CHAPTER FOUR

LEGAL FRAMEWORK OF HEALTH INSURANCE
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Governments, particularly in countries where public health systems are considered inadequate, look upon private health insurers, as partners in achieving health policy goals. Private health insurance is an alternative source of health financing, offered in the voluntary market and geared towards providing health coverage with customized benefits to a large portion of the population. While private health insurance is a potent tool to increase the capacity of a country's health system, government intervention is necessary to prevent market failures.

4.1 RATIONALE FOR PRIVATE HEALTH INSURANCE REGULATION

In order for private health insurance to achieve its objectives and fulfill its functions, effective regulation and supervision of both the carriers of risks (insurers) and the providers of health care are imperative for reasons of public safety and because health care services have aspects of public goods. This requirement is particularly critical in India, as private health insurance is emerging as an important source of health care financing. A Discussion Paper published by the WHO offers a comprehensive rationale for, and the objectives of private health insurance regulation in developing countries, as summarized below:

1. Health insurance is more complex than other types of insurance. The exposures to health risks and the consequential costs of covering those risks are very difficult to assess due to the following factors:
   
   • Health risks are not static; they change over a period of time and, in the long term, every one requires health services.
• An individual has more control of his/her health risks compared to other types of insurance risks.
• The definition, nature and extent of insurable health risks keep changing due to medical advances.

2. Health insurance markets are particularly subject to a number of market failures, preventing or hindering their effective functioning. Some of these failures stem from information asymmetry about health risks and costs. These lead to moral hazard and anti-selection on the part of insured, adverse risk selection on the part of the insurers and potentially poor choice of health care providers for both.

To be effective, regulation and supervision of health insurance must encompass the following objectives:
• Establishing requisite procedures for intervention that safeguard the solvency and financial soundness of health insurers, so that they are in a position to fulfill the promises they made to the insured.
• Providing an environment to allow health insurers to continuously offer health insurance products and carry health risks on sustainable bases.
• Establishing and promoting a level playing field among the carriers of health risk so as to encourage participation of an optimal number of health insurers.
• Ensuring order in the market through the promulgation and enforcement of laws and regulations that address issues such as, the type or types of health policies or covers that insurers can sell.
• Establishing the manner and methodology of arriving at equitable product pricing, the prompt and orderly payment of claims, the contract terms and conditions including the specification of standardized definition of certain policy terms, mandatory minimum policy stipulations and setting market standards for transacting the business of health insurance.

• Establishing similar safeguards and/or standards for the orderly functioning and financial soundness of other programs that assume health expenditure risks, such as subscription plans, health plans of mutual benefit associations, cooperatives, and other community plans.

• Prescribing appropriate authorization (registration) and oversight of entities that carry and manage these plans in order that public policy objectives of health insurance are realized and specific market failures are corrected. It is noteworthy that these entities operate in the same market as duly registered and thus regulated health insurers.

The present chapter describes the legal and regulatory framework of private insurance in India.

4.2 REGULATION OF HEALTH INSURANCE

Reforms in the Indian financial sector led to the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. The Act established the Insurance Development and Regulatory Authority (IRDA) and constituted it as the executive entity to “protect the interests of holders of insurance policies and to regulate, promote and ensure orderly growth of the insurance industry.”
4.2.1 THE INSURANCE REGULATORY AND DEVELOPMENT ACT (IRDA) 1999:

The Act allows for the entry of private sector entities in the Indian insurance sector, including health insurance. There is an entry requirement of a minimum capital of Rs 100 crore. The Insurance Act does not allow the insurers to undertake additional business that is not directly linked to insurance. The Act specifies a Code of Conduct for the insurance agents and also allows for a Tariff Advisory Committee to oversee premium rates, insurance plans and to prevent discrimination. However, there is no specific clause for the consumer.²

The Act specifies the areas where regulations can be made. For instance, where the Act grants power to the Insurance Regulatory and Development Authority to make regulations on licensing of agents, such regulations would describe the qualifications and practical training required for an agent and specifies the corresponding fee etc. for a license to be granted. No Regulation may override the provisions of the Act. Rules and Regulations are made, usually after discussions/consultations with various groups, who are likely to be most affected. They come into effect after their notification in the Official Gazette with the additional requirement, that they are presented (tabled) before the Parliament following their due notification. Rules and Regulations are referred to as ‘secondary legislation’. They are dynamic, and can be modified, revised or supplemented as exigencies arise through time and are therefore pro-active, as they fill in the details of primary legislations.

Rules and Regulations are most used and effective in providing quick help and guidance to the public. For this reason, secondary legislation is a favored route to regulation because bringing in primary legislation is not only
time consuming but also a tedious process. Parenthetically, legislative reforms are taking place internationally, granting more powers, including quasi-judicial (adjudicatory), to the executive branch of government. Additionally, Insurance Regulatory and Development Authority has also the power to issue directions in the public interest or to prevent the affairs of any insurer, from being conducted in a manner detrimental to the interest of policy holders or, in general, to secure proper management of any insurer and, in which case, insurers, or insurer as the case may be, shall be bound to comply with such directions.³

4.2.2 DUTIES, POWER AND FUNCTIONS OF INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY:

Section 14 of Insurance Regulatory and Development Act 1999 lays down the duties, powers and functions of Insurance Regulatory and Development Authority.

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

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

   • Issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;

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

- Specifying requisite qualifications, code of conduct and practical
  training for intermediary or insurance intermediaries and agents;
- Code of conduct for surveyors and loss assessors;
- Promoting efficiency in the conduct of insurance business;
- Promoting and regulating professional organizations, connected
  with the insurance and re-insurance business;
- Levying fees and other charges for carrying out the purposes of
  this Act;
- Calling for information from, undertaking inspection of,  
  conducting enquiries and investigations including audit of the
  insurers, intermediaries, insurance intermediaries and other
  organizations connected with the insurance business;
- Control and regulation of the rates, advantages, terms and
  conditions that may be offered by insurers in respect of general
  insurance business not so controlled and regulated by the Tariff
  Advisory Committee of the Insurance Act, 1938.
- Specifying the form and manner in which books of account shall
  be maintained and statement of accounts shall be rendered by
  insurers and other insurance intermediaries;
- Regulating investment of funds by insurance companies;
- Regulating maintenance of margin of solvency;
• Adjudication of disputes between insurers and intermediaries or insurance intermediaries;

• Supervising the functioning of the Tariff Advisory Committee;

• Specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations referred to in clause;

• Specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector; and

• Exercising such other powers as may be prescribed.

• The Insurance Regulatory and Development Authority facilitate the organization and staffing of its health insurance department and implement continuing training of its staff to achieve higher level of institutional expertise in health insurance.

• The Insurance Regulatory and Development Authority promote and encourage development of health insurance technical expertise in the industry by institutions such as the Institute of Actuaries of India, Insurance Institute of India, and Insurance Educational Institutions to adopt and implement contemporary health insurance curricula as well as organizations that offer studies and certification programs for health insurance professionals.

• The Insurance Regulatory and Development Authority lead in establishing contemporary healthcare financing models that provide accessible basic and primary health insurance products for the elderly and the "vulnerable" who are unable to obtain
coverage in the normal channels. This can be achieved by creating risk pooling facilities among all health insurers, preferably with government participation, for basic and primary covers which could be supplemented with private health insurance obtained voluntarily.\(^4\)

4.2.3 REGULATING THIRD PARTY ADMINISTRATORS:

The Insurance Regulatory and Development Authority set up a working committee in 2000 to suggest regulations for this new type of intermediary dealing with the administration of health insurance. The Committee was made up of representatives of the existing Third Party Administrators, several public and private sector insurance companies (non-life) and members of the Insurance Regulatory and Development Authority. The committee deliberated on a white paper that was circulated by Insurance Regulatory and Development Authority and the result of these deliberations, over a period of one year, was a set of regulations notified as The Insurance Regulatory and Development Authority (Third Party Administrators – Health Services) Regulations 2001, on September 17, 2001. The regulations stipulated the eligibility, scope of services, capital requirements, solvency margins, operating guidelines and code of conduct for Third Party Administrators. The regulations also maintained that TPAs were indeed intermediaries as per the scope of the Insurance Regulatory and Development Authority Act, 1999, and therefore were fully under the jurisdiction of the Insurance Regulatory and Development Authority.

To date, this is the only Insurance Regulatory and Development Authority regulation specific to health insurance. This regulation established Third Party Administrators (TPA), and the rules for their licensing as intermediaries in rendering healthcare for insured beneficiaries and promoting
a “cashless system” with easier access to and faster settlement of covered benefits of medical expense covers. The regulation prescribes high educational and practice standards of individuals, operating and managing a Third Party Administrator and requires adherence to a prescribed Code of Conduct. The salient features are as follows:

- Only an organization registered under the Companies Act 1956 with a share capital of at least Rs. 10 million in equity shares can set up a Third Party Administrator in health services.

- Third Party Administrator will be required to start with a minimum working capital of Rs 10 million at any point of functioning.

- Foreign equity in Third Party Administrator is limited to 26 per cent. In case of any share transfer, exceeding 5 per cent of paid-up capital, IRDA has to be informed within 15 days of such transfer.

- The primary object of the company should be to carry on business in India as a Third Party Administrator in health services. It should not engage itself in any other business.

- At least one of the directors shall be a qualified medical doctor registered with the Medical Council of India.

- The CEO or CAO of the Third Party Administrator should have successfully undergone a course in hospital management from an institution recognized by Insurance Regulatory and Development Authority and have passed the licentiate examination conducted by the Insurance Institute of India, Mumbai. Apart from this, he should have undergone practical
training of at least three months in the field of health management.

- TPAs should have access to competent medical professionals to advise insurance companies and clients on various matters.

- TPAs should obtain license from Insurance Regulatory and Development Authority to function. The application fee is Rs. 20,000 and once the application is approved, another Rs. 30,000 has to be paid as licensing fee. The license will be renewed every third year by Insurance Regulatory and Development Authority. If the application is rejected, Third Party Administrator is not entitled to apply again within two years. The Third Party Administrator should furnish all documents including the agreement with the insurance company while applying for license. This agreement should contain details of the remuneration that may be payable to the Third Party Administrator by the insurance company.

- The Third Party Administrator will be allowed to enter into an agreement with more than one insurer, and similarly insurance companies can engage more than one Third Party Administrators.

- The Third Party Administrator has to spell out the scope of services that it will deliver, while entering into an agreement with a insurance company.

- Third Party Administrators shall not charge any fee from the clients.
• Insurance Regulatory and Development Authority guidelines do not permit marketing of health insurance policies by the Third Party Administrator.

• Third Party Administrators would also have to maintain and report to Insurance Regulatory and Development Authority on transactions carried out on behalf of the insurer. The Authority expects Third Party Administrators to maintain all records properly and maintain professional confidentiality between the parties. The authority holds the power to monitor and check the performance of Third Party Administrators from time to time. Third Party Administrator are expected to furnish to the insurance company and the authority an annual report and any other return as may be required by the Authority.

• The Insurance Regulatory and Development Authority has drawn up a code of conduct for the Third Party Administrators, refraining them from trading in information, submitting wrong information to insurers, and making advertisements without prior approval of the insurer, among other things. Their license will be revoked under such instances.

While this regulation has prompted expanded consumer interest and confidence in medical expenses insurance, many believe that the regulation needs to be revisited and updated considering the changes occurring in the industry and the imperatives to provide quality healthcare. Moreover, there is growing evidence that the Third Party Administrator System has not been effective in promoting quality of healthcare and in containing healthcare costs.
Third Party Administrator business practices are quite often cited as one of the causes of the very high loss ratios in the current health insurance business\(^6\).

Insurance Regulatory and Development Authority regulations place stringent conditions for licensing Third Party Administrators. Current regulation requires Third Party Administrators to meet a minimum equity capital of Rs.10 million. The capital requirements for entering into this sector are not stringent. As a result, there may be a proliferation of players, not all of the best quality. A large number of players will mean pressure on margins. Besides this, Third Party Administrators need to set up infrastructure which would involve large investments, the payback period of which is likely to be long. Third Party Administrators face high operating risk of obtaining economies of scale necessary to break even. Volumes are critical because the revenue generation of Third Party Administrators is linked to the number of policies, they undertake to administer.

4.2.4 JUDICIAL BRANCH:

The judiciary interprets the law, both primary and secondary legislation. It hears and decides disputes between insurers and the policyholders, protects the insuring public by imposing civil fines or criminal penalties for violation of the insurance laws and protects insurers, their agents and intermediaries by overturning arbitrary or unconstitutional legislation, rules, regulations or orders promulgated by the insurance regulator. The Supreme Court is the highest court in India, and its judgment is final in all respects.

Each geographic region is represented by a specific court. To facilitate dispute resolution, India has also Consumer Courts, Insurance Ombudsmen,
Lok Adalats, etc., that address consumer grievances in summary proceedings. Policyholder complaints against insurers, are mostly dealt with at the Insurance Ombudsmen and Consumer Courts. There are also various tribunals dealing generally with industrial or sector-specific matters as appellate authorities exercising specific adjudicatory powers. While these entities do not fall under the judiciary branch, they are considered a part of the court system.

Regulations are effective tools to promote access to private health insurance, improve consumer confidence and orderly growth of the health insurance industry. In addition, regulations provide definitive directions to health insurers and other industry stakeholders that would prime robust development and growth of private health insurance. A common recommendation of the subgroups/committees of the Insurance Regulatory and Development Authority Health Insurance Working Group is the need for regulations specific to health insurance.

To conclude, the legal and regulatory framework for private health insurance, because it operates in the voluntary market, should continually balance competing goals of access, affordability and quality of healthcare and providing health covers to a larger fraction of the population with varying risk characteristics and ability to pay. Regulations, aside from being solely aimed at providing protection of health insurance policyholders and beneficiaries, can be potent tools to promote access to healthcare control pricing of health covers vis-à-vis healthcare providers and enhance the quality of healthcare.
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