MINISTRY OF FINANCE

CHAPTER V

United India Insurance Company Limited, The New India Assurance Company Limited, The Oriental Insurance Company Limited and National Insurance Company Limited

Health Services Insurance

Executive Summary

Insurance industry in India registered substantial growth after enactment of Insurance Regulatory Development Authority Act in 1999. This industry today functions in a highly competitive environment. The health services insurance is provided by 15 private insurance companies and four public sector undertakings viz., National Insurance Company Limited, The New India Assurance Company Limited, Oriental Insurance Company Limited and United India Insurance Company Limited. A performance audit of health insurance services by PSUs was conducted for the three years from 2006-07 to 2008-09. The performance audit revealed that:

- Proportion of premium from health insurance doubled from less than 10 per cent in 2004-05 to around 20 per cent in 2008-09. However, market share declined from 64 per cent in 2006-07 to 57 per cent in 2008-09.
- Four PSU insurers suffered a loss of Rs. 417 crore from individual portfolio, whereas group policies had contributed a loss of Rs. 622.49 crore during the three year period from 2006-07 to 2008-09. Despite these huge losses, it was seen in 115 out of 159 cases reviewed in audit that group policies were renewed without appropriate loading in violation of the rules for renewal of such policies. Further, the group policies with high incurred claim ratio included a corporate house that is itself in the business of providing health insurance.
- The PSU insurers did not attempt to reduce their losses by reducing the cost of medical services through standardization of rates and codes for various clinical procedures despite introduction of TPA Regulations nine years ago.
- The cashless settlement has been achieved to the extent of 55 per cent only and cases of delay in issue of ID cards, and claim settlement beyond 7 working days were noticed in respect of 72 per cent of the cases. There were wide variations in the amount of claims for similar clinical procedures. The PSU insurers failed to monitor the performance parameters resulting in deficiency in services of the third

party administrators to the insured with consequent impact on customer satisfaction.

Summary of recommendations

The PSU insurers may:

(i) Create a data bank on morbidity, claims, inflationary trend and age/gender/disease wise claim analysis to initiate a system to ensure charging of prescribed premium

(ii) Increase the volume of business to achieve break-even in the health portfolio.

(iii) Take initiative to standardise the terms and conditions of mediclaim policies to achieve the goal of portability.

(iv) Review and introduce a system of payment of service fee with suitable incentive/disincentive differentiating between group and individual policies.

(v) Develop a mechanism to evaluate the performance of TPAs on issue of identity cards, settlement of claims on cashless treatment/reimbursement;

(vi) Ensure that the policy conditions are embedded in the system with provision for audit and complied with by the TPAs while settling the claims;

(vii) Strive to achieve standardisation of the hospital charges and clinical procedures through negotiation with the service providers to contain cost.

(viii) Prescribe quantum of checks to be applied by Internal Audit to reduce the risk in the context of outsourcing of settlement of claims.

5.1.1 Introduction

Health insurance is an insurance coverage purchased in advance by an individual or a group after paying a fee called '*premium*'. It is a complimentary financing mechanism for enhancing access to quality health. Health insurance is one of the products offered by the general insurance companies as well as by life insurance companies in India. Health indicators of a nation are assessed through parameters like infant mortality, maternal mortality rate, life expectancy, birth and death rate. India recorded notable achievement in all the parameters since independence. The improvement achieved by India in various parameters *vis-à-vis* other Asian countries is depicted in the **Table 5.1** below:

Table 5.1

Sl. No	Parameter	India			China	Japan	Sri Lanka
		1991	2001	2006	2006		
1	Infant mortality rate (IMR) per 1,000 live births	80.0	66.0	54.0	32.0	3.0	15.0
2	Maternal mortality ratio (MMR) per 1,00,000 live births	437	407	254	56	10	92

3	Life expectancy at birth Male	59.7	62.4	63.9	70.6	78.9	72.2
	Female	60.9	63.4	66.9	74.2	86.1	77.7
4	Birth rate per 1,000	29.50	24.80	22.10	13.25	9.37	15.50
5	Death rate per 1,000	9.80	8.90	8.18	6.97	9.16	6.52

Source: Ministry of Health and Family Welfare - Eleventh five year plan documents (2007-2012)

It can be seen from the table that despite achievements India still was far behind the other Asian countries in health.

The Eleventh Plan observed that the cost of health care services in the country was higher in the private sector in comparison with the public sector. The Planning Commission estimated that the total health expenditure in the country was Rs. 1,05,734 crore in 2001-02 which was equivalent to 4.6 *per cent* of the Gross Domestic Product (GDP), of which the public sector expenditure was only 0.94 *per cent* of GDP. The households spent Rs. 76,094 crore out of their own savings and borrowings which accounted for 72 *per cent* of the total health expenditure of Rs. 1,05,734 crore. A study group appointed by the Ministry of Health and Family Welfare suggested (August 2005) to explore a risk pooling system with a view to reduce the burden of the poor.

5.1.2 Industry profile

Health insurance in India covered around 11 *per cent* of the population (August 2005) provided through voluntary (two *per cent*) and mandatory[1] (nine *per cent*) health insurance schemes. The voluntary health insurance schemes include various medi-claim policies issued by 19 general insurance companies which include two stand alone[2] health insurance companies and four public sector undertaking (PSU) insurers *viz.*, National Insurance Company Limited (NIC), The New India Assurance Company Limited (NIA), The Oriental Insurance Company Limited (OIC) and United India Insurance Company Limited (UIIC).

Gross health insurance premium earned by these insurance companies in India during the past five years is given below in **Table 5.2**:

Table 5.2 ***(Rs. in crore)***

Company	**2004-05**	**2005-06**	**2006-07**	**2007-08**	**2008-09**
NIC	364.07	398.86	466.75	669.92	801.88
NIA	455.39	590.83	748.42	1139.29	1337.67
OIC	249.62	334.00	427.61	508.37	703.26
UIIC	252.08	310.73	393.62	562.43	853.20
PSU Total	**1321.16**	**1634.42**	**2036.40**	**2880.01**	**3696.01**
Private sector	NA	NA	1165.53	1855.56	2801.42
Market share -PSU	NA	NA	64	61	57
Market share-Private Sector	NA	NA	36	39	43

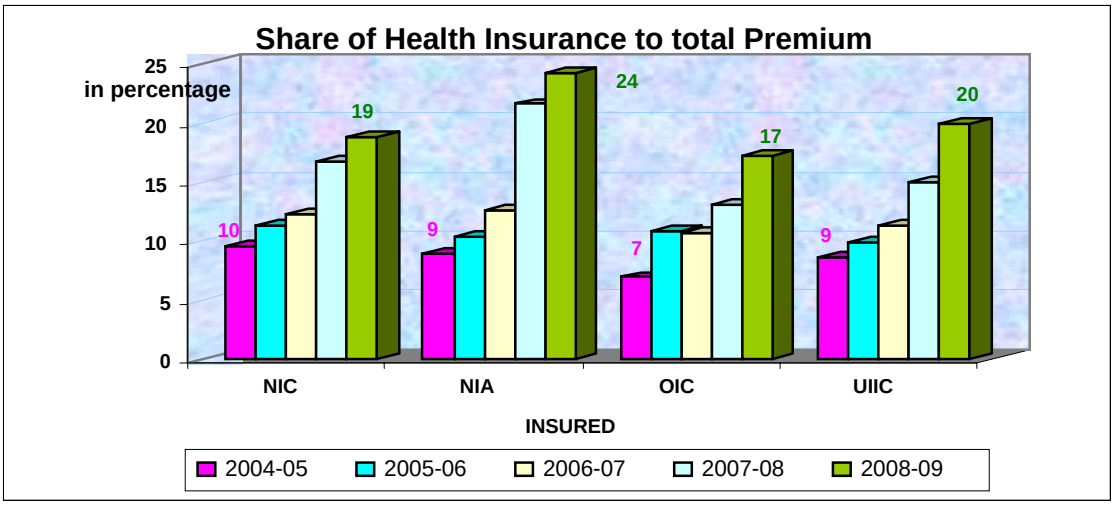
NA-Not Available

[1] ***Mandatory health insurance includes Employee State Insurance Scheme, Central Government Health Scheme, Ex-servicemen Contributory Health Scheme***

[2] ***Star Health and Allied Insurance Company Limited and Apollo DKV Insurance Company Limited, offering Health services insurance only.***

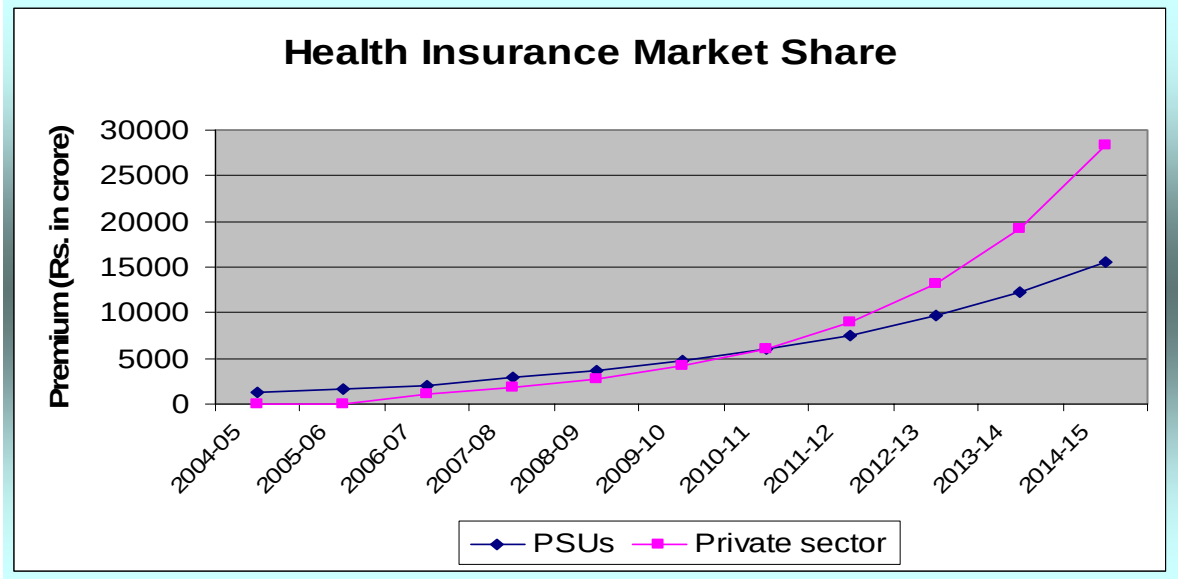
The premium earned by the PSU insurers from the health insurance ranged between 7 and 10 *per cent* in 2004-05 of the Gross Direct Premium (GDP) of the PSU insurers and increased during last five years and ranged between 17 and 24 *per cent* in 2008-09 as given in the **Chart 5.1** below:

Chart 5.1



The health insurance is the most sought after portfolio next to motor insurance. The market share of PSU insurers in health insurance decreased from 64 *per cent* in 2006-07 to 57 *per cent* in 2008-09. The average annual premium growth in private sector was 47 *per cent* as against the PSU insurers' growth rate of 27 *per cent* for the period 2006-07 to 2008-09 which indicates growing presence of private insurance in India as shown in **Chart 5.2**:

Chart 5.2



Source: ***Projections are based on present annual average premium growth rate of PSU and Private insurers***

The incurred claims[3]and incurred claim ratio (ICR) for the PSU and private insurers during 2004-05 to 2008-09 was as given in **Table 5.3**:

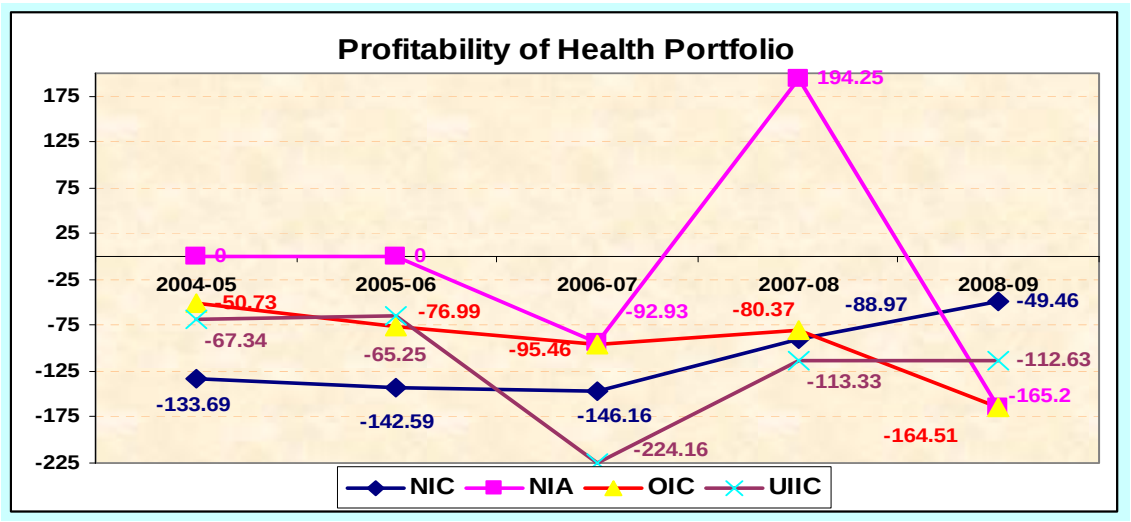
Table 5.3 ***(Rs in crore)***

COMPANY	2004-05	2005-06	2006-07	2007-08	2008-09
NIC	491.54 (135.01)	513.37 (128.71)	550.57 (117.96)	676.62 (101)	729.71 (91)
NIA	489.82 (107.56)	703.74 (119.11)	741.08 (99.02)	932.01 (81.82)	1271.89 (99.10)
OIC	294.05 (117.80)	400.96 (120.05)	526.14 (123.04)	557.31 (109.63)	771.03 (109.64)
UIIC	344.05 (136.48)	361.02 (116.19)	471.61 (119.82)	610.40 (108.53)	994.05 (110.00)
PSU Total	**3121.61**	**3494.03**	**3828.560**	**4374.36**	**5355.94**
Private –total	NA	NA	1205.39	1759.86	NA
ICR- PSU (%)	122.58	121.09	112.42	96.40	85.34
ICR–Private (%)	NA	NA	*103.42*	*94.84*	*85.33*

(figures in brackets represent ICR percentage) ***NA-Not available***

OIC revised the premium upwards in September 2006 and other three PSU insurers revised the premium during 2007. From the Table 5.3 it is evident that the incurred claim ratio (ICR) of the PSU insurers during 2004-05 to 2008-09 remained above 100 *per cent*, except for NIA during 2006-07 to 2008-09 and NIC in 2008-09. The Profit (+)/loss (-) as reported by the PSU insurers in their accounts for health portfolio after netting the commission paid and re-insurance recoveries from the General Insurance Corporation of India (GIC) towards obligatory cession were as given in **Chart 5.3**:

Chart 5.3



[3] ***Claims paid + claims outstanding at the year end – claims outstanding at the beginning of the year.***

From the above, it may be seen that all PSU insurers incurred losses in almost all the years except NIA which earned profit of Rs. 194.25 crore in 2007-08.

Audit further observed actual losses of PSU insurers were much more than what is shown above as the PSU insurers except NIA did not provide the data of actual losses after accounting for operating expenses and allocated investment income. In case of NIA, the actual loss after consideration of the operating expenses and allocated investment income amounted to Rs. 210.71 crore, net profit of Rs. 99.34 crore and net loss of Rs. 355.30 crore during the three years 2006-07, 2007-08 and 2008-09 respectively.

5.2 Scope of audit

The analysis of the data on the financial performance of the PSU insurers was conducted for five years from 2004-05 to 2008-09. However, the Performance Audit (PA) focused on the performance of Health portfolio of the four PSU insurers, NIC, NIA, OIC and UIIC over the past three years from 2006-07 to 2008-09 due to large volume of the transactions involved. The study covered individual and Tailor-Made Group mediclaim Policies[4] (TMGP) issued in India directly and serviced by Third Party Administrators[5] (TPA) except Overseas Mediclaim Policies and policies sponsored by Central/State Governments.

5.3 Audit objectives

The audit objectives were to examine and assess the effectiveness of the system established by the PSU insurers for:

- fixation of the premium rates to ensure profitability of the porfolio;
- adequacy of controls and criteria used in underwriting;
- assessing whether the TPAs contribute to the effective administration of the health portfolio; and
- adherence to the Insurance Regulatory and Development Authority norms/guidelines and circulars issued by respective PSU insurers.

5.4 Audit criteria

Following criteria were used for assessing/evaluating the achievement of the audit objectives:

- Premium rates, underwriting guidelines, various policies issued by the PSU insurers, policy conditions;
- Manuals and guidelines of the companies on health insurance;
- MoUs, Service Level Agreements entered into by the PSU insurers with TPAs; and
- Regulations, guidelines and circulars issued by the Insurance Regulatory and Development Authority and circulars issued by the PSU insurers.

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[4] A set of administrative conditions and claim procedures for various group plans.

[5] Third Party Administrator is one licensed by the IRDA, and is engaged, for a fee or remuneration as may be specified in the agreement with an insurance company, for the provision of health services.

5.5 Audit Methodology

The performance audit was conducted during June-September 2009. Records and compilation of data relating to health policies underwritten by the selected units including the data provided by the TPAs were examined focusing on computation of rates, underwriting of policies, role of TPAs, control mechanism to monitor the activities of the TPAs and claim settlement by them. Sampling techniques adopted for selection of units and data analysis are given in ***Annexure X***. Entry conferences were held with the respective Managements of the four PSU insurers in July 2009. Exit conference with Oriental Insurance Company Limited was held in December 2009 and with other three PSU insurers in January 2010.

5.6 Acknowledgement

Audit acknowledges the active cooperation and assistance provided by four PSU Insurers at all levels of the Management.

5.7 Audit findings

Audit observed deficiencies in underwriting, selection and appointment of TPAs, their performance and claim settlement. The insurers need to address these deficiencies to improve the quality of service in view of competition from the private sector. These deficiencies are discussed in the succeeding paragraphs.

5.7.1 Underwriting

5.7.1.1 Fixation of Premium

The PSU insurers had adopted mediclaim policies designed by the GIC till 2002, the then holding company. The health insurance was not under the tariff regime and companies were free to fix their premium duly approved by IRDA. Consequent to introduction of TPAs, the PSU insurers revised (2002) the premium rates taking into account service fee payable to TPAs. Health portfolio premium was revised upwards by OIC during September 2006 and by other three PSU insurers during 2007. A scrutiny of the data relating to average premium collected and average claim paid per life indicates deficits in the premium collection as given in **Table 5.4** below:

Table 5.4 **(Rs. in thousands)**

Company	Average	2004-05	2005-06	2006-07	2007-08	2008-09
NIC	Premium	0.48	1.35	0.85	1.21	1.23
	Claim	0.65	1.74	1.01	1.22	1.12
NIA	Premium	1.26	1.03	1.20	1.33	2.24
	Claim	1.35	1.23	1.19	1.09	2.22
OIC	Premium	0.87	1.04	1.38	1.55	2.06
	Claim	1.03	1.25	1.70	1.70	2.26
UIIC	Premium	2.75	1.25	1.25	1.42	1.61
	Claim	3.75	1.45	1.50	1.55	1.88

PSU insurers reported loss in the health portfolio from the next year of premium revision in 2006 and 2007. There was no policy for assessing risk while underwriting business and there was no system to review the portfolio periodically and compare the price of similar products in the private sector. The PSU insurers did not collect vital data on morbidity[6], claims settled disease-wise, age-wise, gender-wise analysis and inflationary trend. The risk cost[7] or the burning cost[8] of the policies for assessing the risk to be underwritten was also not worked out. The Committee on Public Undertakings (COPU), in their Eleventh Report on Health insurance submitted to the Fourteenth Lok Sabha, observed (March 2006) that lack of adequate data on morbidity, demographic groups and diseases was a major hindrance in formulating and designing new products in health insurance and this affected the development and progress of health insurance in the country.

The consultants engaged by the UIIC for importing best business practices of the world to meet customer expectations and detailed strategic initiatives on the key issues of health product development and pricing reported (April 2008) that:

- ✓ pricing of products was primarily based on what competition was offering;
- ✓ except age, no other factor was considered to assess the rating; and
- ✓ no profitability analysis was done.

NIA agreed (December 2009) to frame a policy for assessing risk and take necessary action shortly. OIC agreed (December 2009) that exhaustive data was not available at the time of revision of premium during 2006 and assured to consider the inflationary aspect. UIIC stated (December 2009) that age-wise premium and claim data were collected while reviewing the premium in 2007, but lack of adequate data on morbidity, demographic groups and diseases was a major hindrance in formulating and designing new products in health insurance.

5.7.1.2 Targets

The PSU insurers, except OIC, had not fixed target for health department till 2008-09. NIA fixed targets from 2009-10 and specified a performance matrix for reduction of 10 *per cent* in cost per claim through empanelled TPA. Fixing targets for different products based on profitability would improve performance of the portfolio.

5.7.1.3 Individual and Group policies

The individual mediclaim policies cover hospitalisation expenditure with a minimum stay exceeding 24 hours, with exclusions such as 30 days pre-hospitalisation, pre-existing diseases for three/five years, lock-in period for certain diseases, maternity benefits, day one baby care. Group Policies are issued in respect of group of persons. Tailor made Group Policies (TMGPs) are issued to corporate house employees and their families covering pre-existing diseases, maternity and baby day one care, family floater[9] and corporate buffer.[10] These benefits are extended at the option of the insured by suitably

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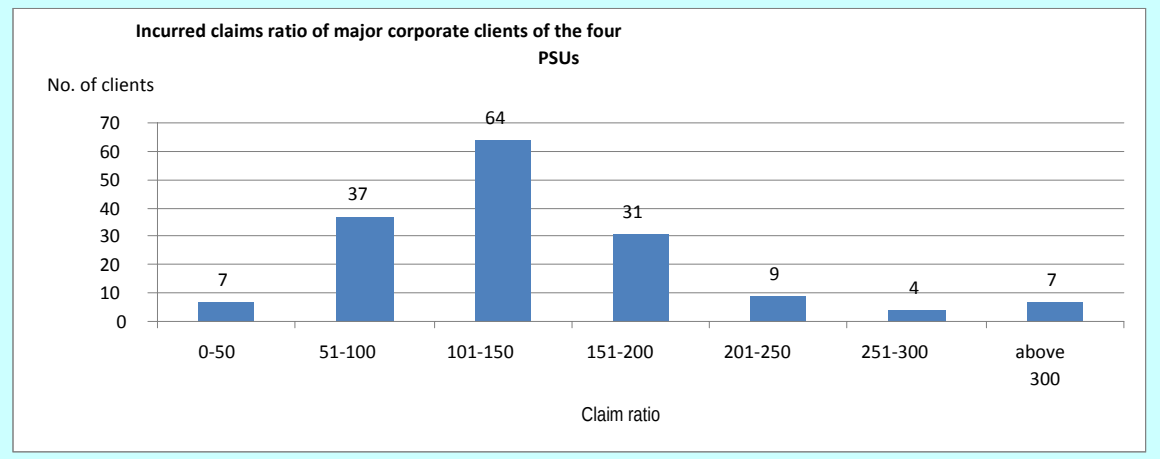
[6] ***Morbidity is the percentage of people in a population that gets sick of a particular disease.***
[7] ***Risk cost-the incurred claims related to the premium for each risk***
[8] ***The premium needed to cover losses based on historical experience for a proposed re-insurance agreement.***
[9] ***the sum insured floats among the family members.***
[10] ***to avail benefit over and above sum insured.***

loading the premium at specified rates. Further, in case of adverse claim ratio in the previous years, appropriate loading at the prescribed rates is made at the time of renewal to contain losses.

Audit observed that the four PSU insurers suffered a loss of Rs. 417 crore from individual portfolio, whereas group policies had contributed a loss of Rs. 622.49 crore during the three year period from 2006-07 to 2008-09 indicating that additional benefits of maternity, baby day one care, pre-existing diseases available only to TMGP were augmenting the loss as discussed in subsequent paragraphs. The TMGPs contributed loss even during the year 2007-08 when premium rates were revised. The premium rates charged for both the TMGPs and individual policy holders were the same, though the former were extended additional benefits.

To see the trend of ICR and loading on renewal a test check of top five corporate clients of each selected RO was made which revealed that PSU insurers had incurred a loss of Rs. 227.19 crore during the three year period 2006-07 to 2008-09 in 115 cases out of the 159 cases test checked. A graphical representation of the ICR is given in **Chart 5.4** below:

Chart 5.4



In 72 *per cent* of the cases test checked the ICR was more than 100 *per cent* with highest claim ratio of 433 *per cent.* A list of these corporate clients is placed at ***Annexure XI***. A scrutiny of these cases revealed that in spite of repeated high adverse claim ratio, TMGPs were renewed without appropriate loading in violation of the PSU insurers' rules for renewal of such policies. Further, the list included a corporate house that is itself in the business of providing health insurance.

Audit also noted that even after high adverse claim ratio, no mechanism was developed to monitor these TMGPs to ensure compliance of loading instructions to contain losses.

Prior approval of the competent authority at Head Office (HO) was required before issue of TMGP. No records were maintained at HO of PSU insurers in respect of these approvals. On a test check of 354 selected cases at ROs it was observed that approvals were delayed or not obtained in 297 cases of TMGP. In 36 cases, approval was taken after the currency of the policy periods and in 261 cases (NIC-73, NIA-71, UIIC-117)

there was no recorded approval. The UIIC in their exit conference stated that such approvals were given over telephone and subsequently through e-mail.

IRDA guidelines prohibit the formation of group with the main purpose of availing insurance. A multi-level agency[11] issued an advertisement inviting membership for the group with the sole purpose of availing insurance. NIA Mumbai DO issued group policies to this multi-level agency in April 2007 and renewed it in April 2008 and incurred total loss of Rs. 7.28 crore during this period. DO also paid a total of Rs. 51 lakh as commission for procuring this business. As it was in violation of IRDA guidelines the HO advised (May 2008) the DO subsequently, on receiving a complaint, to cancel the policy which was not complied with. NIA stated (August 2009) that disciplinary action was initiated against the erring official for not canceling the policy and renewing it without approval. This indicated lack of control at HO level over the issue of TMGPs.

5.7.1.4 Loading

The PSU insurers collect the basic premium approved by IRDA and additional premium called '*malus'* considering the ICR of previous three expired policy periods as per guideline. The premium is further loaded[12] under TMGP at a fixed percentage for other criteria such as coverage of pre-existing diseases, maternity benefit, 30 days waiting period and lock-in period of one year for certain specified diseases, *viz.*, cataract, hernia and other ailments. The PSU insurers, except NIC, did not examine the data on premium and claim in respect of such additional benefits. NIC collected additional premium of Rs. 150 crore but the claim outgo for the period 2006-07 to 2008-09 was Rs. 171.20 crore. It was also seen that the PSU insurers continued to extend the benefit to corporate clients despite losses. The operating offices did not comply with the guidelines on basic premium and malus resulting in loss of premium of Rs. 329.68 crore for three years ended 31 March 2009 as given in ***Annexure XII***. The consultants engaged by UIIC also reported (April 2008) that loading factor for dependents was adopted as a percentage on premium without considering the age and other factors especially in group mediclaim policies.

UIIC stated (December 2009) that the general guidelines on malus and loading for other criteria like exclusion of pre-existing diseases clause and inclusion of maternity benefit at fixed percentages were for the guidance of the operating offices and contended that for major policies these guidelines were not applicable. UIIC further stated (January 2010) that the premium of TMGP was being charged based on the individual claim experience and other business from the client as a whole. The UIIC's guidelines to operating offices did not provide for exemptions for any of the policies and there was no classification like major policy. The underwriting guidelines approved by the Board of Directors of the PSU insurer and filed with the IRDA also prescribed that there should not be any cross subsidy between different products.

In another case, Mumbai RO of NIA issued TMGPs to Life Insurance Corporation of India for the period 2006-07 to 2009-10 and suffered a loss of Rs. 48.81 crore due to high ICR (146 *per cent*). In spite of this, the RO failed to load the premium adequately during

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[11] ***Network of agents selling various products who are not covered by IRDA's definition of a Group.***

[12] ***The amount included in the premiums to meet liabilities beyond anticipated claims payments to provide administrative costs and contributions to reserve funds and to cover contingencies such as unexpected loss or adverse fluctuation.***

the renewal for 2008-09, resulting in short collection of premium amounting to Rs. 11.89 crore. NIA agreed (December 2009) that there was no provision in their system to generate a report for the cost and additional benefits provided to the groups and was considering installing such provision shortly.

OIC stated (December 2009) that, henceforth underwriting of TMGPs would be centralised at HO level.

The PSU insurers in reply to a question by the COPU (March 2006) as to whether the existing health policies cover maternity and out patient care for individual policy holders stated that this facility was not extended to them because the cover would be expensive and unaffordable for the public at large.

On a test check of selected TMGPs issued during the period 2006-07 to 2008-09 by the NIC, Bengaluru RO it was, however, observed that insurance cover for maternity and out patient care was extended to corporate clients as detailed in **Table 5.5** below:

Table 5.5 ***(Rs. in crore)***

Facility	No. of corporates involved	Premium loaded	Claims paid	Deficit
Maternity	5	1.90.	4.79	2.89
Family floater	4	2.94	16.92	13.98
Corporate buffer	2	0.04	0.23	0.19
Total		**4.88**	**21.94**	**17.06**

Thus, NIC extended these additional benefits to eleven corporate clients and incurred a loss of Rs. 17.06 crore.

Recommendation No. 5.1

The PSU insurers may:

(i) create a data bank on morbidity, claims, inflationary trend and age/gender/disease wise claim analysis to initiate a system to ensure charging of prescribed premium; and

(ii) ***increase the volume of business to achieve break-even in the health portfolio.***

5.7.2 Domiciliary hospitalisation benefits

Mumbai RO of NIA issued a policy to Tata Consultancy Services Limited covering 81,491, 1,05,303 and 1,22,886 employees during 2006-07, 2007-08 and 2008-09 respectively, which included reimbursement of domiciliary hospitalisation[13] expenses up to Rs. 5,000 per employee. Audit observed that the reimbursement towards domiciliary hospitalisation for the years 2006-07 to 2008-09 amounted to Rs. 71.64 crore as against the premium of Rs. 11.74 crore and, thus, resulted in a total loss of Rs. 68.03 crore

[13] ***Domiciliary Hospitalisation is a state where a person/patient is unwell that he/she requires medical attention at home itself because he/she is not in a position to go to the hospital or there is no Place in the Hospital. Upon Doctor's Certification stating the patient's position, the Patient becomes eligible for a claim under Mediclaim for Treatment at home.***

including loss of Rs. 59.90 crore on account of domiciliary claim outgo during the three years ended March 2009.

5.7.3 Product variety

The COPU in their Eleventh Report submitted to the Fourteenth Lok Sabha expressed (March 2006) concern over lack of product variety to meet the specific health requirements of various strata of population such as aged, youth, pre-existing diseases. The COPU desired that in addition to the existing range of standard health insurance schemes, the Government and PSU insurers should introduce a host of flexible and client oriented health insurance schemes such as long term health insurance products, maternity and out-patient covers, schemes for widows, physically handicapped. The Government in their reply stated (September 2006) that the companies were alive to the need for long-term health insurance products with coverage starting at a younger age, products covering critical illnesses and special schemes for the vulnerable sections.

Some of the State Governments have since introduced health care schemes to cover Below Poverty Line families. NIC covered critical illness through *Varishta mediclaim* for Senior citizens and Parivar mediclaim policy for family. UIIC introduced family floater policy, top-up and super top-up policies during 2008-09 and critical illness policy, available only for corporate bodies having more than 100 employees. NIA replied (December 2009) that they would consider launching a separate product for critical illness.

None of the PSU insurers have however brought out any scheme covering widows and physically and mentally challenged persons or policies coverings AIDS, organ transplant or for the benefit of vulnerable sections of the society.

5.7.4 Portability

Present healthcare policies prohibit an insured from availing the benefits of a product continuously if the insured migrates from insurance scheme of one insurer to another, while such facilities are available for motor vehicle insurance policies. As a pre-requisite, the benefits of cover should be standardised across the insurers. IRDA in consultation with General Insurance Council initiated (March 2008) a move to bring such portability of health policies, but PSU insurers have not introduced the same so far (December 2009).

Recommendation No. 5.2

The PSU insurers may take initiative to standardise the terms and conditions of mediclaim policies to achieve the goal of portability.

5.7.5 Third Party Administrators

5.7.5.1 Introduction of Third Party Administrators

The Insurance Regulatory and Development Authority (Third Party Administrators-Health Services) Regulations, 2001 promulgated in September 2001 introduced Third Party Administrators **(**TPAs) in the health insurance business. Main objectives of introduction of the TPAs were to ensure higher efficiency, standardisation, cashless health care services to the policy holders and increasing penetration of health insurance in

the country. The TPAs are licensed by the IRDA to act as intermediaries between insurance companies and insured for servicing healthcare policies. There were twenty-seven TPAs as of 31 March 2009. The salient features of the TPA Regulations 2001 are given in **Box 1:**

Box 1

- *Minimum paid up capital should be Rs. one crore.*
- *To carry on business in India as a TPA in health services and should not engage itself in any other business.*
- *At least one of the Directors of the TPA should be a medical doctor registered with the Medical Council of India.*
- *More than one TPA may be engaged by an insurance company and a TPA can serve more than one insurance company.*
- *There should be an agreement between the TPA and the insurance company.*
- *TPA may also agree on the fee payable by the insurance company.*

5.7.5.2 Selection of TPAs

The Government of India advised (July 2002) PSU insurers to appoint TPAs to meet their requirements and finalise service level agreement (SLA) with not more than five TPAs for each company with a maximum of two TPAs per zone for enabling the TPAs to make a long term commitment by investing in infrastructure development. The PSU insurers, however, had entered into (NIC-19, NIA-18, OIC-18 and UIIC-16) SLA with more than five TPAs as of March 2009.

UIIC stated (December 2009) that the decision of engaging not more than five TPAs by each company was an industry decision and not a Government directive. OIC stated (December 2009) that they were making serious efforts to bring down the number of TPAs to a maximum of 10 during 2010.

The reply is not acceptable as GOI directed the PSU insurers to conclude SLA with five TPAs only.

5.7.5.3 Payment of service fee to TPAs

The General Insurers' (Public Sector) Association of India (GIPSA) after negotiation with TPAs communicated (July 2002) the fees payable to TPAs for the service rendered as detailed below:

- for North and South zone at 5.5 *per cent* and East and West zone at 5.4 *per cent* of net premium; and
- an incentive of 10 to 20 *per cent* of the amount by which the incurred claim was reduced against last financial year for a range of ICR 60 to 90 *per cent* and 30 to 60 *per cent* respectively.

The PSU Insurers did not maintain TPA wise premium underwritten and the service fees paid to each of them. UIIC started (September 2009) capturing the data in their system while OIC admitted that no such data was available with them in this regard. In its absence the capability of undertaking work by the TPAs could not be assessed.

The health premium underwritten by PSU insurers rose from Rs. 990 crore in 2002-03 to Rs. 3,696 crore in 2008-09, an increase of 273 *per cent* over the period. Similarly the

number of licensed TPAs increased from 13 in March 2002 to 27 in March 2009. The GIPSA/PSU insurers, except NIA, did not initiate steps to obtain competitive quotes from the TPAs to reduce the cost. By calling for quotations, NIA fixed (May 2009) the service charges at Rs. 75 per life in respect of individual mediclaim policies and at the rate of 4.5 *per cent* on premium for TMGP. NIA expected to save more than Rs. 25 crore by reduction in TPA charges in the current fiscal. In the above context, there is a need for review of service fee in the industry.

UIIC stated (December 2009) that their endeavour was to enhance the quality of service rendered by the TPAs and they were in the process of revising the SLA requiring them to deliver better service thereby getting better value for the fees paid to them.

5.7.5.4 Payment of service fee on malus

The TPAs were required to bring down the claim ratio to less than 70 *per cent* as per SLA. The PSU insurers, however, collect additional premium while renewing the TMGPs, to mitigate the loss arising out of adverse claims ratio. The service fee to the TPAs was, however, paid on the gross premium which includes malus loading. A test check of such service fee paid by two ROs of UIIC amounted to Rs. 3.12 crore in respect of malus loading in 95 cases for the period from 2006-07 to 2008-09. Thus, additional premium was discounted towards the payment of service fee. Hence, there is a need to devise a mechanism in the SLA restricting the service fee on premium excluding malus loadings so as to act as the disincentive for higher claim ratio.

UIIC replied (December 2009) that extension of this logic would result in payment of service charges on the gross premium in case discounts were allowed.

The reply is not tenable as the discount would be based on the claim experience or risk perception of the client and it was the prerogative of the PSU insurers to extend discount to the clients.

Recommendation No. 5.3

The PSU insurers may review and introduce a system of payment of service fee with suitable incentive/disincentive differentiating between group and individual policies.

5.7.5.5 Engagement of a TPA by the insured

Bangalore RO of UIIC issued a group mediclaim policy for 2008-09 covering the employees of IBM India Private Limited (IBM) with a rebate of 5.5 *per cent* on the basic premium for not availing TPA services. IBM, however, entered into a separate agreement to engage a licensed TPA by paying Rs. 75 per life for servicing their employees. Instead of paying the claims settlement amount directly to IBM, UIIC passed payments through TPA engaged by IBM (including service charge of TPA). The agreement between IBM and TPA was against the provisions of Regulation 2(e) of the IRDA, which states that TPAs licensed by IRDA could enter into an agreement only with insurance company(s), for provision of health services. The engagement of TPA by the insured was associated with the risk of leakage of vulnerable business data/information against the interest of the PSU insurers.

UIIC's response was awaited (December 2009).

5.7.6 Service Level Agreement (SLA)

The companies entered into identical SLA with each of the TPAs and the salient features are detailed in the following **Box 2**.

Box 2

- *Enrolment of members.*
- *Provide 24x7 hour call service help to the members.*
- *Issue Identity Card to the members.*
- *Enter agreements with network hospitals.*
- *Settle the claims of the hospitals and reimburse claims to members.*
- *Provide data to insurers for appropriate underwriting and premium fixation.*
- *Provide data for standardisation of rates and cost control to the insurer.*
- *Provide the insurer schedule /rates of charges, of the network hospitals.*
- *Ensure facility of cashless treatment/reimbursement to all the members.*
- *Introduce diagnosis codes and procedure codes in a phased manner in association with the network hoispitals within a period of one year from the date of agreement.*
- *Provide the data to the insurer for actuarial pricing and product development like age group wise/disease wise, number of persons covered, number of claims made, average amount per claim, average stay in hospital, average cost per day.*

5.7.6.1 Performance of TPAs

TPAs are the interface between the insured and the insurer. The delivery of service by them in respect of turn around time for issue of Identity cards (ID cards), reimbursement is to improve the ultimate customer satisfaction. In terms of the SLA the TPAs have to issue the identity (ID) cards, facilitate cashless treatment and reimburse the claim within seven working days. A scrutiny of records at the selected operating offices revealed following deficiencies:

- There were delays in issue of ID cards in respect of all PSU insurers beyond seven working days in 13.39 lakh cases (72 *per cent)* out of 18.62 lakh cases.
- One of the objectives of introduction of TPAs was to facilitate cashless treatment/speedy settlement of the claims. It was, however, observed from the data furnished by the PSU insurers in respect of selected ROs that the TPAs could not settle on an average 45 *per cent* of the claims through cashless treatment defeating one of the purposes of introduction of TPAs to the industry.
- The details of group/individual wise cashless settlement data were not made available and in its absence the satisfaction level/ interface of individuals with TPA could not be assessed.
- TPAs were required to settle all eligible claims (other than cashless facilities) of the insured within seven working days of receipt. Delays were, however, noticed in 4,96,675 cases out of 7,16,726 cases (69 *per cent*), which indicate PSU insurers' failure in implementing the conditions of the SLA entered into with the TPAs.

NIA replied (December 2009) that they had already implemented evaluation and empanelment process for TPA restricting the number to ten on the basis of performance

parameters like percentage of settlement of cashless claims, number of networked hospitals. They further stated that they were streamlining the system of furnishing underwriting details by the operating offices to cut delays in issue of ID cards.

5.7.6.2 Excess settlement of claims by TPAs

PSU insurers had prescribed caps for various ailments. Some of the cases of the claims settled by TPAs during to 2006-07 to 2008-09 are given below:

a) OIC, NIC and NIA revised the terms of individual and group mediclaim policies with effect from September 2006, April 2007 and August 2007 respectively to restrict the payment of room rent at one *per cent* of sum insured subject to a maximum of Rs. 5,000 per day and at two *per cent* of the sum insured if admitted to Intensive Care Unit. NIC put an overall cap of 25 *per cent* of the sum insured per illness under this head. Cap on room rent was introduced in UIIC only from April 2009. These conditions were, however, not enforced by TPAs in 25,856 cases out of 2,13,404 cases in selected ROs resulting in excess payment of Rs. 8.43 crore (NIC-Rs. 18.07 lakh, NIA-Rs. 632.14 lakh and OIC-Rs. 192.62 lakh).

b) Chennai and Bangalore ROs of NIC did not observe the policy conditions such as cap on illness, corporate buffer, specialist fee, X-ray, dialysis fee leading to excess payment of Rs. 97.60 lakh in 443 cases out of 12,476 cases.

c) TMGPs issued by PSU insurers had a clause restricting the payment of claim for maternity. The TPAs had, however, not enforced the cap in 1,353 cases out of 1,80,328 cases, resulting in excess payment of Rs. 1.36 crore (NIC Rs. 8.59 lakh, NIA Rs. 123.57 lakh, OIC Rs. 2.05 lakh and UIIC Rs. 1.59 lakh).

d) The TPAs did not enforce special conditions regarding ceilings in 1,182 out of 10,981 cataract claim cases settled in Chennai and Bangaluru ROs of NIC and UIIC resulting in excess settlement of claims by Rs. 1.19 crore (NIC Rs. 1.25 lakh and UIIC Rs. 117.88 lakh).

e) While settling appendicitis and hernia claims of ROs of NIC and UIIC at Chennai and Bangalore, the TPAs did not enforce caps in 162 out of 4,827 cases resulting in excess payment of Rs. 41.84 lakh (NIC Rs. 1.42 lakh and UIIC Rs. 40.42 lakh).

f) While settling the claims in respect of UIIC of Chennai and Bangalore ROs, the claims were not limited to the sum insured by TPAs resulting in excess payment of Rs. 2.34 crore (1,470 cases out of 85,472 cases).

Non provision of various caps/ceilings in the IT Systems used by the TPAs resulted in excess payment of Rs. 14.71 crore.

NIA stated (December 2009) that many of the TPAs had already embedded caps, conditions and such other limits in their IT systems and had initiated remedial action to recover the excess payment.

5.7.6.3 Standardisation of rates and clinical protocol[14]

As per SLA the TPAs should strive to introduce the diagnostic and procedure codes in the billing service in a phased manner within a period of one year from the date of entering into the agreement. It was, however, observed that the TPAs had neither initiated any step towards standardisation of various clinical procedures nor produced the database to the PSU insurers to analyse variation in the rates charged by different hospitals. An analysis of the data for the period 2006-07 to 2008-09 indicated the following:

- the claim paid by the TPAs varied widely for the same disease for the same period; and
- the TPAs failed to bring about standardisation with the result the hospitals were claiming widely different rates for the same disease during same period and the PSU insurers were forced to accept the rates settled by the TPAs. Illustrative cases of claims paid in respect of select two diseases are given in ***Annexure XIII***.

NIA stated (December 2009) that the industry portfolio of around Rs. 6,000 crore as against the total spending on patient treatment of approximately Rs. 70,000 crore put them in an disadvantageous position in any negotiation with the health care providers. They further stated that as an initial measure they were formulating a policy with specified caps on a number of procedures and filing the product with IRDA.

The reply is not acceptable as the introduction of new product with caps would not be a substitute to the standardisation. The standardisation of rates and clinical procedures through negotiation is essential to contain cost and make the portfolio profitable.

OIC stated (December 2009) that exercise for standardisation of rates had since been initiated and all the PSUs were making joint efforts in this regard.

The COPU in their eleventh Report on health insurance to the Fourteenth Lok Sabha desired (March 2006) that adequate steps be taken for evolving comprehensive and stringent regulatory framework to prevent unregulated mushrooming of health service, undependable and deteriorating quality of health care and rampant instances of under-treatment and over-treatment by doctors and hospitals/nursing homes. The COPU recommended: (i) mandatory registration of hospitals; (ii) standard clinical protocol; and (iii) standardised and graded pricing for medical procedures with a provision to bring violations under criminal offences. The Government in their reply (September 2006) to the COPU stated that they were considering to bring a bill *viz.* Clinical Establishments (Registration and Regulation) Bill for compulsory registration of various healthcare service providers. Though the Bill was introduced in 2007, it was yet to be passed by Parliament (December 2009).

Recommendation No. 5.4

The PSU insurers may:

(i) develop a mechanism to evaluate the performance of TPAs on issue of identity cards, settlement of claims on cashless treatment/reimbursement;

[14] ***A medical guideline (also called a clinical guideline, clinical protocol or clinical practice guideline) is a document with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare.***

(ii) ensure that the policy conditions are embedded in the system with provision for audit and complied with by the TPAs while settling the claims;

(iii) strive to achieve standardisation of the hospital charges and clinical procedures through negotiation with the service providers to contain cost.

5.7.7 Float fund

The Star Health and Allied Insurance Company Limited (Star Health) issued in June 2008 a policy covering employees (7,68,432) of the Government of Tamil Nadu and their families for a period of four years. The maximum claim for hospitalisation per family for the four years would be Rs. two lakh on floater basis. The premium was worked out at the rate of Rs. 495 per employee per annum. All the four PSU insurers participated in the above policy as a co-insurer taking 15 *per cent* each. In terms of the Memorandum of Understanding (MOU) with the Star Health, the PSU insurers paid Rs. 50.00 lakh each towards float fund for meeting the claims. As per provisions of the PSU insurers' Manual, the lead insurer should advise the co-insurers immediately after payment of claim for reimbursement of the same which has to be settled within 30 days. Thus, the payment of float fund to the lead insurer was not justified. The PSU insurers had so far (June 2009) received a premium of Rs. 8.41 crore and incurred a claim of Rs. 13.31 crore each for 2008-09.

In another case OIC provided a float fund to the TPAs for settlement of claims before introduction of single window system (November 2008) which remained unadjusted to the extent of Rs. 5.86 crore as on 31 March 2009. This was an undue advantage to TPAs besides loss of income from investment to OIC. OIC assured (December 2009) that adjustment of the float fund would be sorted out by March 2010.

5.7.8 Internal Audit

The TPAs were required to return the paid vouchers to the operating offices in terms of provisions of the SLA. It was, however, noticed that the vouchers were not received back in the ROs. The Internal audit in NIC and UIIC test checked the claim records randomly and in OIC no internal audit had taken place. In NIA only five *per cent* vouchers were checked. Though, the health portfolio is a major segment, the PSU insurers had not specified quantum of checks to be exercised especially in the context of outsourcing of the services to TPA.

NIA stated (December 2009) that they were examining the option of outsourcing the audit of the claim settlements. OIC assured (December 2009) to undertake at least five *per cent* audit check by internal audit and the results would be reviewed periodically for taking appropriate decision. UIIC agreed (December 2009) to prescribe quantum of check by the internal audit.

Recommendation No. 5.5

The PSU insurers should prescribe quantum of checks to be applied by Internal Audit to reduce the risk in the context of outsourcing of settlement of claims.

5.8 Other Topics of Interest: Re-insurance

The COPU in their eleventh report to the Fourteenth Lok Sabha observed (March 2006) that the health insurance companies were incurring losses primarily due to their inability to insure young people who were relatively free from diseases and absence of proper re-insurance facility for health insurance. It further noted that the absence of such re-insurance adversely affected the confidence of the insurance companies to underwrite health covers on a large scale. The COPU recommended (March 2006) that the Government would give special attention and take time bound action to set up a viable re-insurance mechanism for health insurance. The PSU insurers, however, had (December 2009) not attempted to have any re-insurance arrangement except the obligatory cover provided by the GIC.

5.9 Conclusion

Though the health portfolio was growing at a phenomenal rate, the PSU insurers were losing their market share to private sector companies. Despite growth in the volume of business PSUs continued to incur losses. The underwriting losses were incurred especially in respect of Group medi-claim policies due to lack of monitoring and control of TMGPs which repeatedly recorded high adverse claim ratio. Initiative (March 2008) to introduce portability in health services was yet to be introduced (December 2009) and the main objective of introduction of TPAs for providing cashless services to the policy holders, remained largely unfulfilled. PSUs insurers had not made efforts for negotiating with the network hospitals for standardisation of rates and clinical procedures to reduce the cost of health care services to the Insured. The delays in issue of identity cards, settlement of reimbursement claims and failure of PSU insurers to monitor the performance parameters indicate deficiency in service of the third party administrators to the insured.

The matter was reported to the Ministry in February 2010; their reply was awaited (March 2010).