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COMMITTEES RECOMMENDATIONS FOR THE REGULATIONS OF HEALTH INSURANCE IN INDIA

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The paramount importance of regulations to promote and streamline the functioning of any sector could not be overlooked in any way. Health insurance segment is also not an exception to it particularly when it has remained impoverished due to the lack of effective regulatory system. However, this segment has witnessed a number of structural developments to create an affordable and efficient health care insurance system in the country over the period of time.

Evolution of Regulatory Framework of Health Insurance in India

Health insurance in India has paved its way in formal usage through the Employees' State Insurance Scheme (ESIS) only after passing ESI Act, 1948. This scheme has proved a social security blanket particularly for the workers employed in the formal sector. Since then, ESIS has been providing comprehensive medical health facilities through their own ESI dispensaries and hospitals which were supplemented through the medical attendants and private hospitals. The scheme was mainly financed through the contribution of the employees and the employers which has further been supported by the central and the state governments to provide not only medical benefits but also cash benefits to compensate the losses. Soon, it was followed by a scheme known as the Central Government Health Scheme in 1954 aimed to provide comprehensive medical care facilities mainly to the employees of the central government and their families.

The non-life insurers were engaged in providing health insurance services mainly the customized group cover to the corporates on varying terms and conditions before the nationalization of the general insurance business in 1973 which was continued by four subsidiaries of GIC after the nationalization. The GIC has played the model role of innovators in the Indian health insurance segment by introducing a voluntary health insurance scheme namely 'Mediclaim'. This scheme has initiated the era of standardized terms and conditions for the health insurance segment which made it popular. This scheme has been providing indemnity cover through hospitalization and reimbursement of expenses to the insured. The insurance industry has hosted number of products from time to time even before opening up of the insurance sector to fill the gaps, such as Jan Arogya, Bhavishya Arogya 1990, LIC Asha Deep, Jeevan Asha and Nav Prabhat, Overseas Mediclaim Policy and Cancer Insurance (Committee on Health Insurance for Senior Citizens, 2007).

PRESENT SCANERIO OF REGULATORY FRAMEWORK OF HEALTH INSURANCE IN INDIA

The first remarkable step has been undertaken by the Government of India by setting up Committee under the chairmanship of Shri R.N. Malhotra in 1993 to propose the recommendations for the reforms in the insurance sector. Following the recommendations, an independent body named as 'Insurance Regulatory and Development Authority' was constituted in the year 1999 to regulate and control the insurance sector. Moreover, IRDA Act has been passed to safeguard the interest of the policy holders and to regulate, promote and ensure systematic development of the insurance industry. However, the health insurance industry in India falls under the broad regulatory framework of general insurance business. But, with the passage of time and due to the development in the health insurance business, The Authority felt the need of a

particular framework exclusively for this segment. The Authority has issued exclusive guidelines for health insurance segment on the recommendations of the various study groups and committees.

It has also envisioned promoting competition and increasing customer satisfaction by increasing the choice of the customers and decreasing the premiums to make the financial viability of the health insurance market. Thus, IRDA has put in constant efforts to frame and amend the regulatory framework for the growth and development of the health insurance segment in India, this has been done keeping in view the constant changes and developments in the operating environment at the national and the international level to make health insurance more conducive for policyholders. Even inspite of the entry of the private players in to the insurance market and several other initiatives taken up by IRDA, the health insurance segment is still showing very less penetration.

IRDA has introduced the concept of Third -Party Administrators (TPAs) into the Indian health insurance domain for the first time in 2001 by issuing 'Third Party Administrators- Health Services Regulations, 2001'. Basically, TPAs are independent agencies which act as a mediator between the insurance company and the insured person to smoothen the entire process of the health insurance claim settlement. These agencies deliver the services more effectively and efficiently to ensure transparency and also to assist in the timely settlement of cashless insurance or the reimbursement of the claims of the policyholders which would further increase the health insurance penetration across the country. IRDAI has announced multiple changes from time to time in the regulations governing TPAs. The Authority has further tightened the norms for TPAs by issuing entirely the new set of regulations namely 'Insurance Regulatory and Development Authority of India (Third Party Administrators- Health Services) Regulations, 2016'. Recently, the Authority has provided more flexibility to the policyholders by allowing them to choose TPAs of their own choice at the time of buying or renewing the policy through the amendments in these guidelines as on 3rd December, 2019, namely The Insurance Regulatory and Development Authority of India (Third Party Administrators - Health Services) (Amendment) Regulations, 2019.

The Authority has issued exclusive and comprehensive regulations, namely 'The Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013' to serve the objective of creating a specific regulatory framework for the development and operations of the health insurance products in India. Further, it has replaced these regulations with 'The Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016' to solve the multitude issues of different stakeholders of the health insurance industry. The up-dated regulatory framework has been made customers centric to ensure safety of the interest of the policyholders. It also aims to provide world-class affordable health insurance products to serve the varying needs of the Indian customers. The revised framework has not only put more accountability on the part of the insurers but it also encourages them to bring innovative health insurance products.

Recently keeping up the pace, it has amended these regulations through 'The Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019' to give more flexibility to the customers. Thus, the Authority has worked tirelessly to make health

insurance products more user-friendly and it have striven to develop better and new health insurance solutions.

RECOMMENDATIONS OF THE COMMITTEES

The Insurance Regulatory and Development Authority of India have constituted various committees from time to time to revise the existing regulatory framework pertaining to the health insurance sector and to give the constructive suggestions to strengthen it in the best interest of the policyholders. The details of the various committees formed and their recommendations have been summarized below:

COMMITTEE ON HEALTH INSURANCE FOR THE SENIOR CITIZENS (2007)

This Committee was constituted under the chairmanship of Sri K.S. Sastry to inquire about the impediments in spreading health insurance for the senior citizens and to advise probable solutions in the form of commercially viable health insurance schemes for the senior citizens. The committee has also examined the issue of "portability" of the health insurance by the senior citizens and suggested possible incentives to the senior citizens for adopting healthier life styles.

- The insurers should support distinct products for the senior citizens with the entry age of around 50 years or a compilation policy covering all ages without any age-limit.
- Insurance policies should be in simple language with easily stated terms and conditions.
- Health insurance products for the senior citizens should be scheduled according to their requirements and ability to pay. There was a need of variety of products with different features as well as the different levels of sums insured.
- The policyholders should have freedom to select TPA instead of being bound by a particular TPA and premium should be reduced in case they refuse to take the services of a TPA.
- People should adopt health insurance schemes as early as possible which would accommodate the insurance companies for the better distribution of risks and for building up sufficient reserve for the viability in the long term.
- IRDA should give the directions to the insurance companies to provide health insurance to all the senior citizens irrespective of age, health condition or claim history, except the cases of incurable sickness at the time of taking the policy.
- A senior citizen having a health insurance policy under the present dispensation should not be forced to shift to any other policy under the new regulations/guidelines. He should also not be denied renewal of the existing policy and switching over to a new scheme.
- The IRDA should adopt the measures for the promotion of the stand-alone health insurance companies.
- The non-life companies should not put the accounts for 'health insurance business' under 'Miscellaneous' category but it must be distinct. It should clearly be reflected in the Revenue Account as the separate class of business.
- TPAs, agents and brokers must be adequately trained in handling/ underwriting the health insurance.
- Stand-alone insurance companies should be allowed to take long-term deposits from their policyholders and these deposits should be subjected to income tax concession under Section 80 C.

- Senior citizen beneficiaries of CGHS, ESIS and other such health indemnity arrangements should be given a suitable annual grant equivalent to the average cost being incurred per beneficiary to enable them to buy health insurance provided they had opted to give up their respective health scheme because of the non-availability of the facilities at their residential places.
- The Committee has also recommended that all senior citizens having incomes under the average per capita income but above the poverty line should be given a grant of Rupees 100 per month in the form of a voucher either for buying health insurance or for primary and preventive care services.
- There is also a need of adequate regulation of hospitals and other healthcare providers for increasing their efficiency.

COMMITTEE TO EVALUATE THE PERFORMANCE OF THE THIRD-PARTY ADMINISTRATORS (HEALTH SERVICES) (2009)

A Committee has been constituted under the chairmanship of Sri S.B. Mathur for discussing the various aspects of TPA's. The committee had examined the role of TPAs in the health insurance market and had also evaluated their performance. It had also felt the need of suggesting standards of better practices for TPAs, customer service benchmark for TPAs, minimum skills for TPA staffs and the regulatory changes to ensure smooth functioning of the health insurance. The highlighted recommendations of the Committee are as follows:

- The committee has emphasized to outline service standards with acceptable TATs to set the best practices, which would be followed by the insurer, TPAs, hospitals and the insured.
- It recommended that there should be standardization of the documents; grievance redressal system and the discharge protocols.
- The committee has stressed that there was a need of sharing of the additional data amongst the insurers and TPAs besides the data specified by the regulator's data repository.
- This committee has recommended setting a Common Health Insurance Industry Body to keep a check on the fraud and misuse of the system. It should create common platform to assist interaction among all the stakeholders and could provide mechanism to minimize the differences between the insurers and TPAs.
- There should be regulations regarding the financial exposure of the insurance company and TPAs to provide protection.
- The committee has also highlighted the need of regulations to ensure proper investments in the infrastructure of TPAs as well as the deployment of capital. It has also stressed the need to have specified guidelines to ensure the availability of adequate amount of working capital at all the times.
- It has also felt the need of minimum organizational requirement prior to getting license of TPAs such as at least four offices in the different states in addition to its head office, web enabled software with security and minimum skill set.

EXPERT COMMITTEE ON HEALTH INSURANCE (2015)

The Expert Committee was constituted by the IRDA under the chairmanship of Shri Ramprasad. The committee had examined the existing regulatory framework covering the different aspects of health insurance business such as products,

product distribution, reinsurance, protection of policyholders, and investments and financial matters etc. Its important recommendations were as follows:

- The committee suggested that there should be proper disclosure of terms and conditions on the part of the insurers and TPAs.
- There should be more transparency and clarity in the policy documents for the understanding of the extent of coverage to the policyholders given by the policy.
- There should be a proper system to manage and control frauds on the part of the insurers and the TPAs.
- The provision of compliance may be specified in the regulations regarding the automation and capture of data electronically as specified either by the government or Authority from time to time. Further, KYC norms should also be made compulsory and the Regulator should also encourage online interface with UIDAI.
- It is suggested that the interpretation of the policy terms and conditions should be identical and consistent to gain confidence of the policyholders.
- Tax incentives and saving oriented products with the comprehensive coverage should be introduced to attract currently uninsured segments.
- The committee has also suggested a level playing field for all the types of insurers, launch of innovative products, entry age-based pricing, use of premium discount structures and removal of the restrictions on the rider premiums for health insurance products.
- It has also outlined certain guidelines regarding the commission structures, the use of agency force, changes in the wordings for disclaimer on insurance advertising and micro insurance etc.
- It has advocated quota share reinsurance for all the insurers subject to the appropriate controls.
- It has also recommended certain matters to be stated in the insurance policy and claim procedure to be followed in case of the health insurance products in order to ensure the protection of the interests of the policyholders.
- Finally, it has suggested that the Authority should consider to set up an exclusive department for the issues related with the health insurance business to facilitate the level playing field among the life insurance companies, general insurance companies and standalone health insurers.

WORKING GROUP FOR THE STANDARDIZATION OF EXCLUSION IN HEALTH INSURANCE CONTRACTS (2018)

A working group was formed under the chairmanship of Mr. Suresh Mathur for the discussion on the standardization of exclusion in health insurance in July, 2018. The key recommendations of the group were as follows:

- This Group suggested that all health illnesses attained after taking the policy except those that are purely excluded under the policy agreement such as infertility and maternity etc. must be covered under the contract and cannot be excluded forever.
- The Working Group recommended that there should not be any permanent exclusion in the policy language for any particular sickness condition(s), whether they are degenerative, physiological, or chronic in nature.
- The permanent exclusion would be specific for conditions which are listed, and this list may be reviewed on a yearly basis by the committee that may be set up by the regulator.

- It has also suggested that the insurance companies can be permitted to include waiting periods for any particular illness situation but subject to the maximum of 4 years. It shall be based on objective criteria and sound actuarial principles, while waiting period for the conditions namely, Hypertension, Diabetes, Cardiac conditions should not be for more than 30 days.
- It has also stated that the insurer may generally appeal the cancellation clause for non-disclosure of the important facts which is a major problem in health insurance agreements.
- The group has asked to review the standardization of exclusion of alcoholism and drugs.
- It has recommended setting up of a Health Technology Assessment Committee to examine and to propose inclusion of advancement in medical technology as well as drugs for the coverage under insurance.
- The group has also specified recommendations for a sample list of treatments and procedures under technological advancements.
- There should not be any exclusion of advance technology treatments if they are approved by the Health Technology Assessment Committee.
- It has suggested that the insurers should include Explanation of Benefits (EOB) in their booklet as well as in Policy which should be easily understandable by the clients.
- The Working Group has recommended a list of exclusions which shall not be offered by all the insurers in the health insurance policies.
- It has also specified a list of exclusions for which a uniform standard wording must be used by all the insurers in the industry.
- Every insurance company should publish and communicate either in the policy or as a link on the website about the list of items which will not be compensated in case these are billed individually.
- The recommendations of the group would certainly have some effects on the prices of the products which would require to revise the wordings of the policy and to submit with the regulator.
- It is recommended that all the deaths due to vector borne disease should be classified as death due to disease and cannot be classified as death due to accident. However, injuries/death caused by mauling by wild animals, snake bite, scorpion bite or even dog bites can be termed as accidental injuries.

CONCLUSION

IRDA has played an important role in the development of health insurance sector in India. Due to the initiatives of the IRDA the health insurance scenario has drastically changed in the last few years. It has become a torch bearer in enhancing the concept of health insurance globally. IRDA has streamlined the various issues which come in the way of its development from time to time by framing the particular rules and regulations for that concept. IRDA has built up its own mechanism for spreading the health insurance coverage by bumping the number of insurance companies. For the growth and expansion of this segment IRDA has initiated the concept of standalone health insurers for attracting more players in this sector. The earlier health insurance used to come under miscellaneous categories but now IRDA has made health insurance as a separate class of business.

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