularly to the gym etc, the industry has a long way to go to develop such a pricing mechanism that it attracts an individual to health insurance, thereby ensuring that adequate numbers enter health insurance schemes.

5.15 Another important area that needs attention is making the grievance redressal mechanisms more effective. The grievance redressal mechanism is the channel for insureds to represent or make a complaint where they have been denied access to any scheme by an insurer's office in its normal course of working.

CHAPTER 6

PRODUCT DESIGN

Proper product design—Design mechanisms: Insured persons; Providers ; Insurers --- Basic, Standard, Enhanced products—Policy clauses—Health Insurance data—The 'age' factor—Overseas Travel Insurance— Government Subsidized and Low Cost Health Insurance Plans for Senior Citizens---Recommendations.

Proper product design:

6.1 With the predominance of 'Mediclaim' and similar policies which are purely indemnity policies in the health insurance market, policyholders or prospects are not aware of other designs such as hospital cash or benefit policies as alternatives. These alternatives have not been fully explored by insurers though they can be effective drivers of cost control, as the policy does not pay beyond the specified limits. Policies that are in the nature of hospital cash or are on benefit basis are far and few today.

6.2 Unlike life insurance which deals primarily with mortality, health insurance deals with morbidity. Whereas in conventional life insurance there will generally be one claim, health insurance risk typically involves the possibility of multiple claims. Thus the frequency and severity of claims are important considerations for an insurer when designing as well as underwriting a health insurance product.

6.3 Medical costs have been continuously spiraling upwards and the health insurance policies show increasing levels of utilization. These two phenomena combine to put pressure on the underwriters to raise premiums or put restrictions on benefits and/or utilization. The underwriters, however, as discussed in the previous chapter could have adopted a more structured approach to this problem. Insurers tend to resort to sudden steep increases in rates since the products do not have inherent cost control mechanisms. Proper product designing can go a long way in containing costs for the insurer and the Committee believes that every insurer doing health insurance business can devise a 'basic cover' where the premium could be well below that indicated by the Committee for the cover mandated. Inherent cost control mechanisms in the product can help sustain high end products as well.

6.4 The Committee received various suggestions on controlling costs of healthcare services and also controlling over-utilization of healthcare services, both of which finally impact the premium charged by insurance companies and the long term

sustainability of the premium rates. This section briefly discusses some of the strategies to control such costs, and the committee's recommendations on the subject.

Cost Control Mechanisms:

6.5 Cost control is a key issue in health insurance product design. Insurers incorporate various cost control provisions in health insurance policies to contain over-utilisation of policy benefits which eventually result in high claims ratios. In absence of cost control methods, continued high claims ratios would drive premium rates upwards, eventually making health insurance unaffordable. Basic cost control components include: deductibles, co-payments, co-insurance and internal benefit limits. As the Indian health insurance market evolves on the healthcare continuum from the indemnity to managed indemnity and managed care, other approaches like utilisation reviews, case management etc are bound to develop.

6.6 In addition to reducing the insurance costs of the insurer, application of one or more of cost control measures results in the insured eventually taking the ownership of healthcare services to be delivered to him by weighing considerations of - when to seek care, what kind of care to seek and how much care to seek.

At the level of Insured Persons

Co-Payment

6.7 The widely accepted Mediclaim policy in India does not presently have the feature of co-payment, wherein the insured must bear a part or percentage of the claim costs. If used judiciously, co-payments can reduce over-utilization of healthcare services where the possibility of moral hazard exists, because a part of cost of all healthcare received is also borne by the insured. Also, co-payments can be structured so that specific behaviours are encouraged (e.g. semi-private wards could have much lesser co-payments than deluxe suites, and general wards none.). However, to protect the interest of the policyholder, the amount actually payable, if the co-payment is specified in percentage terms, needs to be capped, as even a small percentage of the cost could be prohibitive in the case of expensive treatment (e.g. cancer).

6.8 To keep costs low, the Committee is of the view that an alternative, lower-premium policy for senior citizens could be designed along with a co-payment clause, say 10% of the bill amount. However, there should be a cap on the maximum co-payment required per illness episode, and this could, for example, be capped at 5% of

the sum insured, per episode, or even eliminated in cases of selected terminal or incurable illnesses. For higher classes of rooms, say rooms costing more than Rs. 2,500 per day (excluding ICU) or 'deluxe' rooms, there could be additional co-pay, say another 10%.

Deductible

6.9 'Deductible' is another mechanism where an initial amount of each claim is borne by the insured. In an effort to reduce the number of claims through unreasonable hospitalization and to reduce high administrative costs in processing such claims and also to contain overall cost, companies may consider using a deductible as another cost control mechanism.

Coinsurance

6.10 A coinsurance amount refers to the percentage of a covered expense to be borne by the insured for each claim. A typical coinsurance percentage ranges from 10 to 20%, implying that the insurer pays 80 or 90 per cent and the insured bears the balance 10 or 20 per cent of the admissible claim. In a health insurance policy that has provisions for both deductible and coinsurance, the coinsurance amount is arrived at after the deductible is satisfied by the insured. The benefit design of Mediclaim at its launch consisted of coinsurance of 20% for package rates.

At the level of Providers

Standard Treatment Guidelines, Negotiated Package rates and Essential Drug Lists:

6.11 In the long run, to ensure consistent quality of services, and to also be able to compare and benchmark the costs of services rendered by health providers, there is a need to move towards accreditation and grading of providers, and also the implementation of standard treatment guidelines for managing cases of specific common conditions, particularly where there is substantial scope for standardization of diagnostic and treatment practices. This could be done through joint initiatives of Government, Regulator, Insurers (with their TPAs) and health providers. However, such initiatives will need time for proper development and implementation, and indeed they should. However, a process to evolve the same should commence immediately with clear timelines and milestones, so that it gets accomplished soon. Availability of such protocols or guidelines and their cost benchmarks will foster availability of more

transparent or 'package' charges from providers, which in turn will contribute to controlling costs. Standardization of treatment provided is required before negotiating for package rates with providers, as packaged rates without clear deliverables and expectations could lead to poor outcomes and be counter-productive.

6.12 Although this is not as significant a contributor to costs in the case of inpatient care as it is otherwise for outpatient care and for the health system as a whole, it is still important to consider the promotion of Essential Drug Lists, rational use of drugs, and arrangements for procurement and use of quality generic drugs, to keep drug costs under control. However, as more hospitals move to negotiated, package-rate based reimbursement systems, such mechanisms will certainly be brought in by the providers themselves. The essential drug strategy is supported by WHO, which states that careful selection of a limited range of essential medicines results in a higher quality of care, better management of medicines, including improved quality of prescribed medicines and a more cost-effective use of available health resources[7].

6.13 The negotiated package rates could subsequently evolve into more refined models of provider reimbursement, like Diagnosis Related Groups, Per Diem Rates etc. There should be no doubt that working on controlling costs at the provider end is as important as the product design itself.

At the level of Insurers:

6.14 While some of the mechanisms discussed above also have elements of product design, some additional cost control mechanisms to offer appropriate products for senior citizens are suggested below:

Sub Limits

6.15 The Mediclaim product has come full-circle, from having sub-limits, to abolition of sub-limits, and finally re-introduction of sub limits as a cost control mechanism. Sub-limits for room charges, surgeon's and anesthetists' fees, OT charges etc., are likely to be useful, as these also tend to be the most variable elements across hospitals and across patients, for similar diagnosis and similar procedures. Particularly until a system of STGs and package rates is in place, sub-limits will play an important role in controlling costs. Thus, capping the maximum reimbursable room charges at, say, 1% of the sum insured per day (higher for ICU) as is indeed now being done by

[7] WHO. http://www.who.int/medicines/areas/rational_use/en/index.html. Internet.

many insurance companies, will help control costs. The reimbursable professional fee (surgeon, anaesthesia, other specialists) could also be capped at a defined percentage of the total claim amount.

‘Basic’, ‘Standard’ and ‘Enhanced’ products:

6.16 The health insurance products for Senior Citizens should be designed according to their needs and capacity to pay. There is a need to offer a variety of products with different features, not just different levels of sums insured.

6.17 Some senior citizens may need a policy with a very low premium and to suit their need there should be a product with limited benefits such as covering stay in a general ward only, during the period of confinement etc. Similarly, senior citizens who can afford to pay higher premium may like to have the benefit of a cover that will be extensive with higher sums insured, upgraded room with better facilities and corresponding treatment packages. Such policies can use the mechanism of co-payment/limits on reimbursement of expenses to keep costs in check as also contain moral hazard. Somewhere in the middle of the spectrum could be a standard product, which allows coverage for semi-private rooms, a moderate sum insured, and some add-on features. The companies could have a ‘basic’ product which provides coverage for treatment in general wards, while entitlement for semi-private rooms or deluxe rooms could come at a higher price as an add-on cover.

6.18 Some companies exclude cost of treatment in respect of some specified diseases/surgeries for a certain period as a matter of policy even though they are not pre-existing illnesses. The higher end product range could examine such exclusions to expand their applicability perhaps for a reduced period of exclusion or even full coverage with appropriate loading in a selective manner. A reference to this type of product has been made while dealing with ‘Pre-existing disease’ exclusion.

Benefit or Hospital Cash products

6.19 Hospital Cash products pay a fixed amount for each day of hospitalization. Benefit policy products provide lump sum amounts on diagnosis of specified diseases for treatment/surgery. As the insured person receives a fixed sum regardless of the actual expenditure, there is incentive to contain costs on his/her part, as he/she is effectively spending his/her own money. Over and above such direct cost containment, the products also entail lesser administrative expenses and management cost at the level of the insurer. In respect of hospital cash or other benefit policies, a word of

caution is necessary since in the case of outright payment, the amount may not actually be utilized for providing treatment to the insured and the money may be misutilized.

6.20 It should be possible to creatively combine these cost control mechanisms and come up with products that come at affordable prices.

Policy clauses:

6.21 In keeping with the philosophy of the National Policy on Older Persons, it is necessary to assure the Senior Citizens that they will be protected through health insurance with guaranteed renewal.

6.22 It is also desirable that the health insurance policy is drafted in simple language with terms and conditions clearly stated for easy understanding by the users. There is also a need for the Industry to have a uniform definition of terminology and standard terms and conditions used in the policy. The Committee notes with satisfaction that the General Insurance Council has taken the initiative in this direction and has commenced its task. The Council has focused on the contentious issue of 'Pre-existing disease' exclusion clause and has suggested a common definition of a pre-existing disease as follows:

"Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed and / or received medical advice/ treatment, within 48 months prior to inception of your first policy"

6.23 Thus the 'look-back' period for pre-existing diseases would be limited to four years. This is a significant advance from the present position, where the look–back period has no limitation, and should provide considerable relief to the senior citizens.

6.24 The General Insurance Council has also proposed a uniform wording for the 'exclusion' of pre-existing diseases as under:

"Benefits will not be available for Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed and / or received medical advice / treatment, prior to inception of your first policy, until 48 consecutive months of coverage have elapsed, after the date of inception of the first policy".

6.25 The Committee feels that the health conditions fully disclosed at the time of proposal should be covered by applying one or more of underwriting methods i.e.,

defined waiting period, appropriate premium loading and capping the covered amount on the preexisting disease for the reference period.

6.26 The same approach should be adopted, in fact a more liberal approach, in respect of diseases which are not categorized as pre-existing. , that is, the waiting period, if any, should be carefully determined in respect of each specified disease keeping in view the probability of occurrence of the disease as well as the cost of treatment.

6.27 It is also necessary for insurers to have a consensus on issues such as portability of covers, sharing of information (such as creation of an information bank of rejected proposals, renewals denied and moral hazard related claims) etc.

Health Insurance data:

6.28 The creation of a common repository of data relating to health insurance is of paramount importance for the use of the industry. The Committee recommends that the IRDA should take initiative to strengthen the present arrangements. The initiatives need to take forward not only expansion of the repository to include data directly from insurers (currently the data flow is only from the Third Party Administrators) but also from other healthcare providers, in a seamless manner. Appended to this Report is a separate note on health insurance data.

6.29 IRDA should also institute a monthly reporting system from the all the companies licensed to conduct health insurance to provide the number of persons insured (monthly and cumulative) under each of their products. The numbers could be broken up by different age groups, such as 0-17, 18-34, 35-49, 50-59, 60-64, 65-69, 70-74, 75-79 and for 80 and above.

The 'age' factor:

6.30 When health insurance first evolved in India in a standardized manner in the form of the Overseas Mediclaim Policy (OMP) for overseas travel and the Mediclaim for domestic medical insurance by the Public Sector companies, old age was not a bar. OMP allowed coverage for individuals upto age 70 and in fact even beyond, but with either loading in premium or restriction in coverage or both. Similarly, the Mediclaim initially allowed individuals upto 75 years to enter into the scheme, this was later extended to 80 years. One of the PSUs extended the outer age-limit even further, upto 90 years subject to appropriate medical examination and review. . However, the

underwriting practices of the companies were not consistent and complaints from Senior Citizens regarding denial of fresh covers or renewals have become very common. Companies resorted to such denials in view of the claims experience of Mediclaim getting more and more adverse. As far as the private insurers are concerned, they have by and large covered only Groups and Corporates (which gives them a viable age-mix) and have paid little attention to insuring individuals. Even where they have offered policies to individuals, the age for fresh entrants years is restricted to 60 years.

6.31 The logic of companies denying cover for the aged, whether they are healthy or not and extending cover to those who are younger, however adverse their health status may be, is rather misplaced. While one does recognize the fact that a medical episode for the aged would mean longer hospitalization and therefore increased cost, it is also acceptable that instead of surgical procedures, very often medical management works well with the aged, involving a much lower cost rather than with younger persons when surgery becomes an easy option. In passing, the Committee observes that, by and large, Senior Citizens look after their health in a regular and methodical manner, which may not be possible for younger people for occupational and other reasons. In the presentations made before the Committee it was revealed that in absolute terms the claims experience for Senior Citizens is not quite adverse when compared to the volume of premium generated by insured persons.

6.32 At the same time, the Committee recognizes that people should enter health insurance schemes as early as they could, for better distribution of risk for the insurance companies and for building up sufficient reserve to be viable in the long term. Senior citizens must recognize that viable health insurance system revitalizes the economy by generating gainful activity all-round and it is as much their duty to strengthen the system as it is the obligation of the insurance companies to insure them. The absolute number of individuals covered must substantially increase to sustain viability. Reciprocal obligations are the essence of traditional *dharma*.

6.33 It is also well recognized that meaningful retirement-planning whether in terms of the retirement income flows, or the life style, or the interests and hobbies to be cultivated for post-retirement living, and above all, the place of residence for post retirement living, must engage the attention of everyone starting from an age not exceeding 50 years. Medical profession too is emphatic that a strict regime of preventive health including proper diet, regular exercise and periodical screenings and tests must commence no later than 45 to 50 years of age.

Personal Accident Insurance:

6.34 The Committee has also received suggestions that insurers should offer Personal Accident coverage as an optional rider along with the senior citizen health insurance products. This would help offer both forms of protection simultaneously to the senior citizens, and would also improve the market for personal accident covers. The Committee suggests that this should indeed be considered by insurers.

Overseas Travel Insurance:

6.35 The number of Senior Citizens traveling abroad is substantial and increasing day by day. Most of the insurers today have procedures for policy coverage that are detailed and at times cumbersome. It is not uncommon for insurers to delay the process of underwriting because of hierarchical set up with authority resting at various levels. The Committee feels that the companies may design a product where an insured could opt for the overseas travel cover during the period of the domestic medical insurance cover without the hassles of further medical examination as is being done by some private companies. The insurance could be granted based on a simple 'good health' declaration duly made by the insured. The objective of OMP is to grant only medical emergencies whilst the insured is outside India on business/vacation, etc. Hence there should be no requirement medical examination in addition to the one for the regular policy. It should be possible to simply provide an "add-on" clause stipulating additional premium for the period of stay abroad. The practice of extending the period of coverage corresponding to the period of stay abroad is clumsy.

6.36 If, however, the insured prefers to take a separate OMP, his/her health status could be evaluated at the discretion of the company.

Other systems of medicine:

6.37 The National Health policy, 2002 states "Under the overarching umbrella of the national health framework, the alternative systems of medicine—Ayurveda, Unani, Siddha and Homoeopathy—have a substantial role. Because of inherent advantages, such as diversity, modest cost, low level of technological input and the growing popularity of natural plant-based products, these systems are attractive, particularly in the underserved, remote and tribal areas." The importance of other systems of medicine for a country like ours needs no further elaboration. Hence, the medical insurance cover envisaged for Senior Citizens shall recognize and bring within its scope of coverage, specific treatment taken under other systems of medicine like Ayurveda, Unani,

Homeopathy etc. The companies may adopt the best practices in reimbursing the cost of treatment taken from recognized treatment centres. Appropriate sub-limits may be prescribed.

Summary of Recommendations

1.	Insurance policies should be drafted in simple language with terms and conditions clearly stated for easy understanding by the users. There is also a need for the Industry to have a uniform definition of terminology and standard terms and conditions such as the pre-existing disease condition etc. It is also necessary for insurers to have a consensus on issues such as portability of covers, sharing of information (such as creation of an information bank of rejected proposals, renewals denied and moral hazard related claims) etc
2.	Health Insurance products for senior citizens should be designed according to their needs and capacity to pay. There is a need to offer a variety of products with different features as well as different levels of sums insured**.** It should be possible to creatively combine cost control mechanisms and come up with products that come at affordable prices. To keep costs low, alternative, lower-premium policy for senior citizens could be designed using mechanisms such as co-pays, co-insurance, deductibles etc
3.	Insurers could also design products that offer an option to cover overseas travel during the period of cover of the domestic medical insurance
4.	The medical insurance cover envisaged for Senior Citizens should recognize and bring within its scope of coverage, specific treatment taken under other systems of medicine like Ayurveda, Unani, Homeopathy etc.
5.	Health conditions fully disclosed at the time of proposal should be covered by applying one or more of underwriting methods i.e., defined waiting period, appropriate premium loading and capping the covered amount on the preexisting disease for the reference period
6.	Senior Citizens must recognize that a viable health insurance system revitalizes the economy by generating gainful activity all round and it is as much their duty to strengthen the system as it is the obligation of the insurance companies to insure them
7.	People should enter health insurance schemes as early as possible for better distribution of risk for the insurance companies and for building up sufficient reserve for their viability in the long term

CHAPTER 7

RISK BASED UNDERWRITING AND PRICING

Pricing adequacy and equity—Pricing of the mandatory cover for Senior Citizens—Underwriting based on health status-Affordability

Pricing adequacy and equity:

7.1 Health insurance can be made viable not only by having properly designed products but also through appropriate pricing and sound underwriting. Good underwriting and rating creates a balance between adequacy and equity of rates keeping in view the affordability to the insured and the demands of competitive market. The Insurers should promote separate product (s) for the senior citizens with entry age of around 50 years or an omnibus policy covering all ages but without any age limit. What is required in terms of the National Policy on Older Persons is that the senior citizens should have access to health insurance.

7.2 The approach suggested by the Committee is that insurers should fix a 'base' price at the age of 50 and adjust it with a 'loading' for each year and a 'loyalty discount' for each year the insured has been with the health insurance system, not necessarily the particular product.

Pricing of the mandatory cover for Senior Citizens:

7.3 The Committee feels that the industry should aim at a 'base' premium of Rs.3,000/- per annum for a healthy individual at age 50 for a Sum Insured of Rs.1,00,000/-, at current levels of prices and healthcare costs. The Committee feels that the 'base' price for a healthy individual at age 50 for a Sum Insured of Rs.1,00,000/- should be around Rs.3,000/- per annum, at current levels of prices and healthcare costs. This would seem reasonable considering that the average per capita income in the country, at current prices, is Rs. 29, 382/- per annum[8]. The health insurance schemes for senior citizens introduced by the four public sector insurance companies are priced at this level of premium based on actuarial advice. If large numbers of senior citizens do take health insurance, insurers should be comfortable to adopt the base premium remaining at about 10% of the average per capita income, absorbing the general rise in healthcare costs.

[8] Figures for 2006-07 at current prices, from National Accounts for India released by the Ministry of Statistics and Programme Implementation, May 2007

7.4 It should be open to the insurance company to add at its discretion age-based loading to the base premium on a per year basis. To illustrate, if a company determines that loading at 2% per year would be appropriate, the age-based premium at age 65 years would have a loading of 30% on the premium fixed for entry age of 50. The present practice of specifying the premium based on 'age brackets' should be discontinued. A progressive increase from year to year, so long as it is a small percentage per year, and without compounding, is likely to be more acceptable.

7.5 On the other hand, it should be open to the insurance company to offer suitable loyalty discount for early entrants. To illustrate, if a company determines that a loyalty discount of 1% per year would be appropriate, the discount at age 65 for someone who joined the insurance system at age 50 would be 15%.

7.6 Since the Insurer would not have the option to refuse health insurance to any senior citizen applying to him, it is only fair that the Insurer be granted the **freedom to adjust the base premium for the health condition of the insured on the basis of a medical examination at the time of first entry**. The **premium adjustment** should be based on the probable impact of the health condition on health care costs and **likely claims** under the insurance policy the senior citizen opts for. **Persons with a credible record of good disease management should be encouraged.** The adjustment in the form of a loading on the basis of health condition should be made to the base premium as adjusted for age and early entry as discussed above.

7.7 On the basis of the initial medical examination, the applicant and the company should mutually **draw up a schedule of periodical examinations, tests and procedures designed to maintain and improve the health condition of the insured.** The insured must follow the schedule scrupulously. Failure to do so could lead to loss of guaranteed access to health insurance.

7.8 **At intervals of five years**, the insured should be required to again undergo a detailed medical examination, as at the time of first entry. Based on the results, the **premium should be adjusted to reflect the current health condition**. If in the opinion of either the insured or the insurer, there has been a material change in health condition of the insured, the medical examination could be arranged even before the expiry of five years.

Health Insurance Underwriting:

7.9 **It is essential that the Health Insurance industry adopts the practice of risk underwriting based on health conditions**. This type of underwriting more appropriately reflects the underlying health risk posed by each individual and allows the risk premium to most accurately reflect this risk. This is particularly important for Senior Citizens as health risks increase significantly with age but specific preventive and health promotion behaviour may go unrewarded if premium is related only to age.

Need is healthcare, not sickness care

7.10 There is worldwide and increasing concern that the present focus of the healthcare and health insurance is on curing sickness rather than promoting good health. A number of presentations have been made before the Committee on how a transformation can be brought about.[9] It has also been asserted, inter alia, that preventive care of the elderly is very cost effective and produces immediate results, unlike the strategies for younger age groups. Indeed, much of the preventive care should be, and is, undertaken by the elderly themselves, individually and in social groups.

7.11 The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Hence, 'healthcare' as distinguished from 'sickness care' should aim at prevention of diseases as far as possible. Prevention can be done in three stages, primary, secondary, and tertiary. Primary prevention (nutrition, hygiene, sanitation, exercise, life-style and environment) is what lay citizens can do on their own, without any active participation of the medical profession. Secondary prevention is early detection of disease and timely therapeutic intervention. Tertiary prevention is what the organized hospitals can do when the medical condition assumes a certain dimension.

7.12 The question of how to transform the present 'illness' based insurance system into a 'wellness' oriented insurance system must engage the attention of the health insurance industry in the years to come.

[9] Based on the presentation made to the Committee by Dr (Col) Kulwant Sharma of MGS Hospital, New Delhi. Two other articles by him on the same theme are appended to the Report.

Differential rating

7.13 It is clearly possible, and necessary, to incorporate elements of primary and secondary prevention into the health insurance system. In the case of senior citizens, this is inescapable. Sickness-based insurance premiums are becoming increasingly unaffordable to an overwhelming majority of the senior citizens.

7.14 “We can predict diseases and prevent them well in time. Our capabilities and competencies in this field are much more refined than curative therapies, especially for modern day diseases/disorders. There is an enormous amount of research data available as to how hypertension causes damage to the ‘end organs’ (like kidneys, eyes, brain and heart), and in how much time, and how to effectively prevent it. The same goes for diabetes mellitus, for arthritis and several other medical conditions,” as one of the eminent doctors who gave evidence before us stated.

7.15 In the immediate future, then, the correct approach to health insurance is to make use of this medical knowledge and expertise to underwrite individual policies. Also, in the context of our recommendation to mandate insurance companies to provide insurance to all senior citizens seeking it, the insurer would do well to adjust the premium for the health condition of the insured on the basis of an appropriate medical examination, instead of relying solely on age to determine the premium.

7.16 While age does enhance the risk of death and disease, the kind of health risk against which insurance is taken does not wholly depend on age. For each type of disease, the risk depends on several parameters of health and lifestyle of the individual insured person. Hence, the Committee recommends that only a modest increase in the annual base premium should be related to the age. To the premium thus arrived at, an appropriate price adjustment may be made depending on the specific health condition of each individual.

Principles to be followed

7.17 The purpose of recommending such price adjustment is two-fold. On the one hand, it increases premium paid as risk increases, which is in line with the risk-based approach to premium which any voluntary insurance system needs to follow. On the other hand, and more importantly, it promotes healthy lifestyles by rewarding health promotion and disease prevention behaviour with a lower premium, thus reducing morbidity in the system as a whole. A word of caution would be appropriate here. Health-status based pricing of insurance should not make it prohibitive for those who

are not so healthy or have a higher risk to take health insurance. Also, it is important to ensure that loading in respect of conditions and factors on which the applicant has no control should be minimal.

7.18 The premium adjustment should be based on the probable impact of the relevant health condition on his health care costs and the likely claims under the insurance policy. Persons with a credible record of preventive behaviour should be rewarded with lower rates. In laying down the underwriting principles for price adjustments, the insurance company should observe the principles of horizontal and vertical equity, that is, like cases should be treated alike and the differential between two classes should be reasonable and justifiable. The price adjustment pattern should be transparently reflected in the prospectus and policy wordings. There should be no arbitrary loading.

7.19 Differential rating based on health condition should demonstrably provide incentives to senior citizens for taking positive steps to maintain good health. It is recognised, however, that in the immediate future it may be difficult for Insurance companies to devise methods of providing positive incentives. But, even steps like adding a loading to the age adjusted premium on the basis of adverse health condition would be a powerful incentive to individuals to take steps to maintain good health and avoid the extra loading on premium.

7.20 The benefit for the insurance company would be lower 'claim' burden in later years. Insurance policies based on these principles would provide a challenge as well as an opportunity for the senior citizens as well as the insurance companies.

Underwriting based on health status

7.21 We recommend the following approach to underwriting and rating:

- Evaluation of Health Risk by:

    i. Health Risk Assessment questionnaire (includes capture of personal and family medical history)

    ii. Preliminary Medical screening for entry to health insurance system (with more elaborate testing if required)

        - Physical Examination by physician (MD)

- Appropriate laboratory, imaging and other diagnostic procedures
- More elaborate testing based on indications from preliminary medical screening, if required

- Age of the prospect
- Age of entry into the health insurance system
- Preventive health behaviour
- Physical fitness at the time of underwriting
- Application of premium adjustments to reflect appropriately the health status of the individual in an additive manner

    i. Health risks due to age, personal and family medical history

    ii. Good physical fitness and current preventive health initiatives

    iii. Entry age into health insurance system

    iv. Improvement in health condition year-on-year (at renewal)

7.22 We recommend that every insurer create meaningful guidelines for risk-based underwriting. These guidelines should be submitted as part of the product filing procedure for each product with IRDA.

7.23 Illustrative thoughts on underwriting and rating measures for a few of the disease conditions which today contribute to high claim ratio are described below.

Cataract:

7.24 An analysis of the disease-wise claim statistics in respect of senior citizens[10] shows that cataract surgery claims are highest by frequency and total amount claimed. Due to the nature of cataracts, the risk for the underwriter approaches one hundred per cent with age. The only viable means of covering risk for cataracts is an appropriate waiting period from the age of entry into the health insurance system.

[10] These statistics are compiled from limited data available and, hence, should be used with some caution.

Digestive and Urinary problems

7.25 Diseases of the digestive and genitourinary systems, that are nearly always preventable, also present a high bill to the insurers. Our recommendation would be for insurers to use methods such as applying co-insurance or other means by which these costs may be contained but benefits still provided.

Cancer

7.26 Cancer presents a most challenging risk to insurers and insured alike. An appropriate frequency of screening is the easiest means of detecting this illness – cancer markers, mammography etc. In addition, appropriate benefits design could have a tremendous impact in providing the best support to cancer patients and yet conserve claims cost to an optimal level. Behaviour that is known to cause cancer such as smoking should reflect a significantly higher premium as compared to a non-smoker.

Arthropathies

7.27 Early entrance to the health insurance system, along with screening such as bone densitometry at regular intervals can bring in early detection of such risks. In addition, longer waiting period and higher co-insurance for certain benefits related to these conditions could ensure the viability of these benefits.

Cardiovascular diseases

7.28 In the matter of claims paid, diseases of the circulatory system, that is, heart diseases and stroke come next only to cataract. The risk factors listed in the medical literature for these two diseases are: age, gender, family history, smoking, heavy consumption of liquor, improper diet, lack of physical activity, overweight, diabetes, high blood pressure and high cholesterol.

Age, gender and family history

7.29 Age, gender and family history are risk factors beyond the control of the insured person. All other factors are controllable, that is, can be modified to reduce the risk of incidence of the diseases. A logical approach, then, is to assess the health status of the applicant on certain remediable, observable and measurable factors.

Obesity and overweight

7.30 For overweight, an easily calculable index of health risk is Body Mass Index (BMI) which is worked out on the basis of height and weight. Premium adjustment could be made based on the BMI.

Diabetes

7.31 Diabetes presents a complex problem due to its being a chronic condition. While a person with diabetes, whose disease condition is managed appropriately doesn't pose a significantly greater risk than someone without diabetes, a diabetic who doesn't control this condition can suffer tremendous complications leading to significant hardship and extensive treatment costs. Chronic illnesses such as Diabetes and Hypertension need to be dealt with differently than other acute illnesses.

Smoking

7.32 Smoking not only increases the risk of coronary heart disease by itself but also increases the risk for diseases like diabetes and high blood pressure. Smokers are twice as likely to suffer a heart attack or stroke compared to non-smokers.

7.33 There remain the factors of **high blood pressure and high cholesterol** which could also play a role in future health status and accordingly used for premium adjustments.

7.34 The Committee recommends the above approach to underwriting and rating for health insurance products offered to Senior Citizens. Each insurer is expected to use its expertise and evolve specific guidelines for each disease category in relation to the coverage in each product.

7.35 Given the above, Senior Citizens might be apprehensive that, instead of a reduction in the premiums they were hoping for, the Committee's recommendations might increase premiums. They must face the reality that in the current scenario, insurance companies are faced with unacceptably high claim ratios in respect of senior citizens. The entire health insurance system can become unviable if premiums are not corrected to reflect current health risks. This can only result in further high increases in the premium levels in years to come especially because we are make it mandatory that all senior citizens seeking insurance should be accepted. In such a context, the only

options are that either all senior citizens face increased premiums or some who pose higher risks to the insurance companies pay more and others less.

7.36 The Committee preferred the option of relating the premiums to the health status of the individuals. It is also the only practicable approach for now to move towards a wellness-oriented health insurance.

Affordability revisited

7.37 Mention has been made of the indicative base premium of Rs 3000 per annum (at age 50 for an individual in healthy condition) for a Sum Assured of Rs One lakh for a standard policy on the lines of extant health insurance policies for senior citizens.

7.38 It should be open to the insurance company to offer policies with a lower sum insured than Rs. One lakh for a proportionate annual premium. For example, a policy with a cover of Rs.40,000 could be offered at a base premium of around Rs.100 per month (at age 50 for an individual in healthy condition). This order of sum insured would match the affordability levels and the costs of healthcare in rural and semi-urban areas and may well be the answer to spread health insurance there.

7.39 A more relevant approach to the question of affordability in all areas is to look at the extent of benefits. A feasible approach to lowering the premium to affordable levels is to restrict the coverage. Some of the health insurance policies introduced in the recent past restrict the coverage to specified critical illnesses. This has enabled them to lower the premiums. A base premium of Rs 2,000 (at age 50 for an individual in healthy condition) for such policies for Sum Assured at Rs one lakh is within the realm of possibility.

7.40 Yet another fruitful approach that has surfaced is what has been termed as ‘benefit’ approach, as distinguished from the traditional reimbursement approach, where, as soon as a specified illness is diagnosed, the insured is paid a specified lump sum amount. Such policies could bring down the premium level to Rs 1,500 or less.

7.41 Yet another way to cater to large numbers is to promote what are known as ‘hospital cash’ supplementary policies where a specified sum is paid to the insured for each day of hospitalization regardless of the disease and irrespective of any other insurance cover available to the insured. The premium for such policies could be brought down to even less than Rs 1,000. Insurance companies would do well to market

such policies aggressively so as to bring into their fold large numbers of beneficiaries of CGHS, ESIS and others

7.42 It would be appreciated that extending health insurance to all senior citizens regardless of their age, health condition or claim history, with unrestricted cover, and at a uniform low premium level is not a feasible proposition for a commercially viable health insurance system in the absence of any significant government support.

7.43 At the other end of the spectrum, there would be a class of senior citizens who wish to have insurance cover for much larger sums and for additional aspirational expectations. There should be no restriction on the health insurance companies catering to that class of people, charging them appropriately high premiums. Indeed, this would be one way for the health insurance companies to remain viable even while discharging the public policy obligation of extending coverage to all senior citizens.

Summary of Recommendations

1.	In keeping with the philosophy advocated in the National Policy on Older Persons, it is necessary that senior citizens should have access to health insurance. The insurers should promote separate products for the senior citizens with entry age of around 50 years or an omnibus policy covering all ages without any age-limit
2.	It is essential that the Health Insurance industry adopts the practice of risk underwriting based on health conditions. The insurer would do well to adjust the premium for the health condition of the insured on the basis of appropriate medical examination, instead of relying solely on age to determine the premium
3.	It is desirable that every insurer creates meaningful guidelines for risk-based underwriting. The Committee recommends evaluation of health risk by a health risk assessment questionnaire to capture personal and family medical history, capture the outcome of preliminary medical screening for entry to health insurance system
4.	It is suggested that insurers fix a 'base' price at the age of 50 and adjust it with an age-loading for each year and a 'loyalty discount' for each year the insured has been with the health insurance system, not necessarily the particular product. The Committee feels that the industry should aim at a 'base' premium of Rs.3,000/- per annum for a healthy individual at age 50 for a Sum Insured of Rs.1,00,000/-, at current levels of prices and healthcare costs. The insurance company, could at its discretion, add age-based loading to the base premium on a per year basis

CHAPTER 8

EXPANDING THE COVERAGE OF HEALTH INSURANCE

Socio-economic scenario in India—Penetration of Health Insurance in India—Health insurance for the elderly—Reaching out to Senior Citizens; Reaching the Elderly through Family clinics

Socio-economic scenario in India:

8.1 India is, today, one of the fastest growing economies of the world. It is witnessing a phenomenal growth rate of 9.3% of Gross Domestic Product. India's economic growth is also reflected in terms of shifting demographics, the details of which have been mentioned in Chapter 1 of this Report, as well as in its socioeconomic transformations. While improved health leads to better economic performance, improvements in the socio-economic sphere too contribute to better health. To quote from the National Health Policy, 2002: "While noting that the public health initiatives over the years have contributed significantly to the improvement of health indicators, it is to be acknowledged that public health indicators/disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education etc."

8.2 However, the paradox is, economic growth in India has also brought with it an undesirable transition in health status, namely, changes in disease patterns. Degenerative and lifestyle diseases are on the rise. The result is an ever increasing need for healthcare. The challenges relating to delivery of healthcare apart, those relating to financing healthcare are looming large. Health insurance as a solution has been recognized but has not really arrived. The Committee is of the view that there have to be concerted efforts on the part of insurers to increase the penetration and, the IRDA on its part has to play its developmental role more actively.

Health Insurance penetration:

8.3 Estimates put the insurable population (for health) in India at 350 million. Hardly 4 to 5% of them are actually insured. In terms of overall population penetration, it is less than 2%.

8.4 In terms of premium, though health insurance standing at over Rs. 3,200 crores is the fastest growing segment (42% growth in 2006-07) of the non-life industry in the country today, it still remains vastly underdeveloped. Swiss Re has estimated a

potential of US$ 7,700 million (over Rs. 30,000 crores) in health insurance premium by 2015.

8.5 Thus, despite the pivotal role that health insurance could play in the healthcare of the people, the penetration of voluntary health insurance in our country has been abysmally low. The figure of about 2% penetration of health insurance in other than the organized sectors is itself misleading. A large portion of this is in the form of 'group' insurance offered to higher paid employees of corporate entities. Penetration of individual health insurance is a small percentage of the total population. About 8% of the population do obtain healthcare indemnity through Central Government Health Scheme, Health Scheme of Railways, Armed Forces and other Government Departments and Agencies and, more importantly, the Employees State Insurance Corporation. Besides, the Life Insurance Corporation of India and some private life insurance companies offer 'health riders' to meet expenses connected with specified illnesses

8.6 The product range being offered by the Insurance Companies as already explained in Chapter V is not so consumer friendly as to become self-selling. Efforts to build a sound base of epidemiological information to evolve health insurance products to meet the needs of different segments have also been lacking. Also, as mentioned earlier, the present insurance policies do not cover the aspect of preventive healthcare even as medical sciences have made such rapid strides that the medical community confidently asserts that 'most diseases are preventable or their impact mitigated if early detection is made and follow-up action is taken.'

8.7 Customer care too has not been of such quality as to win over new applicants. The first ever customer satisfaction survey for the insurance sector done by Consumer VOICE in 2006 found that consumers expressed most dissatisfaction with the health insurance segment. The single largest source of dissatisfaction was disputed claims or their tardy settlement. The institution of Third Party Administrators introduced to redress the situation seems to have done little to improve matters while it has, no doubt, conferred on the insured the benefit of cashless settlement.

8.8 A separate Committee had earlier recommended that for enhanced penetration of health insurance, stand alone health insurance companies should be set up. The Committee endorses and reiterates the recommendation.

8.9 Equally important, IRDA must play an active 'development' role in health insurance. There is clear evidence that the initiatives it has taken in the recent past have had the desired impact on the thinking of the insurance companies. Intensified efforts on its part, on the lines we suggest in this Report, have the potential to dramatically

improve the health insurance scenario—indeed, the healthcare system. IRDA should become the torch-bearer in spreading the message of health insurance in the country.

Health insurance for the elderly:

8.10 Penetration of health insurance among the senior citizens is, of course, less than a fraction of 1% of the population of elderly. This is because health insurance has not been easily accessible for individuals beyond the age of 60 years as has been seen in one of the previous chapters. Even those who insured themselves at a younger age have been able to renew their policies only by way of an exception. Most of the insurance companies also seem to be stuck with an outdated definition of 'pre-existing diseases', exclusion of which from the scope of insurance is the main factor in keeping senior citizens away from health insurance and, incidentally, the cause of most disputed insurance claims. Also, it is facile to assume that senior citizens will have no pre-existing diseases.

8.11 In such a context, by and large, only those senior citizens who expect significant healthcare expenditure in the future are taking up health insurance – 'adverse selection' in the insurance terminology. For this reason, among others, the 'claim ratios' compiled by the insurance companies for the senior citizen groups are relatively high. No doubt, there are certain age-related degenerative conditions but few bear a direct relationship to bouts of illness requiring expensive healthcare. The medical profession rightly asserts that 'many diseases and conditions which are commonly perceived to be an unavoidable part of old age can in fact be treated or limited'.

8.12 The key issues are early entry into the insurance system, preventive healthcare and a careful evaluation of the need for expensive medical treatment *before* it is taken. These would require customer-friendly insurance products, with strong incentives for maintaining good health, and a careful monitoring of health in the context of the insurance policy by medical personnel who have no pecuniary interest in rendering more (or less) healthcare than what is warranted by the health condition of the insured.

8.13 Unfortunately, health insurance experience in some of the developed countries, especially in schemes intended to directly benefit the senior citizens such as Medicare in the US, has been very disconcerting. Health insurance has been illness-centered, not wellness-driven. In most cases, there is no proximate connection between the contribution for health insurance an individual makes and the delivery of healthcare to him, with the result that healthcare providers routinely render more care than necessary for their pecuniary gains and the insured could not care less. This has also

given rise to ‘kickback’ culture - doctors being ‘rewarded’ for prescribing investigations, procedures, and medications - vitiating the entire healthcare system. Resultantly, healthcare costs have risen at a rate more than twice the rate of inflation.

8.14 We should learn form the experience of other countries and do our utmost to contain healthcare costs. We need healthcare driven health insurance, not insurance driven healthcare. We must make sure that each individual buys that kind and extent of insurance as he perceives to be necessary for himself with the larger objective of remaining healthy.

8.15 By all accounts, the proportion of aged persons in the total population is steadily increasing. Unless we take steps to bring them all into the fold of a viable health insurance system and foster healthy ageing, instead of leaving to the uncertainties of family or public care, eventually, healthcare for the aged would snowball into a major socio-economic problem.

8.16 The IRDA Act empowers it to issue Regulations to the insurance companies to cater to the needs of weaker and vulnerable sections of the population in the specified manner. A good proportion of the senior citizens are ‘below the poverty line’. It is appropriate that whatever steps are taken by authorities, including the IRDA, to help this category should keep in mind the special needs of such senior citizens. But it would be wrong to categorise all senior citizens as belonging to ‘weaker’ sections of the society. However, all senior citizens are economically vulnerable since they have little opportunity to augment their incomes to compensate for rising costs, especially on account of healthcare. In such a context, for them to be denied access to health insurance is certainly unfair. Hence, IRDA should mandate the companies granted licenses to carry on health insurance business that all senior citizens should have access to health insurance regardless of age, health condition or claim history, except in cases where the person is diagnosed with selected terminal or incurable illnesses at the time of first entry.

8.17 In order that this mandate does not unduly affect the profitability of the health insurance companies a Health Insurance pool should be created under the aegis of the IRDA to take over high risk cases, for example, those who have health status based loading of 40% or beyond. Appended to this Report is a separate note on the possible mechanisms for the ‘pool’ or ‘fund’ envisaged.

8.18 That said, senior citizens should take health insurance from as early an age as possible so as to make the insurance system financially viable. However, since some of them might be availing of alternative sources of healthcare financing while in active

service, senior citizens could be allowed to enter the health insurance system up to the age of 65 years (or higher at the discretion of the Insurer). If they do so, they should be given guaranteed renewal of their insurance without any upper age limit.

8.19 As a transitional measure, since guaranteed access is being provided to the senior citizens for the first time, there should be no upper age limit for entry or renewal for a period of three years from the date IRDA issues the regulations. After the expiry of three years also, insurance companies should exercise their discretion in entertaining the first entry of senior citizens above the age of 65 years in deserving cases.

8.20 At the same time, a senior citizen holding a health insurance policy under the present dispensation should not be compelled to shift to any other policy under the new regulations/guidelines. He should also not be denied renewal of the existing policy.

8.21 The insurance companies should endeavour to offer continuity in health insurance for applicants who were hitherto covered by corporate insurance or insurance offered by any Government or otherwise, on conditions that they deem fit, subject to observing the principles of horizontal and vertical equity, that is to say, like cases should be treated alike and the differential between any two classes should be justifiable and reasonable.

8.22 It is one thing to provide guaranteed access but quite another to make health insurance affordable to all the senior citizens. The Committee is conscious of need to promote health insurance on sound commercial lines and this would require due regard being paid to the actuarial method of determining the premiums. Nevertheless, it would make a mockery of the principle of guaranteed access if a senior citizen with average income, who cannot be expected to benefit from any Government subsidy, cannot afford to pay for health insurance. Hence, the mandatory cover at the price level suggested by the Committee, earlier in this Report. Over and above this the insurance companies would be expected to offer a variety of plans using different mechanism as suggested in Chapter 6 of this Report. Insurers could innovate and also offer plans specifically suited to the Senior Citizens like capturing the lump sum retirement benefits and providing health insurance coverage for long years. The objective should be to increase the penetration of health insurance in the country (in terms of both numbers and spread) while making health insurance business competitive and commercially viable.

8.23 Retired employees of the Government, Railways, Defence etc, though covered under their respective health indemnity schemes, may find the coverage inadequate. This creates a need for products that could serve as ‘top up covers’. Insurers could consider designing such covers by which not only would the residual

need of the Senior Citizens be met, but also the health insurance net gets extended to a category of citizens who do not participate, barring perhaps a few, in any kind of health insurance scheme today. The number of people in such employer provided schemes being substantial, this strategy would certainly help improve penetration of health insurance in the country.

Reaching out to Senior Citizens:

8.24 The health insurance set up itself needs to be considerably decentralised. Unless the insurance system closely aligns itself with the healthcare of senior citizens, the desired expansion in coverage may not materialise.

8.25 In rendering healthcare to senior citizens, several disadvantages need to be overcome. These include: lack of easy access to medical advice; their reluctance to seek medical advice due low expectations of remedy, failure to recognise the problem, or fear of hospitalisation; inability to comprehend or communicate the nature of their medical problems; attempts at self diagnosis, self prescription and self-regulation of dosage; cascading effect of their medical problems because of the impact of age on different organ systems; prescription of multiple drugs by different specialists that can interact adversely.

8.26 Senior citizens require the help of a 'generalist' practitioner to guide them in seeking specialist advice and in coordinating the treatment given by the specialists so as to derive optimum results. Hospitals are not the best places for older people because of their impersonal character, especially when chronic care is needed.

8.27 What a senior citizen expects is a productive, ongoing relationship with a doctor who helps in obtaining reliable, cost-effective health care; someone needs to hold his hand, both literally and figuratively. He needs a system in which treatment decisions are taken by someone close to him but whose pecuniary interests do not conflict with his own interests.

8.28 The traditional family doctor, who seems to have become almost an endangered species, fits the bill very well. The multi-faceted relationship between the family doctor and his patients has traditionally been one of the most cherished social relationships. There is a strong case for reviving the concept of family doctor to promote healthcare and health insurance of the elderly. However, the functions of the family doctor need to be enlarged and some form of institutionalisation should take place. It will then be more appropriate to call it a 'family clinic,' rather than a family doctor. These family clinics could help decentralise the health insurance function and spread it among senior citizens.

8.29 The family clinics should act as ‘gate keepers’ to the entire healthcare system. They should provide preventive care, outpatient service, and advice on disease management in the case of chronic illnesses. They should be capable of coordinating treatment between specialists, knowing just enough about each specialty to guide a patient through them. They should be able to see the whole picture and see that the specialists do not work in separate compartments. Such one-stop access to healthcare needs would be a boon to the senior citizens.

8.30 There is enough evidence to suggest that the collegial relationship between the senior citizens and the doctors and other personnel in the family clinic, and among the senior citizens attached to the same family clinic, would itself have therapeutic effect on them. Moreover, the insured persons attached to a family clinic would constitute a convenient group for imparting knowledge on healthy life style management including practice of yoga and meditation, preventive care, and disease management in the case of chronic diseases.

Reaching out to the Elderly through Family Clinic

The Perspective

8.31 The life span of humans is finite and deterioration in body function, and ultimately death, is inevitable. The objective of the healthcare system, with health insurance underpinning it, is not prevent to death or arrest the natural process of ageing but to ensure that so long as a person lives he remains happy - physically, psychologically and socially.

8.32 As one ages, DNA mutations are more likely resulting in altered cell and tissue function and also in the slowing down of the cell division. This reduces the response of the immune system, which depends on rapid defence-cell reproduction and mobilization. Reduced immunity with age means that infections are more likely to take hold and dormant infections, if any, can be activated. This general phenomenon could lead to a number of diseases. But the good news is that most of these diseases are preventable. This needs looking into the way the senior citizen lives in his family and his social and physical environment.

8.33 Healthcare of the elderly is thus not just a clinical process. It must be informed by adequate knowledge of biological and behavioural sciences and the context in which the aged person lives. He must be helped to develop a positive outlook on life. His personal values and beliefs must be respected. A trusting relationship between the aged person and the doctor must be valued, developed, nurtured and maintained. In the absence thereof, the aged person might get into depression which not only exacerbates

his other ailments but also lead to diseases connected with the functioning of brain like Alzheimer's and Parkinson's.

8.34 The elderly must also be educated to notice, and recognize the implications of, disease related signs and symptoms, especially those pertaining to heart and circulation, musculoskeletal systems and infections of the digestive and urinary systems.

8.35 The elderly must also be encouraged to promptly consult with the doctor and to be able to duly convey what he has observed. Familiarity and informality should be the hallmark of this consultation. Formal consultation with specialist doctors, requiring advance notice for appointments and each costing a tidy sum of money, is surely not the best way to do so.

8.36 Ageing takes a toll on a number of organs and systems in the body simultaneously. Heart muscle becomes a less efficient pump, blood vessels become less elastic, and hardened fatty deposits form on the walls of arteries leading to higher blood pressure that might result in several cardiovascular diseases. Bones shrink in size and density; lower density weakens the bones making one susceptible to fracture. Motions that move food through the intestines slow down and secretions from stomach, liver, pancreas and small intestine may decrease, disrupting the digestive process.

8.37 All these may require consulting with different specialist doctors but coordination and integration of care is necessary. Moreover, even as the different organs and body systems reinforce each other when one is young, their deterioration in old age will also not be autonomous. Decline in the functioning of one system has its impact on all other systems. An integrated view needs to be taken. This, the aged person may not be equipped to take upon himself. The helping hand of a doctor with continuing familiarity of all his systems becomes a necessity.

8.38 One of the biggest concerns for the aged is the lack of mobility, partly due to deterioration of eyesight and hearing and partly because of the slowing down of his body functions, compounded by the risk of traveling unaccompanied and unaided. His first port of call to the healthcare system should thus be as close to him as possible.

Concept of family doctor

8.39 The above context necessitates our revisiting the institution of the family doctor. Traditionally, the family doctor or family practitioner played a significant role in providing healthcare to generations of our parents and grandparents. However, with the growth in medical specialization, medical technology and greater mobility of population,

the system of ‘family doctor’ has declined in significance. Still, wherever a family doctor exists, the individual/families continue to have faith in him and rely on his advice and experience for the management of their health. The family doctor is seen to be a part of the family and is often responsible for management of the entire family’s health, be it children, parents or grandparents. Due to this continuous nature of the relationship, the family doctor is privileged with important family environmental information that provides significant context to health problems that might occur. This continuous care philosophy is well established and understood over the years.

8.40 Families that continue with this tradition of consulting their family doctor for all their healthcare needs, tend to have less catastrophic health issues due to the constant advice and health management that the family doctor provides, thereby either preventing illness altogether or ensuring that health conditions, particularly chronic ones, are not exacerbated.

8.41 The World Congress of General Practice/Family Medicine (WONCA) defined the following characteristics of the institution of General Practitioner

i. provides comprehensive care
ii. oriented to the patient
iii. co-coordinator of other services
iv. has a family focus
v. committed to the community
vi. advocacy on behalf of the patient
vii. emphasizes the doctor patient relationship.

8.42 The Committee is convinced that such an institution of General Practitioner is imperative in the context of healthcare for senior citizens.

Integrating with the insurance system

8.43 In the modern context, a family doctor can be defined as a general medical practitioner who specializes in primary care management.

8.44 In many healthcare systems, the family doctor termed as ‘primary care physician’ or ‘general practitioner’ plays a vital role in the healthcare of the entire family. However, his role is not confined to primary or preventive care. He plays a significant role even in major illnesses. He acts as a ‘gatekeeper’ to all other components of the healthcare system. His approval is necessary for undergoing any diagnostic procedure

and for admission into any healthcare institution. The gatekeeper is responsible for decisions made regarding referrals into the secondary and tertiary care levels of the system. The family doctor thus becomes responsible for the overall care provided by the entire healthcare system. He plays a role in reduction in the incidence or escalation of illnesses wherever possible.

8.45 What most of us want for ourselves, especially in advanced age, is a productive, ongoing relationship with a doctor who helps in obtaining reliable, cost-effective health care. We need a system in which treatment decisions are taken by someone close to us but whose pecuniary interests do not conflict with our own interests. And, we need to get fully involved in the process of decision-making without being overawed by the environment in which it is taken. The traditional family doctor fits the bill very well. However, his functions need to be enlarged and institutionalised, preferably into a legal entity. It will then be more appropriate to use the term 'family clinic,' rather than family doctor.

8.46 There can be no reservation in adopting a similar practice of 'gatekeeper' to the healthcare system in our country. However, one must examine the context in which he plays a role in the insurance system as well. In health insurance systems, that are near universal and are administered top down, the general practitioner is seen as the lowest rung of healthcare as well as the health insurance systems. This is how the decentralised dispensaries work in our CGHS system as well.

8.47 But, we are addressing the issues connected with voluntary health insurance through market oriented insurance companies. Here, the family doctor must be seen not as the lowest rung but the centre of the healthcare system, since the system meant for the senior citizens must be 'human-centric', not hospital-centric. Developing and strengthening the primary and preventive healthcare system through family clinics especially to cater to the senior citizens is a gigantic task. Genuine apprehensions have been voiced before us that simultaneously burdening the nascent institution with any huge responsibility in regard to health insurance might be counterproductive and, indeed, might lead to developing the institution itself among unhealthy lines.

8.48 The Committee, therefore, feels that the institution of family doctor, or the family clinic as we would prefer to call it, should have only a limited role in the health insurance system as such. The family clinic ought not to be seen as a limb of the insurance company or as its representative. Rather, the family clinic should remain the 'friend, philosopher and guide' of the senior citizen seeking health insurance, and demonstrably so. The clinic can guide the senior citizen in selecting the insurance

product to suit his particular needs. It can provide the necessary administrative support in applying for insurance initially and applying for and processing insurance claims thereafter. The clinic can arrange for storage and retrieval of the medical information pertaining to the insured. (The latter is especially important for a senior citizen since he cannot himself handle this task effectively.)

8.49 Establishment of family clinics through the length and breadth of the country would give a tremendous boost to the spread of health insurance business. It is not intended that the family clinics would serve the senior citizens exclusively. To secure financial viability, it is important that persons of all ages are encouraged to buy health insurance through family clinics. Health insurance business would thus be effectively decentralized through the instrumentality of family clinics, without the insurance companies having to spend a lot of money in establishing offices in rural and semi-urban areas.

8.50 On the clinical front, the family clinic would arrange for all the diagnostic tests and procedures required in connection with the insurance policy of the insured. We have recommended elsewhere that in respect of senior citizens, the cost of all such tests and procedures, with the family doctor concurring in the need from the point of healthcare, should be shared equally between the insured and the insurer so that neither has an incentive to undertake or specify more or less procedures than warranted by the requirements of healthcare or of health insurance. This has been elaborated in Annexure ‘B‘.

8.51 It is very desirable that IRDA issues Regulations under Sections 14 and 26 of the IRDA Act, 1999 to promote and regulate the family clinics with a view to ensuring orderly growth and speedy penetration of health insurance in the country, just as it has created the institution of Third Party Administrators from September 2001.

8.52 The Regulations should, inter alia, specify the requirements of academic qualifications and professional experience of the doctors and others that would man the family clinic, the supporting physical and other infrastructure required to be provided, the required legal framework, and the business plan for the proposed operations. IRDA should also take the initiative and arrange for relevant training of the personnel.

Summary of Recommendations

1.	The key issues are early entry into the insurance system, preventive healthcare and a careful evaluation of the need for expensive medical treatment before it is taken. These would require customer-friendly insurance products, with strong incentives for maintaining good health, and a careful monitoring of health in the context of the insurance policy by medical personnel who have no pecuniary interest in rendering more (or less) healthcare than what is warranted by the health condition of the insured.
2.	Health insurance must be human-centric. To achieve this as well as a significant increase in the penetration of health insurance, it is desirable to promote 'stand alone' health insurance companies. A separate Committee had earlier recommended that stand alone health insurance companies should be set up for better penetration. The Committee endorses and reiterates the recommendation.
3.	The insurance companies should endeavour to offer continuity in health insurance for applicants who were hitherto covered by corporate insurance or insurance offered by any Government or otherwise, on conditions that they deem fit, subject to observing the principles of horizontal and vertical equity, that is to say, like cases should be treated alike and the differential between any two classes should be justifiable and reasonable. This will help increase penetration.
4.	There is need for products that could serve as 'top up covers'. Insurers could consider designing such covers by which not only would the residual need of the Senior Citizens be met, but also the health insurance net gets extended to a category of citizens who do not participate, barring perhaps a few, in any kind of health insurance scheme today. The number of people in such employer provided schemes being substantial, this strategy would certainly help improve penetration of health insurance in the country.
5.	Insurers could innovate and also offer plans specifically suited to the Senior Citizens like capturing the lump sum retirement benefits and providing health insurance coverage for long years. The objective should be to increase the penetration of health insurance in the country (in terms of both numbers and spread) while making health insurance business competitive and commercially viable.
6.	The elderly must also be educated to notice, and recognize the implications of, disease related signs and symptoms, especially those pertaining to heart and circulation, musculoskeletal systems and infections of the digestive and urinary systems.
7.	IRDA should mandate the companies granted licences to carry on health insurance business, that all senior citizens should have access to health insurance regardless of age, health condition or claim history, except in cases where the person is diagnosed with terminal or incurable illness at the time of first entry.
8.	In order that this mandate does not unduly affect the profitability of the health insurance companies, a Health Insurance pool should be created under the aegis of the IRDA (with substantial contribution from the Government) to take over high risk cases, for example, those who have health status based loading of 40% or beyond.
9.	While senior citizens should take health insurance from as an early an age as possible so as to make the insurance system financially viable, some of them might be availing of alternative sources of healthcare financing while in active service. Hence senior citizens could be allowed to enter the health insurance system up to the age of 65 years (or higher at the discretion of the Insurer). If they do so, they should be given guaranteed renewal of their insurance without any upper age limit.
10	As a transitional measure, since guaranteed access is being provided to the senior citizens for the first time, there should be no upper age limit for entry or renewal for a period of three years from the date the mandate is made. After the expiry of three years also, insurance companies should exercise their discretion in entertaining the first entry of senior citizens above the age of 65 years in deserving cases. At the same time, a senior citizen holding a health insurance policy under the present dispensation should not be compelled to shift to any other policy under the new regulations/guidelines. He should also not be denied renewal of the existing policy. Neither should he be barred from switching over to a new scheme.

11	The institution of family clinic should be encouraged. However, the family clinic ought not to be seen as a limb of the insurance company or as its representative. It should be a friend, philosopher and guide of the senior citizen seeking health insurance. The clinic should guide the senior citizen in selecting the insurance product to suit his particular needs. It should provide the necessary administrative support in applying for insurance initially and applying for and processing insurance claims thereafter. The clinic should arrange for storage and retrieval of the medical information pertaining to the insured. Hence, it is very desirable that IRDA issues Regulations under Section 14 and 26 of the IRDA Act, 1999 to promote and regulate the family clinics with a view to ensuring orderly growth and speedy penetration of health insurance in the country.

CHAPTER 9

PROCEDURAL ASPECTS

Service issues – Insurers/TPAs

9.1 The players in the health insurance chain include Insurer, Insured Senior Citizen, Agent, Third Party Administrator, Provider Hospital.

Insured – Insurer:

9.2 A fresh health insurance policy is prospected in the form of a proposal form to be filled up by the insured and accepted by the insurer. The proposal form seeks information about the individual proposing for insurance and that of the covered persons. The information, inter alia, includes complete medical history of the prospects. Copies of the photographs of the proposed persons are also collected from the insured. Insurance contracts are governed by the doctrine of Utmost Good Faith and it is incumbent on the insured to lay bare his medical condition in the application form.

9.3 The first time senior citizen insurance entrants are usually subject to pre-acceptance medical check ups in the form of a referral arrangement with an empanelled diagnostic laboratory of the insurer. The referral slip has a list of medical tests and the fee is usually borne by the prospecting insured. The insurer accepts the proposal based on the medical reports and quotes the prescribed premium upon payment of which, policy document is issued to the policy holder. A policy document consists of policy schedule and a clause detailing the terms, conditions and exclusions of the insurance policy.

9.4 As per the provisions of Sec 64 v b of the Insurance Act, no insurer shall assume any risk unless and until the premium payable is received by him. Further, where the premium is tendered by postal money order or cheque sent by post, the risk may be assumed on the date on which the money order is booked or the cheque is posted, as the case may be.

9.5 Since a health insurance policy entails income tax exemption, premium payment is usually by way of a cheque and assumption of cover is subject to realization of the cheque. In the event of cancellation or bouncing of cheque, policy is cancelled from the date of commencement of insurance.

9.6 In case of a TPA arrangement, copies of the insurance policy and photograph are sent by the insurer to the concerned TPA for their generation of Photo I.D card and the same is sent by the TPA to the policy holder. The photo I.D. card has a unique I.D No. giving reference to the name of the insurer, policy number, expiry date of insurance and the validity period of the card that is the same as policy period. A list of network hospitals of the TPA for availing cashless service is also enclosed along with the I.D. Card. Thus, the existence of insurance is evidenced by two documents emanating from two different organizations. A few insurers having I.T. connectivity with the TPAs, transmit the above information through the network.

9.7 For the post-sale service, the insured heavily depends on the services of the TPA and the role of insurer comes into play usually on the eve of renewal. In case of any change of address or amendments in policy record, insured has to approach the insurer.

9.8 Health insurance policy conditions stipulate the payment of renewal premium before expiry of the period of insurance. In the event of failure of the same, the policy will lapse and a 'fresh' policy is issued in which case insured may have to undergo another pre-acceptance medical check up and then the policy may be subject to pre-existing disease clause/waiting period. In the case of senior citizens it should be made mandatory for insurers to issue renewal notice along with the basis of premium calculation especially where there is revision in premium. In case of renewal not being accepted by the insurer, the insurer must convey the same to the insured in writing along with reasons thereof.

9.9 After receipt of renewal notice, the policy can be renewed by the insured upon payment of the renewal premium. Insurers usually do not insist for medical check up at the time of renewal unless there is increase in sum insured. Every renewal is communicated by the insurer to the TPA, along with policy records, and a fresh I.D. Card thereof is issued to the policy holder.

Insured-TPA

9.10 The Photo I.D Card number is the TPA's reference in the matter of their service to the policy holder. The role of the TPA, as far as the policy holder is concerned, is mainly during claims servicing. The TPA processes and reimburses claims as per terms and condition of the insurance policy.

9.11 Intimation of claim has to be given to the TPA either in writing or through their 24-hour Toll Free Call Center. The claim intimation has to be substantiated by hospital admission note and upon verification of the policy coverage in their systems, the TPA gives the authorization to the network hospital for cashless service. In the event of an emergency, such correspondence between the provider and the TPA is effected by Fax/e-mail. However, if the TPA is not sure of the coverage or about the admissibility of claim they advise the insured to pay out of his pocket and then file with them for reimbursement of the claim. Similarly, in the event of the policyholder taking treatment in a non-network hospital, claim is settled on reimbursement basis. Sometimes, coordination with the insurer is required in regard to clarification on the conditions terms of the policy such as pre-existing, past policy details, etc. All claim payments are made from insurer's funds made available to the TPA and replenished at regular intervals.

9.12 Denied claims are also informed to the policy holder by way of separate correspondence. TPAs are required to take prior approval of the insurer before issuance of denial letter.

9.13 The Third Party Administrators are paid service charges by the insurer based usually on the premium serviced by them. A service level agreement is entered into by the insurer with the TPA which, among other things, gives a time frame for issue of I.D Cards and settlement of claims.

9.14 TPAs are expected to build up a network of hospitals and negotiate with them for a discounted schedule of charges for the benefit of the policy holders. The negotiated rates are filed by the TPA with the concerned insurer. These rates are subject matter of an agreement between the hospital and the TPA.

9.15 The processed and paid claims are usually audited by the insurer on a periodic basis.

Insured-Provider

9.16 The insured-hospital (network or otherwise) relationship is a personal contract between them outside the insurance contract.

Insured-Agent

9.17 An insured has an option to make use of the services of an agent of the insurer for which the latter is remunerated by the insurer in the form of commission. As

per norms, insured cannot get a discount on premium in lieu of agency commission. The IRDA Licensing Regulations, 2000, prescribe, inter alia, the following code of conduct.

9.18 Inform promptly the prospect about the acceptance or rejection of the proposal by the insurer

9.19 Obtain the requisite documents at the time of filing the proposal form with the insurer and other documents subsequently asked for by the insurer for completion of the proposal

9.20 Render necessary assistance to the policyholders or claimants or beneficiaries in complying with the requirements for settlement of claims by the insurer

POLICYHOLDER GRIEVANCES

9.21 In the event of a grievance, an individual policyholder can choose the following redressal mechanism:

i. In-house redressal procedures of the insurers

ii. Insurance Ombudsman

iii. Consumer Forum

iv. I.R.D.A

v. Civil Courts

9.22 Most of the insurers have an on-line facility for registering of complaints and a separate grievance department or customer service in charge.

9.23 The Insurance Ombudsman is empowered to receive and consider complaints in respect of personal lines of insurance from any person who has any grievance against an insurer. Ombudsman's powers are restricted to insurance contracts of value not exceeding Rs. 20 lakhs. The insurance companies are required to honour the awards passed by an Insurance Ombudsman within three months. The procedures adopted by the Ombudsman is informal but there is no mechanism for summary disposals or separate window for senior citizens.

9.24 There is no grievance redressal mechanism within the TPAs and the policy holder has to depend on the insurer's hierarchy for any issue with the TPA.

Suggested improvements in procedural aspects

9.25 Traditionally, insurance is marketed through intermediaries like agents and this should continue for the Senior Citizens. Some of the insurers have withdrawn or reduced agency commission for higher age group policies forcing senior citizens to become walk-in- customers. An agent's service is needed more by the senior citizens who are less mobile than others. Agents selling health insurance deserve all encouragement and need to be paid commission at the maximum rate permissible. The contact information of the agent should be available in the documents given to the insured and their role as envisaged in the regulation, including after sales support to the insured, must be diligently followed. However, the senior citizen should have the option to deal direct with the insurer for which the insurer can offer an appropriately lower premium.

9.26 In the context of the consumers' need to be able to make a comparison of the health insurance products available from different insurance companies, especially in the case of Senior Citizens, IRDA should examine to what extent the existing agency system and/or broker community can be utilized to propagate Individual Health Insurance. Meanwhile, the agents should be permitted to market health insurance policies of more than one company.

9.27 The insuring policy schedule is often not issued in complete form, without the policy clauses leading to complaints galore from senior citizens that they were not privy to the terms and conditions of the policy issued. The clauses are usually a printed matter that must be attached to the computer generated policy schedule, and should be incumbent upon the insurer to comply with this regulatory requirement. Policy clauses could also be computer generated, super-scribed with the policy number and all the sheets of the policy document are duly numbered. The policy document must contain full address and telephone numbers of the policy issuing office and the contact number of the agent servicing the policy. All documents issued by the insurance companies should be in standard size of paper.

9.28 The manner of payment of premium for senior citizens can be simplified if more insurers accept payments through credit/debit cards, Internet, E-Transfer as such

modes of premium payment are already regulated in the IRDA (Manner of Receipt of Premium) Regulations 2002.

9.29 The principle of Utmost Good Faith is equally applicable for the insurer and a bounden duty exists by making the insured know upfront the terms of renewal especially in the matter of premium and coverage.

9.30 The cost of Pre-acceptance medical check up is initially borne by the insured and different insurers deal with the reimbursement of this cost differently. A few insurers reimburse the insured upon acceptance of the proposal while a few insurers make the senior citizen policy holder foot the bill. In the case of senior citizens it is but fair that this expenditure is shared between the insurer and insured on 50/50 basis. A copy of the medical report should be given to the policy holder and the findings of the same should be incorporated in the policy document in a manner that the policy documents speaks for itself at the time of servicing of claim or during the renewal of the policy with the same or different insurer.

9.31 A policy holder should renew the policy sufficiently in advance of the expiry date just as he makes timely payment for other services like credit card, electricity or telephones. Where he fails to do so, insurers may condone the break by way of a penalty amount. However, some health insurers are harsh and invoke the 'fresh' policy condition. Though there are discretionary provisions in the policy clause for condoning the delay, they are invoked arbitrarily. Senior citizens health policies should provide for condoning delays up to 15 days of the expiry of the concerned insurer's policy and the policy treated as 'renewal'. Of course, any illness contracted during the break-in period may be excluded. It is imperative that senior citizens do not misuse this exception and repetition of similar breaks may be dealt with by the insurer as deemed fit.

9.32 The timely receipt of the Photo I.D.Card depends not only on the TPA's service but also on the turnaround time between underwriting of the policy document and submission of the policy details by the insurer to the TPA. Non-receipt of I.D. cards makes the life of a senior citizen policy holder all the more difficult for availing cashless service. This irritant can be almost eliminated through I.T. connectivity between the insurer and the TPA. The volume of insurance data is huge and complicated and ad hoc methods of sending by e-mail will not serve the purpose. The system of fresh I.D.Card during every renewal and that too in respect of the same insurer/TPA is vexatious. The Committee recommends that the I.D. card should not denote the expiry date of the policy as its primary purpose is to establish the identity of the insured. The

card read along with the policy copy can confirm the existence of the insurance coverage. Insurers should not resort to frequent change of a policy holder's TPA resulting in the need for repeated change of I.D. Cards and portability of the insurance data.

9.33 The Committee received overwhelming evidence that senior citizens are unhappy with the emerging institution of the TPA and feel that the fees paid to the TPA is an avoidable expense from them. In other words, they feel that they are not getting 'value for money', though they do welcome the cashless feature. To improve the quality of service, the Committee recommends that the policyholder should be given a choice of TPAs to choose from. Likewise, the insured should have the option of not availing of the services of a TPA, thereby forgoing the benefit of cashless service, and deal directly with the insurer. In such cases, the insurer can offer an appropriately lower premium.

9.34 The insurance policy should carry a summary, written in plain and workmanlike language, highlighting the important conditions of the policy and the benefits, with the caveat that in case of doubt the version drafted in legal terms shall prevail. The clause should also define the various terminologies like pre-existing, portability, hospitalization, day-care, etc. The insurance policy handed over to the insured should mention the available grievance redressal channels, address and contact details of the Customer Service Cell at the headquarters of each insurer that can be approached by the insured in case of any grievance against the insurer or the TPA. The insured should not be expected to work his way up the hierarchy of the organization of the insurer or the TPA. The Customer Service Cell should function under the direct supervision of the CEO of the insurer. Telephone numbers of the concerned executives and the procedure for grievance disposal should be printed as a separate condition (like the 'arbitration and conciliation' condition) in the policy clause supplied as part of the policy document to the insured. The address and telephone number of the concerned Insurance Ombudsman should also be highlighted in this clause.

9.35 The recent revisions in health insurance policies have caught the senior citizens unawares in view of the doubling of premium and forfeiture of benefits enjoyed by them over a period. No doubt, marketing and competition strategies are involved while revising a product, but personal lines of insurance, especially health, needs to be treated differently. In the case of significant changes, at least three months notice should be given to the policy holder so that he can make financial provision or scout elsewhere for the renewal. The systems and administration with the insurers should be

geared up before effecting revision of these types of products. The basis of increase in premium, if any, at the time of renewal, should be duly explained to the insured in the renewal notice.

9.36 The primary role of the insurer is financial intermediation, not provision of healthcare. Processing of insurance claims is intertwined with the latter and is best left to be done by people qualified to do so. Towards this end, health insurance companies should be lean organizations, staffed only by executives and using modern data processing techniques. They should ensure that the system works as intended rather than get involved in decision making in individual claims. Pending the formation of Stand- Alone Health Insurance companies, the existing insurers should undertake 'verticalization' of health insurance business on the above lines.

9.37 There should be a separate channel/ set up in insurance companies and TPAs for quick processing of all matters including disposal of the claims of senior citizens. For this purpose, the Photo I.D card should contain a unique code for identification of the senior citizens.

9.38 Large number of representations were received by the Committee stating that there was an overlap of responsibility between insurers and TPAs in the matter of claim settlement. Repudiation or rejection of a claim is a serious matter and should only be done at the appropriately senior level in the insurance company. TPAs are not authorized to repudiate claims.

9.39 **Procedure for Cashless Authorization**: Delay in arranging for cashless authorization is a serious issue for senior citizen policyholder. During the Committee's depositions, the TPAs and Providers were of the unanimous view that most of the disputed claims were in respect of direct admissions even though they did not involve any emergency. The Committee was informed that cashless authorization could work very smoothly if only the policy holder gives the TPA at least 2 days' notice before the proposed date of hospitalization. The TPAs have volunteered to even suggest to the policyholder the schedule of charges of various network hospitals so that the insured can exercise due diligence and make a considered choice of the hospital for his/her treatment. If cashless service is to succeed the procedure needs to be adequately addressed in the terms and conditions of the insurance contract by stipulating a time limit for the policy holder to give prior notice to the TPA in the event of non-emergency admissions.

9.40 Hospitalization is necessary for admissibility of claims in almost all the health insurance policies (other than domiciliary hospitalization) available in the country. The Committee has taken note of complaints of senior citizen policyholders who are denied claims because of inconsistent interpretation of this policy condition. In the case of non-emergency admissions with the prior concurrence of the TPA as mentioned above, the issue can be easily addressed. In the case of direct admission because of emergency, the point is who should decide whether hospitalization is/was required or not. The Committee is of the view that the treating doctor or the family doctor of the policy holder is the best person to decide on the matter since he is privy to the ground situation.

9.41 There were complaints from hospitals that the personnel employed by most of the TPAs are not qualified medical professionals or without specialist medical qualifications. They cannot be expected to challenge senior doctors in hospitals on matters of 'pre-existing' diseases or otherwise, of an ailment, decision to hospitalize a patient, the line of treatment or the treatment protocol. The TPAs should have an advisory panel of senior doctors for different specialities who would be in a position to review decisions taken by specialist doctors in the hospitals. The Committee also received many complaints that doctors and other staff employed by the TPAs to facilitate cashless service are not always available especially on holidays and Sundays, thus denying cashless service to policyholders on these days. TPAs should address this problem adequately.

9.42 There should be a **systems audit of the TPA** operations by the insurers and the IRDA, especially **in customer service parameters.** There have been several complaints, mostly from senior citizens, that claim documents are sought by the TPAs on a piece-meal basis at the time of settlement of 'reimbursement' claims. While the Insurers/ TPAs are free to call for reasonable claim documents evidencing the claim, they cannot bother the policy holder repeatedly especially after having denied the cashless service. Even the providers have complained of frivolous queries raised by the TPAs at the time of cashless authorization.

9.43 The delay of processed 'reimbursement' claims on account of non-availability of funds and consequent delays is another issue that has to be addressed between the TPAs with the insurers. Claims shown as 'settled' in the TPA's web site are finally paid after more than 30 days and in some cases after 2 months! An insurer may open an Escrow Account in respect of each TPA in such a way that funds are transferred by insurer's corporate office directly to this account periodically and the TPA authorised to operate such account directly.

9.44 IRDA Regulations for Protection of Policyholders' Interests needs to be amended to incorporate health insurance service parameters, especially for providing specific time frame for settlement of claims by the Insurers. A time limit of 30 days from the date of receipt of claim for conveying the offer of settlement to the claimant and the 7 days limit (from the date of acceptance of offer of claim settlement) for the payment of the amount due appear reasonable for health insurance policies. In case of investigations, the 30 days limit may be extended by another 30 days subject to the insured being informed of the same. Similarly, a time limit of 15 days should be prescribed for an insurer to convey the decision to deny a claim. Such a denial letter should unambiguously specify the reasons and relevant policy condition(s) for repudiating the claim and also specify the procedure for appeal against the decision.

9.45 **Standardization of documents for claims by senior citizens** should also be done by all insurers and TPAs, so that senior citizens (and also hospitals undertaking treatment for senior citizens on cashless basis) do not face any discretionary issues and consequent delays in payments of claim. Any medical or investigation document, if required for verification in original, should be returned to the insured after such verification. If the purpose of collecting such documents is to prevent multiple claims, the originals of such documents could be duly stamped but returned to the insured.

9.46 The Committee also recommends that insurers organize the capacity to undertake periodic as well as random investigation of health insurance claims, to identify and weed out fraudulent cases. Also, the details of any hospitals, TPAs or policyholders found to have indulged in fraudulent practices should be widely shared in the industry. Suitable action must be taken against fraudulent hospitals and TPAs, by common disempanelment by all insurers, and also against fraudulent policyholders, including non-renewal of their health insurance by any insurer for a period of 3 years. Mechanisms may be worked out by the insurance industry for sharing of this database, and for the establishment of a nodal agency to investigate fraud.

9.47 The senior citizens already covered in any other health insurance scheme of an insurer should have the choice to continue in the same scheme and should not be compelled to join any new product designed for senior citizens and at the same time, should be allowed to free switch over if he so desires. Also, the senior citizen opting to switch to the senior citizen plan of the same insurer should be allowed to join the new product with due consideration for the number of years he has already been with the same insurer for the purpose of pre-existing disease and other such exclusions.

9.48 Rejection of proposal or rejection of renewal of health insurance for senior citizens, if any, should be done by an insurer, duly according the reasons in writing.

9.49 The offices of the insurers, TPAs and the Insurance Ombudsmen should have a separate window for dealing with cases of senior citizens. Disposal of their cases should be given priority. It may not be necessary for the senior citizen policy holder to present himself before the Ombudsman.

Summary of Recommendations

1.	Policyholders should be given choice of TPAs to choose from and not bound to one particular TPA. Where they choose to forego the services of a TPA, lower premium ought to be charged
2.	There should be a separate channel/set up in insurance companies and TPAs for quick processing of all matters including disposal of claims of senior citizens. For this purpose, the Photo ID card should contain a unique code for identification of the senior citizens
3.	The working and the procedures followed by TPAs as well as the regulations themselves require a review by IRDA with a view to bringing improvements in them

CHAPTER 10

GOVERNMENT INTERVENTION

Regulation of Healthcare Providers

10.1 According to the National Commission on Macroeconomics and Health, selective, fragmented strategies and lack of resources have made the health system unaccountable, disconnected to public health goals, inadequately equipped to address people's growing expectations and unable to provide financial risk protection to the poor.

10.2 India has a large and heterogeneous private health sector: which ranges from voluntary, not-for-profit, for-profit, corporate, trusts, societies, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks). Nearly 77% of the allopathic (MBBS and above) doctors practice in the private health sector. The private sector accounts for 82% of all outpatient visits and 52% of hospitalization at the all India level[11]. A significant development over the last two decades has been the emergence and growth of corporate hospitals in the private sector, which has become a key player in the provision of inpatient services to the beneficiaries of private insurance plans as well as to public payors like the CGHS and Ex-Servicemen's Contributory Health Scheme (ECHS). Considerable investment in infrastructure, equipment and human resources has been made by these corporate hospitals and also by many large trust hospitals, but the costs of care continue to be high. Poor regulation, absence of accreditation mechanisms or standard treatment guidelines, and no incentive/ disincentive to control costs of healthcare has also meant that these costs continue to rise further.

10.3 For the smooth functioning and success of the health insurance system, the Committee recommends that the health sector itself be streamlined. There should be adequate regulation of hospitals and other healthcare providers. Legislation should be promoted under Article 249 of the Constitution. Pending the passage of such legislation, Central Government should set an example by legislating for the Union Territories as early as possible.

[11] Health – Human & Social Development - Tenth Five Year Plan document Vol 2, page 94. Planning Commission. GoI.

Promotion of stand alone health insurance companies

10.4 **The multi-dimensional and complex nature of health insurance sets it apart from other types of insurance** such as motor, fire or even life. The risk perception, its underwriting, heterogeneity in treatment protocols impacting the claims settlement procedures, and the system of building of reserves etc are different from other classes of business. Financial intermediation in health insurance also requires a different mindset. Transaction of **Health insurance business, must therefore, be human-centric, and not claim-centric as is the case with other types of insurance.**

10.5 To remedy the situation and achieve significant increase in the penetration of health insurance **it is desirable to promote 'stand alone' health insurance companies**. Measures should be taken to improve their financial viability while the message of health insurance spreads across the length and breadth of the country. Also, they could be encouraged to undertake related branches of insurance such as personal accident insurance and overseas travel insurance as well as other activities that directly contribute to the well-being of senior citizens such as provision of facilities for long-term care.

10.6 **All insurance companies, both life and non-life, should promote separate health insurance subsidiaries**. Government should suitably address the problem of capital requirements to facilitate the formation of these health insurance companies.

Creation of insurance pool for health insurance

10.7 At present, insurance premiums attract Service Tax of 12.36%, including cess. It is recommended that, if health insurance premiums cannot be exempted from Service Tax altogether, **at least 50% of the Service Tax on all health insurance premiums should be allowed to be credited to the Insurance Pool recommended to be created with the IRDA for dealing with high-risk health insurance cases of senior citizens (where health status based loading is greater than 40%)**.

Taxation of Health Insurance Companies

10.8 With health insurance cover being made available for all senior citizens, health insurance might turn out to be high risk business for the health insurance companies. The extent of risk can only be assessed through actuarial valuation. IRDA should appoint independent actuaries, in terms of its own mandate under Section 14(l)

of the IRDA Act, to examine the books of the companies periodically, say, once in three years, and recommend the extent of reserve that needs to be provided to cover future claims. Reserves thus created would be statutory in nature and, hence, should be deductible from current income of the companies before computing the taxable income. Suitable provision should be made to this effect in the Income Tax Act. Unless this is done, fresh investments in health insurance business might dry up.[12]

Income Tax Concession to Individuals for health insurance

10.9 The present income tax concession 'above the line' under Section 80 D for health insurance premiums is regressive – a taxpayer in the highest tax bracket gets a tax rebate of Rs 6000 or so whereas a senior citizen in a lower tax bracket gets less. **Tax concession for health insurance should be given 'below the line' in the form of a tax credit** at a uniform rate of Rs 6000 (if possible, at a higher level) for each taxpayer, **to transform the concession into a progressive one** – taxpayers with lower incomes would then get proportionately higher benefit. Also, unabsorbed tax credit should be allowed to be carried forward to future years. This would be logical because, in the case of a senior citizen, he would be paying higher and higher premiums as age advances.

10.10 Besides the above, **stand-alone insurance companies should be permitted to accept long-term deposits from those insured with the company**. Such deposits should be made into a 'healthcare savings account' broadly patterned on the lines of Public Provident Fund accounts but without any time limit, premature deposits being permitted only for bona fide medical treatment. Savings made therein would come in handy, especially, in the case of senior citizens, as insurance benefits do not often cover hundred per cent of the expenses connected with major illnesses. **These deposits should be extended income tax concession under Section 80 C.** Such deposits could also be made on behalf of the senior citizens by any of their close relatives (as defined in the Gift Tax Act) the latter enjoying the same tax benefit.

CGHS and ESIS beneficiaries

10.11 Representations have been received by the Committee that several of the **senior citizen beneficiaries of CGHS, ESIS** and other health indemnity arrangements like those of Railways are unable to actually avail of those facilities if they retire to places where such facilities are not available. In order to avoid hardship to such

[12] The Committee is grateful to Justice (retd) T N C Rangarajan for an illuminating discussion on the subject.

beneficiaries, the Committee recommends that they **be given the facility of opting out** of their respective Schemes. Such optees should be given a suitable annual grant, say, equivalent to the average cost being incurred per beneficiary to enable them to buy health insurance.

Subsidisation of health insurance for lower income groups

10.12 'Promise less and deliver more' (not the other way around) is the message that anyone who understands the psychology of older persons would give. This should be the watch word for Governments and Government agencies in the matter of giving succor to the lower income groups.

10.13 **First of all, the Committee feels that subsidization of health insurance should be preferably on the supply side**, that is, subsidising healthcare services rather than on the demand side, that is, subsidising premiums. For, the latter would merely increase demand for the existing supply of healthcare services and bid up their prices. Moreover, philanthropic hospitals or public spirited pharmaceutical companies would come forward to cooperate with schemes on the supply side because of their greater visibility.

10.14 When supply of health services is available at a lower cost, the claim ratios, and hence the premiums remain low This is far better than subsidising premiums and raising the costs of the healthcare for the uninsured, leading to a vicious cycle which has taken place in the Western world and raised healthcare costs to very high levels.

10.15 In Chapter 8, the Committee has recommended the setting up of Family Clinics to spread the message of health insurance though the length and breadth of the country and cater to the needs of the senior citizens, primarily though not exclusively. If such clinics are to be set up on commercial lines entirely through private efforts their costs of operation and, consequently, the fees they would charge the beneficiaries would be high and unaffordable. The Committee recommends that the State Government and/or the local authorities should **provide** those intending to set up such **family clinics in accordance with IRDA Regulations land and buildings on long term lease at highly concessional rates**.

10.16 The National Policy on Older Persons approved in 1999 stated: (health insurance) packages for lower income groups will be entitled to state subsidy and that various reliefs and concessions will be given to health insurance to enhance the base of coverage and make them affordable". Some initiatives have been taken to provide

insurance cover to people below the poverty line, including the senior citizens among them. Tax concession under the Income Tax Act would benefit only those with incomes five to six times the average per capita income or more. In our Report we are suggesting that IRDA should mandate the health insurance companies to evolve policies that would cater to with or above the average per capita income. But, a substantial majority of the older persons would fall below this level. These clearly belong to the 'lower income groups' that the NPOP has spoken of.

10.17 The Committee recommends that **all senior citizens with incomes below the average per capita income but above the poverty line should be given a grant of Rs 100 per month**. This should not be given in the form of cash but in the form of a voucher either for buying health insurance or for primary and **preventive care services provided through institutions like the proposed family clinics**.

10.18 The latter type of arrangement has tremendous potential to keep down costs of healthcare. Agreements could be entered into between senior citizens receiving grants and such providers for providing all diagnostic services at this flat rate of Rs 100 per month either by themselves or through others.[13] In such an arrangement the clinic would order only such tests as are absolutely necessary for forming an accurate diagnostic and or prognostic assessment. There would be no wasteful expenditure on unnecessary tests and procedures, and consequent treatments.

10.19 Such agreements would be in the nature of insurance contracts. If the idea catches on and a fairly large number of such contracts emerge, the insurance market could even provide reinsurance relieving the healthcare providers of much anxiety.

Old Age Pension Scheme for BPL category

10.20 Government of India has recently announced an old age pension scheme, effective from 19th November, 2007, for persons aged 65 and above if they belong to the BPL category. Out of a pension of Rs 400 per month, the Central Government would bear Rs 200 and expect the State Government to bear the other Rs 200 per month. This is a laudable development. However, the Committee would recommend that **Rs 100 per month out of the Central Government contribution should be disbursed in the form of a voucher as recommended above**.

[13] The Committee is grateful to Dr Kulwant Sharma (please see Annexure F) for these insights.

Low Cost Health Insurance Plans for Senior Citizens

10.21 In 2006, the Ministry of Health and Family Welfare has published a well thought through Framework for developing health insurance programs as part of the National Rural Health Mission. This framework states that in addition to strengthening public health facilities, health insurance would also be used to remove financing barriers and improve access to healthcare, for financial protection and to improve quality of healthcare. This framework has, inter alia, laid down certain pre-requisites for successfully implementing government subsidized health insurance schemes, which include:

i. There must be ownership and a structure- i.e. a body that will be able to organize the health insurance programme. This could be the state health department or any other agency, and should have managerial, administrative, technical and social capacity to organize the programme.

ii. There must be a network of health care providers (public or private).

iii. The payers for the scheme must have the capacity to pay the premium on a sustained basis, especially people expected to contribute premium in a contributory programme.

iv. There must be basic data available regarding the demographic profile of the community, the morbidity rates, the utilization rates, the cost per unit utilized etc. There is adequate secondary data in our country for this (Census, NCMH, NSSO etc) and can be used till primary data is collected.

10.22 If these pre-requisites for establishing a low-cost or subsidized health insurance scheme are satisfied, there is every prospect of the insurers coming forward to participate in such group insurance schemes. Their willingness to come forward and join such initiatives has already been demonstrated in some cases.

10.23 In this context, the committee undertook a study of two schemes initiated by local government bodies which were intended specifically for senior citizens and were partially or fully subsidized by the respective municipal corporations. These schemes, initiated in Indore and Pune, are briefly described in Annexure G.

10.24 Although the schemes do differ substantially in using insurance companies or not, using TPA or not, number of hospitals from where treatment can be taken and in other features, there are certain common features across these schemes which stand out. The salient ones include:

i. Focus on senior citizens

ii. Use of enrolment forms and photo-ID cards (and not blanket coverage where beneficiaries may not even be aware of their being insured, as in some other state government run schemes)

iii. Wide scope of cover through inclusion of pre-existing diseases

iv. Subsidy from the municipal corporation

v. Cashless system is made available

vi. Reimbursement or benefit is not full (by excluding pre and post-hospitalization, excluding implants or by capping reimbursements to low amounts) which is aimed at keeping costs low- thus the packages do not cover the entire costs of treatment and only serve to reduce the burden on the insured

vii. Low premium or contribution, vis-à-vis other available products in the market, in the range of Rs 500 per annum

viii. Aimed particularly for the not so well-off, by reducing scope to hospitalization in general ward. However, as beneficiaries have been able to avail higher-priced wards by paying the difference themselves, this coverage has been utilized by well-off segments also.

10.25 IRDA should keep a watchful eye on the schemes thus being evolved to ensure that they are fully funded and there is a long-term commitment to care for the insured.

Summary of Recommendations

1.	Transaction of Health insurance business is human-centric, and not claim-centric. Hence it is desirable to promote 'stand alone' health insurance companies. All insurance companies, both life and non-life, should promote separate health insurance subsidiaries
2.	Stand-alone insurance companies should be permitted to accept long-term deposits from those insured with the company. These deposits should be extended income tax concession under Section 80 C
3.	At least 50% of the Service Tax on all health insurance premiums should be allowed to be credited to the Insurance Pool recommended to be created with the IRDA for dealing with high-risk health insurance cases of senior citizens
4.	Reserves created on the basis of independent actuarial valuation and approved by IRDA should be treated as statutory reserves and should be deductible from current income of the companies before computing the taxable income. Suitable provision should be made to this effect in the Income Tax Act
5.	Tax concession for health insurance premiums should be given 'below the line' in the form of a tax credit at a uniform rate of Rs 6,000 (if possible, at a higher level) for each taxpayer, to transform the concession into a progressive one – taxpayers with lower incomes would then get proportionately higher benefit. Also, unabsorbed tax credit should be allowed to be carried forward to future years
6.	Some of the senior citizen beneficiaries of CGHS, ESIS and other health indemnity arrangements like those of Railways are unable to actually avail of those facilities if they retire to places where such facilities are not available. In order to avoid hardship to such beneficiaries, it is recommended that they be given the facility of opting out of their respective Schemes. Such optees should be given a suitable annual grant, say, equivalent to the average cost being incurred per beneficiary to enable them to buy health insurance
7.	The Committee feels that subsidization of health insurance should be preferably on the supply side, that is, subsidising healthcare services rather than on the demand side, that is, subsidising premiums
8.	The Committee recommends that the State Government and/or the local authorities should provide those intending to set up such family clinics in accordance with IRDA Regulations, land and buildings on long term lease at highly concessional rates
9.	The Committee recommends that all senior citizens with incomes below the average per capita income but above the poverty line should be given a grant of Rs 100 per month. This should not be given in the form of cash but in the form of a voucher either for buying health insurance or for primary and preventive care services
10	It is recommended that Rs.100 per month out of the Central Government contribution of recently announced old age pension scheme of the Government of India, should be disbursed in the form of a voucher as recommended in '10' above
11	For the smooth functioning and success of the health insurance system, the Committee recommends that the health sector itself be streamlined. There should be adequate regulation of hospitals and other healthcare providers. Legislation should be promoted under Article 249 of the Constitution
12	Transaction of Health insurance business is human-centric, and not claim-centric. Hence it is desirable to promote 'stand alone' health insurance companies. All insurance companies, both life and non-life, should promote separate health insurance subsidiaries
13	Stand-alone insurance companies should be permitted to accept long-term deposits from those insured with the company. These deposits should be extended income tax concession under Section 80 C

CHAPTER 11

ROLE OF INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

11.1 IRDA must play an active 'development' role in health insurance, which has clearly been established in the preamble of the IRDA Act, section 14 of the IRDA Act and Section 3 (2AA) of the Insurance Act.

11.2 There is clear evidence that the initiatives IRDA has taken in the recent past have had the desired impact on the thinking of the insurance companies. Intensified efforts on its part, on the lines we have suggested in this Report, have the potential to dramatically improve the health insurance scenario and the healthcare system. IRDA should become the torch-bearer in spreading the message of health insurance in the country.

11.3 IRDA has much to do to develop the health insurance market not only in terms of creating the right environment for its expansion but also resolving/streamlining the various issues in the sector that confront it today. To begin with, it is important for IRDA to strengthen its own machinery and begin taking a lead role in enhancing the coverage—nudging the insurance companies on the one hand and, on the other, propagating the idea of insurance among all citizens and specifically senior citizens through public campaigns and by enlisting the support of their associations as well as voluntary agencies working in the field. Our recommendations are as below:

Registration of stand-alone health insurers:

11.4 The IRDA must initiate necessary action for amendment in the law for registration of stand-alone health insurance companies. It could adopt a risk-based capital approach for stand-alone and subsidiary health insurers whereby more such players will definitely be attracted. Risk-based capital approach for stand-alone health insurers would ensure that companies bring in the required capital based on the products they intend selling, the volume of business, the operating expenses etc. Where such stand-alone health insurers are subsidiary companies, the solvency requirements should be independent of the solvency requirements of the promoter insurers. The solvency requirements may need to be revisited to be in line with the proposed new approach to capital requirement. As far as the life and non-life insurers are concerned,

IRDA would do well to encourage the existing insurers to set up health insurance subsidiaries. We consider a timeframe of two years for this purpose would be adequate.

Separate statement of accounts for Health Insurance:

11.5 The Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) regulations, 2002 governs the formats in which the annual accounts of insurers are prepared and also mandates the bare minimum disclosures which an insurer needs to make in the statements. In case of a general insurance company, the Regulation provides that Revenue Accounts shall be prepared separately for Fire, Marine and Miscellaneous classes of business. Health insurance forms just one part of the many sub-classes of insurance that fall under the category 'Miscellaneous'. Where companies (life and non-life) carryout health insurance business, they ought to ensure that accounts for health do not get subsumed under 'Miscellaneous' category but is made distinct and the Revenue Accounts reflect Health Insurance as a separate class of business. Similarly, segregation of the management expenses and investment income is necessary for health insurance business. As regards reserving, health insurance policies having duration of more than 1 year should have reserves calculated based on actuarial estimates. For 1 year policies, it may be done on the lines prescribed for all other non-life policies.

11.6 To monitor the performance of health insurance business of companies, IRDA could adopt a reporting system of major performance parameters (on the lines of what RBI has developed for the banking industry called 'Long Form Audit Report') which could include indicators such as claim disposal rates including settlements and repudiations, outstanding claims including disputed claims, performance under the rural and social sectors etc.

Investments in health sector:

11.7 The Committee recommends that the government should come out with specific securities which earmark funds for the health sector, and a proportion of the mandated investment in government securities could be reserved for such government health sector securities, for all insurers undertaking the health insurance business. Similarly, the present investment regulations of IRDA mandate that not less than 10% of the investment assets should be in the 'Infrastructure and Social Sector'. While 'infrastructure' includes roads, bridges, airports, irrigations projects, industrial parks etc,

health infrastructure does not find a place. IRDA investment regulations must encourage investment in health infrastructure. To this end, it must mandate that a certain percentage of the investment fund of a company should be specifically invested in health infrastructure. This prescription should not only be applicable for stand-alone health insurers but also for any insurer, life or non-life, carrying on health insurance business.

Investments in the TPA business:

11.8 In order to promote greater professionalism in the institution of the Third Party Administrators and attract foreign investors with global reach, and having experience of operating in varied countries, it is desirable that the restriction on foreign investment may be relaxed from the present 26% to 49%. IRDA may also consider mandating TPAs to invest part of their funds in the health sector.

Regulations for access to health insurance for senior citizens:

11.9 The IRDA Act empowers it to issue Regulations to the insurance companies to cater to the needs of weaker and vulnerable sections of the population in the specified manner. A good proportion of the senior citizens are 'below the poverty line'. It is appropriate that whatever steps are taken by authorities, including the IRDA, to help this category should keep in mind the special needs of such senior citizens. But it would be wrong to categorise all senior citizens as belonging to 'weaker' sections of the society. However, all senior citizens are economically vulnerable since they have little opportunity to augment their incomes to compensate for rising costs, especially on account of healthcare. In such a context, for them to be denied access to health insurance is certainly unfair. Hence, IRDA should mandate the companies granted licenses to carry on health insurance business that all senior citizens should have access to health insurance regardless of age, health condition or claim history, except in cases where the person is diagnosed with selected terminal or incurable illnesses at the time of first entry.

11.10 In order that this mandate does not unduly affect the profitability of the insurers, a Health Insurance pool should be created with the active Government funding as well as other stakeholders, to take over high risk cases, for example, senior citizens above the age of 80 years, or those who have risk-based loading of 40% or beyond.

Family Clinics:

11.11 IRDA must promote the concept of family clinics, primarily to reach the senior citizen population and propagate health insurance, but also to help them take health insurance appropriate to their health condition and thereafter to monitor their health and disease management.

Micro Insurance and Social Sector Schemes:

11.12 The Regulations governing the obligations of insurers under the rural and social sectors could be expanded to include prescription of obligations for health insurance specifically, especially for the rural segment. Insurers could also be required to offer some products specifically in Health Insurance, under the Micro Insurance regulations. There could be a separate schedule in the microinsurance regulations for the health insurance products for senior citizens.

11.13 There is also a role for IRDA to be informed about, to study and to undertake need-based evaluation of large group schemes, particularly where governments have taken initiatives to implement health insurance schemes, so that the implementation lessons learnt across schemes can be shared for improvements in such schemes and consequentially improved benefits for the intended beneficiaries.

National Health Data Repository:

11.14 This Committee has noted the need for reform in the manner, details and methodology of data collection for health insurance and its subsequent collation, analysis and publication being done presently, through the data repository located at TAC.

11.15 While the system has contributed to significant amount of transaction level data on claims and policies now being available, there is substantial scope and need for improvement. This is particularly important because risk-based underwriting, as also further development of health insurance industry, needs the constant availability of updated data, and also various analytical tools being applied to this data.

11.16 IRDA should maintain nation-wide data base on the insured people, in respect of not only the insurance taken, claims settled etc but also their health status, so as to facilitate rating, product design, and subsequently, portability. In view of the above, the Committee strongly recommends a National Health Data Repository located within

IRDA, and manned by professionally qualified health researchers, data analysts and other appropriate resources engaged by IRDA. This repository shall procure, own, operate and analyze the health insurance related national database, which should receive information from insurance companies as well as providers. The repository should make appropriate aggregate level data available to all users, including insurers, to help product design and to contribute to business intelligence. Thus, IRDA should act as a model owner for establishing and operating the required information technology tools in the health insurance / health sector and to bring industriousness in its use by all stakeholders. This approach will bring trust and credibility of insurers, consumers, providers and other stakeholders to exchange and share the relevant data.

Health Insurance data and Management Information Systems (MIS):

11.17 IRDA must evolve and maintain a common management information system for the health insurance companies in respect of their coverage by different segments of population, their operations and their financial condition. Thus, in addition to the compiled transaction level reporting for the Health Data Repository discussed below, IRDA should also institute a monthly reporting system from the all the companies licensed to conduct health insurance to provide, for example, the number of persons insured (monthly and cumulative) under each of their products, broken up by different age groups such as 0-17, 18-34, 35-49, 50-59, 60-64, 65-69, 70-74, 75-79 and for 80 and above.

11.18 IRDA should analyze the data and publish the findings for public and academic use as part of its disclosure requirements.

Publicity and Awareness Generation:

11.19 ***Developmental role*****:** The Committee has observed that not much has been done to ensure adequate publicity and awareness generation for health insurance. IRDA should earmark a separate budget for this, which could be raised through contributions from IRDA, industry and providers. The publicity budget should be benchmarked to premiums or any other appropriate peg, so that adequate funds are assured for awareness and publicity efforts undertaken by IRDA.

11.20 ***Information Access Through Internet*****:** IRDA shall mandate insurers to put up the details of all their health insurance products on their websites in the public domain. Also, IRDA itself should develop a portion on its own website providing details and enabling consumers to compare various health products being offered by insurers.

11.21 ***Awareness about initiatives for Senior Citizens*:** To start with, IRDA could organize seminars for dissemination of the recommendations of this Committee. Thereafter also, on an ongoing basis, the awareness and publicity initiatives of IRDA must incorporate special focus on the information needs of senior citizens.

Training requirements in Health Insurance:

11.22 Health insurance needs a professional approach. IRDA must ensure that insurers train the personnel handling health insurance so that they become real 'health insurance underwriters'. There is also need for developing greater actuarial skills in health insurance. An institutional structure for training in health insurance thus needs to be put in place. The personnel manning the TPAs, agents and brokers too need to be adequately trained in this area. Personnel in the 'Family Clinics' as well as billing staff in hospitals, and other health care personnel dealing with insurance including the hospital management, also need training on the subject.

Integrating Providers of Healthcare in the Health Insurance system:

11.23 IRDA should involve providers of healthcare in the data repository. It should also act as a catalyst and a focused body for integrating and co-ordinating the performance of various health providers, and in particular the hospitals. Various initiatives in the long-term interest of the health sector need to be addressed on a priority basis, including accreditation, grading, quality assurance and rating of hospitals, development of STGs and protocols, development of alternative provider payment systems like DRGs and package rates, uniform billing procedures, data sharing etc. IRDA should set up a Health Insurance Advisory Committee comprising of technical experts and representatives of industry, providers and consumers.

Product approval:

11.24 Rather than the 'File and Use' system, health products for senior citizens need to be specifically approved. Whilst on this, IRDA should help evolve sound principles of premium rating based on health condition, as part of its approval process of the products that are expected to be evolved by the insurance companies in pursuance of the public policy on healthy ageing. It must ensure transparency, fairness and vertical and horizontal equity in premium rates by the insurers. IRDA must bring out guidelines for health insurance to ensure all this and other aspects such as portability and continuity of cover.

Uniformity in definitions and terminology:

11.25 The terminology used and standard terms and conditions should be uniform across health insurance policies. IRDA must take steps to ensure this. For instance, a basic uniformity in the definition of 'pre-existing disease' as well as the wordings for exclusion of 'pre-existing disease' is necessary and the initiative by the General Insurance Council in this direction is laudable. The Committee's recommendation on this specific issue covered in Chapter 6 needs to be implemented by IRDA. Similar initiative needs to be taken with regard to the definition of 'Critical Illnesses'.

Effective grievance mechanisms in insurance companies:

11.26 IRDA Regulation for Protection of Policyholders' Interests needs to be amended to incorporate distinct health insurance service parameters, especially for providing specific time frames for settlement of claims by the Insurers. IRDA should also monitor the functioning of the grievance machinery in the insurance companies.

Individual agents:

11.27 Health insurance needs a special focus in terms of training requirements of agents. They should be paid adequate remuneration. Incidentally, senior citizens' associations could also be recognized as corporate agents to facilitate spread of health insurance among senior citizens.

Separate Health Department within IRDA:

11.28 IRDA needs to establish a full fledged Health Insurance department headed by a whole time Member. , This department should be made responsible for the implementation of the above recommendations. The department should engage professional resource persons with the appropriate mix of skills and understanding of the dynamics of the health sector and of health insurance. They should be recruited from diverse backgrounds through transparent recruitment procedures. This is essential to provide the Health Insurance industry with the appropriate developmental support and also adequate regulatory inputs in its crucial years of development. As multi-faceted inputs are required for this department, the Committee suggests that at any given time, not more than half the officials in this department should be permanent or from the insurance industry.

Summary of Recommendations

1.	The IRDA should promote stand-alone health insurance companies. It should initiate necessary action for separate treatment of such companies to ensure their viability. It could adopt a risk-based capital approach for stand-alone and subsidiary health insurers so that more such players are attracted
2.	IRDA should appoint independent actuaries, in terms of its own mandate under Section 14(l) of the IRDA Act, to examine the books of the companies periodically, say, once in three years, and recommend the extent of reserve that needs to be provided to cover future claims
3.	Where non-life companies carryout health insurance business, it should be ensured that the accounts for 'health insurance business' do not get subsumed under 'Miscellaneous' but are made distinct and the Revenue Accounts reflect health insurance as a separate class of business
4.	The present investment regulations of IRDA mandate that not less than 10% of the investment assets should be in the 'Infrastructure and Social Sector'. Investment in health infrastructure should be included in the definition of 'Infrastructure and Social Sector'
5.	IRDA should mandate the companies granted licenses to carry on health insurance business that all senior citizens should have access to health insurance regardless of age, health condition or claim history, except in cases where the person is diagnosed with selected terminal or incurable illnesses at the time of first entry. In order that this mandate does not unduly affect the profitability of the insurers, a Health Insurance pool should be created with the active Government funding as well as other stakeholders, to take over high risk cases, for example, senior citizens above the age of 80 years, or those who have risk-based loading of 40% or beyond
6.	The Regulations governing the obligations of insurers under the rural and social sectors could be expanded to include prescription of obligations for health insurance specifically, especially for the rural segment. Insurers could also be required to offer some products specifically in Health Insurance, under the Micro Insurance regulations. There could be a separate schedule in the microinsurance regulations for the health insurance products for senior citizens
7.	There is also a role for IRDA to be informed about, to study and to undertake need-based evaluation of large group schemes, particularly where governments have taken initiatives to implement health insurance schemes, so that the implementation lessons learnt across schemes can be shared for improvements in such schemes and consequentially improved benefits for the intended beneficiaries
8.	IRDA should maintain nation-wise data base on the insured people, in respect of not only the insurance taken, claims settled etc but also their health status, so as to facilitate rating, product design, and subsequently, portability. In view of the above, the Committee strongly recommends a National Health Data Repository located within IRDA, and manned by professionally qualified health researchers, data analysts and other appropriate resources engaged by IRDA. IRDA should analyze the data and publish the findings for public and academic use as part of its disclosure requirements. IRDA must also evolve and maintain a common management information system for the health insurance companies in respect of their coverage by different segments of population, their operations and their financial condition
9.	IRDA, in pursuance of its developmental role which is all the more pertinent for Health insurance, should earmark a separate budget for publicity and creation of awareness through contributions from IRDA, industry and providers
10	IRDA must ensure that insurers train the personnel handling health insurance so that they become real 'health insurance underwriters'. There is also need for developing greater actuarial skills in health insurance. An institutional structure for training in health insurance thus needs to be put in place. The personnel manning the TPAs, agents and brokers too need to be adequately trained in this area
11	Rather than the 'File and Use' system, health products for senior citizens need to be specifically approved. IRDA should help evolve sound principles of premium rating based on health condition, as part of its approval process of the products that are expected to be evolved by the insurance companies in pursuance of the public policy on healthy ageing

12	The terminology used and standard terms and conditions should be uniform across health insurance policies. IRDA must take steps to ensure this. For instance, a basic uniformity in the definition of 'pre-existing disease' as well as the wordings for exclusion of 'pre-existing disease' is necessary
13	IRDA Regulation for Protection of Policyholders' Interests needs to be amended to incorporate distinct health insurance service parameters, especially for providing specific time frames for settlement of claims by the Insurers. IRDA should also monitor the functioning of the grievance machinery in the insurance companies
14	Health insurance needs a special focus in terms of training requirements of agents. They should be paid adequate remuneration. Incidentally, senior citizens' associations could also be recognized as corporate agents to facilitate spread of health insurance among senior citizens
15	IRDA needs to establish a full fledged Health Insurance department headed by a whole time Member. This department should be made responsible for the implementation of the above recommendations. The department should engage professional resource persons with the appropriate mix of skills and understanding of the dynamics of the health sector and of health insurance
16	The Committee recommends that the government should come out with specific securities which earmark funds for the health sector, and a proportion of the mandated investment in government securities could be reserved for such government health sector securities, for all insurers undertaking the health insurance business

CHAPTER 12

SUMMARY OF RECOMMENDATIONS

INDUSTRY

12.1 In keeping with the philosophy advocated in the National Policy on Older Persons, it is necessary that senior citizens should have access to health insurance. The insurers should promote separate products for the senior citizens with entry age of around 50 years or an omnibus policy covering all ages without any age-limit (Chapter 7).

12.2 It is suggested that insurers fix a 'base' price at the age of 50 and adjust it with a 'loading' for each year and a 'loyalty discount' for each year the insured has been with the health insurance system, not necessarily the particular product. The Committee feels that the industry should aim at a 'base' premium of Rs.3,000/- per annum for a healthy individual at age 50 for a Sum Insured of Rs.1,00,000/-, at current levels of prices and healthcare costs (Chapter 7).

12.3 The key issues are early entry into the insurance system, preventive healthcare and a careful evaluation of the need for expensive medical treatment before it is taken. These would require customer-friendly insurance products, with strong incentives for maintaining good health, and a careful monitoring of health in the context of the insurance policy by medical personnel who have no pecuniary interest in rendering more (or less) healthcare than what is warranted by the health condition of the insured (Chapter 8).

12.4 Health insurance must be human-centric. To achieve this as well as a significant increase in the penetration of health insurance, it is desirable to promote 'stand alone' health insurance companies. A separate Committee had earlier recommended that stand alone health insurance companies should be set up for better penetration. The Committee endorses and reiterates the recommendation (Chapter 8).

12.5 The insurance companies should endeavour to offer continuity in health insurance for applicants who were hitherto covered by corporate insurance or insurance offered by any Government or otherwise, on conditions that they deem fit, subject to observing the principles of horizontal and vertical equity, that is to say, like

cases should be treated alike and the differential between any two classes should be justifiable and reasonable. This will help increase penetration (Chapter 8).

12.6 Insurance policies should be drafted in simple language with terms and conditions clearly stated for easy understanding by the users. There is also need for the Industry to have a uniform definition of terminology and standard terms and conditions such as the pre-existing disease condition etc. It is also necessary for insurers to have a consensus on issues such as portability of covers, sharing of information (such as creation of an information bank of rejected proposals, renewals denied and moral hazard related claims) etc (Chapter 6).

12.7 Health Insurance products for Senior Citizens should be designed according to their needs and capacity to pay. There is a need to offer a variety of products with different features as well as different levels of sums insured**.** It should be possible to creatively combine cost control mechanisms and come up with products that come at affordable prices. To keep costs low, alternative, lower-premium policy for senior citizens could be designed using mechanisms such as co-pays, co-insurance, deductibles etc (Chapter 6).

12.8 It is essential that the Health Insurance industry adopts the practice of risk underwriting based on health conditions. The insurer would do well to adjust the premium for the health condition of the insured on the basis of appropriate medical examination, instead of relying solely on age to determine the premium (Chapter 7).

12.9 It is desirable that every insurer creates meaningful guidelines for risk-based underwriting. The Committee recommends evaluation of health risk by a health risk assessment questionnaire to capture personal and family medical history, capture the outcome of preliminary medical screening for entry to health insurance system (Chapter 7).

12.10 There is need for products that could serve as ‘top up covers’. Insurers could consider designing such covers by which not only would the residual need of the Senior Citizens be met, but also the health insurance net gets extended to a category of citizens who do not participate, barring perhaps a few, in any kind of health insurance scheme today. The number of people in such employer provided schemes being substantial, this strategy would certainly help improve penetration of health insurance in the country (Chapter 8).

12.11 Insurers could innovate and also offer plans specifically suited to the Senior Citizens like capturing the lump sum retirement benefits and providing health insurance coverage for long years. The objective should be to increase the penetration of health insurance in the country (in terms of both numbers and spread) while making health insurance business competitive and commercially viable (Chapter 8).

12.12 Policyholders should be given choice of TPAs to choose from and not bound to one particular TPA. Where they choose to forego the services of a TPA, lower premium ought to be charged (Chapter 9).

12.13 Insurers could also design products that offer an option to cover overseas travel during the period of cover of the domestic medical insurance (Chapter 6).

12.14 The medical insurance cover envisaged for senior citizens should recognize and bring within its scope of coverage, specific treatment taken under other systems of medicine like Ayurveda, Unani, Homeopathy etc. (Chapter 6).

12.15 Health conditions fully disclosed at the time of proposal should be covered by applying one or more of underwriting methods i.e., defined waiting period, appropriate premium loading and capping the covered amount on the preexisting disease for the reference period (Chapter 6).

12.16 There should be a separate channel/set up in insurance companies and TPAs for quick processing of all matters including disposal of claims of senior citizens. For this purpose, the Photo ID card should contain a unique code for identification of the senior citizens (Chapter 9).

12.17 The working and the procedures followed by TPAs as well as the regulations themselves require a review by IRDA with a view to bringing improvements in them (Chapter 9).

SENIOR CITIZENS

12.18 Senior Citizens must recognize that a viable health insurance system revitalizes the economy by generating gainful activity all round and it is as much their duty to strengthen the system as it is the obligation of the insurance companies to insure them (Chapter 6).

12.19 The National Policy on Older Persons advocates the concept of healthy ageing. Older persons and their families need to be educated that diseases are not a corollary of advancing age nor is a particular chronological age the starting point for decline in health status. On the contrary, preventive healthcare and early diagnosis can keep a person in reasonably good health and prevent disability (Chapter 2).

12.20 People should enter health insurance schemes as early as possible for better distribution of risk for the insurance companies and for building up sufficient reserve for their viability in the long term (Chapter 6).

12.21 The elderly must also be educated to notice, and recognize the implications of, disease related signs and symptoms, especially those pertaining to heart and circulation, musculoskeletal systems and infections of the digestive and urinary systems (Chapter 8).

IRDA

12.22 IRDA should mandate the companies granted licences to carry on health insurance business, that all senior citizens should have access to health insurance regardless of age, health condition or claim history, except in cases where the person is diagnosed with terminal or incurable illness at the time of first entry (Chapter 8).

12.23 In order that this mandate does not unduly affect the profitability of the health insurance companies, a Health Insurance pool should be created under the aegis of the IRDA (with substantial contribution from the Government) to take over high risk cases, for example, those who have medical loading of 40% or beyond (Chapter 8).

12.24 While senior citizens should take health insurance from as an early an age as possible so as to make the insurance system financially viable, some of them might be availing of alternative sources of healthcare financing while in active service. Hence senior citizens could be allowed to enter the health insurance system up to the age of 65 years (or higher at the discretion of the Insurer). If they do so, they should be given guaranteed renewal of their insurance without any upper age limit (Chapter 8).

12.25 As a transitional measure, since guaranteed access is being provided to the senior citizens for the first time, there should be no upper age limit for entry or renewal for a period of three years from the date the mandate is made. After the expiry of three years also, insurance companies should exercise their discretion in entertaining the first entry of senior citizens above the age of 65 years in deserving cases. At the same time,

a senior citizen holding a health insurance policy under the present dispensation should not be compelled to shift to any other policy under the new regulations/guidelines. He should also not be denied renewal of the existing policy. Neither should he be barred from switching over to a new scheme (Chapter 8).

12.26 The institution of family clinic should be encouraged. However, the family clinic ought not to be seen as a limb of the insurance company or as its representative. It should be a friend, philosopher and guide of the senior citizen seeking health insurance. The clinic should guide the senior citizen in selecting the insurance product to suit his particular needs. It should provide the necessary administrative support in applying for insurance initially and applying for and processing insurance claims thereafter. The clinic should arrange for storage and retrieval of the medical information pertaining to the insured. Hence, it is very desirable that IRDA issues Regulations under Section 14 and 26 of the IRDA Act, 1999 to promote and regulate the family clinics with a view to ensuring orderly growth and speedy penetration of health insurance in the country (Chapter 8).

12.27 The IRDA should promote stand-alone health insurance companies. It should initiate necessary action for separate treatment of such companies to ensure their viability. It could adopt a risk-based capital approach for stand-alone and subsidiary health insurers so that more such players are attracted (Chapter 11).

12.28 IRDA should appoint independent actuaries, in terms of its own mandate under Section 14(l) of the IRDA Act, to examine the books of the companies doing health insurance periodically, say, once in three years, and recommend the extent of reserve that needs to be provided to cover future claims (Chapter 11).

12.29 Where non-life companies carryout health insurance business, it should be ensured that the accounts for 'health insurance business' do not get subsumed under 'Miscellaneous' category but are made distinct and the Revenue Accounts reflect health insurance as a separate class of business (Chapter 11).

12.30 The present investment regulations of IRDA mandate that not less than 10% of the investment assets should be in the 'Infrastructure and Social Sector'. Investment in health infrastructure should be included in the definition of 'Infrastructure and Social Sector' (Chapter 11).

12.31 IRDA should mandate the companies granted licenses to carry on health insurance business that all senior citizens should have access to health insurance

regardless of age, health condition or claim history, except in cases where the person is diagnosed with selected terminal or incurable illnesses at the time of first entry. In order that this mandate does not unduly affect the profitability of the insurers, a Health Insurance pool should be created with the active Government funding as well as other stakeholders, to take over high risk cases, say, senior citizens above the age of 80 years, or those who have risk-based loading of 40% or beyond (Chapter 11).

12.32 The Regulations governing the obligations of insurers under the rural and social sectors could be expanded to include prescription of obligations for health insurance specifically, especially for the rural segment. Insurers could also be required to offer some products specifically in Health Insurance, under the Micro Insurance regulations. There could be a separate schedule in the microinsurance regulations for the health insurance products for senior citizens (Chapter 11).

12.33 There is also a role for IRDA to be informed about, to study and to undertake need-based evaluation of large group schemes, particularly where governments have taken initiatives to implement health insurance schemes, so that the implementation lessons learnt across schemes can be shared for improvements in such schemes and consequentially improved benefits for the intended beneficiaries (Chapter 11).

12.34 IRDA should maintain nation-wise data base on the insured people, in respect of not only the insurance taken, claims settled etc but also their health status, so as to facilitate rating, product design, and subsequently, portability. In view of the above, the Committee strongly recommends a National Health Data Repository located within IRDA, and manned by professionally qualified health researchers, data analysts and other appropriate resources engaged by IRDA. IRDA should analyze the data and publish the findings for public and academic use as part of its disclosure requirements. IRDA must also evolve and maintain a common management information system for the health insurance companies in respect of their coverage by different segments of population, their operations and their financial condition (Chapter 11).

12.35 IRDA, in pursuance of its developmental role which is all the more pertinent for Health insurance, should earmark a separate budget for publicity and creation of awareness through contributions from IRDA, industry and providers (Chapter 11).

12.36 IRDA must ensure that insurers train the personnel handling health insurance so that they become real ‘health insurance underwriters’. There is also need for developing greater actuarial skills in health insurance. An institutional structure for

training in health insurance thus needs to be put in place. The personnel manning the TPAs, agents and brokers too need to be adequately trained in this area (Chapter 11).

12.37 Rather than the 'File and Use' system, health products for senior citizens need to be specifically approved. IRDA should help evolve sound principles of premium rating based on health condition, as part of its approval process of the products that are expected to be evolved by the insurance companies in pursuance of the public policy on healthy ageing (Chapter 11).

12.38 The terminology used and standard terms and conditions should be uniform across health insurance policies. IRDA must take steps to ensure this. For instance, a basic uniformity in the definition of 'pre-existing disease' as well as the wordings for exclusion of 'pre-existing disease' is necessary (Chapter 11).

12.39 IRDA Regulation for Protection of Policyholders' Interests needs to be amended to incorporate distinct health insurance service parameters, especially for providing specific time frames for settlement of claims by the Insurers. IRDA should also monitor the functioning of the grievance machinery in the insurance companies (Chapter 11).

12.40 Health insurance needs a special focus in terms of training requirements of agents. They should be paid adequate remuneration. Incidentally, senior citizens' associations could also be recognized as corporate agents to facilitate spread of health insurance among senior citizens (Chapter 11).

12.41 IRDA needs to establish a full fledged Health Insurance department headed by a whole time Member. This department should be made responsible for the implementation of the above recommendations. The department should engage professional resource persons with the appropriate mix of skills and understanding of the dynamics of the health sector and of health insurance (Chapter 11).

GOVERNMENT

12.42 Transaction of Health insurance business is human-centric, and not claim-centric. Hence it is desirable to promote 'stand alone' health insurance companies. All insurance companies, both life and non-life, should be encouraged to promote separate health insurance subsidiaries (Chapter 10).

12.43 Stand-alone insurance companies should be permitted to accept long-term deposits from those insured with the company. These deposits should be extended income tax concession under Section 80 C (Chapter 10).

12.44 At least 50% of the Service Tax on all health insurance premiums should be allowed to be credited to the Insurance Pool recommended to be created with the IRDA for dealing with high-risk health insurance cases of senior citizens (Chapter 10)

12.45 Reserves created on the basis of independent acturial valuation and approved by IRDA should be treated as statutory reserves and should be deductible from current income of the companies before computing the taxable income. Suitable provision should be made to this effect in the Income Tax Act (Chapter 10).

12.46 Tax concession for health insurance premiums should be given 'below the line' in the form of a tax credit at a uniform rate of Rs 6,000 (if possible, at a higher level) for each taxpayer, to transform the concession into a progressive one – taxpayers with lower incomes would then get proportionately higher benefit. Also, unabsorbed tax credit should be allowed to be carried forward to future years (Chapter 10).

12.47 Some of the senior citizen beneficiaries of CGHS, ESIS and other health indemnity arrangements like those of Railways are unable to actually avail of those facilities if they retire to places where such facilities are not available. In order to avoid hardship to such beneficiaries, it is recommended that they be given the facility of opting out of their respective Schemes. Such optees should be given a suitable annual grant, say, equivalent to the average cost being incurred per beneficiary to enable them to buy health insurance (Chapter 10).

12.48 The Committee feels that subsidization of health insurance should be preferably on the supply side, that is, subsidising healthcare services rather than on the demand side, that is, subsidising premiums (Chapter 10).

12.49 The Committee recommends that the State Government and/or the local authorities should provide those intending to set up such family clinics in accordance with IRDA Regulations, land and buildings on long term lease at highly concessional rates (Chapter 10).

12.50 The Committee recommends that all senior citizens with incomes below the average per capita income but above the poverty line should be given a grant of Rs 100 per month. This should not be given in the form of cash but in the form of a voucher

either for buying health insurance or for primary and preventive care services (Chapter 10).

12.51 It is recommended that Rs.100 per month out of the Central Government contribution of recently announced old age pension scheme of the Government of India, should be disbursed in the form of a voucher as recommended in '10' above (Chapter 10).

12.52 The Committee recommends that the government should come out with specific securities which earmark funds for the health sector, and a proportion of the mandated investment in government securities could be reserved for such government health sector securities, for all insurers undertaking the health insurance business (Chapter 11).

12.53 For the smooth functioning and success of the health insurance system, the Committee recommends that the health sector itself be streamlined. There should be adequate regulation of hospitals and other healthcare providers. Legislation should be promoted under Article 249 of the Constitution (Chapter 10).

CHAPTER 13

TERMS OF REFERENCE (TOR) AND METHODOLOGY ADOPTED BY THE COMMITTEE

13.1 The Committee was mandated with the following terms of reference:

1.	Suggest commercially viable health insurance schemes for the senior citizens taking care to see that they do not spiral into a high cost healthcare system.
2.	Identify the problems in extending health insurance to senior citizens without age limit and at affordable cost and suggest possible solutions.
3.	Examine the pros and cons of separate health insurance schemes for the senior citizens considering the profitability and claim ratios of different segments of health insurance.
4.	Examine the issues connected with “portability” of health insurance by the senior citizens from one scheme to another and from one insurer to another and suggest the manner and conditions in which such portability is achieved.
5.	Examine the feasibility of offering a menu of options to the senior citizens in terms of the type of diseases (including “pre-existing diseases”) to be covered, the proportion of expenses to be paid, and the quantum of “deductible”.
6.	Suggest streamlining of procedures such that medical treatment is on “cashless” basis and is rendered promptly.
7.	Suggest ways to incorporating alternative systems of medicine into the health insurance system.
8.	Suggest possible incentives to the senior citizens for adopting healthier life styles.
9.	Examine the feasibility of incorporating the concept of “family doctor” into the health insurance schemes for the senior citizens.
10.	Examine the feasibility of integrating travel insurance such as “Overseas Mediclaim” policy into the health insurance schemes of senior citizens.
11.	Any other relevant issue.

The order of the IRDA constituting the Committee and detailing the Terms of Reference is attached herewith:

बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

OFFICE ORDER

No.IRDA/HI/OO/04/07 April 27, 2007.

Re: Constitution of Committee on Health Insurance for Senior Citizens

I. Background:

Issues relating to health insurance for Senior Citizens of the country need a special focus, as they are more vulnerable, due to which they also fall in a higher risk category. Concerns have also been voiced by Senior Citizens across the country on matters relating to policy issuance and claims servicing of health insurance policies. The Insurance Regulatory and Development Authority (IRDA) has received representations relating to entry barriers for the aged, refusal of renewals, imposition of harsh terms without justification, sharp increases in premium rates, delays in claims servicing, etc.

Health Insurance for Senior Citizens requires a careful study by all stakeholders involved – the Regulator, the Government, the insurance industry, the medical service providers, the TPAs, etc. In the backdrop of the concerns voiced by the Senior Citizens and in order to study issues involved as well as make recommendations thereon, the IRDA has decided to constitute a **Committee on Health Insurance for Senior Citizens**, with the following Terms of Reference:

II. Terms of Reference (TOR) :

1. Suggest commercially viable health insurance schemes for the senior citizens taking care to see that they do not spiral into a high cost healthcare system.

2. Identify the problems in extending health insurance to senior citizens without age limit and at affordable cost and suggest possible solutions.

3. Examine the pros and cons of separate health insurance schemes for the senior citizens considering the profitability and claim ratios of different segments of health insurance.

4. Examine the issues connected with "portability" of health insurance by the senior citizens from one scheme to another and from one insurer to another and suggest the manner and conditions in which such portability is achieved.

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परिश्रम भवन, तीसरा तल, बशीर बाग, हैदराबाद - 500 004. भारत
Parishram Bhavan, 3rd Floor, Basheer Bagh, Hyderabad - 500 004. INDIA

5. Examine the feasibility of offering a menu of options to the senior citizens in terms of the type of diseases (including "pre-existing diseases") to be covered, the proportion of expenses to be paid, and the quantum of "deductible".
6. Suggest streamlining of procedures such that medical treatment is on "cashless" basis and is rendered promptly.
7. Suggest ways to incorporating alternative systems of medicine into the health insurance system.
8. Suggest possible incentives to the senior citizens for adopting healthier life styles.
9. Examine the feasibility of incorporating the concept of "family doctor" into the health insurance schemes for the senior citizens.
10. Examine the feasibility of integrating travel insurance such as "Overseas Mediclaim" policy into the health insurance schemes of senior citizens.
11. Any other relevant issue.

In order to examine the above issues, the Authority hereby constitutes a group on the subject of Health Insurance for Senior Citizens comprising of following members :

1. Shri K.S.Sastry - Chairman
2. Shri V.Hariharan - Member
3. Shri A.N.Sood - Member
4. Shri K.N.Bhandari - Member
5. Shri B.D.Banerjee - Member
6. Shri C.Chandrasekhar - Member
7. Shri Nimish Parekh - Member
8. Shri P.C.James - Convenor

The committee for the group will work in an expeditious manner and submit their report to the Authority within a period of six months from the date of commencement of the first meeting.

The Chairman and Members of the Committee shall be entitled to a sitting fee of Rs.2000/- per day whenever there are meetings and a conveyance allowance of Rs.600/- per day apart from reimbursement of travel expenses whenever the meetings are held outside their normal living place. The Chairman and Members will be entitled to reimbursement of travel expenses by air in Economy Class and expenditure on stay will be limited to actuals up to a limit of Rs.6000/- per day.

C S Rao
27.4.07

(C.S.Rao)
Chairman

13.2 The constitution of the Committee is as follows:

Chairman:

Sri K.S.Sastry	I.A & A S (Retd.) & former Chairman, National Housing Bank

Members:

Sri V.Hariharan	Former President, M/s Sundaram Fasteners
Sri A.N.Sood	President, Delhi Federation of Association of Senior Citizens,
Sri K.N.Bhandari	Secretary General, General Insurance Council of India & former CMD of The New India Assurance Co Ltd
Sri B.D.Banerjee	Former CMD of The Oriental Insurance Co Ltd and former Insurance Ombudsman, Mumbai
Sri C.Chandrasekhar	Chief Marketing Officer, M/s Apollo DKV Insurance Co Ltd,
Sri Nimish R.Parekh	CEO, M/s Parekh Health Management (Pvt.) Ltd,

Convenor:

Sri Prabodh Chander	Executive Director, IRDA

Resource Group:

Sri Aloke Gupta	Special Invitee and Consultant to the Committee
Smt Yegna Priya Bharath	Officer on Special Duty, IRDA
Dr. Somil Nagpal	Special Officer- Health Insurance, IRDA
Sri R. Srinivasan	Officer on Special Duty, IRDA

13.3 The IRDA notification constituting the above Committee was hosted in its website on 22.5.2007 inviting suggestions from the stakeholders on the Terms of Reference. The Committee sought the comments and suggestions from the insurers (life and non-life) and also from the TPAs. The claims experience of TPAs, age-wise, disease-wise etc., was also sought and considered.

13.4 The Committee examined the complaints of Senior Citizens received by the IRDA, the insurers, and also by the Committee directly, in regard to access, affordability and service parameters of Health Insurance Policies.

13.5 A comprehensive study of the existing health insurance policies in general and that of Senior Citizens' health insurance policies in particular, was done. The policy conditions with regard to the entry age limit, pre-existing disease exclusions, premium, renewal clauses etc. were critically evaluated. The Committee also took note of the Critical Illness and other health riders of the life insurance policies.

13.6 To enable it to have wider and nation-wide perspective of the issues concerning senior citizens, the Committee undertook its meetings in different cities, namely Hyderabad, Chennai, Kolkata, New Delhi and Mumbai, wherein it took evidences of the Insurers, TPAs, Health Insurance Consultants, Healthcare Providers, C.G.H.S. officials, Senior Citizens' Associations, Pensioners' Associations, Insurance Agents, Insurance Brokers Association, Health Management Consultants, Practicing Doctors, Medico-legal consultants, Consumer Activists, Insurance Ombudsmen, Tax Consultants and others, as listed in an annexure to the Report. The Committee also engaged the services of professional persons with expertise in Health and Health Insurance sectors, throughout its deliberations. The team of IRDA officials associated with the Committee also interacted extensively with the members of the health committees of the industry chambers to elicit their inputs.

13.7 The nuances of the health insurance schemes operated in other countries like USA, Philippines, Singapore, were studied through presentations made to the Committee and evidence presented before it.

13.8 The presentations made by the stakeholders were extensively deliberated during the seven Committee meetings. The Committee analyzed the health insurance data of the Tariff Advisory Committee and the insurers/TPAs.

13.9 The Committee's attention was drawn to the currently operational subsidized Senior Citizens' Insurance Schemes, namely Senior Citizens Health Welfare Scheme at Pune and Pandit Deendayal Upadhyaya Varishtha Jan Swasthya Bima Yojana at Indore. In order to develop an insight into these schemes, these schemes were studied in detail and also discussed with the authorities administering these schemes by an IRDA official who is working as part of this Committee. A brief on the working of these schemes is attached as an Annexure G to the Report.

Acknowledgements

At the outset, the Committee would like to place on record its sincere appreciation for Shri C S Rao, Chairman, IRDA and Members of IRDA, for identifying this important area which required study and for their understanding of the issues and concerns of the senior citizens for coverage of their health related contingencies.

The Committee gratefully acknowledges the valuable inputs given by one and all and specifically the organizations and individuals with whom the Committee had the opportunity to interact and also whose evidences were received by the Committee. The Committee has endeavored to incorporate in the Report, as far as possible and feasible, suggestions received by it. In particular, we would like to name: Dr.Arbind Prasad, Dr. D V S Sastry, Shri A C Mukerjee, Shri K Sridhar, Shri Rangabashyam, Dr. Kulwant Sharma, Dr Jyoti Parekh, Dr. M S Kamath, Shri C N S Shastri, Justice (retd) T N C Rangarajan, Shri S Krishnan, Shri Edgar Balbin, Dr B Badrinarayan, Dr N Ravindra Shetty, Shri S K Sethi, Shri S Krishnamurthy, Shri Pawan Bhalla, Shri V Jagannathan, Shri Ajit Narain, Shri Rakesh Jain, Shri Rajan Subramaniam, Shri Yogesh Lohiya, Shri T S Vijayan, Shri V Ramasaamy, Shri Neeraj Kumar, Shri Raju Sharan, Shri V Sekar, Dr R K Kaushik, Dr (Ms) V Balambal, Nayan Shah, Shri R N Mittal, Shri I V L N Chary, Dr. Brig (retd) Jaya Rao, Shri P Vyasamoorthy and all the other individuals who contributed significantly to the knowledge and deliberations of the Committee.

The Committee is grateful to the following organizations who had hosted the Committee Meetings- M/s United India Insurance Company Ltd, Chennai; M/s National Insurance Company Ltd, Kolkata; The Tariff Advisory Committee, Mumbai; Insurance Regulatory & Development Authority, Hyderabad & Delhi. The Committee would also like to express its gratitude to Dr D C Garg of Indore Municipal Corporation, Dr S T Pardesi of Pune Municipal Corporation & officials of Sahyadri Hospital for extending their support in the studies of their senior citizen schemes.

The Committee acknowledges with appreciation the highly pro-active and indispensable role of Shri Prabodh Chander as its Convenor and for helping organize and structure the deliberations of the Committee. The Committee also gratefully acknowledges the valuable contributions made by the resource group consisting of Smt Yegna Priya Bharath, Shri Aloke Gupta, Dr Somil Nagpal and Shri R Srinivasan. They complemented each other in several respects but functioned as a cohesive team. It would not have been possible but for the untiring efforts of the group to have been able to produce this Report in the short time frame available.

The Committee also appreciates the valuable support provided by Shri Aloke Gupta who was invited as a special invitee and consultant to the Committee. The Committee would also like to thank the various officials of IRDA & in particular, the administration department, for making available support and infrastructure necessary for the smooth conduct of the proceedings of the Committee, certainly more than what is customarily provided.

ORGANIZATIONS AND INDIVIDUALS WHOSE EVIDENCES WERE TAKEN BY THE COMMITTEE

1.	Dr.Arbind Prasad, IAS, Jt.Secretary, Govt of India, Ministry of Social Justice & Empowerment – Special Invitee
2.	All India Senior Citizens' Confederation, Central Council, 7th National Conference delegates at Jaipur on 27.10.07
3.	Federation of A.P. Senior Citizens Organizations, Hyderabad
4.	The Probus Club, Chennai
5.	General Insurance Pensioners' Association (Western Zone)
6.	All India Insurance Agents' Association
7.	Mr.S.K.Sethi, Vice President & Director, Insurance Brokers Association of India
8.	a) Dr.(Brig.) Jaya Rao b) Dr.Indumati c) Dr.Anasuya d) Dr.V.V.Subba Rao (Doctors from Federation of A.P. Senior Citizens Organizations)
9.	M/s Batra Hospitals, Delhi
10.	M/s Gangaram Hospitals, Delhi
11.	M/s Asian Heart Institute, Mumbai
12.	M/s HelpAge India
13.	Mrs.Rekha Shetty, MD Farstar Distribution Network Ltd
14.	Dr.(Col.) Kulwant Sharma, MGS Hospital, New Delhi
15.	Mr.Edgar Balbin, Senior Manager, Bearing Point
16.	Dr.B.Badrinarayana, CMO (NFSG), Central Government Health Scheme, Ministry of Health & Family Welfare, Govt of India
17.	Mr.S.Krishnan, I.A.A.S. (Retd.), Consumer Coordination Council, Delhi
18.	Dr.Jyoti Parekh, Peder Polyclinic
19.	Dr.M.S.Kamath, Medico-Legal Consultant, Mumbai
20.	Hon'ble Insurance Ombudsman, Chennai Jurisdiction, Shri K.Sridhar
21.	Hon'ble Insurance Ombudsman, Kolkata Jurisdiction, Shri Rangabashyam, ,
22.	Mr.Yogesh Lohia, CMD, General Insurance Corporation of India
23.	Shri A.C.Mukherjee, former CMD of The New India Assurance Co Ltd,
24.	Dr.D.V.S. Sastry, D.G. (R & D), IRDA
25.	Shri T. S. Vijayan, Chairman of Life Insurance Corpn of India
26.	Bajaj Allianz General Insurance Co Ltd
27.	ICICI Lombard General Insurance Co Ltd
28.	IFFCO Tokio General Insurance Co Ltd
29.	National Insurance Company Ltd
30.	The New India Assurance Co Ltd
31.	Oriental Insurance Co. Ltd
32.	Reliance General Insurance Co. Ltd
33.	Royal Sundaram Alliance Insurance Co Ltd
34.	Tata AIG General Insurance Co Ltd
35.	United India Insurance Co Ltd
36.	Cholamandalam MS General Insurance Co Ltd
37.	HDFC General Insurance Co Ltd
38.	Star Health and Allied Insurance Co Ltd
39.	Apollo DKV Insurance Co Ltd
40.	Good Health Plan Ltd
41.	Anyuta Medinet Healthcare Pvt. Ltd.
42.	TTK Healthcare Services Private Limited
43.	Family Health Plan Ltd

44.	Medi Assist India Pvt. Ltd.
45.	Grand Healthcare Services India Private Limited Heritage Health Services Pvt. Ltd.
46.	Med Save Health Care
47.	E-Meditek Solutions Ltd
48.	Universal Medi-Aid Services Ltd
49.	M/s Vipul Med Corp. Pvt Ltd
50.	Raksha TPA Pvt. Ltd
51.	East West Assist Pvt. Ltd.
52.	Alankit Health Care Limited
53.	Park Mediclaim Consultants Private Ltd.
54.	Genins India Ltd.
55.	Safeway Mediclaim Services
56.	Dedicated Healthcare Services (India) Private Limited
57.	Parekh Health Management (Pvt.) Ltd.
58.	Paramount Health Services Pvt. Ltd.
59.	Rothshield Healthcare (TPA) Services Limited
60.	MD India Healthcare Services (Pvt.) Ltd.

Notable suggestions received by post/ e-mail from:

1.	All India Central Confederation ofPensioner Associations, Delhi
2.	Senior Citizens' Forum, New Delhi
3.	The Retired LIC Class-I Officers' Association,New Delhi
4.	Consumer Education &Research Society, Ahmedabad
5.	All India Retired Insurance Employees' Federation, Ahmedabad
6.	All India LIC Employees Federation, Mumbai
7.	Senior Citizens' Forum, Hyderabad
8.	LIC OF INDIA (Retired) Employees Association, Mumbai
9.	Shri Kharni Nagar Vikas Samithi, Kota
10.	Pensioners' Forum, Madras
11.	Voluntary Action for Citizens' Help and Awareness, Ahmedabad
12.	Shri K.Madhavan, Inspector General of Police, CBI (Retd)
13.	Dr.S.N.Sur, Mumbai
14.	Dr.K.R.Bhattacharya, Dy.Director (Retired), M/s Central Food Technological Research Institute
15.	Shri G.M.Rama Rao, Chartered Accountant & Project Implementation Expert, Visakhapatnam
16.	Shri G.M.Chopra, Member – National Council for Older Persons
17.	Shri B.Raghavan, Chennai
18.	Shri S.W.Khankhoje, Retd. Dir.(Telecom), Bilaspur
19.	Shri Sripada Rama Rao, Vizakhapatnam
20.	M/s S.Sivaprasad & M.Syamaladevi
21.	Mr. Nalin Thakor, Ahmedabad
22.	Shri S.K.Jain, Managing Director, M/s Embe Insurance Brokers Ltd, Chandigarh
23.	Shri Partha Chowdhury by e-mail
24.	Shri Vijayaraghavan Rajan by e-mail
25.	Shri V.Ramamurthy, Secunderabad
26.	Shri R.Rajagopalan, Professor of Physics (Retd.), Chennai
27.	Shri N.L.N.Murthy by e-mail
28.	Shri S.Ramanujam, Manager (Operations), M/s Sundaram Finance Ltd
29.	Shri S.K.Balasubramanyam by e-mail
30.	Shri N.Gopalakrishnan , Visakhapatnam
31.	Shri Solomon Rajendran, Mysore
32.	Dr.P.V.Chandrasekaran, MBBS; MD;DM(Cardiology)
33.	Shri George Cheriyan
34.	Shri L.Gopalan, AGM, Retd,, M/s BHEL by e-mail

35.	Shri V.V.Kumar, Kakinada
36.	Shri K.R.Arunachalam, Retired Divisonal Manager, LIC,Chennai
37.	Shri Satish Viswanathan by e-mail
38.	Shri B.R.Sampath, Bangalore
39.	Shri S.Ramachandran, Chennai
40.	Shri R.Parthasarathy by e-mail
41.	Shri T.S.Sriraman, Chennai
42.	Shri S.Jayarajan, Trichy
43.	Shri P.J.Joseph, Chennai
44.	Shri A.Sreenivasan, Income Tax Officer (Retd.) & Advocate,Chennai
45.	Shri Deshpande Narender Rao, Hyderabad
46.	Shri F.C.Bhambmri,New Delhi
47.	Shri A.S.Gopala Krishnan,Bangalore
48.	Dr.V.Subbiah, Dean of Electrical Sciences, Sri Krishna College of Engg & Technology, Coimbatore
49.	Shri Sudheendra Batni, Bangalore
50.	Shri N.Muthukrishnan by e-mail
51.	Shri T.Satyananda Rao by e-mail
52.	Shri B.C.Kunneth by e-mail
53.	Shri N.Ahuja by e-mail
54.	M/s Raja & Jayam by e-mail
55.	Shri Baseudeo Gaggar by e-mail
56.	Shri V.G.K.Murti by e-mail
57.	Shri Raja Narayanan by e-mail
58.	Shri Madhavan Sowmyanarayanan by e-mail
59.	Shri R.Venkatesan, Chennai

Annexure A

PROPOSAL FOR UNIFORM TREATMENT OF PRE-EXISTING MEDICAL CONDITION[14]

"Pre-existing" implies that the medical condition continues to exist. Thus, for example, if a person suffered from Chikungunya and got fully cured, it cannot be treated as "pre-existing".

2. The logic of special consideration for any pre-existing medical condition is that such condition:

a. exposes the person to a much higher risk of illness requiring medical treatment of a nature covered by the insurance (hereinafter called insured treatment); or
b. makes it inevitable that the person will require insured treatment in the near future; or
c. already requires insured treatment but which can be deferred in time for a period, to take advantage of insurance.

3. Certain pre-existing medical conditions may increase the risk of the person requiring insured treatment but does not require any specific medical treatment that can be fore-seen as inevitable. For example, diabetes or blood pressure may increase the risk of the person requiring insured treatment but they can be controlled by medication and do not inevitably require insured treatment. In such cases, it is possible to underwrite the higher risk in one of several ways, namely:

a. require a full medical examination of the proposer at his cost as a pre-requisite for consideration of the proposal; or
b. require a higher premium rate to reflect the increased exposure to risk; or
c. impose a co-insurance share in the cost of insured treatment directly related to the pre-existing condition; or
d. impose a deductible applicable to the cost of insured treatment directly related to the pre-existing condition; or
e. offer a smaller limit of cover for insured treatment directly related to the pre-existing condition.

4. Certain pre-existing medical conditions may make insured treatment inevitable but leave the timing uncertain. In such cases, the insurer's anxiety should be only to exclude insured treatment soon after insurance is effected. Such excluded period can be sufficiently long to prevent elective insured treatment and go on the basis that no person would voluntarily undergo insured treatment just because someone else is paying for it, if it was not considered essential enough to be done immediately. Thus an exclusion period of say, 2 years can be considered long enough. The insurer, of course has the ability to take note of the increased risk of insured treatment in such cases and deal with it as stated in para 3 above.

5. Normally, general insurance policies are annual contracts and do not give any assurance of continuity of cover. However, certain personal insurances are sold in the expectation of a

[14] The Committee gratefully acknowledges Shri C N S Shastri, Advisor, IRDA, for these inputs.

continuing relationship and so, features are introduced into the annual contract to attract continuity such as cumulative addition to sums insured on renewal or renewal bonus in premium rate for renewal following a claims free year or assurance of maintenance of the premium rate in case of renewal without a break. Personal Accident insurance and Medical expenses insurance fall in this category. So, the policyholders have a reasonable expectation of maintenance of cover at the next renewal even if they have incurred insured treatment during the year.

6. It is improper for insurers to cover up for their underwriting mistakes by refusing renewal. There is no compulsion on insurers to provide cover to every proposer. They have the liberty to refuse cover or require higher than normal premium or offer restricted cover. But once they take on the risk, it would be considered unprofessional behaviour to throw out the policyholder just because he made a claim. So, a fair basis of dealing with renewals can be as follows:

i. Where the policyholder requires insured treatment during the year and the treatment is of a nature that will inevitably lead to recurring treatment for the same cause in subsequent policy periods, this risk should be factored into the initial pricing but that illness should not be put under pre-existing exclusion at renewal.

ii. Where the policyholder claims for insured treatment during the year from a medical condition that reasonably ought to have been known to the policyholder before proposing for cover, but the policyholder failed to disclose such information, the insurer may refuse renewal or apply different terms for the renewal depending on the facts of the case.

7. Medical insurance should be portable. Such portability can be from a group insurance policy to an individual insurance policy with the same insurer or from one insurer to another insurer. Where a person insured under a group insurance policy moves to an individual policy, he cannot claim the benefit of any wider cover that may have been specially provided under the group insurance policy but he should be entitled to the standard cover provided by the company for individuals. The insurer can require the person seeking such continuation of insurance to fill in a complete proposal form and underwrite the insurance on merits except that the exclusion period for pre-existing medical condition should count from the date of commencement of protection for him under the group insurance without any break in insurance.

8. Where a person insured with one insurer moves to another insurer for his medical insurance, the pre-existing period should count from the first day of un-interrupted cover with any insurer. Where the policyholder is moving to a wider scope of cover from a restricted scope of cover, the continuity of cover concept will only apply to the more restricted scope of cover that he had earlier. If there was a gap in renewal of cover with the same insurer exceeding 1 month or if there was a gap of cover of more than 15 days in moving from the cover with one insurer to a cover with another insurer, the benefit of continuity of cover can be refused.

9. Where a policyholder seeks increased limits of cover or wider cover, the period for the purpose of pre-existing condition in respect of such increased cover will start from the date such increased cover is first secured.

10. Insurers should be encouraged as a matter of courtesy to issue notices to policyholders about the date of expiry of current insurance cover, at least one month before the date of expiry. Where a policyholder does not renew his insurance despite receiving such a notice, and seeks renewal after 15 days of expiry of the earlier cover, the insure will be within its rights to refuse renewal or to require a full medical examination or impose any other conditions of cover on par with cases of new insurances.

11. All insurers should use a standard wording for exclusion of pre-existing condition. The wording will have the following elements in it:

1. The medical condition should be such as to require insured treatment;

2. The medical condition should continue to be in existence on the date of insurance; and

3. The proposer should be reasonably expected to be aware of the existence of such medical condition or should have consulted a doctor or have been under treatment for it any time during the preceding two years on the date of proposal.

12. All insurers should agree on a list of medical conditions that call for different types of treatment as specified in para 3 above. They should also design the proposal form in such a way that there will be no unintended non-disclosure of material information. It is open to individual insurers to depart from the market standard but such departure should be clearly disclosed in the prospectus and proposal form and also explained at the point of sale.

Annexure B

HEALTH INSURANCE FOR SENIOR CITIZENS[15]

Family Doctor

I. Concept

Traditionally India have Family doctor concept. Present life style have brought in Hospital centric. What we need today is health care Human centric. Senior citizens need better consultation culture and least hospitalization, especially when joint family system is becoming a thing of the past.

II. Nomenclature

"**Family Doctor**" is an age old thing like a village school teacher or a postman in the locality who serve the people without Pomp. They are known to everyone and they know in turn everyone in the area.

Family doctors serve the society in general as general practitioners and in a family from the newborns to grandmothers i.e. a few generations and they are well versed with all the ailments and anything beyond their reach is directed to specialists" save hands. Their services are cordial and the charges are affordable.

Family doctor is a doctor who takes care of the whole family. They create caring relationships with patients and their families. They really get know their patients. They listen to them and help them make the **right health care decisions**.

III. Scope

The role of Family physician in Indian society is not only to safeguard health of all family members and also preventing possible health disorders. This is possible as the Family doctor is the only person who can evaluate and identify the early warning signals physical/mental/communicable/emotional disorders.

The role of Family physician starts from as early as conceiving by a lady through delivery, referring to correct pediatrician, childhood stage, adolescence stage of the child, marriage and so on till the child becomes senior citizens.

Family doctors take care of the physical, mental and emotional health of both their patients and their patients' families. They know family's health history and how it can affect you. They are trained to care for you through all the stages of your life.

Family doctors are trained in all areas of medicine. They can diagnose and treat the full range of problems people usually bring to their doctors. They know when to treat you, and, if necessary, **when to bring in specialist** you can trust.

Family doctors know the most current treatments and technologies. They are trained in real practice settings, treating patients in the office, the hospital and at home. They also continue to educate themselves. This allows them to apply the latest medical breakthroughs to the everyday care of their patients.

Senior Citizens differ in many ways from the young. Such distinctions underlies the medical specialty. They differ because social problems. So practical skill and

[15] Contributed by Shri V Hariharan, Member of the Committee

experience are needed in order to obtain adequate history. Such physician can make an accurate and early diagnosis.

Also while investigating diseases in the elderly, the standard set for younger patients cannot be always used. For example, if the laboratory investigations reveal slightly higher blood sugar levels in the elderly, it may not indicate diabetes. So results of the investigation should systematically analyzed before arriving at a conclusion on the nature of the disease.

Multiple diseases mean multiple prescriptions. This leads to more drug related side effects, interactions and omissions. Sometimes side effects of the drugs may be more than its beneficial effects. It is not necessary to have a "pill for every ill". Many diseases in old age can be managed by non-drug regiments like diet, exercise, physical therapy and counseling.

In addition, the elders suffer from socio-economical problem like isolation, dependency, poverty, etc., These problems will precipitate or aggravate the already existing medical problems. Total assessment only can give appropriate management to improve the quality of Senior Citizens

IV. Objective

a) Importance of Family doctor in senior citizens life is :-

1. In today's world the senior citizens are the most neglected in family life and also in getting treatment of illness associated with old age.

2. The costs are high and it prohibits the elderly from accessing the same and in the result they die of illness unattended.

3. Savings of the senior citizens are hardly sufficient for the livelihood and in the process the cost of treatment and medicines are highly unaffordable.

4. Right time and right medicine and by right doctors treatment is not in their reach.

b) *Need of a family doctor*

1. Family doctors are specially **trained in preventive medicine**. They believe that preventing a health problem is better than having to overcome one. They help you make the right health choices to keep you and your family healthy.

2. You needn't have a complete **physical examination** every year, though. Research has shown that complete physical examinations every year are no more efficient in catching developing health problems that less-frequent examinations. The most effective strategy seems to be for every body to adopt some broad **preventive measures**, and then for individuals with specific risk factors to adopt some additional measures tailored especially for them. Periodic checkups – not too infrequent – give you the best chance of **arresting** any **disease in its early stages**.

V. Approach

1. Standardize health Insurance set up for senior citizens in India.

2. All health related problems routed through a Single Channel – Family doctor.

3. All referrals routed through family doctor .

4. Standardize protocols throughout India.

VI. Family doctor in Insurance setup

1. Qualification M.B.B.S. with 5 years clinical experience or Post-graduate with 3 years clinical experience.

2. Office space for working essential with timing specified.

3. Shall have the minimum equipment required to handle outpatient work.

4. Has to be accessible by phone at all time.

5. Should have access to past medical history of possible clients around the community where doctor lives.

6. Each Family doctor should have list of specialist consultants to whom he/she can refer the patient to.

7. List of accredited Labs / Consultants should be available.

8. As a general rule's Family doctor's advice to be sought for, before any treatment commences.

9. Doctor should prescribe only essential drugs for the ailment.

10. Doctor can refer the patient to clinical Labs / X-ray / Scan etc which are authorized by the Insurance company and must be in the vicinity of the Insured person.

11. All elective hospitalization shall be authorized by the family doctor.

12. Doctor should maintain a register and should be preserved. The register must show the date, time of the patient visit, his complaint and doctors examination notes briefly and treatment advised / referral to hospital.

13. After each consultation the doctor shall update the file of the patient.

14. Patient documents should be potable to another family doctor within the country subject to Insurer mobility.

15. Family Doctor should be allowed to cover a certain area – Community Doctor.

VII. Senior Citizen in the Insurance set up

1. Each senior citizen should choose Family doctor of his/her choice who is enrolled by IRDA / Insurance company.

2. Normally all Mediclaim policies cover full hospitalization only. Hence the scheme should cover domiciliary treatment as well, since many of the Elders go for temporary medical help like BP, Blood Sugar, Blood test etc.

3. The Family doctor will examine and give treatment and if need, will suggest further investigation and for hospital admission.

4. Policy holder can get admitted to any of the approved hospital with Family doctor's essentiality certificate.

5. The involvement of Family doctor will reduce the high cost healthcare system.

VIII. How do I find a family doctor

- Do they accept your insurance?
- What are the office hours?
- What hospital does the doctor use?
- How many doctors are in the practice?

Once you find a doctor who meets your needs, schedule an appointment so that you can meet and talk to the doctor. During the appointment, make sure:

- You're comfortable talking to the doctor
- The doctor answers all your questions
- The doctor explains things so that you can understand
- You had enough time to ask all your questions

Remember, it takes time to build a relationship with your doctor.

IX. IRDA Role

a. To reduce the chances of misusing the system the cost of therapy could be borne equally by the Insurance company and the patient i.e. 50% by patient 50% by the Insurance company. Since the patient has to bear 50% of expenses for Doctors consultation, Investigation, specialist fees and hospitalization. This will certainly remove the malpractice of unnecessary admission or consultation by the patient. This can also result in reducing the premium amount to be borne by the patient, thus making mediclaim affordable to senior citizen.

b. The scheme should also cover house visits by Family doctor, since senior citizen may find this beneficial. The cost of services provided can be nominally fixed to make this project viable as follows :

c. Family doctor consultation fees Rs.100/-, House visits for Rs.200/-, Lab test fixed at normal rate, Specialist consultation can be fixed at Rs.150/- and Hospitalization services can be monitored by TPA

d. Pre-existing disease should be covered in this scheme with a marginal increase in premium.

e. Normally scientific Allopathy medicine is prescribed in this field. However well established alternative system of medicines may be considered.

f. Annual health check up at reasonable interval to be done for all senior citizens which will be borne 50% / 50%, Family doctor will be core in this scheme. He should be given powers to decide the mode of management if need be after consulting specialist.

g. If the senior citizen travel within the country the scheme should still be in force, since many elders go to the children residence on & often. Insurance policy to be potable.

h. The same scheme can be extended for overseas mediclaim with extra premium

i. Normally all mediclaim policies cover full hospitalization only. Scheme should cover domiciliary treatment as well. Since many of the senior citizens go for temporary medical check up like BP, Blood sugar, Blood test etc.

j. The success of this scheme depends on one or more Family doctor in a pincode who will deliver the scheme.

X. Strategy

To increase the involvement and responsibility of family physicians for resources in their community has happened in the UK National Health Service. Large groups of family physician/ general practitioners (75 to 100) have been given most of the health care resources for the 200,000 people they serve and are required to manage these resources in a way that addresses the community needs most efficiently and effectively.

XI. Benefit

a. The Family doctor's regular care may minimize the risk of sickness to a great extent.

b. The involvement of Family Doctor will reduce the high cost of Healthcare system.

c. Case history of the insurer will be available for life time use.

d. Single window concept will benefit the family.

e. The involvement of patient paying a sum of the medical expenses will evolve participative healthcare approach.

f. Adopting healthier life style must be given a pat by sending Health magazines, Free preventive check-up etc by Insurance company.

g. Basis for cost cutting on bringing the claim ration down. Family doctor can provide you with domiciliary care and reduce hospitalization. It can reduce litigation and consumer forum activities.

HEALTH INSURANCE FOR SENIOR CITIZENS

Family Doctor - International Practice

General practitioner (GP), family physician or family practitioner (FP) is a physician/medical doctor who provides primary care. The term general practitioner is common in the United Kingdom and some other Commonwealth countries, where the word "physician" is only used for certain specialists and not for GPs.

The scope of family practice is extremely variable among Family Physicians. In fact it can be argued that the scope of practice is a very individual, and unique for every Family Physician. Every Family Physician will have a different level of comfort with managing any disease. Each physician's referral threshold will be influenced by their own perceived competence, as well as the access to consultants in their community. Furthermore the scope of practice is very

dynamic, changing almost weekly as new technology and new information becomes available. The scope of practice of each Family Physician should be very dynamic and undergoing continual change.

India

India has the highest number of medical schools in the world, with approximately 262. In India to become a GP or a Family Physician, one has to enroll in a Medical Council Of India (MCI) recognised medical college and complete the Bachelors of Medicine and Surgery (M.B.,B.S) course, which is of four and a half years duration to be awarded the degree of M.B.,B.S and provisionally registered with the Medical Council of India. After one further year of compulsory rotatory internship, the Medical Council of India (or any of the State Medical Councils) confer permanent registration which licences the holder to practise as a GP.

Higher medical education

An M.B., B.S Doctor can appear for pre-post-graduate examinations (Pre-PG) at national, state or institute levels and gain entry to a MD (Doctor of Medicine), MS (Master of Surgery) or a Diploma course in a number of specialisations including Internal Medicine (or General Medicine).

One can also opt to join the National Board of Examinations (NBE)'s fellowship for Family Medicine at any of the NBE designated and recognised Health care center or hospital and appear for qualifying exams for fellowship to the National Board on successful completion of which, one is awarded the "Diplomate of National Board" degree and title.

Other than allopathic doctors, graduates of homeopathy, ayurveda, and unani courses from recognised medical colleges and institutions and duly registered with the respective state or national boards of **these medical systems can also practice as family practitioners.**

United Kingdom

In the United Kingdom, doctors wishing to become GPs take at least 4 years training after medical school, which is usually an undergraduate course of five to six years (or a graduate course of four to six years) leading to the degrees of Bachelor of Medicine and Bachelor of Surgery (MB ChB/BS).

Under the programme Modernising Medical Careers. Doctors graduating from 2005 onwards will have to do a minimum of 5 years postgraduate training:

- two years of *Foundation Training*, in which the trainee will do a rotation around either six 4-month jobs or eight 3-month jobs - these include at least 3-months in general medicine and 3-months in general surgery, but will also include jobs in other areas
- two years as on a General Practice Vocational Training Scheme (GP-VTS) in which the trainee would normally complete four 6-month jobs in hospital specialties such as obstetrics & gynaecology, paediatrics, geriatric medicine, accident & emergency or psychiatry
- one year as a general practice registrar.

At the end of the one year registrar post, the doctor must pass an examination in order to be allowed to practice independently as a GP. This summative assessment consists of a video of two hours of consultations with patients, an audit cycle completed during their registrar year, a multiple choice questionnaire (MCQ), and a standardised assessment of competencies by their trainer.

Membership of the Royal College of General Practitioners is optional and can be awarded by examination, or by systematic assessment of an existing practitioner. After passing the exam or assessment, they are awarded the specialist qualification of MRCGP – Member of the Royal College of General Practitioners. General practitioners are not required to hold the MRCGP, but it is considered desirable. In addition, many hold qualifications such as the DCH (Diploma in Child Health of the Royal College of Paediatrics and Child Health) and/or the DRCOG (Diploma of the Royal College of Obstetricians and Gynaecologists) and/or the DGH (Diploma in Geriatric Medicine of the Royal College of Physicians. Some General Practitioners also hold the MRCP (Member of the Royal College of Physicians) or other specialist qualifications, particularly if they had a career in another specialty before coming into General Practice.

There are many arrangements under which general practitioners can work in the UK. While the main career aim is becoming a principal or partner in a GP surgery, many become salaried or non-principal GPs, work in hospitals in GP-led acute care units, or perform locum work. Whichever of these roles they fill the vast majority of GPs receive most of their income from the National Health Service (NHS). Principals and partners in GP surgeries are self-employed, but they have contractual arrangements with the NHS which give them considerable predictability of income.

The MB ChB medical degree is generally considered equivalent to the North American MD medical degree. Doctors educated in the United States, Canada, Ireland, and Great Britain have more ability to move between the countries than other national systems.

Visits to GP surgeries are free in the United Kingdom, but most adults of working age who are not on benefits have to pay a standard charge for prescription only medicine.

GPs in the United Kingdom may operate in community health centres.

Recent reforms to the NHS have included changing the GP contract. General practitioners are now not required to work unsociable hours, and get paid to some extent according to their performance, e.g. numbers of patients treated, what treatments were administered, and the health of their catchment area, through the Quality and Outcomes Framework. They are encouraged to prescribe medicines by their generic names. The IT system used for assessing their income based on these criteria is called QMAS. A GP can expect to earn about £70,000 a year without doing any overtime, although this figure is extremely variable. A recent report[2] notes that a GP can potentially earn £250k per year. These potential earnings have been the subject of much criticism in the press for being excessive [3]. However, an average full time GP is more likely to earn a little less than £100,000 before tax.

GP Practices have been criticised by their lack of accountability, in particular with complaints procedures, as recent report described "an NHS complaints system failing to detect issues of professional misconduct or criminal activity".[4] However complaint procedures have been tightened up and there is now a growing threat that malicious complaints and unrealistic expectations from patients are making General Practitioners stress levels soar. Practices are independent contractors and thus are able to exercise discretion in how they conduct themselves, the Primary Care Trust is not able to handle complaints before the Practice has, and patients do run a risk of being removed from the practitioner's list[5].

Australia

The basic medical degree in Australia is the MBBS (Bachelors of Medicine and Surgery), which has traditionally been attained after completion of a six-year course. Over the last few years, four-year postgraduate courses have become more common. After graduating, a one or two-year internship (dependent on state) is required for registration before specialist training begins. For general practice training, the doctor applies to enter the three-year "Australian General Practice Training Program", a combination of coursework and apprenticeship type training leading to the awarding of the FRACGP (Fellowship of the Royal Australian College of General Practitioners), if successful. Since 1996 this qualification or its equivalent has been

required in order for the GP to access Medicare rebates as a general practitioner. Medicare is Australia's universal health insurance system, and without access to it, a practitioner cannot effectively work in private practice in Australia. Most GPs work under a fee-for-service arrangement although increasingly a portion of income is derived from Government payments for participation in chronic disease management programs.

Canada

In Canada, all medical students go on to a specialty, and family medicine accounts for almost 40% of the residency positions for graduating students. Following four years in medical school, a resident will spend 2-3 years in an accredited family medicine program. At the end of this, residents are eligible to be examined for Certification in the College of Family Physicians of Canada. Many hospitals and health regions now require this certification. To maintain their certificate, doctors must document ongoing learning and upgrade activities to accumulate "MainPro" credits. Some doctors add an extra year of training in emergency medicine and can thus be additionally certified as CCFP(EM).

Canadian Family Physicians have a very broad scope of practice compared to most countries other than the United States and possibly rural Australia. In most European countries the family physician works only in the community and there is no expectation of working in or having more than a superficial relationship with hospitals. Family physicians do not have any appointments in hospitals. However when examining the role definitions from different countries you will find common themes running through the definitions. It is from these themes that the basic principles of Family Medicine as a discipline can be derived.

United States

In the United States, a general practitioner has completed the one-year internship required to obtain a medical license, after having received at least an undergraduate Baccalaureate degree and a four-year M.D. Doctor of Medicine or a D.O. Doctor of Osteopathic Medicine degree. A physician who specializes in family medicine (also known as a family physician), however, has completed a three-year family medicine residency in addition to the undergraduate and doctoral studies, and is eligible for the board certification now required by most hospitals and health plans.

A family physician is board-certified in family medicine. Training is focused on treating an individual throughout all of his or her life stages. Family physicians will see anyone with any problem, but are experts in common problems. Many family physicians deliver babies as well as taking care of patients of all ages. Family physicians complete undergraduate school, medical school, and three more years of specialized medical residency training in Family Medicine. Board-certified family physicians take a written examination every six, seven, nine, or ten years to remain board certified, depending on what track they choose regarding the maintenance of their certification. Three hundred hours of continuing medical education within the prior six years is also required to be eligible to sit for the exam.

France

In France, the *médecin généraliste* (commonly called *docteur*) is responsible for the long term care in a population. This implies prevention, education, care of the diseases and traumas that do not require a specialist, and orientation towards a specialist when necessary. They also follow the severe diseases day-to-day (between the acute crises that require the intervention of a specialist).

They have a role in the survey of epidemics, a legal role (constatation of traumas that can bring compensation, certificates for the practice of a sport, death certificate, certificate for hospitalisation without consent in case of mental incapacity), and a role in the emergency care (they can be called by the *samu*, the French EMS). They often go to a patient's home

when the patient cannot come to the consulting room (especially in case of children or old people).

Brazil

General practice in Brazil is called *clínica geral* or *clínica médica*. Any physician is legally allowed to practice without any training after graduation in the medical school, but recent efforts by the government, the Brazilian Medical Association and the specialized Sociedade Brasileira de Clínica Médica are trying to demand also a specialist title for its practice, just like for others such as cardiology, endocrinology, etc. The majority of Brazilian GPs are located in the public health sector and is constituted mostly by young, recently graduated physicians. Each medical society is in charge of organizing the examinations (which usually are carried out once a year) and granting the titles to those physicians who passed the requirements. The title is recognized by the Federal Council of Medicine (the Federal professional regulatory body), the Ministry of Education and the Ministry of Health.

Netherlands

General practice in The Netherlands is considered fairly advanced. The *huisarts* (literally: "home doctor") administers all first-line care, and makes required referrals. Many have a specialist interest, e.g. in palliative care.

Training consists of three years of specialisation after completion of internships

Spain

After the graduation in medicine (with a duration of 6 years), the medical doctors pass a national written exam called MIR (Internal Resident Doctor). The speciality devoted to primary care is "Family and Community Medicine Specialist".

To obtain it, the postgraduate doctors must complete a 4-years training period working in primary care centers (2 years) and hospitals (2 years) as residents.

New Zealand

The Royal New Zealand College of General Practitioners defines the role of the GP as: A general practitioner is an appropriately qualified medical graduate who has particular knowledge and skills to provide personal, family care and community oriented, comprehensive primary care that continues over time, is anticipatory as well as responsive, and is not limited by age, sex, race, religion, or social circumstances of patients, nor by their physical or mental status.

HEALTH INSURANCE FOR SENIOR CITIZENS

Family Doctor - International Definition

I. WONCA: WONCA stands for the world congress of **General Practice / Family Medicine** which has more than 60 member countries at present.

   The WONCA statement of 1991 defined the following characteristics of the **General Practitioner**:

   Provides comprehensive care Oriented to the patient. Is co-ordinator of other services. Has a family focus. Is committed to the community. Advocacy on behalf of the patient. Emphasizes the doctor patient relationship.

UNITED KINGDOM: The principles of discipline of general practice suggested were

1. Patient centered approach
2. Orientation on Family and Community context
3. Field of activity determined by patient needs and requests.
4. Unselected and complex health problems
5. Efficiency
6. Low prevalence of serious disease.
7. Disease at early stage
8. Simultaneous management of multiple complaints and problems).

They defined the core competencies as:

Patient centeredness- in communication, priority setting and actions to start from and end with the patient in the context of family and community. Primary contact- used to deal with unselected and complex health problems. Low prevalence procedures- working with decision-making models that accept uncertainty and the low risk of serious disease. Comprehensive approach-continuing management and coordination of health promotion, cure and care. Academic professionalism-the effective combination of experience and evidence in a life long learning attitude.

The domains include

a) Contextual-using the bio-psycho-social model in every encounter.

b) Attitudinal -maintaining the personal capacities, values and ethics to be a personal doctor.

c) Scientific -using a critical and research based mind.

II. EURACT Definition: The Family Doctor General practitioners/Family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for providing comprehensive and continuing care to every individual seeking medical care irrespective of age, sex, and illness. They care for individuals in the context of their families, their community and their culture. They recognize that they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological and social factors, utilizing the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health and providing cure, care, or palliation, either directly or through the services of others according to their health needs and resources available within the community they serve, assisting patients where necessary in accessing these services.

The family physician is community based

a) The first principle is that the discipline of family medicine is person centered, not disease centered and the benefits that arise from a well-established physician patient relationship are the cornerstone of the discipline. The second principle that was universally identified was that the family physician is a skilled clinician. Patients clearly identified that they expected their physician to know their community well. The review of what people expect from their physician found that everywhere patients want their physician to know their context, so the physician can better understand them as individuals. To achieve this objective or principle the family physician needs to be community based.

b) Family Medicine is a Community based discipline. Patients in their focus group sessions identified the doctor's role in the community as being important in understanding the patients and their context. Quoting from the Main study: "Participants expected their doctors to get to know the community – to learn about the issues facing the

community, as well as give back to the community. Participants also talked about wanting doctors to live in their community instead of coming in from larger towns to provide care.

Doctors should look at what they can give to the community. What they can give to the community." The EFPO report also identified several aspects of the community base of the family physician as being important. The family physician being community based places the family physician as a manager of community resources. In this role the family physician must make appropriate referrals to community resources and other professionals.

The family physician is also expected to deal with a conflict of interest between the interest of the patient and the interest of the community by discussion with the patient and seeking appropriate advice from others including medical ethicists.

As a part of being community based the family physician is expected to work effectively as a member of community based teams with other health care workers either as a participant or as a leader.

This includes collaborating effectively with patients and their families without having to be in charge and be skilled in finding common ground when there are differences of opinion.

The principle emerging from the community perceptions is that "Family Medicine is based in the community and not in hospitals or institutions and is strongly influenced by community factors. As members of their practice communities, family physicians are able to respond to peoples changing needs, to adapt quickly to changing circumstances and to mobilize appropriate resources to address patient's needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from minor and self-limiting to life threatening) and complex bio-psychosocial problems. Family physicians provide palliative care to people with terminal illnesses.

Family physicians care for people in offices, hospitals (including emergency departments), other health care facilities and patient's homes. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They consult with and refer to specialists and community resources judiciously.

Family Medicine is based in the community and is strongly influenced by community factors. As members of their practice communities, family physicians are able to respond to people's changing needs, to adapt quickly to changing circumstances and to mobilize appropriate resources to address patient's needs. The use of information technology on a registered population will alert the physician of changing patterns of illness in the practice in relation to the community. The skills to access the information from a patient registry on a regular basis are required too fulfill the need to be aware of the patterns of illness in the community and be alerted to changing needs. Few family physicians presently have the information systems or the skills to carry out this analysis.

As the family health networks become a more common way to practice in Ontario, the population cared for by the groups of 5 to 10 family physicians will be rostered or registered. Family physicians may earn bonuses from the program if they have high rates of immunization, Pap smears and mammography in women over 50. This means that family physicians will have incentives to develop computer reminder systems that will remind both physicians and the patient that they are overdue for a procedure. These systems have been demonstrated to work and should improve the rates of

preventive screening and ultimately improving the health of the population and improving longevity. This approach to prevention in family practice marks a very significant shift towards a population health approach away from the traditional approach of practice which was only to deal with health problems that arrive at the doctors office.

c) By being involved in community activities the physician can maintain awareness of significant changes that may occur and should advocate against any changes that are likely to adversely effect health. The family physician can use the strategies outlined in community oriented primary care programs to identify from practice data community needs, determine strategies to address the needs, implement a program and then measure the effect of the program in addressing the need. By being based in the community and in effect having the capacity for community outreach, family physicians are in a unique position to improve the overall health status of the communities they serve. The interface between the individual needs of each patient and the population needs of the practice or the community served bridges the gap between medicine and public health. The lack of dependence on hospital resources also differentiates the family physician from most of our specialist colleges. These unique characteristic assist in defining our discipline and are commonly encountered at an undifferentiated stage. The problems of dealing with undifferentiated problems as discussed in detail in the paper on “the Skilled Clinician” is a distinguishing feature of family practice. The low prevalence of most problems in the general population makes the style of practice of comprehensive family medicine quite different than the specialties. All specialists need to understand the basic principle that low prevalence lowers the accuracy and value of a test. Since most specialist practices are referred, the value of many tests in a high prevalence population is much greater than in family practice. A lack of understanding of this issue frequently leads to unnecessary disputes between specialist and family physicians.

d) Family physicians are skilled at ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from minor and self-limiting to life threatening) and complex bio-psychosocial problems. Family physicians provide palliative care to people with terminal illness. Comprehensive family practice may include any known medical problem. The fact that most new problems present in their very early stages of development provide major challenges for family physicians. The complexity of the multiple problems in one individual interwoven with the psychological, social, and spiritual values of the individual make the practice of the discipline intellectually challenging, stimulating and rewarding. The variety of problems seen in the daily work of the family physician is great. The physician must always feel competent to deal with these problems efficiently and effectively. This point emphasizes the need for skills to seek and obtain the latest information on any condition and to be able to continually assess their own skills, knowledge and competence to deal with whatever problems present. The scope of any family physician’s competence to practice will be unique for any physician. The family physician’s competence to deal with in any specific medical problem will be dynamic as the skills and knowledge to care for individuals will be constantly changing as new approaches and technology become available. The professional skill of the family physician to constantly determine where the boundaries of their skills and knowledge are become increasingly important as the exponential growth of new information continues.

SPACE REQUIREMENT

IN SQ FT

CONSULTING ROOM	10 X 16' = 160 SQFT
TREATMENT ROOM (3 CUBICAL WITH COTS)	10' X 20' = 200 SQFT
OUT PATIENT WAITING AREA	10' X 16' = 160 SQFT
RECEPTION COUNTER	10' X 10' = 100 SQFT
LAB	10' X 10' = 100 SQFT
TOTAL AREA (720 SQ.FT@RS.12/-	720 SQ.FT

A. CAPITAL EXPENDITURE

EQUIPMENT			
EXAMINATION COUCH	1 NO	20,000	
EMERGENCY DRUG TROLLEY	1 NO	12,000	
ECG MACHINE	1 NO	45,000	
STERILIZER	1 NO	1,500	
DRESSING TROLLEY	1 NO	4,000	
BP APPARATUS	1 NO	1,000	
WEIGHING MACHINE	1 NO	1,000	
DRESSING SET	3 NO	3,000	87,500
LAB EQUIPMENT			
POTOMETER 5010	1 NO	300,000	
CENTRIFUGE	1 NO	30,000	
MICROSCOPE	1 NO	40,000	
URISYS1100	1 NO	50,000	
GLUCOMETER	1 NO	6,000	426,000
COMPUTER			
SYSTEM	2 NO	60,000	
SOFTWARE		25,000	
PRINTER	2 NO	12,000	97,000
FURNITURE			
COT WITH MATTRESS	3 NO	12,000	
TABLE	2 NO	6,000	
CHAIRS (5 IN 1)	3 NO	15,000	
CHAIRS 'S'	4 NO	2,500	
FAN	4 NO	6,000	
WATER PURIFIER	1 NO	8,000	
EMERGENCY LGHT	2 NO	3,000	52,500
TOTAL (A)			**663,000**

(B) RECURRING EXPENDITURE

BUILDING RENT		9,000	9,000
MAN POWER			
QUALIFIED STAFF NURSE	3 x 5000	15,000	
RECEPTIONIST CUM SECRETARY	2 x 4000	8,000	
LAB TECHNICIAN	2 x 4000	8,000	
HOUSE KEEPER	1 x 3000	3,000	34,000
CONSUMABLES			
SURGICAL CONSUMABLES		3,000	
LAB CONSUMABLES		5,000	
HOUSE KEEPING MATERIALS		1,000	
STATIONARY		3,000	12,000
OTHER EXPENDITURE			
ELECTRICITY CHARGES		3,000	
TELEPHONE		3,000	
WATER CHARGES		1,000	7,000
TOTAL (B)			62,000

CAPITAL EXPENDITURE: (A)	**663,000**
RECURRING EXPENDITURE (B)	**62,000**
TOTAL (A)+(B)	**725,000**

Annexure C

The Family Practice

First Port of Call for Health Insurance in India[16]

The Role of a Family Practitioner as Gatekeeper in The Health Insurance System for Senior Citizens

Table of Contents

[16] Contributed by Shri Nimish R. Parekh, Member of the Committee

Background

The family practitioner and his practice has played a significant role in a consumer's life for the generation of people born in the early part of this century and before. It is only in the next generation, that the role of the "family doctor" has diminished, as consumers now tend to frequent specialists directly, without referrals from family physicians.

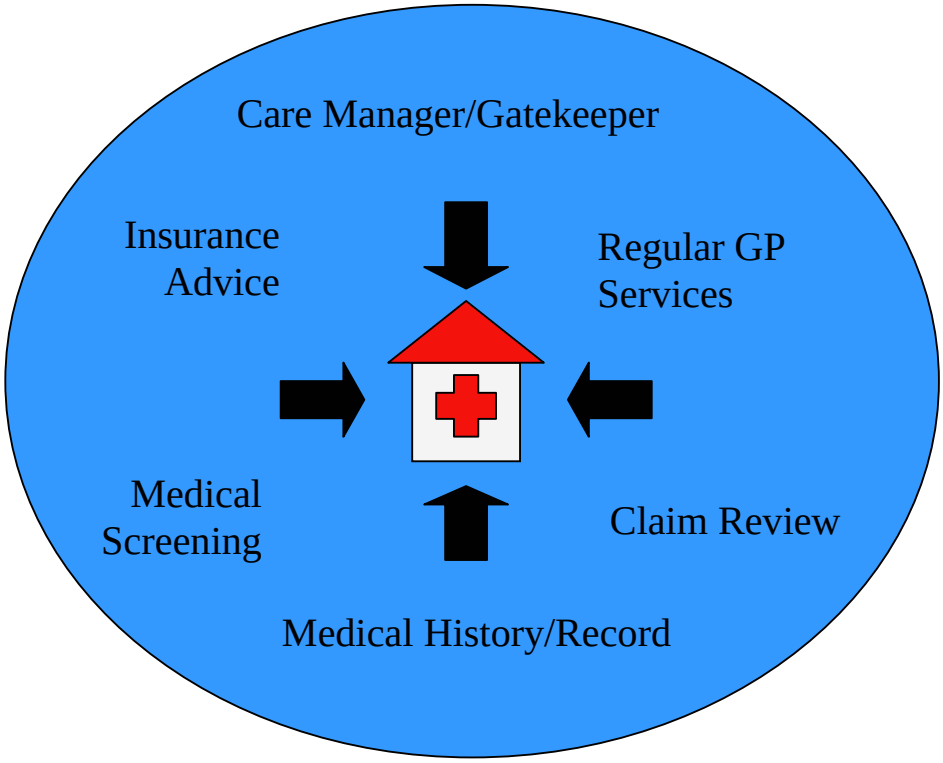
Most consumers from the previous generation and most senior citizens continue to have faith in their family doctor and rely on his advice and experience for the management of their health. In many families, the family doctor is seen to be a part of the family and is often responsible for management of the entire family's health, be it children, parents or grand parents. Due to this continuous nature of the relationship, the family doctor is privileged with important family environmental information that provides significant context to health problems that might occur with the family members. This continuous care philosophy is well established and understood by the previous generation.

It has been observed that families that continue with this tradition of consulting their family doctor for all their healthcare needs, tend to have less catastrophic health issues due to the constant advice and health management that the family doctor provides, thereby either preventing illness altogether or ensuring that health conditions, particularly chronic ones, are not exacerbated.

In many healthcare systems around the world, the family practitioner, often a General Practitioner plays the role of the "Gatekeeper". This role allows the doctor to play a significant role in care management throughout the life of the family member. In particular, the family doctor plays a significant role in care management during an illness event. This Gatekeeper approach has been adopted and empowered in many health systems. In such systems, the family doctor is assigned to a family and becomes responsible for the overall care provided by the larger healthcare system. The gatekeeper is responsible for decisions made regarding referrals into the secondary and tertiary care levels of the system. The Gatekeeper system has proven itself to provide effective control on costs and reduction in escalation of illnesses where possible.

Introduction

It is envisaged that the recognition of family clinics as gatekeepers, albeit with a few enhancements, by the health insurance system in India, can prove to be an effective method of providing quality care management to Senior Citizens and controlling the burgeoning costs of healthcare for the elderly.



What is proposed is a Family Clinic with a practicing physician (MBBS) enhanced with the addition of trained manpower to support insurance liaison for advice on purchase of appropriate policies and for review of claim documentation, basic medical screening capability to support medical underwriting and technology to store medical records. The physician will be responsible for care management of the policyholder and will provide authorization and referrals for every aspect of the medical treatment provided and covered under the health insurance policy. The clinic would also be responsible for upkeep of the patients' medical records.

We would further propose that such clinics be recognized by IRDA such that insurance companies are able to empanel them for the smooth management of the health insurance policy program.

How Will It Work

Eligibility

1. Practicing General Practitioners can apply for recognition by IRDA
2. GPs will have to provide evidence that they have:
    a. Clinic with adequate area for all services envisaged
    b. Medical screening services as required by insurance companies
        i. General physical fitness – height, weight, BP etc.
        ii. Blood collection and access to pathology lab
        iii. ECG
        iv. Easy access to X-Ray (within 1 km of clinic)
3. GPs will add the following (if they are not already available at their clinic):
    a. Computer with printer and scanner
    b. Internet connectivity (broadband)
    c. Practice Management Software (as certified by IRDA)
        i. Patient registration
        ii. Electronic Medical Records input and storage capability
        iii. Transmission capability for EMR (inward and outward)
        iv. Referral/prescription information storage
        v. Reporting capability (for insurer, patient and IRDA)
    d. Insurance advisors – persons who are adequately trained in available health insurance programs to provide advice to prospective policy-holders on the appropriate policy to purchase across ALL insurance companies
    e. Claims Reviewers – persons adequately trained in claims review for ALL insurance companies and ALL health insurance products.

Role of The Family Clinic and Physician

1. Prior to Policy Issuance
    a. Advisory services to prospective purchaser on best health insurance policy for their requirements[17]
    b. General guidance on the utilization of health insurance policy, policy conditions and the gate keeping process
    c. Medical Screening (underwriting support) of prospective policy holder and submission of medical underwriting report to insurer[18]
2. After Policy is Issued
    a. Patient registration into clinic's practice management system
    b. Storage of EMR information into the system
    c. Physician in the clinic would be responsible for
        i. General care management for the patient
        ii. Promotion of preventative healthcare services to the patient so that patient's health is managed appropriately

[17] We will have to explore whether or not the Clinic can play the role of a broker and therefore collect premium and issue policies on behalf of the insurance company, and earn a commission on the sale.
[18] We will have to work out a process where doctor is compensated regardless of whether or not the policy is issued

iii. In case of hospitalization, will authorize hospitalization and refer patient to treating physician and hospital (in writing).
iv. Monitor treatment in the hospital and ensure that no over-prescription of diagnostics and pharmacy purchases are taking place
v. Has the right to modify treatment and change the physician if necessary, during the course of treatment if there is a moral hazard.
vi. Physician would also be responsible for approving discharge planning to ensure that recurrence of the illness or complications can be avoided

d. The clinic would also have staff that are trained in claim assessment for ALL health insurance products and would provide claim review services without charge to patient prior to submission of
e. Clinic will make EMRs available to patient as and when requested by patient. EMR will NOT be available to anyone else without the patient's explicit written permission
f. Clinic will be responsible for confidential and secure storage of ALL EMRs of patients and would be liable for data theft or security breaches.[19]
g. Clinic will be responsible for reporting to insurance companies as required by each insurer.

Commercial Arrangements

Each policyholder will have to select a recognized Family Clinic as their primary clinic at the time of purchase of the policy. Insurance company will then instruct Family Clinic regarding policy issued to that individual. Clinic will then register patient on their systems and be responsible for the care and referrals for that policyholder. The clinic will also store information in the patient's EMR and provide the claim review service to the policyholder without charge.

Family clinic will be compensated X% of premium at the inception of the policy for providing the above mentioned services. In addition, the Family Clinic will be eligible for a bonus based on the savings brought to the insurer in management of the health of all constituents. It is envisaged that

Family clinic will be eligible to continue to serve existing patients in addition to the above-described services for insured patients.

[19] Clinic will have to sign confidentiality agreement with each patient and may also need to purchase liability insurance coverage

Issues & Concerns to be Addressed

Regulatory

1. Does the clinic need to be a body corporate?
2. If so, what controls and measures will need to be in place?
3. Under what regulations would clinic recognition fall?
4. Can TPA regulations be expanded to include such entities?
5. Can the clinic also be allowed to offer broker services and earn commission? If so, what regulations would apply?

Financial

1. Will the percentage of premium paid to a clinic be adequate to cover the clinic's costs?
2. Bonus computation and supporting data will also have to be established by each insurance company in advance

Training

1. Training and certification for insurance advisors and claim reviewers will have to be defined
2. Physician may need to undergo training on medical underwriting
3. Physician and staff will have to be trained on each new health insurance policy that is launched by the respective insurance companies at no cost to the clinic
4. Practice Management Software training will have to be supplied by the manufacturer of the software

Other

1. Practice Management Software packages will have to be reviewed and "certified" by IRDA or other appropriate body for purchase by clinics
2. Medical screening plans for each insurer will have to be devised
3. Medical underwriting guidelines for each product will have to be distributed to the clinics

Annexure D

Note on Third Party Administration in Health Insurance[20]

[20] Contributed by Shri C Chandrasekhar, Member of the Committee

Third Party Administrators and Health Insurance in India:

Background and Introduction:

The Third Party Administrators (TPAs) are licensed by IRDA which undertakes the implementation and administration of Heath Insurance schemes. A TPA acts as nodal agency between the Insurance companies, Insured member and the Hospitals (provider of services) for rendering the right service, at right time, to the right person, at a right price. The TPAs can contribute largely in transforming the old health insurance mechanism into the newer user friendly, efficient and cost effective instrument, through assisting in designing suitable product of Health Insurance or Self Funded schemes.

The advent of Third Party Administrators (TPAs) is expected to play an important role in health insurance market in ensuring better services to policyholders. In addition, their presence is expected to address the cost and quality issues of the vast private healthcare providers in India. However, the insurance sector still faces challenge of effectively institutionalizing the services of the TPA. A lot needs to be done in this direction.

The health infrastructure in India is facing daunting challenge of meeting the health goals and complexities merging from the changing disease pattern. The proliferation of various healthcare technologies and increase in cost of care has necessitated the exploration of health financing options to manage problems arising out of increasing healthcare costs. Health insurance is emerging fast as an important mechanism to finance the healthcare needs of people. Further, the uncertainty of disease of illness is accentuating the need for insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalization by charging premium from a wider population base of the same community.

However, the complexity of health insurance industry has been much talked about but less understood, especially in Indian scenario. With the advent of Third Party Administrators (TPAs) this sector has assumed a new dimension. TPAs are presumed to infuse new management system and enrich knowledge base of managing healthcare services and costs. Their presence is aimed at ensuring height efficiency, standardization and improving penetration of health insurance in the country. TPAs potentially have a wider role to play in standardization of charges and managing cash-less services in health insurance. However, their actual roles and responsibilities have remained less understood, less clear and much debated.

There are questions that in what ways the TPA is going to influence the developments in the health sector. The influence of TPAs to a large extent would be determined by their activities, the way they organize their services and their revenue generation model. In present from, TPAs earn their major revenue from fees charged as commission on insurance premium. Insurance Regulatory and Development authority (IRDA), the regulatory body for insurance sector in India has standardized this

rate. Besides this, TPAs have a potential source of revenue from benefit management, medical management, provider network management, claim administration and information and data management.

However, the insurance sector still faces challenge of institutionalizing the TPA service and there is substantial scope for improvements. TPAs also face challenge of developing appropriate system of financing their operations. It has been argued that the current health insurance sector would require substantial amount of working capital and bank guarantee of finance operation of TPAs. These include lack of data to determine price of products and ability to negotiate payment rates with providers, a regulatory framework that does not recognize the unique features of health insurance products, lack of quality assurance measures for health providers, and lack of consumer awareness about the benefits of health insurance.

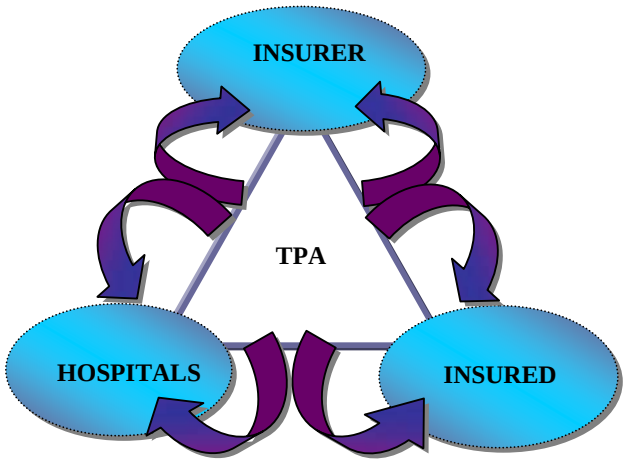
Third Party Administrators and their role

Third Party Admistrator (TPA) was introduced through the notification on TPA-Health Services Regulations, 2001 by the IRDA. Their basic role is to function as a intermediary between the insurer and the insured and facilitate the cash-less service of insurance. For this service they are paid a fixed percent of insurance premium as commission. This commission is currently fixed at 5.5 per cent of premium amount.

Following are the major responsibilities of a TPA:

1. Enrolment and issuance of member card
2. Claims Management
3. 24 hours call centre services for information
4. Pre authorization and Organizing cashless treatment

The figure below provides a graphical representation of working environment of insurance industry and role of the TPA in the system. The core product or service of a TPA is ensuring cashless hospitalization to policyholders. Intermediation by TPAs ensures that policyholders get hassle-free services, insurance companies pay for efficient and cost-efficient services, and healthcare providers get their reimbursement on time. By doing this it is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs, developing protocols to minimize unnecessary treatments/investigations, improve quality of services and ultimately lead to lower insurance premiums.



1. **Enrolment and Issuance of Member Card**

The TPA receives the policies from the insurers along with the member details. The TPA processes this information and issues an ID card to the insured member.

This card is utilized by the insured members for availing cashless treatment at network hospitals of TPA.

2. **Claims Management:**

Healthcare Outsourcing and accuracy in health insurance claims processing are the key elements in improving turn-around time and claims throughput. This is achieved through high potential segments in healthcare outsourcing to the TPA health insurance claims processing.

The target is to manage core processing cost drivers and generate significant financial improvements for the insurer's overall plan performance. The health insurance claims processing services are driven by transactional efficiency. The TPA helps in achieving maximum automation of claims resolution processes. They support new products and services by leveraging the existing legacy system.

The outsourcing of claims processing to the TPA ensures cost and advanced process engineering savings that are critical to healthcare outsourcing and claims management functions and processes.

The TPAs has a team of medical professionals and the technical staff to handle the claims management for the members enrolled with the insurance company.

Largely the TPA provides the following features in claims management:

- Providing Claims management services that include complete evaluation of all claims, data entry and adjudication
- Facilitating better control and monitoring of claims funding processes

- All information on claim form captured in the software for complete reporting of information
- Access to Claims, Eligibility, Enrolment, Processing as desired by the insurance company
- Utilization and Case Management

3. Call center services :

Call center services are available 24 hours at the TPA to give the following information:

- Provides the status of the claims on phone, fax or e-mail
- Information on coverage of treatments within the members benefit plan
- General questions regarding procedures and protocols.
- Provide information related to Network Hospitals and their contact details.
- Address grievances of customers

4. Preauthorisation

Pre-Authorization is a system of approval of treatment and guarantee of payment by an administrator or an insurer to the treating provider for services rendered to the enrolled members of a pre defined benefit plan.

Objectives of pre authorization system

The main objectives of Pre authorization are:

- Cashless treatment for the enrolled member
- Utilization review along with cost containment

Cashless treatment is a payment authorization or guarantee to the provider for cost of treatment rendered to the enrolled member. Cashless service relieves the member from upfront payment to provider for the treatments which are covered in his / her benefit plan. The administrator settles the bill of the patient directly once the authorization has been issued.

Utilization review is a method of ensuring quality of care within parameters of cost containment.
Unlike the retrospective claim audits of traditional insurance, utilization review evaluates appropriateness of health care before it is delivered in order to help eliminate waste and potential risks to the patient. Utilization Review techniques are mechanisms that attempt to control costs by examining whether services provided are medically necessary and services are provided at an appropriate level of care at a minimal cost.

Utilization review in an authorization system has the following components:

Prospective review:

Prospective review in the form of preauthorization determines before a patient is admitted to the hospital, the appropriateness of the plan of treatment, associated costs, procedure, or length of stay.

The system identifies, whenever possible, outpatient alternatives of care. If a hospital stay is needed, the proposed length of stay and procedure requested are compared with norms to determine appropriateness. Preauthorization determines if a proposed treatment is medically necessary and if so authorizes payment for services. If the treatment being proposed is deemed not necessary or appropriate, payment is not authorized.

Concurrent review:

Concurrent review verifies the need for continued hospitalization and determines the appropriateness of treatment rendered in the hospital setting. It is done by medical or paramedical personnel at the administrator or at the insurer's end that examines medical records and interviews the patient's care givers (and some times the patient and patient's family) to determine whether the length of stay and treatment seem appropriate for the condition.

Discharge planning:

Discharge planning determines the need for and manages the care that a patient may receive upon discharge from the hospital. It is often integrated with concurrent review and case management and helps meet the objective of planning for the most appropriate and cost-effective alternate to inpatient care.

For patients who have not fully recovered or do not require the highly specialized and expensive services of hospital care, discharge planning ensures that the patient receives the most timely, appropriate, safe and cost effective discharge.

In the current Indian scenario the TPA s and insurers have very limited role in utilization review.

The preauthorization is mainly used as a cashless service for the following reasons:

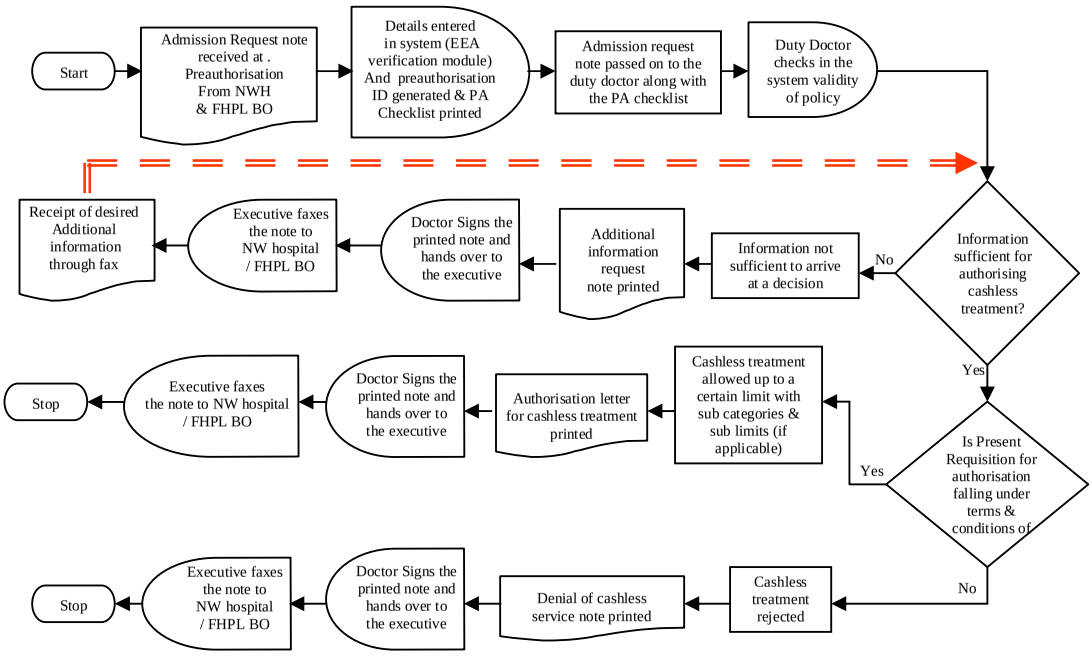
- Low penetration of Health insurance – multiple administrators – less assured volume to service provider – less co operation by providers with TPAs
- Lack of availability of online information of patients to track and manage care
- No universal health identifier used to trail information
- Lack of transparency by providers to avoid denials and deductions
- Due to issues with the payer, the administrator fails to live up with the SLA s signed with the providers
- Non standardized information from providers
- No common or universal coding methodologies used by providers for diagnosis or procedures

- Lack of resources and understanding of health insurance concepts and requirements of TPAs and insurers from the provider side
- Information supplied to TPA is dependent on the treating doctor's honesty in stating the diagnosis and history of ailment
- No standardized rates of services and professional fees, hence very poor control on the cost of treatment.
- unrealistic incentives for the administrators for doing utilization review

- Non usage of standardized clinical protocols by doctors which allows subjective decisions of treating doctors and physicians leading to over utilization of services at the provider
- Queries of TPAs not answered in time, which leads to delay in processing of authorizations and cashless approval
- Lack of reconciliation methodology for pending authorizations leading to delay and denial of cashless by TPAs
- No standardization of benefits offered to insured by different insurers

Even though the utilization management is not performed by the administrators with the above constraints, the cashless service is also not very smooth.

A typical process for preauthorization in a TPA is described below:



The bottlenecks and painful areas are the points of interfaces between the TPAs and the providers. The current system used by most of the TPAs is not very successful for the following reasons

1. **System dependent on fax which throws up following difficulties:**

    - Bad quality of documents received
    - Non receipt of faxes by both the parties
    - Communication issues between the TPA and the provider
    - Lack of resources at the provider to understand TPA s requirement
    - Loss of important data for processing the pre authorizations
    - Too many queries by the TPAs since, the formats do not have sufficient space for the providers and the insurer supplies very limited information about the insured at the time of enrollment.

2. **Multiple software used**

Both the parties use different software system without having a common id for the patient, which delays information exchange and delay of the whole preauthorization process as such. Even reconciliation process for cases is thorny.

3. **Lack of trained resources at the providers end**

Singularly TPAs provide very little volumes to providers; hence, they do not invest much in resources for managing business from TPAs. Moreover, since, the providers have to deal with multiple TPAs with varied requirements; it burdens them with inadequate staff and other resource requirements

4. **Dependency of TPAs on insurer for confirmation of coverage**

Data supplied by the insurer or the payer is inadequate to ascertain pre existing conditions and other exclusions.
Underwriting documents like proposal forms and declared ailments by the insured is not available with the TPAs.
Frequent change of TPAs by the insurer misplaces the history of the patient's information and continuity of benefit administration by a single organization.

Moreover, the information supplied by the provider and the patient at the time of pre authorization, creates confusion for the TPA to ascertain coverage and authenticity of information.

TPAs are often penalized by refusal of payments by the insurer for authorization already issued by them to the provider. This is because of lack of clarity of information supplied and overlook of certain facts by the TPAs due to manual processing of authorizations, scarcity in the information available at the time of authorization and tremendous pressure from patients relatives at the authorization phase.

The preauthorization requests are seldom sent by providers in advance for planned hospitalization or treatments.

Many a times, due to protocols set by the insurer, the TPA has to confirm with the insurer before authorizing a case to provider.

If the information received by the TPA is inadequate and delayed from the provider, the cashless treatments are denied, which puts the insured in a very awkward situation to pay the hospital bill upfront before he gets discharged from the hospital.

Probable solution for improving the existing system:

If we summarize the issues in administering cashless services we conclude as follows:

A. Improper information exchange between all the stake holders
B. Lack of accountability and shifting of risk by all stake holders
C. In appropriate training, orientation and clarity of duties of each stake holders

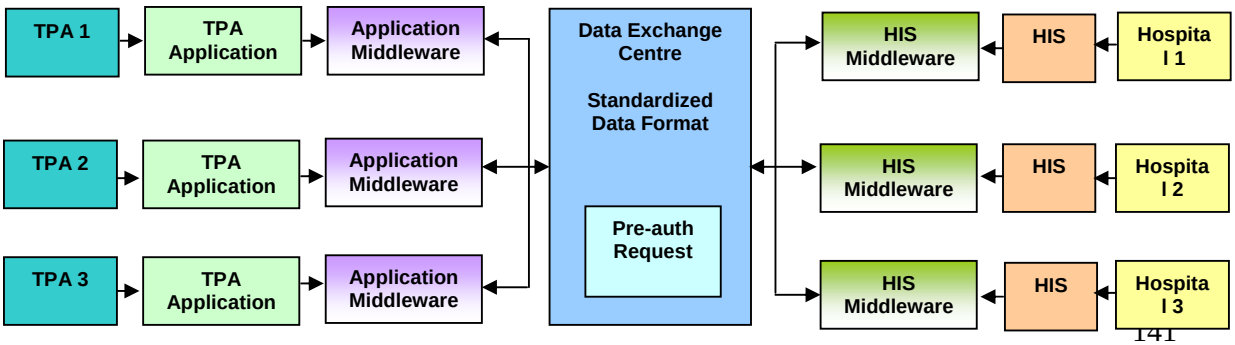
While **B** and **C** are Macro level and evolutionary issues, **A** can be addressed suitably with the assistance of appropriate IT platform

A web based IT platform which is shared by the TPAs and providers can be developed by a software solution provider and controlled by the regulator.

The issue of funding such a project is open for the regulator to decide. All TPA s and providers can exchange information through this interface online. Providers can log in with their id and password and send preauthorization request to TPAs

TPAs are available online 24hours and can respond immediately to providers with their queries, approvals or denials. This system will ensure no loss of information or delay in pre authorization. Availability of updated online information of patients during the hospitalization period, will allow the TPA s to do a utilization review of patients thus saving costs for insurers and having more transparency at the provider's end.

Fig: Schematic Diagram of E-Preauthorisation



Merits of this system:

1. Easy and fast capture of complete paper record to electronic media.
2. Quick and easy retrieval of records from any node without physically visiting the records store
3. Easy transmission of records in soft form
4. Can have a workflow built in with reminders to the user for a response
5. Reduction in turn around time for response from both the sides
6. View and track all information added, documents, discussions and comments
7. validations in the system will help to receive standardized and clear information

General Measures to smoothen the process of preauthorization:

- To have frequent interactions between TPAs and providers with the support and presence of insurers
- Standardize rates at least for the surgical packages at the provider's end
- To have tripartite agreement between TPA, providers and insurers for better accountability for all parties
- To insist on developing products which are transparent and administrable
- To bring in common coding methodologies for securing consistent information
- Provider credentialing to be initiated
- Data integration between TPAs and insurers to reduce redundancy of data maintenance and increase the standards of service
- Definition of pre existing should be defined and accepted by all the insurers
- Clinical protocols should be introduced for providers and its physicians to be followed
- Realistic incentives for TPA s for controlling costs
- Lock in period for contracts between insurer and TPAs is recommended to avoid frequent changes affecting delivery standards
- Centralized team for TPA co ordination and payments are to be established at the insurer to avoid multiple directives and confusion.
- It should be made mandatory to have advance approval of at least 48 hours for planned hospitalization and treatments.

Annexure E

Health Insurance Data of the National Repository at TAC[21]

Number of Records – Policies, Insured Members, Claims			
	Policies	Member	Claims
2003-04	2,265,451	8,361,629	360,088
2004-05	2,059,449	8,987,239	555,273
2005-06	3,749,205	16,684,760	1,031,664

Records as per TPA, Member Records (Individual and Groups)

Total Premium, Total Claim Paid and Claim Ratio			
	Premium (Crs.)	Claims Paid (Crs.)	Claims Paid Ratio
2003-04	944	785	83.16%
2004-05	987	948	96.11%
2005-06	1,873	1,700	90.77%

Avg Premium, Avg Claim Paid and Avg Number of Insured			
	Premium Per Policy (In Rs.)	Claim Paid Per Policy (In Rs.)	Member Covered Per Policy
2003-04	4,166	3,465	4
2004-05	4,792	4,606	4
2005-06	4,995	4,534	4

Avg Premium and Avg Claim Paid per Insured Member			
	Premium	Claim Paid (In Rs.)	
2003-04	1,129	939	
2004-05	1,098	1,055	
2005-06	1,123	1,019	

Avg No of Claims per 1000 Policies and per 1000 Insured Members			
	Per 1000 Policies	Per 1000 Member	
2003-04	159	43	
2004-05	270	62	
2005-06	275	62	

[21] Tariff Advisory Committee, Mumbai. We are grateful to Dr D V S Sastry, DG (R&D), IRDA, for making available the analysis of this data to the Committee.

Disease-wise Number of Claims, Amount Claimed and Paid for 2005-06

Disease Name	Records	Total Claimed (Crs.)	Total Paid (Crs.)
Accident	5,663	8.41	6.96
Arthropathies	29,624	97.92	82.15
Blood Diseases	3,276	7.12	5.79
Cholera	47,511	53.63	48.59
Circulatory	54,694	295.30	217.49
Clinical Findings	61,048	58.66	49.59
Digestive	83,166	165.05	145.93
Ear	6,540	11.72	10.31
Endocrine	13,695	30.19	24.24
Eye	57,299	105.48	99.74
Health Services Related	10,609	8.64	7.22
Infectious	59,510	67.62	59.09
Injury	56,544	131.22	110.08
Malformations/Deformations	1,746	6.96	5.25
Mental Disorders	1,933	2.60	2.22
Neoplasm	29,717	111.78	93.07
Nervous	11,522	29.88	24.27
Factors influencing health status and contact with health services	1,106	0.45	0.12
Prenatal period conditions	1,697	3.62	2.91
Pregnancy	36,100	72.66	62.24
Respiratory	53,808	69.21	60.64
Skin	12,615	18.45	16.12
Urology	64,085	136.61	120.89
	703,508	**1,493.18**	**1,254.91**

Caveats:

- *The statements have been drawn from the data submitted by TPAs/insurers to TAC's data repository and TAC will not be liable for any errors/ inconsistencies in the data.*
- *Claims figures reflect pure claims cost/burning cost. Expenses not included.*
- *Findings are not complete/conclusive. TAC is not liable for any unintended use of these figures by any party and any deductions drawn therefrom.*
- *The information contained in the tables cannot be the subject matter for any litigation affecting IRDA/TAC/Insurance Companies/Insurance Intermediaries.*
- *Errors and Omissions Excepted.*

Annexure F

1. Is It Healthcare Or Sickness Care?[22]

Medical profession is often described as 'Healthcare Industry'. But today's hospital centric, commercially orientated medical profession is more like a 'Sickness Care Industry'. World Health Organization (WHO) defines "Health" as: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Let me try to explain it in simpler language. If you happen to get surgery done for a Gall Bladder or a kidney stone in any hospital, be it a government hospital or a private one, you are likely to get excellent quality medical care till the stage when your stitches are removed. All this is "Sickness care". But unfortunately, no attention is likely to be paid to the reason for stone formation in the first place; other likely attendant medical conditions and towards preventive strategies/ interventions to ensure that it doesn't happen again. Had the foregoing been done, it would truly have been "Healthcare". But this exercise is almost never undertaken. Why? Because nobody asks for it. Whatever you get in life, the least you are required to do is to ask for it. How can something; which you have not even desired; be thrust upon you in a civilized society? Let us go back to the previous two examples given above: Gall bladder stones and kidney stones. Do you know that the basic processes that lead to stone formation may be such that stone formation itself may only be a tip of the iceberg, i.e. there may be many more likely complications due to the basic underlying defect/ malfunction; stone formation being only one amongst many? For example, people with gall bladder stones are more likely to have heart disease and diabetes in the future, if not having the same already. Similarly, there are some underlying disorders related to bones, to calcium absorption & metabolism and to phosphorus absorption & metabolism, wherein calcium rich or phosphorous rich kidney stones are formed. If these underlying conditions; which are not giving rise to any symptoms on their own at present; are not attended to properly, then not only will the stones come up again in the future, but many more troubles will erupt. When medical technology and knowledge is used to detect these 'silent' disorders, and proper treatment plan is instituted well in time, this is called "Secondary Prevention" ("Primary Prevention" is what the lay public can do on its own, without active participation of medical profession). But you do not see it being done anywhere, not only in our country but also almost nowhere in the world. Reason is that medical profession today is not controlled by doctors, but it is being controlled by big businessmen & industrialists, who also control other related, lucrative activities like diagnostic industry and pharmaceutical industry. A basic principle of business or commerce is that the client is supreme and his wish is a command for you. You give him precisely what he wants, only then can you hope to succeed in pulling the bucks out of his pocket. In 'healthcare' profession, the big business was quick to realize that people shell out money only when in trouble and big money lies in hospital admissions, lab tests and surgical operations. So they started pumping big money into setting up large, sophisticated and posh hospitals and diagnostic centres. Public was mesmerized & awed by the glamour & glitz. Gradually the good old family physician was relegated to the background; who could give sound & timely advice based upon a wealth of professional knowledge & experience and robust common sense. In the backdrop of a 'quick-fix' culture, in which the patient wants the stone out as quickly as pulling out a thorn and is least interested in finding out or bothering about it's causation & prevention, and a pliant & compliant commercial healthcare provider ready to serve the 'valued client' eagerly; you have a fertile ground ready to spawn "sickness care industry". But is it just a case of wrong nomenclature? What's in a name after all, one may say. No, a lot more is involved. Huge amount of research based medical intervention in the form of "Secondary Prevention" is being

[22] Articles numbered 1 and 2 contributed and presented before the Committee by Dr. (Col) Kulwant Sharma. MD (Med), MGS Hospital, West Punjabi Bagh, New Delhi.

wasted, most of it knowledge based. Is there any practical method of making the medical profession to apply this "Secondary Prevention" vigorously? Appeals to ethics, morality & conscience are woefully inadequate and application of administrative mechanisms is not practicable. One solution is to allow individual medical professionals to offer Health Insurance. Competition will take care of the premium rates and fear of claims will keep the doctors on their toes to ensure application of the best of "Secondary Prevention". Role of Health Insurance companies should be restricted to offering "Indemnity Insurance" to doctors. As the financial burden for lab tests and hospital admissions shall shift to the medical professionals; use of commonsense, medical knowledge & clinical acumen amongst clinicians will automatically be encouraged and shall obviate unnecessary lab tests and hospital admissions. Accordingly, overall expenditure on healthcare will drastically come down, while improving the health status of society. Moreover, it will redefine the relationship between the public and healthcare providers; wherein peoples' health will become directly proportionate to the prosperity level of the latter. At present, this relationship is rather awkward & embarrassing: peoples' sickness is directly proportionate the level of prosperity of healthcare providers i.e. sicker the people, happier & richer the healthcare providers and vice-versa.

2. Health Insurance & Medical Profession:

Do We Share a Common Goal?

Revenue generation capacity and accordingly, prosperity of medical profession (esp. in the private sector) is directly proportionate to incidence & prevalence of sickness and inversely proportionate to that of health, whereas that of the Health Insurance industry is other way round. Therefore, aims and goals of the two are opposite to each other and accordingly, apparently and logically, we are adversaries.

But in this seminar, we are trying to come together as if our goals are common. There is *some* lacuna somewhere. Either our goals are *actually* common, the apparent disparity being an illusion, or there is some fault in our understanding of each other. World Health Organization (WHO) defines "Health" as: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". If, and it is a big IF, this utopian dream comes true, hospital centric and sickness orientated medical profession, as it is being practiced today, shall be in a serious trouble, but insurance industry shall have all the reason to celebrate. But this celebration shall be only temporary, as health insurance premiums shall start tumbling, and the disease/ sickness centric so called health insurance industry, as it is functioning today shall also collapse. This proves that we both are in the same boat, having a symbiotic relationship. Medical profession, with its focus on only commercially viable diagnostic & therapeutic services, drives the costs high and makes the medical services inaccessible to the common man. Health Insurance steps in to the rescue of the beleaguered common man, bringing down the costs (only slightly) for him. This technique is often used in interrogation chambers: two interrogators work as a team- one menacingly scares and the other tenderly cares. Ultimate goal is to break the subject into submissiveness and co-operation. Some hunting animals too use the same technique-one tires & exhausts the prey and the other goes for the kill. On the surface they seem to be adversaries, competing for the common prey. Do you find a similarity in the coming together of our two professions? I do. It creates a win-win situation for both of us, but a lose-lose situation for the patients and the public. If we keep ourselves (the two comrades with common goals) on one side and patients/ public (our clients) on the other, then it is win-lose situation.

Marketing and business experts often say that only those business enterprises; where the businessman and the client share a win-win situation; survive & thrive. Those businesses where it is a win-lose situation loaded against the user/ consumer, do not succeed,

in the long run at least. If we consider the situation in the context of Healthcare-Insurance Industry combine as the service providers vis-à-vis the consumers, it surely is a win-lose one. True to the aforementioned principles of business, both of us, healthcare as well as insurance industries are in trouble. Unfortunately, this is just the beginning of the end, unless we do some soul searching. Can the two of us come together and join hands as service providers in such a way that we offer to the public a win-win situation? I take this opportunity to make a couple of humble suggestions to this august gathering.

Our first step has to be a change in the mindset. We have to become 'Healthcare' providers in true sense of the word, and abandon our fixation on 'Sickness- care'. In this direction, the initiative has to be taken by the insurance industry. At present, you are approaching us to seek therapeutic intervention to treat/ cure established diseases. My profession is doing a commendable job of it; I am proud and happy to say. But we are doing that and just that-no more & no less. We have lot more to offer; probably the insurance industry does not know this. We can predict diseases and we can prevent them well in time. Our capabilities & competencies in this field are much more refined than curative therapies, esp. for modern day diseases/ disorders. There is an enormous amount of research data available (wastefully unutilized) as to how much hypertension causes how much damage to the 'end organs' like kidneys, eyes, brain and heart in how much time and how to effectively prevent it. The same goes for Diabetes Mellitus and for Rheumatoid Arthritis and so many more medical conditions. But we are NOT doing it, because no one seeks this service from us. Almost none of us is monitoring and treating Diabetes Mellitus as per the recommendations of the expert committee, which deliberated upon the findings of a research study called 'UKPDS clinical trial', published in 1996. Almost none of us is following the recommendations & guidelines of JNC-VII committee on detection and treatment of hypertension. I can unabashedly state that almost none of us is monitoring lipids as per recommendations made by the NCEP-ATP III. But medical professionals cannot be blamed for the foregoing. We can offer only that which is sought from us. In our professional capacity, we cannot be expected to go around thrusting clinical research findings upon an unwilling public/ insurance companies. We are aware (this is one of the basics taught to us in medical schools) that when we break the news of a diagnosis to a patient and his family, they go through five stages before coming to terms with the ground reality: Denial, Anger, Blame, Dejection and finally Reconciliation. To take the patient and his family though this quagmire needs enormous amount of resources in the form of clinicians' time and time & efforts of paramedical counseling staff. In addition building, furniture and communications equipments are required. Also required is software of various types (recorded dramas, skits and messages from leading expert authorities in respective fields) prepared by professionals, to effectively communicate the message. But who will pay for these resources? After all, there ain't no free lunch, as Americans say. At present, no one is paying, neither attention nor money, to this vital service we are crying ourselves hoarse to offer to a needy but unaware public. Neither the Governments, nor the Insurance companies and of course nor the public. Now, the public cannot be faulted, because they shall do whatever the leadership decides is good for them. And Governments in democracies cannot be expected to take the initiative because in a democracy, the public is not lead by leaders but by vote seeking petty politicians, whose vision beyond the tips of their noses extends only to as far as the outer limits of their cherished vote banks. That leaves only the two of us in the field, to take up this challenge. At least a hundred times more revenue generation is assured. Are you a game? If yes, we are ready to play ball, most enthusiastically.

Annexure G

Subsidized Health Insurance Schemes for Senior Citizens[23]

Case Study 1: Pandit Deendayal Upadhyaya Senior Citizen Health Insurance Scheme

Of Indore Municipal Corporation

Introduction: The Senior Citizen Health Insurance Scheme of Indore Municipal Corporation (IMC) is a group health insurance scheme, which is fully funded by IMC and is made available free of cost to the senior citizens of Indore city. The scheme covers hospitalization for a sum insured of Rs 20,000, with sub-limits based on the nature of hospitalization (conservative, minor surgery or major surgery). The scheme began in 2003-04 and is presently in its fifth year.

Eligibility and Costs: The scheme is applicable to all senior citizens between 60-80 years of age and residing in the jurisdiction area of the IMC, who submit their applications to IMC with the relevant documents within the prescribed time period. The premium is determined through a bidding process and is entirely paid by IMC. Services are available through a network of hospitals in Indore, administered by a TPA, and cashless services are available in network hospitals upto the specified sub-limit. The premium paid for 2007-08 is Rs 395 per beneficiary, including taxes and TPA costs. The members getting hospitalized are required to pay a deductible of Rs 500 per hospitalization, which is taken in the corpus of IMC to partially pay for the next year's insurance.

Benefits Covered:

IPD: Inpatient treatment in General Ward of hospitals in Indore city, for hospitalization > 24 hrs and specified day-care procedures, subject to the sub limit of Rs 4000 per hospitalization for conservative treatment, Rs 7000 for minor surgeries and Rs 12000 for major surgeries, upto a sum insured of Rs 20,000 for the year. All pre-existing diseases are covered, subject to the common exclusions. There are also no first-year exclusions.

Main Exclusions:

1. All pre-hosp and post-hosp care or domicilary hospitalization
2. First 30 days (waiting period) for new members
3. Other usual mediclaim exclusions, except first year exclusions and pre-existing diseases, which are covered.

Statistics and Financials:

2003-04: 6000 members were covered at a cost of Rs 546 per person, and a total of 547 claims amounting to Rs 33.22 lakhs were paid during the year.

2004-05: 15,000 members were covered at a cost of Rs 500 / Rs 475 (in two different policies) per person, and a total of 959 claims amounting to Rs 1.19 crores were paid during the year. Because of the adverse claim ratio in this year, sub-limits based on type of hospitalization were applied from the next year for controlling costs.

2005-06: 16,477 members were covered at a cost of Rs 475 per person, and a total of 1038 claims amounting to Rs 44.3 lakhs were paid during the year.

2006-07: 16,723 members were covered at a cost of Rs 495 per person, and a total of 1006 claims amounting to Rs 65 lakhs were paid during the year.

2007-08: 14,202 members have been covered so far, at a cost of Rs 395 per person, and about 200 claims have been paid during the year. There was a change of insurance company and TPA for this year, and a major delay in issue of identity cards, which has led to reduced utilization so far.

Analysis:

[23] Based on the study undertaken for the Committee by Dr Somil Nagpal, Special Officer- Health Insurance, IRDA

The scheme has been structured in a way that it covers only treatment taken in general wards, and since the amount of reimbursement to the hospital or the individual is fixed, it serves as a strong incentive to control costs, as any additional costs are payable by the insured. Thus, to derive maximum benefit from this scheme, the beneficiary would need to avail of services in charitable or medical college hospitals, where these amounts would largely meet the expenses. In other cases, the scheme only serves to reduce the burden on the insured to the extent borne by insurance under the scheme. However, the classification of conditions could perhaps be improved, as even high cost conditions like acute MI would be managed conservatively and eligible for Rs 4000 only.

The scheme's strongest point is perhaps its demonstrated viability even at this price point- the claim ratios over the last 5 years have been manageable and because of the application of low monetary ceilings on costs of care, the premium has actually come down over the years. Also, it demonstrates the local government body's commitment and ability to generate resources and fund the scheme for senior citizens from within its own resources. The design of sub-limits is the strongest incentive to seek the lowest cost care as virtually any additional cost beyond these limits is borne by the insured. And finally, the deductible, which is not given to the insurer but to the sponsor of the scheme, minimizes administrative costs and has a role in reducing moral hazard further.

However, the scheme has provision for automatic renewal, and members dying or leaving Indore are reduced from the group based on a verification exercise conducted by IMC officials. This system could be further improved, as it is possible that some members continue to covered and paid for despite not being part of the system any more.

Also, the experience when TPA got changed this year demonstrates a greater need for the corporation to take control of its data base. At the same time, these hiccups should not dissuade the corporation from continuing the scheme, which certainly has merit and has proved its utility.

Case Study 2: Pune Senior Citizen Health Welfare Scheme

Of Pune Municipal Corporation
(Implemented through Sahyadri and Bharati Hospitals, Pune)

Introduction: The Senior Citizen Health Welfare Scheme of Pune Municipal Corporation (PMC) is a self-insurance scheme, which pools in the funds from the registered members of the scheme and a matching grant from the Pune Municipal Corporation, for providing a range of health-related benefits to the members of the scheme. The scheme began in January 2006 and is presently in its second year.

Eligibility and Costs: The scheme is applicable to all senior citizens above 59 years of age (no upper limit) and residing in the jurisdiction area of the PMC, who submit their applications to PMC with the relevant documents within the prescribed time period. The contribution for the scheme is Rs 225 from the member with a matching Rs 225 from PMC, and another Rs 25 for the ID card and enrolment is payable by the member. The pooled amount is then provided to one designated hospital, which then takes the responsibility of providing the defined benefits to the member. All services are provided by this designated hospital only and no reimbursement is available for services taken from other providers.

Benefits Covered:
IPD: Inpatient treatment in General Ward of the designated hospital for hospitalization > 24 hrs (all day-care procedures, including cataract, are taken as OPD procedures) upto a sum of Rs 1 lakh for the year. All pre-existing diseases are covered, subject to the common exclusions.
Main Exclusions:

1. All pre-hosp and post-hosp care or domicilary hospitalization
2. First 90 days (waiting period) for new members

3. Transplants, specialty ophthalmic care, AIDS, cancer, blood products, extensive burns, addictions, dialysis, other systems of medicine, dental, cosmetic, vaccination, dietetics, drugs unrelated to admission, suicide attempt

4. Beyond 60 days hospitalization per year
5. All implants, balloons, stents, lenses etc
6. Chemotherapy and Radiotherapy
7. Special instruments for surgeries
8. Ambulance, food for patient, attendant expenses
9. War and allied perils
10. Hazardous activities
11. Psychiatric conditions
12. Maternity, pre and post natal, MTP etc

OPD: General consultation for Rs 20/- (new) and Rs 10/- (follow up)

50% discount on published tariff for specialist consultation, OPD procedures and diagnostic imaging and routine procedures.

10% discount on branded medicines

Statistics and Financials:

2006: The pooled amount available with the designated hospital (only Sahyadri hospital in 2006) for the calendar year 2006 was approximately 1.15 crore rupees, for the 24,237 members under the scheme. Of these members, 609 people took IPD treatment during the year, with 780 admissions.

2007: In 2007, 21, 557 members have registered for the scheme, of which less than 5% are with the second designated hospital (Bharati) and the rest are with Sahyadri hospital. A sum of about Rs 98 lakhs was made available to the hospitals as corpus for running the scheme, from PMC. Of these registered members in 2007, only about half were renewing members from the earlier year, while the rest were new members. The median age of the group is 67 years, and there exist members well above 90 years of age.

Till Sep 2007, 591 admissions had already been reported from amongst the beneficiaries of the scheme. The hospital claimed to have given discounts/waiver of service costs as per provisions of the scheme which amounted to Rs 1.62 crore from Jan to Sep 07.

Analysis:

The scheme has been structured as a hospital-oriented, self-insurance product with subsidy from the municipal corporation. Because of the exclusion criteria, the hospitalization still costs a significant amount of money, as the patient still pays for all implants, for food/housekeeping costs, and other incidental costs. However, the scheme does ensure substantial subsidization of IPD costs, and the enrolment comes at a very low price as compared to commercial health insurance plans presently available.

And although the financial position above may reflect that the hospital lost money and the scheme is unviable, it needs to be understood further. The hospital did get Rs 94.5 lakhs as the corpus at the start of the year, and it also did give concessions on services worth 1.62 crores till September, but these concession are implied costs, calculated at the listed prices of the hospital, and the hospital did receive payments towards implants, pre-hosp investigation, additional drugs, and other services, which would have contributed to recovering the costs of the treatment given. Further, despite the discounts, the OPD services are not likely to be loss-making, and the hospital would have also gained in terms of occupancy and goodwill. Thus, it is **likely that there is no significant cash loss in the scheme** and the costs of the hospital were more or less recovered, with simultaneous gains in visibility, occupancy and goodwill. A little check on pre-existing conditions could perhaps turn the scales in favour of the hospital.

At the same time, there is also the issue of **very low renewal rate- only about 40%** of the enrollees of 2006 renewed their membership for 2007. While the hospital does mention the important role of municipal leaders in promoting the scheme in their wards, and the fact that due to political situation

around the time of renewal, their support could not be received to the optimum level, there are also other reasons for the same. One major issue was probably geographical access, with only one centre to provide services, which meant t hat people residing far away from the hospital running the scheme would not see value in continuing their membership. Some members have even stated that their money was 'wasted' as they were healthy during the year and did not need the scheme, something which needs greater communication efforts at explaining the nature of the scheme. Surprisingly, about 5000 members of 2006 did not even come to pick up their cards after having paid the membership fee- and many more only picked up their cards when they needed hospitalization. There could also have been service issues with the hospital, with limited capacity to service its existing patients, the PMC scheme, and another Sakaal scheme being run in the same hospital.

Discussion and Future Directions:

The hospital needs to analyze its data further, which could help it to identify patterns of over-utilization and to contain costs, particularly by members who know that they would need surgery soon and can wait for the three months waiting period. Thus, it could still be possible to continue the scheme at similar price levels. The hospital has written to PMC to raise contribution to Rs 1500 per member, a level at which neither PMC nor members are likely to be comfortable, and would only lead to adverse selection with higher-risk members enrolling for the scheme. Thus, the **key to sustainability of this scheme may well be some re-designing of the scheme with better data now being available** from about 34000 (original 24000 plus new 10,000) members over two years of implementation. A model of providers taking up the risk on themselves and offering a low-cost alternative to senior citizens with support from local government can be demonstrated successfully if this scheme is continued.

Annexure H

Why patient education should be made compulsory for all companies issuing health insurance policies to senior citizens

Indian patients are becoming increasingly articulate and they want more information about their medical problems. Sadly, patient education has been a neglected area in India so far. This is a big opportunity for the IRDA because it can play a key role in mandating health insurance companies to fulfill this demand. This is a great chance , not just to improve the way healthcare is financed and delivered in India, but also to catalyse a change in the quality of health provided ! Patients are the largest untapped healthcare resource, and by empowering them by educating them, they can be taught to utilize medical facilities more efficiently !

This is a win-win situation, as all players stand to benefit.

1. Patients are much happier when they are well-informed because they know what to expect from the treatment. Many studies have shown that patient education helps to improve patient satisfaction with the healthcare they receive
2. Good doctors are much happier when treating well-informed patients. These patients have realistic expectations from the treatment; are much more compliant, because they are active partners in the treatment; and are much less likely to sue for alleged negligence
3. Insurance companies benefit, because patient education offers them an excellent return on investment. For example, their cost of claims will come down, as well-informed patients will not allow doctors to perform unnecessary surgery and unindicated testing . Studies have proven that a dollar spent on patient education ends up saving the insurance companies over 10 dollars. In the USA, a growing number of health insurance companies are providing their customers access to patient education for disease management in order to reduce the cost of their disease expenses. An excellent example is the CIGNA HealthCare Web site at www.cigna.com.
4. The entire nation will benefit, as the medical services provided will be tailored to what the patients actually need not what hospitals and doctor choose to provide.
5. Senior citizens will be motivated to take a proactive approach in maintaining themselves in good health, so that rather than use medical resources only after they fall ill, they can use healthcare services to remain healthy and prevent sickness ! Isnt this much healthier ?

Patient education is a powerful tool to promote health, manage chronic disease, prevent medical mistakes, achieve patient-centered care, improve health care system efficiencies, and improve the overall quality and experience of patient care. Information is the best prescription, and Information therapy (the right information to the right person at the right time) can be very powerful medicine !

Regards,

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Annexure I

FEATURES OF A FEW HEALTH INSURANCE PRODUCTS MARKETED BY NON-LIFE INSURERS

Sl No	Name of the product	Product Design	Policy age-band
1	**Individual Mediclaim (Reliance General Insurance Co Ltd)**	Indemnity	3 mths. To 75 yrs
2	**Critical Care (ICICI Lombard General Insurance Co)**	Benefit	20-45 yrs
3	**Mediclaim 2007 (New India Assurance Co)**	Indemnity	3 mths to 60 yrs.
4	**Senior Citizens Policy (New India Assurance Co)**	Indemnity	60 yrs. To 90 yrs. Entry upto 80 yrs.
5	**Health insurance policy Silver - United India Insurance Co Ltd**	Indemnity	61 to 80 yrs.
6	**Health insurance policy - Gold - United India Insurance Co Ltd**	Indemnity	36 yrs to 80 yrs.
8	**Medi Classic Insurance (Star Health & Allied Insurance)**	Indemnity	5 mths to 80 yrs.
9	**Senior Citizen Red Carpet (Star health & Allied Insurance Co)**	Indemnity	60 to 69 years. Guaranteed Renewal after 69 years
10	**Medi Premier (Star health & Allied Insurance)**	Benefit	26 to 75 yrs
11	**Individual Medishield policy (IFFCO-TOKIO)**	Indemnity plus Hosptial Cash	3 mth-70 yrs
12	**Individual Health Insurance(Cholamandalam MS General Ins. Co.)**	Indemnty plus Hospital Cash	6 mth-65 yrs. Renewals upto 69 yrs.
13	**Health Shield Gold (RSA) - Royal Sundaram Alliance Co**	Indemnity	91 days to 75 yrs.
14	**Health forever - Royal Sundaran Alliance Co Ltd**	Indemity+Hospital Cash+ICU benefit+Critical Illness Benefit	91 days to 75 yrs.
15	**Mediclaim - Oriental Insurance Co Ltd**	Indemnity	3 mths-80 yrs.
16	**Mediclaim - National Insurance Co Ltd**	Indemnity	3 mths. To 59 yrs.Renewals upto 80 yrs
17	**Varishta Mediclaim(NIC)**	Indemnity+Benefit	60 yrs. To 80 yrs

19	**Individual Critical Illness(Bajaj Allianz General Ins. Co)**	Benefit	6yrs to 59 yrs
20	**Silver Health(Bajaj Allianz General Ins.Co.)**	Indemnity	46 yrs. To 75 yrs.
22	**Critical Illness(Tata AIG General Ins. Co.)**	Benefit basis	18 yrs. - 60 yrs. Renewals upto 65 yrs

Universal Health Insurance, Swasthya Bima Yojana, Jan Arogya Yojana catering to lower income group are marketed by a few PSU Non-Life Insurers

Annexure J

FEATURES OF A FEW HEALTH INSURANCE PRODUCTS MARKETED BY LIFE INSURERS

S.No.	Name of rider	Maximum Sum Insured	Maximum entry age	Coverage provided upto age	Illnesses covered	Remarks
			BAJAJ ALLIANZ LIFE INSURANCE CO			
1	Critical Illness benefit	Upto basic sum insured	50	65	First heart attack, CAD requiring surgery, Stroke, Cancer,Kidney Failure, Major Orgaan Transplantation, Multiple Sclerosis, Aorta Graft Surgery, Primary Pulmonary Arterial Hypertension, Alzheimer's disease and paralysis.	Rider
2	Hospital Cash Benefit	Upto basic sum insured or Rs.2.5 lakhs whichever is less	50	65	- do -	Rider
			BIRLA SUN LIFE INSURANCE CO			
3	Critical Illness Plus Rider	Upto basic sum insured or Rs.10 lakhs whichever is less	50	65	Heart Attack,Stroke,Cancer,Surgery to coronary arteries, kidney failure, major organi transplantation,Aorta Graft surgry, heart valve surgery, paraplegia, blindness, benign brain tumour,motor neurone dsease, multiple scelrosis,coma,end stage liver Disease, End stage Lung Disease, Aplastic Anaemia	Rider
			ICICI PRUDENTIAL LIFE INSURANCE			
4	Health Assure - Long term critical illness plan	Rs.1.5 lakhs to 10 lakhs	55	65	Cancer, CABG, Heart Attack, Kidney failure, Major Organ Transplant, Stroke	Not a rider
5	Health Assure Plus - Long term critical illness plan with life cover	Rs.1 lakhs to Rs.10 lakh	55	65	Cancer, CABG, Heart Attack, Kidney failure, Major Organ Transplant, Stroke	Rider
6	Hospital Care - Hospitalization Cash Benefit	4 Plans based on graded surgeries	60	80	> 2 days hospitalization	Not a rider Guaranteed covrage upto 20 years.

Annexure K

HEALTH INSURANCE POOLS[24]

The concept of Health Insurance pools:

Health Insurance pools serve two primary roles—they provide a means for guaranteed access to insurance that enable individuals (who otherwise may not be insurable) to protect themselves from catastrophic medical bills; and they help in keeping the individual insurance markets viable for companies to compete in.

A Health Insurance 'pool' or 'fund' is basically a safety net for risks that are sub-standard from the point of view of insurers, given the adverse health status of the individuals concerned.

The types of 'pools' or 'funds' meant for sub-standard risks could vary:

1. There could be a state or government pool created out of special cess (like on tobacco etc) or other types of taxes, to be used for the medical expenses of the generally uninsurable—like those with terminal illnesses and/or the very aged.

2. There could be a non-profit association either created by the state or the IRDA with contributions from the Government as well as the various stakeholders.

3. There could be an association created by all the concerned stake holders themselves. The administration of the pool could be outsourced to an identified existing organization or one specially created for the purpose.

There could be several options when it comes to the mechanism for administration and the procedures that could be adopted by the pool. The issues that would need to be addressed are:

1. **Underwriting:**
Products could either be different from the market ones or products already available in the market could be made available for the risks that are being transferred to the pool. In fact, there could be an option for documentation being done by the insurance companies themselves and accounting adjustments being made with the pool or documentation being done by the organization administering the pool.

2. **Data capture and build up:**
The pool should have the systems and infrastructure to capture and build up data required for proper pricing and design of products necessary for this category of people/risk.

3**. Claims servicing:**
Claims could either be serviced directly by the 'pool' organization or could be done by the participating insurers and accounting adjustments made with the pool. Outsourcing of claims services i.e. using Third Party Administrators, of course, would be part of this whole set up.

In a pool mechanism, while individuals would definitely contribute to the pool by paying premium (and this could be higher than the normal premium), the losses which are large will have to be paid out of the government contribution and the contribution of other

[24] Contributed by Smt Yegna Priya Bharath, OSD, IRDA

stakeholders. Government's active commitment and participation in the pool mechanism is a must.

Health Insurance pools in the United States:

In the US, Health Insurance pools are special programmes created by state legislatures to provide for the 'medically uninsurable' population. These are people who have been denied health insurance coverage because of a pre-existing health condition, or who can only access private coverage that is restricted or has extremely high rates.

Each of the state risk pool-type programs is different. Generally, the programs operate as a state-created nonprofit Association overseen by a board of directors made up of industry, consumer and state insurance department representatives. The board contracts with an established insurance company to collect premiums and pay claims and administer the program on a day-to-day basis. Insurance benefits vary, but risk pools typically offer benefits that are comparable to basic private market plans -- 80/20 major medical and outpatient coverage, a choice of deductible and co-payments. Maximum lifetime benefits vary by state from as low as $350,000 to $2 million.

Generally, there are no exclusions. However, risk pools do have waiting periods for coverage of pre-existing conditions to make sure individuals pay for continual coverage and the program can operate financially sound. Without waiting periods, the concern is that too many people could forego paying for insurance until they had a high cost claim, and the programs could not function financially. However, under the federal portability legislation, people who have had continuous coverage in the group market, not broken by more than 63 days, can access coverage in risk pools without any waiting periods.

Risk pool insurance generally costs more than regular individual insurance, but the premiums are capped by law in each state to protect the individual from exorbitant costs. The caps range from as low as 125 percent of the average for comparable private coverage in some states, up to 200 percent of the average or more in other states. Most states offer coverage at less than 150 percent of the average.

All state risk pools inherently lose money and need to be subsidized. While the individuals in risk pools pay somewhat higher premiums, roughly 50 percent of overall operating costs need to be subsidized. Subsidy mechanisms also vary from state to state -- some states assess all insurance carriers, HMO's and other insurance providers; others provide an appropriation from state general tax revenue; some states share funding of loss subsidies with the insurance industry using an assessment of insurance carriers and providing them a tax credit for the assessment, or other states have a special funding.

Annexure L

The Health Sector in India: Key Stakeholders and the Need for Reform[25]

Constitutional Provisions:

As per the Constitution of India, the areas of Public health, hospitals, sanitation, etc. fall in the State list. Thus, the States are largely independent in matters related to the delivery of health care to the people. Each state has developed its own system of health care delivery and created the necessary infrastructure. At the same time, some items having wider ramification like population control and family welfare, medical education, prevention of food adulteration, quality control in manufacture of drugs etc. have been included in the Concurrent list, where both centre and the states can issue legislation. In addition, the Centre also supports key health sector initiatives through National Health Programmes, particularly the National Rural Health Mission, which are funded by the Centre and generally implemented through the State machinery.

Government Health Departments:

The public health system exists at all levels of government, Central, State and Local. However, in addition to the Ministry of Health and Family Welfare, which is discussed in greater details below, it is important to remember that there are other important stakeholders in the government system which have significant contribution and impact on the health sector. These include the Ministry of Women and Child Development, which runs the nutritional support programme, ICDS (Integrated Child Development Scheme), the Ministry of Chemicals which regulates the Pharma sector, the Ministry of Labour, which regulates the ESIS (Employees State Insurance Scheme), the Finance Ministry, which houses the Insurance division, the Ministry of Water Supply and Sanitation, and the Ministries of Rural and Urban Development, etc.

At the Centre: The official 'organs' of the public health system at the national level consists of:

(1) The ***Ministry of Health and Family Welfare*** headed by the Union Minister of Health and Family Welfare. The union ministry has 2 departments - the 'Department of Health and Family Welfare' and the 'Department of AYUSH' (Ayurveda, Unani, Siddha and Homeopathy – earlier known as the Department of Indian Systems of Medicine and Homeopathy- ISM&H).
(2) The ***Directorate General of Health Services*** is the principal advisory body to the Union Government in both medical and public health matters.
(3) A large number of health subjects fall in the concurrent list which calls for continuous consultation, mutual understanding and cooperation between the centre and the states. The ***Central Council of Health*** with the Union Health minister as the chairman and the state health ministers as its members, works towards promoting coordinated and concerted action between the Centre and the states in the implementation of all the programmes and measures pertaining to the health of the nation.

At the State level:

(1) ***State Ministry of Health and Family Welfare*** (or its equivalent, as nomenclatures differ amongst states) is headed by the Minister of Health & FW. The Health Secretariat is the official organ of the State ministry of H&FW and is headed by a Principal Secretary or Secretary. The state governments provide funds for primary, secondary and tertiary care institutions (including medical colleges and their associated hospitals). State governments also receive funds from centrally sponsored health sector programmes.

(2) ***State Health Directorate*** – The directorate usually consists of the State Director of Health & Family Welfare, the State Director of Medical education and the State Director for ISM&H. The State Director of Health Services or the Director of Health & Family Welfare is the chief technical advisor to the state on all matters relating to medical and public health.

[25] Contributed by Dr. Somil Nagpal, Special Officer-Health Insurance, IRDA

At the District and Local Levels:

(1) The Chief District Medical/Health Officer (also known in some states as the Civil Surgeon/ Chief Medical Officer) is the technical head of the health system in the district.

(2) There is also often a Health Officer with his own team, looking after Public Health activities of Municipal Corporations and other similar local government bodies.

Health infrastructure

Health planning in India is an integral part of the national socio-economic planning. The Health care system in India is represented by following major sectors or agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

Public Health Sector

Village level: Though the health system does not extend up to the village level – to implement the national health policies, community volunteers have been involved to serve as links between the village community and government infrastructure. These include:

i. the Anganwadi worker (1/1000 population) – enrolled under the nutrition supplementation programme – the Integrated Child Development Service scheme (ICDS) of Ministry of Human Resource Development;
ii. the trained birth attendants (TBA) and the Village Health guides (of an earlier scheme of health ministries).
iii. ASHA (Accreditated Social Health Activist) volunteers, selected by the community under the NRHM programme, who are new, village-level, voluntary health workers being identified and trained to serve as effective links in the rural areas.

Sub-centre: The Sub-centre (SC) is the most peripheral public health institution available to the rural population. These have been established for every 5000 population (3000 in hilly, tribal and backward areas) and are manned by a Health worker (Female), also called the Auxiliary Nurse Mid-wife (ANM) and a Health worker (Male).

Primary Health Centre (PHC) is a referral unit for about six sub-centres. PHCs have been established for every 30,000 population (20,000 in hilly, tribal and backward areas). All PHCs provide outpatient services, and the majority also have four to six in-patient beds. According to the norms they have one medical officer, 14 para-medical workers(including 1 Health Assistant Male; 1 Health Assistant Female (Lady Health visitor; 1 Laboratory Technician) and other supporting staff.

Health Centres/ Hospitals

1. **Community Health Centre (CHC)** is the first referral unit(FRU) for four PHCs offering specialist care. According to the norms each CHC (for every 1 lakh population) should have at least 30 beds, one operation theatre, X-ray machine, labour room and laboratory facilities and should be staffed at least by four specialists i.e. a surgeon, a physician, a gynecologist and a pediatrician supported by 21 para-medical and other staff.
2. **Rural hospitals** : these include the sub-district hospitals called as the sub-divisional / Taluk hospitals/specialty hospitals (estimated to be about 2000 in the country);
3. **Speciality and teaching hospitals** – these include the medical colleges (~270 in number presently) and other tertiary referral centres.

Other agencies: hospitals and dispensaries of railways, defence and similar large departments (Ports/ Mines etc) are also publicly funded but services are often restricted to the employees and their dependents.

According to the National Commission on Macroeconomics and Health of the Government of India[26], the principal challenge for India is the building of a sustainable health system. The commission report adds that selective, fragmented strategies and lack of resources have made the health system unaccountable, disconnected to public health goals, inadequately equipped to address people's growing expectations and inability to provide financial risk protection to the poor.

[26] NCMH, Govt of India. Report of the NCMH. New Delhi, 2005

Private Sector Providers

India has a very large and heterogeneous private sector: which ranges from voluntary, not-for-profit, for-profit, corporate, trusts, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks), each addressing different market segments. Nearly 77% of the allopathic (MBBS and above) doctors in the country practice in private sector. It is estimated that private health expenditure accounts for more than 80% of all health spending in India. The private sector accounts for 82% of all outpatient visits and 52% of hospitalization at the all India level[27]. This, coupled with the fact that the proportion of health insurance coverage in the country is very low, implies that bulk of the expenditure on health services in the country is out-of-pocket and procured from the private providers of care. A significant development over the last two decades has been the emergence and growth of corporate hospitals in the private sector, which has become a key player in the provision of inpatient services to the beneficiaries of private insurance plans as well as to public programmes like CGHS and ECHS. Considerable investment in infrastructure, equipment and human resources has been made by these corporate hospitals, but the costs of care continue to be high and beyond the reach of the common citizen, unless supported through some form of financial protection, like health insurance, which at present only covers a small fraction of the population. Poor regulation, absence of accreditation mechanisms or standard treatment guidelines, and no incentive/ disincentive to control costs of healthcare has also meant that these costs continue to rise further.

India also has the largest number of qualified practitioners in other systems of Medicine (Ayurveda/ Siddha/ Unani/ Homeopathy)– over 717,860 practitioners.[28] These are located in the public as well as the private sector.

Voluntary Health agencies/ Non-Government/ Non-Profit entities: Apart from purely private providers of health care, the NGOs and the voluntary sector have also been engaged in providing health care services to the community. It is estimated that more than 7000 voluntary agencies are involved in health-related activities[29]. NGOs providing a variety of services are relatively few, unevenly distributed across and within states and have limited areas of operation. Some are also involved in implementing government programmes, while still others run integrated or basic health services programme or provide special care/ rehabilitation to people suffering from some specific diseases e.g., leprosy patients. A large number of secondary and tertiary providers of care are also registered as non-profit societies or trusts, and contribute significantly to provision of inpatient services to insured persons. Many of these non-profit hospitals have priced their services at highly affordable levels, and are extensively utilized for both OPD and IPD services across the country. At the same time, there do exist many trust hospitals, particularly the large ones, which have made similar investments in equipment and infrastructure, and have taken recourse to similar pricing of their services as their corporate peers, though with some proportion of subsidized care for the poorer sections of society.

Pharmaceutical Industry

India has a large pharmaceutical industry, which has grown from a Rs 10 crore industry in 1950 to a Rs 55,000 crore business today (including exports), employing about 5 million people, and with manufacturing taking place in over 6000 units. The central level price regulator for the industry is the National Pharmaceuticals Pricing Authority (NPPA), while the pharma sector is under the Ministry of Chemicals. Only a small number of drugs (74 out of the 500 or so bulk drugs) are under price control[30], while the remaining drugs and formulations are under the free-pricing regime, but under the watch of the price regulator. The Drug Controllers of the States manage the field force which oversees quality and pricing of drugs and formulations in their respective jurisdictions.

NSSO data suggests that over half of the household health expenditure is on drugs, making it the single largest component of out of pocket spending on healthcare. At the same time, drugs and supplies constitute only about one-tenth of the government health expenditure. It is, however, to be remembered that the prices paid by Government for bulk procurement of drugs is also much lesser

[27] Health – Human & Social Development - Tenth Five Year Plan document Vol 2, page 94. Planning Commission. GoI.
[28] Health Information of India 2005.
[29] RNTCP, Govt of India. Background Papers for Joint Monitoring Mission, 2006.
[30] Website of the National Pharmaceutical Pricing Authority. http://nppaindia.nic.in/index1eng.html . Accessed 19th November 2007.

than the prices of the same drugs in the retail market, also indicating that the margins in the retail chain continue to be very high.

With the emerging changes in the patents regime, there is a risk for upward revision of prices, especially for newer drugs. At the same time, the industry is making huge investments in research, which is expected to further grow the industry's prospects in the days to come.

Some of the problems in the pharmaceutical sector include the fact that the industry is characterized by supplier-induced demand (and therefore loss of consumer sovereignty), uncertain demand for the patients, oligopoly elements, problem of spurious drugs etc[31]. This, combined with the fact that this accounts for the largest share of health expenditure, indicates need for policy intervention and reform, as well as continuous monitoring.

Need for Reforms in the Health Sector

The above sections do indicate that the health sector has numerous unresolved issues which need reform initiatives, both on the side of provision of care and its financing. While financial protection through health insurance, which is the area entrusted to this Committee, is only one component of the financing reforms, there are equally important reforms needed on the provision of health services and in other areas of health financing. While health reform issues are fairly complex and beyond the mandate of this committee to study or recommend on, some important areas of reforms are listed below, based on published documents of the government like the NCMH report and the NRHM documents, as a framework and context within which all health insurance reform is to be seen. The identified broad reform areas under the NRHM include:

- 'architectural correction' of the health sector, also including reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures
- delegation and decentralization of authority
- involvement of communities and local bodies and community participation and ownership of assets
- reform measures in the areas of medical education
- public health management and induction of management and financial personnel into district health system
- incorporation of Indian Systems of Medicine
- regulation of health care providers
- new health financing mechanisms and increasing public expenditure on health
- optimization of health manpower

With limited resources, not all aspirations and expectations from the health sector can be attended to. However, prioritization from amongst these areas for reforms need be made, so that the unfinished agenda of healthcare in India gets addressed. Some priorities for reforms identified by the National Commission on Macroeconomics and Health (2005) included:

1. Raising accountability of the existing system of primary health care
2. Stepping up prevention of disease and health promotion for behavioural change as an imperative to reduce disease burden.
3. Regulations and institutional infrastructure for coping with health markets, including regulators and institutions for Drugs, Medical Devices, Health Information, Health Quality, Health Research and Medical Education
4. Professionalization of Service Delivery

Health Insurance is only one mechanism of health financing, and is substantially dependent on simultaneous reforms in the health sector itself.

[31] NCMH India. Financing and Delivery of Healthcare Services in India. New Delhi, 2005