GENESIS AND OVERVIEW OF HEALTH INSURANCE IN INDIA
CHAPTER III

GENESIS AND OVERVIEW OF HEALTH INSURANCE IN INDIA

India is estimated to be a market with high potential currently but still only a meagre percentage of population are covered by some form of health insurance. Though health insurance plans are available in the market today, the scenario was not the same during first half of 20th century when health insurance was discussed for introducing it in India. Since then, health insurance has passed through various forms to reach the form of today. This chapter details about the development cycle of health insurance since its genesis in India which can help to understand the importance given to health insurance during various phases and also help to realise the value of health insurance in current scenario. This chapter is classified into two parts, the first part details about the Genesis and overview of the developments in Indian health insurance arena and the second part details about the health insurance statutory environment in India.

Section 1: Genesis and Overview

In general, the insurance sector in India has come a full circle, from being an open competitive market to nationalisation and back to a liberalised market again. But historically, the growth of health insurance in India can be segmented into four following phases.

Pre Independence Era (till 1947)
Pre Nationalisation Era (1947-1973)
Nationalisation/Pre-liberalisation Era (1973-1999)
Post Liberalisation Era (from 1999)
Pre-Independence Era

In 1923, the Workers Compensation Act was passed by the Central Government covering 3 million workers. But till 1930 very few provinces like Bombay and Central Province took some actions on this like passing of bills, providing maternity benefit to women workers. Though efforts were made to secure legislation on an all India basis, they were defeated by the British Government, which tried to put the recommendations of the Whitley commission for welfare legislation on an all India basis in cold storage.

Actually the subject of health insurance for industrial workers was first discussed by the Indian legislature in 1927 when the applicability of the conventions adopted by the International Labour Conference at its tenth session to India was considered by the Government of India. But Government expressed its inability to sponsor a health insurance scheme but recommended the provincial governments to examine the possibility of implementation of such schemes. But many provincial governments too found it difficult.

In, 1928 The Indian Insurance Companies Act was enacted to enable the government to collect statistical information about both life and non-life insurance businesses. The subject of health insurance for industrial workers was first discussed by the Indian Legislature in 1927 when the applicability of the conventions adopted by the International Labour Conference at its tenth session to India was considered by the government.

The Royal Commission Scheme

A Royal commission on labour was appointed in 1929 to find the need for health insurance among workers. It submitted its report in 1931. It observed that the incidence of sickness is substantially higher than in western countries; the medical facilities are much less adequate; wages are low to meet the health care spending without borrowing. Though the Commission realised that the difficulties in the way of a health insurance scheme for the workers were many and formidable, it proposed a tentative scheme. Though these suggestions could have helped in embarking upon scheme of provision against sickness and old age no action was taken on the recommendations of the Royal Commission.

Though these suggestions could have helped, but no action was taken on these recommendations. During the period of Second World War, the social insurance movement accelerated in India.

The Scheme of the Government of Bombay

The Government of Bombay prepared a scheme of sickness insurance. According to this scheme, every industrial worker was given the legal right to 3 or 4 weeks sick leave with pay every year. The unutilised leave could be turned into cash, which was to be handed over to a fund to be maintained by the government. The amount thus accumulated could be drawn by the worker either on his retirement or on his reaching a particular age or by his relative if he died during the period of service. The scheme, however, was inadequate as it failed to provide for medical benefits.

In 1938, earlier legislation was consolidated and amended to by the Insurance Act with the objective of protecting the interests of the insuring public.
The Bombay Textile Labour Committee scheme

As a result of the general awakening during the Second World War, the pace of social insurance movement was accelerated in India. Accordingly, the second important step in the direction of sickness insurance was taken in 1940 by the Government of Bombay when the Bombay textile labour enquiry Committee formulated a scheme:

Table 3.1

<table>
<thead>
<tr>
<th>Insured Worker</th>
<th>Employer</th>
<th>Government</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male – As.5</td>
<td>As.10</td>
<td>Anna 1</td>
<td>Re.1</td>
</tr>
<tr>
<td>Female – As.5</td>
<td>As.10</td>
<td>Anna 1</td>
<td>Re.1</td>
</tr>
</tbody>
</table>

This contribution scale was subject to the condition that the contribution by the insured worker was in no case to exceed 5 percent of his average monthly income during the preceding quarter. This scheme was an important step forward in the direction of comprehensive sickness insurance plans in as much as it suggested non-separation of cash and medical benefits, setting up of a single and unified fund under central management and recommended contributions from the state. Unfortunately, the government could not implement it. The conference of labour ministers held in 1940 discussed the question of health insurance for the industrial workers and decided that the views of the employers’ and employees’ organisations should be elicited. The workers’ organisations also favoured the principle of compulsory contribution but urged that in view of the low wages of the workers, their contribution should be nominal. The matter came up for discussion before the second conference of labour ministers held in 1941, where it was decided that instead of contributing to the health insurance fund, the government should consider the proposal of standing guarantee to ensure the solvency of the fund.
The Labour Department Scheme

The labour department of the government of India prepared a tentative scheme of health insurance and placed it before the conference of labour ministers held in 1942. No action was taken on this scheme. It was suggested at the conference that the details of a comprehensive scheme should be worked out by a small committee of about three experts. Later, however it was decided to entrust the work to a special officer. Accordingly, Professor B.P. Adarkar was appointed for this work in 1943. He submitted his report in 1944.

Adarkar's Scheme

The scope of the scheme was restricted to three major industries textiles, engineering and minerals and metals. All the perennial factories except those falling under scheduled exceptions, like employment in the armed forces, public departments, public utility concerns etc. were covered by the scheme. A further restriction on its scope was that it was to apply only to the workers between 12 and 60 years of age and drawing less than Rs. 200 a month. The Government of India thought it fit to obtain expert opinion on the report submitted by Professor Adarkar before taking any action on it and requested the international Labour office to send a deputation to examine the scheme. In response to this request, Messrs. M.Stack and R. Rao of the International Labour Office came to India in 1945 and prepared a note on professor Adarkar's report.

Stack and Rao Scheme

The two experts agreed with the fundamental principles enunciated by Professor Adarkar. The chief medications suggested by them were (i) the separation of the
medical and the cash benefit, (ii) the integration of the maternity benefit and workmen’s compensation in the health insurance scheme and (iii) the extension of the scheme to all perennial factories covered by the Factories Act and to non-manual workers.

On the basis of Adarkar’s Report and the modifications and alterations suggested in the Stack and Rao scheme, the Government of India introduced a bill in the Central Legislative Assembly on November 6, 1946. It was referred to the select committee on 22nd November 1947. The select committee submitted its report on the 11th February 1948 making substantial improvements in the original Bill. It modified the provisions making it applicable to all the employers in the factories and changed the name of the Bill to the ‘Employees’ State Insurance Bill’, which became a law in the form of the Employees’ State Insurance Act in 1948. This Act is the first of its kind not only in India but also in the whole of the South East Asian region.

Pre-Nationalisation Era

Employees State Insurance Corporation Act (ESIC), 1948 enabled the establishment of ESIC dispensaries across various parts of the country. ESIC provides benefits to employees in cases of sickness, maternity and employment injury. Under the Act, the ESIC has been setup to administer the Insurance Scheme. ESIC hospitals have been set up in many industrial areas and workers get treatment and medicines at concessional rates. Both employers and employees are required to contribute towards a fund, which is used to meet the following expenses.

Various benefits provided for under the Act for including disablement and death benefits and medical treatment.
Establishment and maintenance of hospitals, dispensaries etc.

Administration of the scheme.

Central Government Health Scheme

The scheme, introduced in 1954 as a contributory plan, was aimed at providing comprehensive medical care to the central government employees (both in service and retired) and their families to replace the cumbersome and expensive system of reimbursement. The contribution by the employees is nominal but progressive with salary scales (the contribution starts at an amount as low as Rs. 20 per month). Separate dispensaries are maintained for the exclusive use of central government workers. There are also central government run hospitals where the CGHS beneficiaries are treated.

Railways Health Insurance Scheme

The scheme was started to cater to the health care needs of railways personnel.

Nationalisation/Pre-Liberalisation Era

In 1956, 245 Indian and foreign insurers and provident societies taken over by the central government and nationalised. LIC formed by an Act of Parliament, viz. LIC Act, 1956, with a capital contribution of Rs. 5 crore from the Government of India.

In 1972, The General Insurance Business (Nationalisation) Act, 1972 nationalised the general insurance business in India with effect from 1st January 1973. 107 insurers amalgamated and grouped into four companies viz. the National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd. and the United India Insurance Company Ltd. GIC
incorporated as a company. But even after such reforms, health insurance or medical expense insurance schemes have been in existence for a number of years prior to nationalisation of insurance business. These policies were granted on a group basis, only to large corporate clients purely on an accommodation basis, as claim experience was unsatisfactory. There was no scheme for individual and families.

In 1981, a limited cover was devised for individuals and families. This was replaced by a mediclaim policy in 1986 under a market agreement. This scheme was modified in 1996 in the light of experience and suggestions from the insuring public and the medical fraternity. This scheme is available both on an individual and group basis.

In 1984, OMP was introduced to provide payment of medical expenses in respect of illness suffered for accident sustained by Indian residents during their overseas trips for official or holiday purpose. In 1998, Videsh Yatra Mitra policy was introduced with enhanced scope of overseas mediclaim coverages.

In 1990, a deferred health insurance policy ‘Bhavishya Arogya Policy’ was introduced to cater to the medical care of retired persons. The policy reimburses medical, surgical expenses following illness/accidental injury, incurred by the insured person during his retirement age as defined in the policy.

In 1993, another public sector Unit Trust of India introduced Senior Citizens Unit Plan (SCUP) to provide coverage for hospitalisation expenses up to Rs. 500,000 for the investors after attaining the age of 58 years. Anyone in the 18–54 years age group can join the scheme by a one-time investment and his/her spouse can also become eligible for the medical insurance benefits.
Though it is not a health insurance policy primarily, in 1995, the LIC introduced a special policy known as Asha Deep II in 1995 to cover insurance against four major ailments, namely cancer, paralytic stroke, renal failure, and coronary artery diseases.

In 1996, a mini version of the scheme viz. Jan Arogya Bima Policy for the weaker sections of the society was also introduced by GIC.

In organisational front, some schemes like Police Sanjeevani Nidhi Yojana for police personnel in Maharashtra was started in 1998, the scheme today covers 90,000 personnel out of the total strength of 1, 44,000. That is quite a huge membership considering the fact that the scheme is voluntary. The scheme covers ‘hospitalisation’ expenses of a number of ailments including cardiac operations, dialysis, kidney stone removal, cancer surgery, brain tumour, etc.

Similarly, many NGOs’ like SEWA, CINI provided health insurance coverages to its members.

Many of the health insurance policies floated by GIC of India were not popular and some of it were restricted to some selected branches Barring Mediclaim other policies were not very popular even among the insured’s. The coverage of mediclaim is about 2.5 million, which is very low as compared to India’s 300 million middleclass. The industry claims ratio in this era was (ratio of claims amount over the premium income) 65.35% in 1996-97 on a gross premium of Rs. 1.67 billion. During liberalisation, it shot up to 98.45% in 1999-00 on a gross premium of Rs. 4 billion.
Liberalisation Era (From 1999)

IRDA Act was passed in 1999 and after its passage, insurance sector was thrown open to private participation. But no specialised health insurance company entered into the market due to various factors like lack of data, past claims history, higher capital norms etc. Cigna which showed interest initially withdrew its application due to the above factors.

However, after liberalisation, new age insurance companies have started offering health insurance policies in the lines of mediclaim policy i.e., the features of those policies are similar to that of mediclaim policies offered during pre-liberalisation era. This is due to the fact that due to lack of proper data, the new age insurance companies follow almost similar rates as that of mediclaim policies. On the other hand, after liberalisation, life insurance companies started offering critical illness rider.

In 2001, IRDA introduced TPA services in the market. TPAs were introduced to promote the concept of cashless benefit schemes. Though the concept of TPAs existed even before the liberalisation, TPA services were limited to only a few corporate clients. But through IRDA (TPA) Regulations, 2001, TPAs can service to both private and public sector insurance companies. During the same period, IRDA allowed life insurance companies to sell policies with critical illness insurance riders. As per the latest available figures of IRDA (Sep 2004), the sale of critical illness insurance policies is around 3.2 million. Critical illness rider is not a pure form of health insurance by itself. Though the concept of ‘critical illness rider’ cover may be new to India, the concepts originated around 20 years back itself (1985) in South Africa. The basis of critical illness rider is that to offer risk coverage against life transforming diseases which hit many of the people like stroke, cancer, heart attack and has the
capability of ruining the accumulated wealth of a person, spoil his active work etc. The list of such life transforming diseases are very few and unlike the health insurance policies which promises to cover unlisted various diseases, these critical illness riders limits itself to only certain diseases. To say it simply, critical illness rider is concerned only about diseases, which affect most of the people and not all the diseases, which rarely affect any rarest people. The idea works out because, people are aware of the diseases listed in the critical illness rider benefits and able to visualise the coverages. Though these diseases are covered in health insurance policies offered by non-life companies also, the premium paid includes coverage for all the diseases including the rarest diseases.

But whether critical illness rider falls under health insurance or life insurance is a question? When we compare the requirement of actuarial calculation for pricing health insurance policies (non-life companies) with the critical illness rider (life companies), the pricing of health insurance is more complex as several factors like morbidity rate, incidence rate, hospitalisation expenses etc. are involved. But for critical illness rider, only the age-specific incidence rate is enough, no need to worry about the hospitalisation expenses, inflation rates etc. This looks similar to the mortality rate basics of life insurance though the critical illness rider works on the basis of morbidity. Hence there is no wonder that critical illness riders are promoted by life insurance companies where no specialised health insurance actuaries are required.

A thing to remind again is that though critical illness rider offers health risk coverages, it can no way comparable to the benefits of core health insurance policies. For example, though the policyholder if diagnosed with any of these illnesses listed by the life insurer at any time during the policy term, he would get benefits under the
rider, there is a clause that if policyholder is once diagnosed with any one of the illnesses, the rider would terminate. The list of diseases varies from company to company and there are conditions like the policyholder must survive for at least 30 days after the diagnosis. This period of 30 days varies from company to company. Health Insurance policies also have lots of restrictions when compared but the benefits are more. Hence basically, the policyholders should get cleared of all the doubts before taking policy.

In 2004, IRDA published a concept paper on ‘micro insurance’ in order to introduce the concept micro-insurance to enable insurers to design and distribute and service micro-insurance products (including health insurance products) and discharge their obligations to the rural and social sectors as per provisions of the Insurance Act, 1938.

It is proposed that an insurer transacting life insurance business shall be permitted to provide life micro-insurance products as well as general micro-insurance products provided it ties up with an insurer transacting general insurance business for the general micro-insurance products, and vice versa.

In addition to an insurance agent or corporate agent or insurance broker who are authorised to solicit and procure insurance business, including micro-insurance business with an insurer in accordance with the provisions of the Insurance Act, 1938 and the regulations made there under it is also proposed to introduce the concepts of ‘micro-insurance product’ and ‘micro-insurance agent’

The operational issues of the above regulations are under review by IRDA.
A note about Growth of Individual Health Insurance Policy Segment

The individual health insurance sector is showing steady growth. Especially both private and public insurance companies are slowly penetrating into the market. The following figure depicts the same

Table 3.2

Details of health business across various insurers during 2003-2004

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>ICICI Lombard</td>
<td>118.78</td>
<td>13.4</td>
<td>257.0</td>
<td>74.7</td>
</tr>
<tr>
<td>Bajaj Allianz</td>
<td>70.39</td>
<td>8.3</td>
<td>242.2</td>
<td>79.0</td>
</tr>
<tr>
<td>Royal Sundaram</td>
<td>30.02</td>
<td>9.1</td>
<td>88.8</td>
<td>28.5</td>
</tr>
<tr>
<td>IFFCO-Tokio</td>
<td>28.37</td>
<td>5.6</td>
<td>73.3</td>
<td>55.0</td>
</tr>
<tr>
<td>TATA AIG</td>
<td>26.64</td>
<td>5.7</td>
<td>35.3</td>
<td>32.7</td>
</tr>
<tr>
<td>Cholamandalam</td>
<td>20.12</td>
<td>11.8</td>
<td>-</td>
<td>75.3</td>
</tr>
<tr>
<td>Reliance</td>
<td>7.98</td>
<td>4.9</td>
<td>2.4</td>
<td>0.3</td>
</tr>
<tr>
<td>HDFC Chubb</td>
<td>1.97</td>
<td>1.1</td>
<td>-</td>
<td>59.2</td>
</tr>
<tr>
<td>Private sector</td>
<td>304.27</td>
<td>8.6</td>
<td>148.0</td>
<td>55.3</td>
</tr>
<tr>
<td>New India</td>
<td>504.28</td>
<td>11.9</td>
<td>43.9</td>
<td>4.5</td>
</tr>
<tr>
<td>National</td>
<td>364.29</td>
<td>9.5</td>
<td>26.3</td>
<td>11.9</td>
</tr>
<tr>
<td>United India</td>
<td>294.19</td>
<td>10.0</td>
<td>5.2</td>
<td>-3.8</td>
</tr>
<tr>
<td>Oriental</td>
<td>265.14</td>
<td>8.7</td>
<td>13.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Public sector</td>
<td>1,427.9</td>
<td>9.8</td>
<td>24.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Total</td>
<td>1,732.17</td>
<td>9.6</td>
<td>36.0</td>
<td>12.3</td>
</tr>
</tbody>
</table>

The above table provides details of the growth of the Health and other non-life businesses. The health segment looks quite vibrant among the private players. ICICI Lombard and Bajaj Allianz are the main players in the health business. Cholamandalam – the latest entrant - seems to be focusing more on its health business; 12 per cent of its business comprises health insurance, which is the second highest among the private players, followed by 13 per cent of the top player ICICI Lombard. The rapid growth of total non-life and health during the past two years suggests that the insurance market, including health, has benefited immensely from the opening up and privatisation, and is probably going to see an even higher growth in the near future. In comparison to the private sector, the public sector companies
have witnessed relatively slower growth. The total business has grown by just five per cent while the health segment has increased 24 per cent, both the numbers being much lower than the 55 per cent and 148 per cent, respectively, in the private sector. However, it must be remembered that the private sector companies have the advantage of being latecomers with a lower base, so any increase over these levels would look substantial. Also, in terms of volume of business, the four public sector companies had about Rs. 1,428 crore of business in 2004-05, whereas the private sector companies together had a modest Rs. 304 crore. Among the public sector insurers, NIA seems to be more focused on the health portfolio, with 44 per cent growth in 2004-05. Overall, even in the public sector, the health business is growing faster than other non-life business. It is interesting to see that the market shares of different companies keep changing over time, which is an indicator of a thriving and competitive market.

In summary, though Insurance companies are showing steady growth in health insurance business (negligible when compared to market potential), exorbitant claims ratio nullify the positive effects of such growth. Hence only way is to improve the customer base aggressively for health insurance and establish more controls over claims ratio.

**Section II: Health Insurance Statutory Environments**

In any country, the statutory environments play crucial role for the growth of business. Health Insurance Statutory Environments are detailed in this part.
Constitutional Environment

The Constitution of India is the fountainhead of all our laws, rules and the regulations. Hence it is useful to begin with the provisions of the Constitution relating to health care and insurance to get idea about the structure encompassing health care and insurance in India.


Article 246 of the Constitution of India deals with the subject matter of laws made by the Parliament and the Legislature of States. The Seventh Schedule of the Constitution contains 3 lists, List I – Union List, deals with the subject matters within the purview of the Parliament. List II – State List, deals with the subject matters within the purview of the State Legislatures. List III – Concurrent List, deals with the subject matters, which are common, both, to the Parliament and to the State Legislatures. Insurance falls under the Union List (Item No. 47). Public health and sanitation, hospitals and dispensaries fall under the State List (Item No. 6).

Medical professions fall under the Concurrent List (Item No. 26). Protection and Improvement of environment (Art. 48A) and bio-medical environmental issues fall under the Concurrent List (item Nos. 17, 17A). Drugs (pharmaceuticals) fall under the concurrent list. (Item 19). The Supreme Court of India has evolved principles regarding interpretation of the lists:
Predominance of the Union List over the State List and the Concurrent List and that of the Concurrent List over the State List

If the Union List and the State List overlap, it is the Union List, which shall prevail.

If the Union List and the Concurrent List overlap, it is again the Union List, which shall prevail.

In case of conflict between the Concurrent List and the State List, it is a Concurrent List that shall prevail.

Thus, health care is a sector fragmented between the Centre and the States and the overall legal scenario relating to regulation of health care is not simple. This is affecting the reforms in health insurance in India, as unlike Reserve Bank of India, Insurance Regulatory and Development Authority of India (IRDA) has limitations in exercising its duties. Any changes proposed in the health insurance arena by IRDA have to be implemented by hospitals, which fall under Union and State list.

Regulatory Environment

Insurance in India was governed under Insurance Act, 1938 till IRDA Act was passed in 1999. IRDA Act adopted majority of the provisions of Insurance Act, 1938. But now IRDA is thinking to change some provisions with respect to health insurance. For Example, under Insurance Act, 1938, insurance against sickness and medical treatments is not part of life insurance business. It gets covered under miscellaneous insurance business, which is part of general insurance business. This is not the situation in many other countries. They consider health insurance as part of the
life insurance business. But IRDA is planning to allow life insurers also into the segment.

Under the IRDA Act 1999, the IRDA is vested with the powers of licensing and regulating insurers, including health insurers. The Act states its aim as ‘to provide for the establishment of an Authority to protect the interests of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto and further to amend the Insurance Act 1938, the Life Insurance Corporation Act 1956 and the General Insurance Business Nationalisation Act 1972.’

Section 4(2) of IRDA - Registration of Indian Insurance Companies Regulations 2000 states ‘the classes of business of insurance for which requisition for registration application may be made are, life insurance business consisting of linked business, non-linked business or both; or, general insurance business including health insurance business (or health cover).’

Section 2(f) of the IRDA - Registration of Indian Insurance Companies Regulations 2000 defines 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 an indemnity, reimbursement, service, prepaid, hospital or other plans basis, including assured benefits and long term care’.

Multi-Disciplinary Nature of IRDA Regulations

A simple reading of the IRDA regulations gives the impression that it aims to regulate, not only insurance companies but also hospitals and other organisations that run insurance (like) plans.
Though health insurance has been brought under the purview of general insurance business, it is reasonable to presume that life insurance companies, which market endowment and other products with health riders, will continue to do so. However, hospitals, which run health-plans, may have to register themselves as insurers. So far none of the private hospitals, which run health plans, appear to have registered themselves as insurers. But stakeholders from other sectors that influence health insurance viz. medical, pharmaceutical industries are primarily governed by its own regulations. Hence how IRDA intends to tackle this issue remains to be seen. Some important regulatory aspects of IRDA are detailed below. The following paragraphs give details of the main provisions of the Insurance Act as many have been elaborated or clarified by the IRDA. They deal with:

Registration and licensing
Management of funds, including control on investments
Control on Management
Solvency margins
Powers to investigate and to issue directions
Special provision protecting policyholders

Registrations and Licensing

Every insurer is required to obtain a certificate of registration from the IRDA, which has to be renewed every year. An insurer can be registered to transact life insurance business or non-life insurance business, but not both. The fee for registration is Rs. 50,000 for each class of insurance business. The fees for renewal will vary according to the gross premium written direct in India in the previous year, but not exceeding one-fourth of one percent of such premium or Rs.5 crores whichever is less, but not less than Rs. 50000, for each class of insurance business.
Only Indian insurance companies with a share capital of not less than Rs.100 crores consisting of ordinary shares are entitled to be registered. Experts opine that the share capital may be too high for a specialised health insurance company as the break-even period is expected to be more than the rest of the insurance company. Reason for higher break-even period is due to the fact that health insurance industry is having lot of demerits like lack of data, lack of centralised regulation covering all stakeholders under single umbrella etc.

Regulations related to shareholding states that if there is a foreign shareholding, it should not be more than 26 percent. Some of the insurance companies have given the management control to their foreign partner despite the low share of the foreign partner. This is due to the fact that Indian partner lack required expertise in handling the business. Now Government is planning to increase the stake to 51% but it is opposed by some of the political parties supporting the government.

In India, the reinsurance for health insurance is not present in a significant manner, rather it can be said it is almost nil. But the regulations are also not in favour of any reinsurance company to set up its shop in India, it states that if a company wants to do reinsurance business, the capital requirement would be Rs. 200 crores.

There are limitations on how much of the share capital can a person hold and also on the voting rights of a single shareholder. Every insurer is required to keep with the Reserve Bank of India a deposit of Rs. 10 crores or 1% of gross direct premium, whichever is less in the case of life insurance business, 3% of gross direct premium or Rs. 10 crores, whichever is less, in the case of general insurance business, Rs. 20 crores in the case of reinsurance business. The IRDA has the authority to cancel the registration of any insurer for reasons of non-compliance with the
provisions of the Act and the Regulations. The above infers that investment atmosphere is not so conducive for Health Insurance Company.

Management of Funds

An insurer is required to keep a separate account of all receipts and payments in respect of each class of insurance business, viz, life, fire, marine and miscellaneous. In the case of miscellaneous business, the IRDA may prescribe that separate accounts be kept in respect of any sub-class of miscellaneous business. In the case of a life insurer, all the receipts in respect of such business shall be carried to and form a separate fund to be called the life insurance fund, the assets of which are kept separate and distinct from all other assets of the insurer. An insurer is required to prepare, at the end of each financial year in the prescribed form a balance sheet; a profit and loss account, except where the insurer is doing only life, fire, marine business and no other business; a revenue account in respect of each class of insurance business. Insurers are also required to prepare the balance sheet, profit and loss accounts, separate account of receipts and payments and revenue accounts, in respect of insurance business transacted by the insurer in respect of the shareholders funds. Insurers are required to maintain separate accounts relating to funds of shareholders and policyholders. The balance sheet, profit and loss accounts etc, are required to be audited by an auditor and be accompanied by a report on the affairs of the business during that period. Copies of these are to be submitted to the IRDA within 6 months. Every insurer transacting life insurance business has to get an actuarial investigation made into its financial conditions, including valuations of its liabilities. This has to be done every year. An abstract of the report of the actuary had to be submitted to the IRDA within nine months, in the prescribed form. The IRDA has the right to order a revaluation. Records have to be maintained of cover notes specifying name of party.
type of cover granted the amount of premium, policies issued, stating the policy number, dates of commencement and expiry of risk, names of the insured, premiums showing date of receipt, the amount and name of party from whom received, endorsements mentioning the policy number to which attached, dates of commencement and expiry of the endorsements, the type of endorsement and the additional premium charged or refund due and cross reference to premium register; bank guarantees and deposits giving particulars of the party, amount and conditions of guarantee or deposits and cross-reference to the relevant policy or policies; claims giving reference to policy number, loss or damage, details of settlement, recoveries from salvage, reinsurance ceded and accepted. But IRDA is not strict enough in imposing actuarial investigations with respect to health insurance business. This creates a sense that health insurance is not much regulated in India.

**Control on Investments**

Every insurer is required to invest his assets in accordance with the provisions of the Act. Not less than 25 percent of the assets have to be in Government securities, not less than 50% in Government or other approved securities and the balance in any of the approved investments. All the securities are to be held free of all encumbrances, charge, hypothecation or lien. The approved securities and investments are specified in the Act, the IRDA has the authority to make exceptions or to specify new investments. The approved investments are mostly shares and debentures of companies, which have a consistent record of making profits and paying dividends. Immovable property and loans and advances on hypothecation of property are approved. There are limits on the amounts that may be invested in banking companies or investment companies or any one company. The insurer is allowed to invest in an unapproved investment up to 15% of its funds. Loans or
temporary advances cannot be given to directors, managers, or officers, except as loans on policies held by them. Returns in the prescribed form are to be submitted to IRDA every quarter, showing changes in investments. At the end of the year a full statement of all investments as at 31st March has to be submitted. Any contravention of the provisions on investments would make every director manager or officer jointly and severally liable to make good losses apart from being subject to other penalties. In the context of health insurance, the insurers do not feel that the investment norms are very strict. This is one of the reasons that prevents a specialised health insurer to enter India. In USA, authorities of Blue Cross and Blue Shield plans are free to invest in equities market to any extent. This gives an advantage for the health insurance companies to modify the investment mix accordingly relevant to the financial scenario. Many times, such investment returns are capable enough to offset the underwriting losses. Similar situation does not exist in India, which needs proper consideration by IRDA.

Control on Management

The Act seeks to regulate the expenses of an insurer. Managers cannot be paid any remuneration by way of commission of bonus or share in surplus or share in profits. There are limits on the commission that may be aid to licensed agents, employed for the purpose of procuring business. Limits are prescribed for expenses of management. The percentages are prescribed in relation to the total premium income of the insurer. Officers of insurers have to be whole-time employees. Insurers are required to transact business from the rural areas and also among the unorganised sector and backward classes. The minimum business requirements from these sectors are prescribed by the IRDA. The IRDA has the authority to lay down the solvency margins in respect of the different kinds of businesses. The IRDA can
order an investigation into the affairs of any insurer five directions to an insurer in the 
public interest or to prevent actions detrimental to the interests of the policyholders, or 
to secure proper management. The IRDA can also appoint additional directors on the 
Boards of insurers or order the removal of managerial persons from office. The 
IRDA can also order the search of any office of the insurer and seize documents or 
books of accounts. There are of course, safeguards against the arbitrary use of these 
powers. In health insurance context, no specialised investigations are done by IRDA. 
Though IRDA is stipulating norms for expenses, expert quotes states that nearly 35% 
of health insurance premium goes towards expenses. Proper control over expense 
norms can help the public to avail health insurance premiums at cheaper costs.

Protecting Interests of Policyholders

The Act provides for nomination in the case of life insurance policies, making 
settlement of claims much simpler. It provides that life insurance policies cannot be 
called into question after two years on the ground of misstatements, unless the 
misstatements are on material information and that they were fraudulently made. 
Provisions exist for disputes being attended to by the IRDA or by the Ombudsmen.

Regulation by Courts of Law

The law courts, particularly consumer courts, have dealt with a variety of 
medical issues, like, medical negligence, hospital records, wrong diagnosis, Quackery 
(medical practice by un-qualified persons), medical ethics, hospital facilities, 
jurisdiction, etc. On health insurance, issues of delay and denial of claims have been 
dealt with.
Keeping in view the emerging trend of increased consumer activism in the country, it is reasonable to infer that the role courts of law in regulating medical professionals, medical practices and bio-medical environment, will become more pronounced in the coming years.

**Ombudsman Scheme**

The IRDA has also appointed ombudsmen. Their function is to resolve complaints in respect of disputes between policyholders and insurers in cost effective, efficient and impartial manner. The complaints to the ombudsman may relate to (a) partial or total repudiation of claims (b) any dispute regarding premium paid or payable in terms of the policy (c) any dispute on the legal construction of the policy relating to claims (d) delay in settlement of claims (e) non-issue of any insurance document to customers after receipt of premium.

The ombudsman is not a judicial authority. It will act as counsel and mediator in matters within its terms of reference. It has no right to summon witnesses. It has to make its decision on the basis of documents submitted to it. The complainant and the insurer are allowed to make personal submissions. But lawyers are not permitted to argue the case.

Complaints to the ombudsman lie only when the insurer has rejected the complaint or no reply was received within one month of the complaint or the reply was not satisfactory. A complaint can be made within one year after the insurer has rejected the representation. The subject matter should not be already before any court or consumers' forum or arbitration.
The ombudsman is expected to make a recommendation within one month from the date of receipt of complaint. If the complainant accepts this recommendation, the insurer has to comply within 15 days and inform the ombudsman accordingly. If the complainant does not accept the ombudsman’s recommendation, the ombudsman shall pass an award in writing, stating the amount awarded which shall not be in excess of what is necessary to cover the loss suffered by the complainant as a direct consequence of the insured peril or for an amount not exceeding Rs. 20,00,000, whichever is lower. The award has to be passed within 3 months. The complainant has to intimate his acceptance to the insurer and the insurer has to comply within 15 days and inform the ombudsman. If the complainant does not intimate acceptance, the award cannot be implemented.

Insurance Councils

Sections 64A to 64T of the Insurance Act, provide for the incorporation of the Insurance Association of India, in which all insurers operating in India are members. This Association will have two councils. The Life Insurance council will consist of members who carry on life insurance business in India and the General Insurance Council will consist of members who carry on general insurance business in India. Both these councils will have executive committees, which are required to aid, advise and assist the insurers, set up standards of conduct and sound practice, render advise to the IRDA with regard to controlling expenses and with regard to action against insurers acting in ways prejudicial to the interest of policyholders. The decisions of the council and the Executive Committees will have to be respected by the insurers.

Looking at the statutory factors and given the fact that health insurance is facing many problems, this research suggest that amendments can be made to make the statutory environment more insurer friendly.