



Health initiatives for
Healthy communities.

Planning and Implementing Health Insurance Programmes in India

An Operational Guide



Editor

Dr. N. Devadasan

Technical Advisor

Mr. Sunil Nandraj

Institute of Public Health
Bangalore, India

In collaboration with the WHO India Country Office



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Preface

Health Insurance is gaining importance in India as it is one of the alternatives for financing healthcare. At the national level, the Ministry of Health and Family Welfare and Ministry of Finance have expressed commitment to support related initiatives. The National Health Policy 2002 articulates the need to increase the populations covered under health insurance and the recently launched National Rural Health Mission intends to support community health insurance programmes. At the state level, many governments have initiated health insurance programmes. This ranges from health insurance for government personnel to micro health insurance for the self help group members.

However, the capacity to design, implement and monitor a health insurance programme is currently limited in India. This document attempts to provide a “How to” approach for planning and implementing Health Insurance programmes in India.

In this context, the WHO India office commends the Institute of Public Health – Bangalore for bringing out this operational manual. It is aimed to assist officials in various sectors, in public and private, in designing and implementing related programmes.

This manual has explored the broad spectrum of health insurance types – from social health insurance to private health insurance. Thus, the manager has various options at his/her disposal when planning for their constituencies. And in the process, it would benefit the citizens of this country.

New Delhi,
May 2006

Dr. S.J. Habayeb,
WHO Representative to India

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Abbreviations

CBHI	Community-Based Health Insurance
CBO	Community-Based Organisation
CGHS	Central Government Health Scheme
CHI	Community Health Insurance
CHIC	Centre for Health Insurance Competency
CHID	Committee on Health Insurance Data
CPF	Central Provident Fund
DRG	Diagnosis Related Groups
ECS	Electronic Clearing System
EDL	Essential Drugs List
EHIF	Employees' Health Insurance Fund
EPF	Employees' Provident Fund
ESIC	Employees' State Insurance Corporation
ESIS	Employees' State Insurance Scheme
GIC	General Insurance Corporation
HMO	Health Maintenance Organisation
IP	In-Patient services
ICD	International Classification of Diseases - 10
IRDA	Insurance Regulatory and Development Authority
MHF	Mutual Health Funds
MHI	Micro Health Insurance
MIS	Management Information Systems
MSAs	Medical Savings Accounts
NABH	National Accreditation Board on Healthcare Services and Hospitals
NGO	Non-Governmental Organisation
OP	Out-Patient services
OPD	Out-Patient Department
PHI	Private Health Insurance
QCI	Quality Council of India
RBI	Reserve Bank of India
SHG	Self-Help Group
SHI	Social Health Insurance
TAC	Tariff Advisory Committee
TPA	Third-Party Administrators
UHS	Universal Health Insurance Scheme

Foreword

This manual has grown from a deep desire when we observed the way health insurance in India was being introduced and implemented. We, Sunil and I, watched with growing frustration as institutions, especially governments, introduced insurance programmes that were poorly designed and managed. We realised that this was a new area for most policy makers and planners and that they needed some support. We explored and reviewed the available literature and found limited information that was India-specific. Most of it was generic and tended to expound the theory rather than implementation. This is how this idea of a practical ‘how to ..’ operations manual was developed.

The WHO India Country Office was kind enough to generate the resources for this initiative. Realising that no ‘one option’ is possible for a diverse country like India, we looked at what was happening in our neighbourhood, especially South East Asia and Africa. Veloshnee Govender conducted a literature review for us (the detailed document is in the CD). We then invited a few resource persons who had knowledge and expertise to review this document and come up with India-specific options. The experts came up with four possibilities – expanding the current ESIS, strengthening private health insurance, introducing community health insurance schemes and piloting medical savings accounts.

We then went back to the drawing board and contacted the resource persons who then developed each option. These chapters form the core of this manual. This manual is basically aimed at providing persons who are intending to take up health insurance or are involved in health insurance programmes – either in the government or in non-government organisations. It helps them explore what is possible for their state or region or target group. They can choose one option, e.g. an NGO can choose to insure their population using Community Health Insurance. Or they can use multiple options, e.g. a state planner may want to use the ESIS, private health insurance and CHI to cover various strata of the state’s population. The choice is with the planner, we just offer the options. Kindly note that the options are not a blueprint but provide a framework for planning and implementing health insurance programmes, taking into consideration the local conditions.

One interesting innovation that we have introduced is the ‘Premium’ tool, a software that has been developed by Mr. Francois Hay, an actuary. This software helps

the manager calculate the premium by inputting basic data and benefit package requirements. It demystifies setting of the premium to a large extent and we hope that it will empower the users when they negotiate with the insurance companies.

I would like to take this opportunity to thank a lot of wonderful people, without whom this manual would not have taken place. First of all, thanks to Sunil Nandraj for sharing the vision and for being there with all his advice and comments at every step of the way. Sincere thanks to the experts* who attended the meeting at very short notice and came up with the options. And of course, thanks to all the authors who worked on the project and came up with the chapters. Thanks to New Concept, especially to Ms. Ritu Singh for patiently editing numerous versions of the text. And last but not least, we would like to thank the WHO India office for financing this project.

Dr. N. Devadasan
May 2006

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Health Insurance in India

N. Devadasan and Sunil Nandraj

Health financing

Financing of healthcare is an important determinant of the performance of health services. While it is generally true that the higher the expenditure on healthcare, the better the outcomes, it also depends on many other factors – basically how efficiently the resources are translated into effective outputs. Nevertheless it is agreed that low spending on healthcare results in poorly functioning health services and hence poor healthcare.

India spends 4.6% of its GDP on healthcare, but this is a paltry US \$23 per capita (Rs 1021), which is one of the lowest globally (Table 1). What is worse is that most of this Rs 1,057 billion is spent by individual households, who pay for care at the point of use. While in most high and middle-income countries, the governments contribute a sizable portion of the health expenditure, in India it is one of the lowest, less than a

Table 1: Sources of healthcare financing in various countries

	Government	Private enterprises including donors	Individual households	Per capita health expenditure (US\$)
UK	96.9%	0	3.1%	1303
Germany	77.5%	11.2%	11.3%	2713
USA	44.1%	39.3%	16.6%	4187
Brazil	48.7%	7.7%	45.6%	319
South Africa	46.5%	7.2%	46.3%	268
Uganda	35.1%	16.7%	48.2%	14
India	21%	7.0%	72%	23
Thailand	33%	1.6%	65.4%	133
China	24.9%	0	75.1%	20

Source: World Health Report, WHO, Geneva, 2000. Data for India from National Health Accounts 2001–2002.

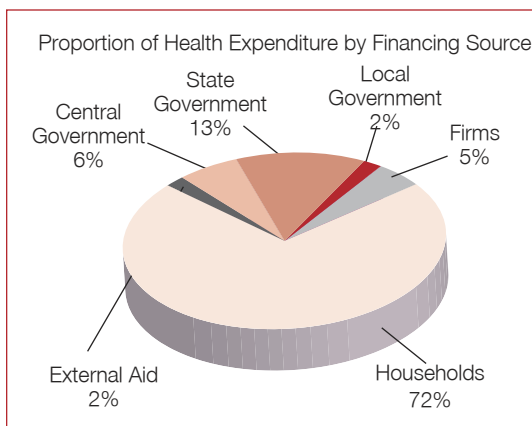
quarter of the total expenditure. In fact, as a percentage of GDP it has declined from 1.3 in 1990 to 0.9 at present. Donor money is a negligible amount (Figure 1). The most common source of health expenditure in our country is the out-of-pocket payments. This means that individual households pay at the time of illness. It is accepted that this form of payment is very inefficient and inequitable. There is no risk pooling and the patient is not able to purchase care efficiently.

Data from the National Sample Survey Organisation, Ministry of Statistics, GoI indicate that escalating healthcare costs is one of the reasons for indebtedness not only among the poor but also in the middle-income group. With 40% of the hospitalised having had to borrow money or sell assets during the decade 1986–96, there was an increase in the absolute number of persons unable to seek healthcare due to financial reasons (NSSO, 1998). Around 24% of all people hospitalised in India in a single year fall below the poverty line due to hospitalisation. An analysis of financing of hospitalisation shows that a large proportion of people, especially those in the bottom four-income quintiles borrow money or sell assets to pay for hospitalisation (World Bank, 2002).

In the light of the fiscal crisis facing the government at both the Central and State level, the shrinking public health budgets, the escalating healthcare costs coupled with the demand for healthcare services and lack of easy access of people from the low income group to quality healthcare, health insurance is emerging as an alternative mechanism for financing of healthcare. Presently the penetration of health insurance is very limited in our country – just about 4% of the population is covered by any pre-payment mechanism. The government is exploring various mechanisms to protect the population with a health insurance mechanism, so that they pay a small amount when healthy and are protected from high medical costs at the time of illness.

In the following chapter, we give a brief overview of health insurance and review some of the existing health insurance programmes in our country.

Figure 1: Health expenditure in India



Source: National Health Accounts 2001-02, MoHFW, GoI.

Health Insurance

Health insurance is a method to finance healthcare. The ILO defines health insurance as *“the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member”* (ILO, 1996). To put it more simply, in a health insurance programme, people who have the risk of a certain event contribute a small amount (premium) towards a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g. hospitalisation).

The essentials in a health insurance programme are **prepayment** and **risk pooling**. The main advantage of a health insurance programme is that of prepayment. Individuals or families pay when they are healthy and are able to pay. However, when they are affected by illness, the insurance fund can be used to finance their healthcare needs. Thus there is no burden at the time of illness.

Yet another essential is that of risk pooling. There are three types of risk pooling:

- *Between the sick and the healthy* : When a group of people contributes towards a health insurance fund, it is not clear who will fall sick. While most will remain healthy, some will fall sick. However, the funds from all the contributions are used to finance the treatment of the sick.
- *Between the rich and the poor* : A group of people, who contribute towards an insurance fund, should ideally belong to different socio-economic strata. So the rich, by paying more, will cross-subsidise the poor.
- *Between the active and inactive* : While it is usually the employed who contribute, their contribution should be used to finance their own healthcare as well as the that of the children and the elderly.

Health insurance functions when there are **large numbers enrolled**. This is because with large numbers, the chances of adverse events are reduced and so is the outflow from the insurance fund.

There are some important values in health insurance – an important one is that of **solidarity**. A successful health insurance programme requires people to contribute, knowing fully well that their contribution may not help them directly, but will help others who require the support. Without this value, a health insurance programme is doomed to fail as people will insist on withdrawing at least their contributions from the

fund. This will destroy the concept of health insurance and will result in bankruptcy of the programme.

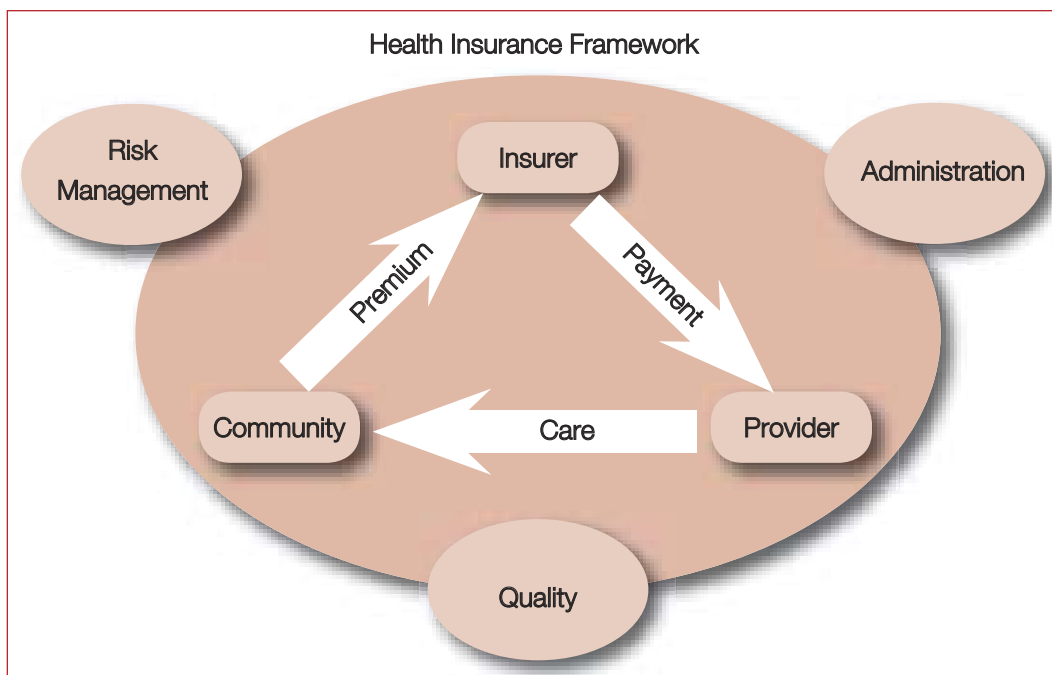
Yet another value, rarely talked about is one of **equity**. A health insurance programme should ideally promote both horizontal equity and vertical equity. This promotes cross-subsidy between equals and also between unequals.

A health insurance programme usually has two main functions (Kutzin):

1. To **increase access to healthcare**.
2. To **protect households** from high medical expenses at the time of illness.

The basic elements in a health insurance programme are shown in Figure 2. A health insurance programme requires an insurer who takes the risk and organises the health insurance programme. There should be a community that will pay the premium and enrol into the health insurance programme. And finally, patients in this community need to avail of services from healthcare providers (doctors/hospitals) when they fall sick. The insurer should organise to pay the providers for the services rendered. Other than these six core elements, there are three subsidiary elements – that of administering

Figure 2: The basic elements in a health insurance programme



the programme, that of managing the risk, and finally of ensuring quality both in the healthcare as well as in the health insurance programme. It is essential that these nine elements are in place for a health insurance programme to be successful.

There are some risks that are peculiar to health insurance:

- **Adverse selection** – Normally we expect that both the healthy and sick would enrol in a health insurance programme. However, if poorly designed, there is a chance that the sick will enrol in larger numbers as compared to the healthy. Thus the programme becomes unviable as the outflow exceeds the inflow.
- **Cream skinning** (risk selection) – This is the opposite of adverse selection and occurs when insurance companies selectively choose low-risk individuals and reject the high-risk individuals.
- **Moral hazard** – This takes place when the fact of being insured changes the behaviour of the patient or the provider. There are two types of moral hazard. In the supply side moral hazard, we find that the provider tends to intervene unnecessarily or charge higher bills for an insured patient. In the demand side moral hazard, the patient tends to demand more care, or indulges in risky behaviour, because of the insurance status.

These risks can be managed by certain design measures (Table 2).

Table 2: Managing risks in a health insurance programme

Risk	Measures to manage risk
Adverse selection	<ul style="list-style-type: none"> ● Have a large unit of enrolment, e.g. a family, a village, a self-help group ● Have a compulsory enrolment as opposed to a voluntary enrolment ● Have a definite collection period ● Have a definite waiting period ● Exclude pre-existing diseases
Supply side moral hazard	<ul style="list-style-type: none"> ● Have a flat/case-based payment mechanism as opposed to a fee for service mechanism ● Preferably pay the providers a fixed salary – this will minimise incentives for interventions ● Insist on standard treatment guidelines ● Insist on medical/chart audits
Demand side moral hazard	<ul style="list-style-type: none"> ● Have a referral system or a pre-authorisation system ● Introduce co-payments

There are broadly **three types of health insurances**:

- **Social health insurance:** A compulsory health insurance, usually for the formal sector. Here the employees contribute through payroll deductions and the employers provide a grant. This is used to finance healthcare of the employees, their dependents and, as in many European countries, the rest of the population.
- **Private health insurance:** A voluntary health insurance wherein people can enrol and purchase the insurance product of their liking, paying a risk-rated premium.
- **Community health insurance:** A voluntary but not-for-profit health insurance scheme and targeting the informal sector. These are usually small schemes and the community is very involved in its management.

Health insurance is administratively a more complex form of financing healthcare. The basic shift is from providing services to purchasing healthcare. So before a planner initiates a health insurance programme, he/she should be very clear why he/she is doing so. It is necessary for the planner to ask the most important question – WHY HEALTH INSURANCE?

- Is there a problem of access to healthcare?
- Is there a problem of high medical expenditure for the households?
- Is there a problem of quality of care?

Health Insurance

Social security in India for medical emergencies is as old as the Indian civilisation. Even today it is common practice for villagers to take a '*piruvu*' (a collection) to support a household with a sick patient. However, health insurance as we know it today was introduced only in 1912 when the first Insurance Act was passed. The current version of the Insurance Act was introduced in 1938, but since then there has been very little change till 1972 when the insurance industry was nationalised and the few hundred private insurance companies were brought under the umbrella of the General Insurance Company (GIC). The winds of liberalisation that blew across India in the 1990s affected the insurance industry also. Private and foreign entrepreneurs were allowed to enter the market in 1999 with the passage of the IRDA bill.

Social Health Insurance

There are two mandatory and contributory health insurance schemes in India – the CGHS for the government of India's civil servants and the ESIS for the low-paid industrial workers. Here the eligible people contribute through a payroll tax towards a specific health fund. This fund then finances specific benefits for them.

The Central Government Health Scheme (CGHS)

The CGHS was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. The list of beneficiaries includes all categories of current as well as former central government employees, members of parliament, Supreme Court and High Court judges. In 1997, there were approximately 4.2 million beneficiaries. The staff contributes a nominal amount (ranging from Rs 15 to Rs 150 per month) from their salaries.

The benefit package includes both outpatient (OP) care and hospitalisation. OP care is provided through its own dispensaries, 320 in 2002 in 17 major cities. It also uses the facilities of the government and approved private hospitals to provide inpatient care and reimburses the expenses to the patient.

The entire scheme is funded by the government of India and is administered by a separate directorate. Various evaluations have noted that while it has been effective in providing health security for more than 4 million people, there are certain problems in the scheme that need to be addressed. These are:

- Equity – In a country where the government spends less than 0.9% of the GDP on healthcare, it is unacceptable that a sizable amount of this goes to the better-off section of the society.
- Demand side moral hazard – It is noted that 83% of the hospitalised patients are self-referred. It appears that most patients prefer to bypass the dispensaries and directly avail of specialist services. The number of annual visits per beneficiary was 3.5 (1994–95).
- Poor quality care – There are regular complaints about long waiting periods, inadequate supply of medicines and equipment and unhygienic conditions.
- High out-of-pocket expenditure – A study in 1994 documents that an average patient pays about Rs 1507 for the first treatment episode.

The Employees' State Insurance Scheme (ESIS)

Established in 1948, the Employees' State Insurance Scheme (ESIS) is an insurance system, which provides both cash and medical benefits. It was conceived as a compulsory social security benefit for workers in the formal sector. The Employees' State Insurance Corporation (ESIC) manages the scheme and is a corporate semi-government body headed by the Union Minister of Labour as Chairman and a Director General as the chief executive. Its members are representatives of central and state governments, employers, employees, medical professionals and Members of Parliament.

The Act compulsorily covers: (a) all power-using non-seasonal factories employing 10 or more persons; (b) all non-power-using factories employing 20 or more employees, and (c) service establishments like shops, hotels restaurants, cinema, road transport and newspapers. The plantation and mines sector or those institutions that provide similar or better benefits than the ESIS are exempt from joining the ESIS. In the eligible organisations, only those workers with a salary of less than Rs 7500 per month can join the ESIS¹. To avail of the sickness benefit, the employee has to have worked for 78 days prior to the sickness. Similarly, to avail of the maternity benefit, the woman has to have worked for 70 days prior to the sickness.

Contributions are paid through a payroll tax of 4.75% levied on the employer and a tax of 1.75% levied on the employee. Workers earning less than Rs 40 a day are exempt from contributing. State Governments contribute 12.5% of total shareable expenditure worked out by prescribed ceiling on expenditure which is Rs. 600 per insured person per annum and expenditure incurred over and above the prescribed limit.

All workers and their dependent relatives are eligible for the benefits. These include healthcare at ESIS facilities, cash compensation for illness, maternity benefits, disability benefits, survivorship and funeral expenses in the event of death of the worker. Healthcare includes preventive, promotive, curative and rehabilitative services. ESIS has its own dispensaries, hospitals and medical staff. It also empanels select private practitioners to provide medical care. Patients requiring treatment from specialists not available at the ESIS hospitals can receive it at the speciality facilities, with the ESIS programme reimbursing the expenses.

Presently the scheme is spread over 677 centres in 25 states and Union territories across India covering 7.8 million employees and more than 25 million beneficiaries². In 1992, of a total expenditure of Rs 3.8 billion, Rs 2.2 billion was spent on healthcare. In 2001, the ESIC had surplus funds of Rs 67 billion, invested mostly in government securities.

While the ESIS has managed to cover the low-paid workers in many organisations and provided them with a degree of comprehensive health security, it has been criticised for the following reasons:

¹ <http://esic.nic.in/> - accessed on 08.09.04.

² Aloke Gupta, The Healthcare continuum, *IRDA Journal*, January 2003.

- Less than half the enrolees use the ESIS facilities because of the low quality of care (Gumber A, 2002). This is further compounded by the rude and impudent behaviour of the ESIS staff, shortage of staff, inadequate drug and supplies and non-functional equipment.
- Many of the staff are not aware of the benefits. The employers also do not disseminate the information to their staff. Further, some employers manipulate records to make the staff ineligible for the benefits. Also, because of the salary limits on eligibility, some staff keep shifting in and out of the ESIS and they may not be aware of their eligibility status (Gumber A, 2002).
- There is duality of control, with both the ESIC and the State governments trying to establish superiority. Also, there is conflict between the health department and the labour department for control of the ESIS.
- Poor penetration in rural areas.

Private Health Insurance

Both public and private insurance companies market a variety of health insurance products. In this document, we describe ‘Mediclaim,’ which is the most sold product.

Mediclaim

Health insurance in India is usually associated with the ‘Mediclaim’ policy of the GIC. Introduced in 1986, it is a voluntary health insurance scheme offered by the public sector (and since 1999 the private sector) health insurance companies.

Anybody (3 months to 80 years) who can afford the risk-rated premium is eligible to join the scheme. The premium depends on the age, risk and the benefit package opted for. The minimum premium is Rs 201 for < 25 years old for a maximum benefit of Rs 15,000. Group membership allows for discounts in the premium. In 2001, there were 7.8 million persons covered under Mediclaim³. The subscribers are usually the middle and upper class, especially as there is a tax benefit in subscribing to Mediclaim.

The standard Mediclaim policy covers only hospital care and domiciliary hospitalisation benefits. Most medical conditions are reimbursed though there are important exclusions. These include – pre-existing diseases, pregnancy and child birth, HIV-AIDS, etc. Traditionally only reimbursement insurance is provided, though the companies have tried a third payment system with TPAs. Hospitals with more than 15 beds and registered with a local authority can be identified as providers.

³ Aloke Gupta, The Healthcare continuum, *IRDA Journal*, January 2003.

The insurance company (or the TPA where applicable) administers the scheme. Being an indemnity scheme, the patient pays the hospital bills and submits the necessary documents to the company. The company in turn reimburses the patient. A study done in Gujarat showed that the average time between submission of documents and reimbursement is 121 days. There is also uncertainty about the amount reimbursed; there are times when the patient is only reimbursed partially, the usual reason provided being that the documentation is insufficient.

During 1994, 4.4% of insured persons made a claim, of which only 75% of claims were settled. The claims ratio was 45%. However, of late the claims ratio is growing at a fast rate, allegedly because corporate Mediclaim policies are used to subsidise other non-life policies, e.g. an insurance company sells fire insurance to a corporate client by offering Mediclaim policy at a very low premium.

Some of the strengths of the Mediclaim policy are:

- The only voluntary health insurance policy in the country currently, with about 8 million subscribers.
- Provides protection against catastrophic health expenditure.
- Easily available in most insurance companies.
- Is being modified to make it customer friendly.

However, there are some major weaknesses that need to be addressed.

- Most of the insurance companies are wary about selling health insurance as they do not have the data, the expertise and the power to regulate the providers.
- There are a lot of problems in reimbursing the patients, ranging from long delays to partial reimbursements.
- There are also reported fraud and manipulation by clients and providers. The monitoring systems are weak.
- The benefit package needs to be modified to suit the needs of the customers. Exclusions go against the health system logic of covering risks.
- Lastly, the reimbursement method of payment is highly unpopular among the customers. The experiment with TPAs appears to have been unsuccessful and the reasons for this need to be studied.

These weaknesses have resulted in Mediclaim topping the number of grievances in the non-life insurance sector.

Universal Health Insurance Scheme (UHS) – a voluntary health insurance scheme for the poor

The Government of India launched the Universal Health Insurance Scheme (UHS) in 2003. It is a standard Mediclaim product with an annual cover of Rs 30,000 for a family (or Rs 15,000 for an episode of illness). The premium was Rs 365 per individual, Rs 548 for a family of five and Rs 730 for a family of seven. The scheme was to be marketed by the public sector insurance companies and was targeted at the BPL sections of society.

Box 1: Features of the Universal Health Insurance Scheme

Initiated by the Government of India, through the four public sector insurance companies.

Target population: BPL families in any state.

	Total Premium	Payable by the insured	Subsidy by the Government of India
For an individual	Rs 365	Rs 165	Rs 200
For a family of 5	Rs 548	Rs 248	Rs 300
For a family of 7	Rs 730	Rs 330	Rs 400

Benefit package: Hospitalisation benefit up to Rs 15,000 per patient per year or Rs 30,000 per family per year. Also personal accident benefit and loss of wages compensation.

Reimbursement model, patient has to pay bills first and get it reimbursed from the insurance company.

Performance	2004 – 2005	2005 – 2006 (Up to Sep 2005)
Number of families covered	65,718	45,118
Number of individuals covered	1,82,641	1,49,442
Claims ratio*	X	12%

* Amount of claims made by the total premium collected.

It was felt that the original UHIS was skewed in favour of the non-poor. As a result, only a very small number of BPL families (9252) was covered in the first year. Keeping this in view, it was decided to make the scheme exclusively for people below poverty line and also to enhance the subsidy. In 2004, the new UPA Government restricted it to BPL families only and increased the subsidies on the premium. Currently a BPL individual/family needs to only pay Rs 165, Rs 248 or Rs 330. In spite of this generous subsidy, BPL families are not coming forward to avail of this scheme. This is due to the fact that this scheme has many restrictive features. In Table 1 we have listed these and suggested some changes in the scheme to make it more acceptable to the poor.

These changes should improve the acceptability of the UHIS, enhance the enrolment to the scheme, and hopefully bring in a culture among the poor of insuring oneself. The current premium may have to be revised as there are a few additions to the benefit package.

Community Health Insurance

Community health insurance is defined as any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks. This definition includes mutual health organisations (MHOs), local health insurances and micro health insurances.

While the CHI movement is vibrant in Africa, it is slowly picking up momentum in India. Currently there are about 30+ CHIs in the country, many of which have begun operations in the past two years.

There are 3 types of CHIs in the country. The first and the oldest type is the ‘direct’ model, where a hospital has initiated a health insurance product. The hospital is both the provider of care as well as the insurer. The second type is the ‘mutual’ model, where the NGO organises and implements the insurance scheme and purchases care from various providers. There are very few examples of this, the most famous being the Yeshasvini model. And finally, the most common type is the ‘linked’ model, where the NGO collects premium from the community and purchases insurance from a formal insurance company and healthcare from providers.

The membership to these CHIs varies from 1000+ to more than 2 million. Most of these schemes operate in rural areas and cover people from the informal sector. Enrolment is usually facilitated by membership organisations, e.g. micro finance groups, cooperatives, trade unions. The premium ranges from Rs 20 to Rs 60 per

individual per year. Only three schemes had premiums larger than Rs 100. In most of the schemes, the unit of enrolment is the individual and membership is voluntary.

About 22 of the CHIs offer hospitalisation as the benefit package. This ranges from the classical Mediclaim product to a very comprehensive cover including all conditions and no exclusions. It is clear that many of the NGOs have been successful in negotiating an appropriate insurance package for their community. Most of the providers are either NGOs or private-for-profit providers. The utilisation rates range from 6 to more than 240 per 1000 insured. The latter obviously indicates extreme adverse selection.

All the CHIs have been initiated by NGOs, and they are the ones who administer the scheme. In many of the schemes, the community is also involved in various administrative activities, e.g. in creating awareness, collecting premiums, processing claims and reimbursements and in the management of the scheme (deciding the benefit package, the premiums, etc).

The main strengths of the CHIs are that they have been able to reach out to the weaker sections of society and have been able to provide some form of health security. Evidence from some CHIs indicates that they have been able to increase access to healthcare or protect the households from catastrophic health expenditure. Community involvement increases the participation of the members in the scheme. The benefit packages are tailored to meet the needs of the community and so are more acceptable. Also, these meet health system needs as compared to schemes designed by actuaries.

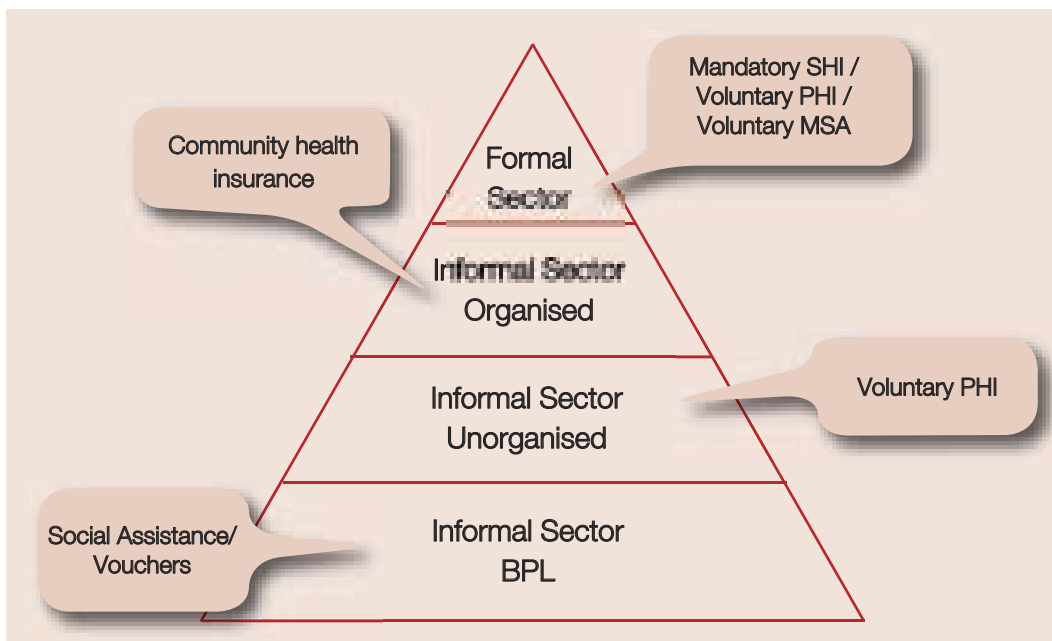
On the other hand, there are certain weaknesses, the main one being the low level of risk sharing. Usually the members are the poor and there is very little cross-subsidy between the rich and the poor. The premiums are low and so the benefit packages are also small. This means that financial protection is also limited in many of the schemes. Some of the NGOs manage the scheme by themselves, which may be illegal within the current IRDA regulations. Also, some of the schemes cover very small numbers and so the potential for scaling up is restricted. Finally, many of the schemes see health insurance as an end in itself. However, it must be remembered that health insurance is a means for a more equitable and functional health system.

Conclusions

While India has the spectrum of social, private and community health insurance, the penetration in each of these is very low. The reasons are obvious – poor designs, unsatisfactory products, low quality healthcare and inefficient administration of the scheme. For health insurance to be a reality in India, these shortcomings need to be addressed. It is precisely this reason why this document is being published – to help the planner and manager to design and implement a robust programme that takes the needs of the people and the technical requirements into account.

India is very diverse and one single solution will not meet the needs of all its citizens. It is a clear case of ‘One size will not fit all’. The planners and policy makers need to stratify the population into various categories, and design schemes that are specific for each category. Thus for those in the formal sector, mandatory social health insurance, voluntary private health insurance or voluntary medical savings accounts are viable options that need to be explored. For the informal sector, especially those who are organised, community health insurance (or micro health insurance) are reasonable options. This can also be used in the interim period for the formal sector. However, for the poorer sections in the informal sector, insurance may not be the answer. In such cases, either ‘voucher systems’ or social assistance should be explored. This is shown in Figure 3.

Figure 3: Multiple risk pools in India.



Developing Community Health Insurance Programmes

Deepti Chirmulay and N. Devadasan

Introduction

A number of community health insurance programmes (CHIs) has come up in India over the last twenty years. CHIs can be defined as “any *not-for-profit* insurance scheme aimed primarily at the *informal sector* and formed on the basis of a collective pooling of health risks, and in which the *members participate in its management*”. These programmes developed in response to the limited reach and unsuitable health insurance products of insurance companies in India. Most of these CHIs attempt to protect the community from high medical expenditure. Common features of these schemes, normally run by NGOs, are:

- small membership group
- small and affordable premium with limited benefits and coverage
- simple procedures and considerable member participation in management of the programme.

Why this Option?

In India, the informal sector forms more than 90% of the population. This comprises farmers, labourers, the self-employed, traders, etc. Currently most of this population has to rely either on the poorly functioning government health facilities or on the expensive private health services. Obviously these form a considerable barrier to healthcare, especially for the weaker sections of society. CHIs have been effective in removing these financial barriers and protecting the poor through the mechanism of prepayment of an affordable premium.

So if a planner wants to cover

- the informal sector
- unorganised groups
- poorer sections of the community,

then CHI would be a good option to try out.

Based on the local circumstances the specific objectives for starting a CHI could be a combination of the following:

- Increasing financial access to healthcare for the weaker sections of society.
- Extending protection against high medical costs.
- Improving the quality of care.

Pre requisites

Even before a CHI can be designed, some requirements should be in place.

Essential

- A need for introducing health insurance, i.e. if there are problems with access to healthcare or there are high out-of-pocket payments for medical care.
- An organised group that is willing to pool its health risks through a health insurance mechanism.
- NGOs/CBOs or other organisations, who are willing to organise the CHI and have the administrative capacity.
- Healthcare providers who can provide adequate quality of care.

Desirable

- Willingness to pay – Community members have to understand the principle of risk sharing, should have solidarity, and think of healthcare as a risk that needs to be managed. These aspects together lead to ‘willingness to pay’.
- Ability to pay – People should have the ability to pay the premium, i.e. the premium should be affordable as well as the people should have access to resources. In some subsistence economies, cash may be difficult to come by, so it may be necessary to collect premium in kind.
- Reliable data – Demographic and morbidity data is essential for calculation of probabilities and risks regarding the population. Costs of healthcare are required to estimate the cost of the benefit package.
- Legal aspects – There should be regulations to allow a variety of CHI models to

function. Currently the only model that is possible is the linked model, and this is not very user friendly.

- Technical and managerial capacity – Either the organisation should have this in-house capacity, or should be able to access it from other sources.

The Main Steps in Initiating a CHI

Any health insurance programme, including CHI, has to grow according to the local needs, health system, governance scenario, and institutional set-up and capacity. The main steps in the process of CHI development are:

1. Identifying the Need for CHI

There must be a need for a health insurance programme. This can be classified into two:

- Either the people are facing financial barriers while seeking healthcare and so are prevented from receiving good quality and effective healthcare.
- Or, high medical costs are impoverishing households, pushing them into indebtedness and poverty.

If either or both of these conditions exist (and they usually exist in most parts of our country), then there is definitely a need for introducing health insurance in that region. On the other hand, if there is a good government health service or an NGO network that is providing good quality care at affordable rates, then health insurance may not be a need in this area.

2. Identifying an Organisation that will Manage and Administer the CHI

Once a need is recognised, one must identify an organisation that will develop, implement, administer and manage the CHI scheme. This could be a local NGO, or a CBO or a federation of MFI or a cooperative society. But one needs such a body to take on the responsibility. Ideally this organisation should be familiar to the local people and should also be trustworthy and credible. After all, the people are putting money into this organisation.

This organisation ideally should:

- be a registered body,
- have good links with the community,
- have the technical and managerial capacity to implement a CHI, and
- be transparent in its operations, especially accounts.

3. Identifying the Target Community

The organiser of the CHI (be it an NGO or a CBO) should now identify the target community for whom the CHI is going to be implemented. This may have been decided from the needs assessment. Or it may be decided by the donor. Or the CBO may decide to insure its target population.

Ideally the target community should be 'organised', i.e. they must have a structure and should be coming together for some purpose other than health insurance. For example, cooperative society members come together to market their produce, self-help group women come together for savings and credit, unions come together for their rights-based demands. These are excellent communities to initiate health insurance in a community. The main advantages are that they are organised and meet regularly, have inherent solidarity and have existing channels for information and fund flow.

Such 'organised' groups are available both in the urban and rural areas. The urban informal sector is made up of two sub-sections: (i) Those that are organised in some form or the other, e.g. the drivers' association, the shopkeeper's association (ii) Those that are not organised at all, e.g. the vendors, the rag pickers, the unorganised maid servants. For the first group, CHI schemes are ideal and can easily be operationalised as they are already organised into formal groups. The second group is more difficult to reach and should be approached through indirect mechanisms, e.g. existing micro credit groups, neighbourhood groups.

Similarly, the rural informal sector can be divided into the organised and unorganised informal sector. The organised sector has members of co-operative societies, workers' associations, caste-based organisations and members of self-help groups, who can be targeted for CHI schemes. The unorganised sections, e.g. the landless labourers, the subsistence farmers, will need to be approached using a different strategy.

While CHI is usually synonymous with lower income groups of society, it can easily be used for middle-class communities also. They also require financial protection against high medical costs and are currently at the mercy of insurance companies. By approaching such families through housing societies, one will be able to cover a large group of people. For them, the main attraction is providing an affordable and acceptable package without any administrative problems.

Targeting 'unorganised' sections, e.g. landless labourers, BPL families is more difficult, as they are amorphous and do not have existing structures to build on. In

such cases, it may be advisable to cover organised groups first and then try and include the 'unorganised' groups at a later stage in a phased manner.

A word of caution here – the poorest sections of society usually cannot afford to pay the premiums and are usually excluded from CHI programmes. So if a CHI wants to include these members, other measures like direct subsidies need to be considered.

4. Designing the CHI

Once the community is identified, then this organising NGO/CBO should discuss with them the design of the CHI. Currently there are three basic models of CHI in our country (Figure 1) – variations of this can be developed depending on the local situation.

Provider model – Here usually a hospital takes on the responsibility of initiating and organising the health insurance programme. They are then both the financers as well as providers of healthcare. It is similar to the 'Health Management Organisation' (HMO) or 'Managed Care'. The main advantage is that the costs remain low and the quality of care is acceptable. However, hospitals usually have limited access to community groups and also are not able to communicate with them. Thus such models tend to be technically and administratively sound, but socially weak. Community aspirations are rarely expressed and met.

Mutual model – Here the NGO/CBO takes on the responsibility of initiating and organising the CHI programme. It collects premium from the community and then purchases healthcare (on behalf of the community) from empanelled providers. The main advantage is that the scheme is developed in keeping with the community needs. However, usually the NGO does not have the technical capacity to negotiate with the hospitals. And finally, the CHI is financially not sustainable, as it does not have control over costs. So there is a high risk of its becoming bankrupt unless it has large numbers.

Linked model – Here the NGO/CBO collects the premium from the community and passes it on to a health insurance company. The insured community is free to go to any hospital for healthcare. And then it usually submits the bills to the insurance company (via the NGO) and is then reimbursed the costs. The main advantage is that the risk sharing is on a larger scale as the small pools are merged with the larger pools of the insurance company. The main disadvantages are that the products are

usually inflexible and not suited to the local needs. And being a reimbursement model means that the patient has to pay upfront at the time of illness.

Any one of the three models can be adopted depending on the organisation's strength and weaknesses. For example, if the NGO is also a hospital, then the provider model may be a good option. On the other hand, if the numbers enrolling are small, then the linked model would be a better bet. There can also be combinations of these models. An organisation can provide some benefits linked to the insurance agency and the other benefits through a self-managed fund; or providers may be paid directly by the organisation as 'cash-less benefits'. The advantages and disadvantages are given in Table 1.

Table 1: The advantages and disadvantages of the three models of CHI

	Provider model	Insurer model	Linked model
Freedom to suit the local needs	Very free		Depends on the insurance company's products
Premium	Set by the NGO/CBO and usually based on affordability		Set by the insurance company and usually based on actuarial calculations
Benefit package	Usually comprehensive and meets the local needs		Traditional Mediciam policy with its exclusions and limitations
Financial risk	With the NGO/CBO		With the insurance company
Quality of care	Better because the NGO/CBO has a relationship with the provider	No difference in the quality of care between insured and non-insured patients	
Community involvement	Minimal, as the hospital is in charge and usually too technocratic	Varies, depends on the NGO/CBO	

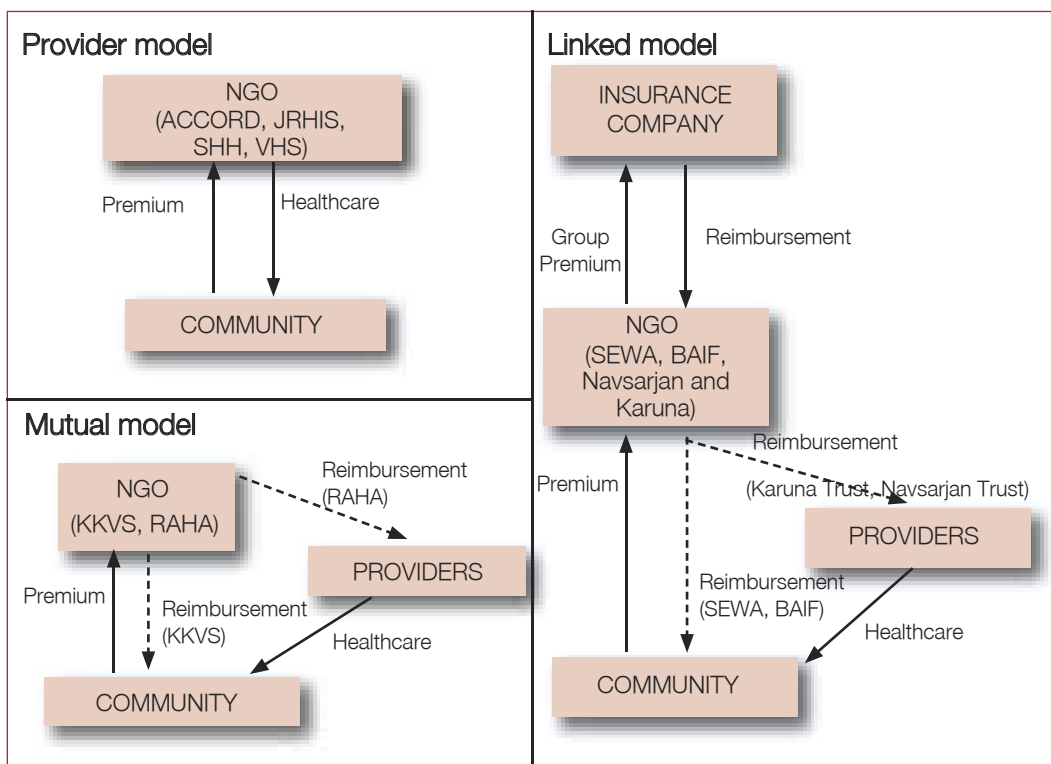
5. Defining the Benefit Package

The fifth step in initiating a CHI is to define the benefit package. Once the design is decided upon, the organising NGO/CBO should discuss the benefit package with the community – what are their expectations, their needs, their demands. Focussed

group discussions are ideal in order to understand this. However, while defining the benefit package, the community should be aware that this is linked to the premium. So the more benefits they demand, the higher the premium that they have to pay. Ideally the 'Premium' software (in the CD) should be used while this discussion is taking place, so that the community has an idea of the cost of the benefit package that they are asking for.

The benefits that are required by the community usually range from OP to IP to transport costs to cash benefit for loss of wages, etc. One way of addressing this is to consider expanding the benefit package in a phased manner, maybe starting with the most desirable – hospitalisation benefits. This is because the other benefits are much more difficult to administer. Later and especially after the NGO and the community have gained some experience and the people start trusting the CHI, OP, transport costs or loss of wages can be included. Ideally the NGO should provide primary care

Figure 1: The three models of community health insurance in India



Source: Devadasan et al. The landscape of community health insurance in India, Health Policy 2006.

(including OP) through other resources. This will make the health insurance scheme more acceptable to the community.

All illnesses should be covered under the benefit package. Exclusions should be avoided as much as possible. Upper limits can vary, depending on the capacity of the local community to pay the premium and the medical costs in the locality. A prototype could be a basic package covering the hospitalisation expenses for most of the common illnesses and having a family upper limit of Rs 15,000. For those who want more, and are willing to pay higher premiums, the upper limits can be increased to Rs 25,000 and Rs 50,000. So while the package remains the same, the upper limit rises. In this way, depending on the individual household's requirements, they can purchase care.

If desirable and if experience shows that it is necessary, a catastrophic cover can be included. This will cover those conditions that are of high costs, e.g. a severe road traffic accident, the treatment of cancer, ischemic heart disease, etc. and usually costing more than Rs 100,000. The CHI can re-insure with an insurance company and purchase a catastrophic cover for a small premium. This would protect those who are unfortunate to experience such events.

6. Fixing the Premium

The premium is usually decided by the extent of the benefit package. The larger the package, the higher the premium. This usually means that the poor cannot afford the premium (and hence the scheme). To prevent this, the premium must be kept as low as possible. Experience shows that most people in the lower income group are willing to pay up to Rs 250 per family per year for health insurance. Any amount above this will exclude large sections of the poor. If the premium is higher, it needs

Table 2: Registers and records that need to be maintained

Activity	Register	Record	Flow of data
Money transaction	Receipt book	Receipt/Insurance card	Village organiser to insured
Reporting to higher level	Receipt book/ Accounts book	Insured list/Accounts	Village organiser to Block/District organiser
Reporting to higher level	Insurance register/ Accounts book	Collated data	B/D organiser to Insurer

to be subsidised by external resources, be it the government or independent donors. Without this, very few people will subscribe to the scheme.

It is possible to have different slabs for the premium, based on the benefit package. But in the process the poor should not subsidise the rich. This will happen if only a few rich people opt for the higher scheme, but take a lot of benefits from it. Then the money will flow from the poorer majority to the richer minority.

Premiums should ideally be income rated, i.e. the rich pay a higher premium while the poor pay a lower premium – for the same benefit. However, in a rural community, with no formal methods of assessing income, it is easier to introduce a community-rated premium, wherein everybody pays a flat rate. In this way, at least the healthy will subsidise the sick. However, in the interests of equity, one should consider reducing the premium for those households who live far away from the provider network because they will have a lot of indirect costs and it is fair that they pay a smaller premium.

Some governments/NGOs pay the entire premium on behalf of the people. This is good for the community but has some weaknesses. The main one is that most of the insured do not know that they are insured. Thus they do not go for healthcare and their situation remains the same, especially in the short term. Another weakness is that this is not sustainable in the long run. Donors lose interest after a few years and then the entire scheme collapses. On the other hand, contribution from the community makes the insured aware and gives them a sense of ownership.

An advantage of using 'organised' communities for introducing CHI is that this organisation can be the channel for collecting premium. For example, unions can collect it during their membership drive, cooperatives can collect it at source when the agricultural product is being marketed, micro credit groups can collect the premium in instalments when they collect the monthly contributions.

The premium can be collected either in cash or in kind. The advantage of kind is that it is more acceptable in areas where subsistence economy exists and people do not have ready cash at hand. On the other hand, managing such premiums is difficult as people may contribute different quality of grains, etc. Storing and selling becomes an administrative problem.

It is always advisable to have a specific period for collecting premiums. This should ideally be the period when the community has the highest income. It then becomes easy for them to pay the premium. The collection period should be for a limited period (one or two or three months). Premiums may also be collected on a running basis, i.e. people join the scheme whenever it is convenient for them. However, this sort of collection is difficult for the organisers, as throughout the year they need to check who needs to renew. Collecting in instalments also is not easy. The organisers have to monitor the instalments, an additional task. One solution is that the micro credit groups (or other similar organisations) advance the premium amount and then collect it in instalments from the individual households.

Insuring the family as a unit is a practical way out. Of course, we need to look into the problem of large families. Can we give some concessions to large families, so that they are encouraged to join? There are various possibilities, e.g.

- *The premium is calculated on an individual basis, e.g. Rs 20 per person per year. Thus a family of 5 will pay Rs 100, while a family of 8 will pay Rs 160. This obviously means that the larger families will not join, as the premium may not be affordable.*
- *The premium is calculated on a flat basis, irrespective of the size of the family. Thus a family has to pay Rs 100. This will tend to exclude the smaller families as they may feel that they are paying a large sum for just two members, etc.*
- *The premium is calculated on a slab basis, e.g. a family of 2 pays Rs 50, a family of 3–5 pays Rs 100, and a family of 6+ pays Rs 125. This will ensure families joining, but is more difficult to calculate and monitor.*
- *The dependents pay a lower premium. Thus large families will pay relatively less as compared to the smaller families.*

While collecting the premium, proper registers and records should be kept. Some of these are given in Table 2. All the primary records can easily be maintained at the village level by organisers.

The unit of enrolment should ideally be the family or the village or the local group. Individuals as units promote adverse selection and there are chances for only the sick to enrol.

7. Identifying the Providers

The success of the entire health insurance programme depends upon the availability of reliable providers. To improve access, there should be both private and public sector providers empanelled by the NGO. In the case of public sector institutions, the government should consider replacing user fees with insurance reimbursements. However, as in most of these regions the health services are not the best that can be provided, the criteria for empanelling should not be too rigid. For hospitals to be empanelled, they should:

- be registered with the local administration
- have a resident medical officer (allopathic or ayurvedic or homeopathic or sidha or unani) available round the clock
- be acceptable to the local community
- have facilities to admit at least 10 patients at a time
- have at least 3 nurses (or nursing assistants), one for each shift
- have their own pharmacy or access to an independent pharmacy that will supply medicines to the patients
- have their own laboratory or access to an independent laboratory where investigations will be done on a credit basis for the insured patients
- be willing to use generic medicines for the treatment of the insured patients
- be willing to follow standard treatment guidelines for the treatment of the insured patients
- be willing to provide cashless services to the insured patients
- not charge any money from the patient. All services (medicines, investigations and consumables will be supplied by the hospital)
- accept the tariff rate developed by the NGO
- maintain necessary records and registers (e.g. IP register, OT register, labour room register, pharmacy register, accounts register) as per the prescribed format
- allow inspection of their records by prescribed representatives of the community or NGO
- be willing to change their treatment practices if some indicators (e.g. infection rates, Caesarean rates, admission rates, investigation rates, etc. are found to be higher than average
- be willing to submit claims as per the requirements
- be willing to wait for at least 30 days for reimbursements
- bear the cost of the fraudulent bills in the event of any fraud.

Table 3: Distribution of management functions in the Indian CHIs

Functions	Provider model	Insurer model	Linked model
Creating awareness in the community	NGO staff	NGO staff and community	
Fixing the premium	NGO staff	NGO and community	NGO and Insurance company
Collection of premium	NGO staff	NGO and community	NGO and community
Managing the insurance fund	NGO staff	NGO/Community	NGO
Negotiations with providers	Inherent	Nil	
Negotiations with insurance company	Not applicable		NGO
Providing care	NGO	Purchasing care from other providers	
Managing claims	NGO	NGO/Community	NGO and Insurance company
Managing reimbursement	NGO	NGO/Community	NGO and Insurance company
Managing the risk	NGO	NGO	Insurance company
Monitoring	Financial monitoring by NGO	Financial monitoring by NGO	Minimal monitoring by NGO
Feedback to the community	NGO	NGO	NGO

It is essential that hospitals be empanelled both at the district and sub district level in order to fulfil the original objective of improving access to healthcare.

Hospitals may not want to get involved in an insurance scheme as they may perceive it as extra work. So while negotiating, the managers must present two facts, one that by joining the scheme, the hospital will benefit from more patients. Two, many of the poor patients, to whom the hospital normally gives concessions, will now be

able to pay their entire bill. Both these points will ensure that the hospital will get more income.

Can we use government hospitals for health insurance? It has been successfully used by the Karuna Trust in Karnataka. All their patients are admitted in the local government hospitals and the insurance covers the cost of medicines (that are prescribed outside). Thus the patient does not have to pay any money at the time of illness.

It is important for the insurer to negotiate with the hospital for lower costs and good quality healthcare, and for some administrative facilities, e.g. cashless system of payment, special treatment for the insured patients (e.g. they do not have to wait in the queue), etc. Providers are not comfortable with cashless systems. They are afraid that they may not get reimbursed or will be reimbursed after a long delay. An atmosphere of trust needs to be built between the organisers and the hospital, so that they see the advantages and are willing to share some of the risks. Yet another way out is to create a rolling fund at the hospital, so that the hospital can use this fund to meet the bills of the insured patients. Once this fund is nearing depletion, the hospital submits the claims and is reimbursed the money by the NGO.

8. Who is the Insurer?

Depending on the design, the insurer can be either the NGO or a hospital or the insurance company. If the numbers are small, say a few thousands, then it is advisable to link up with a health insurance company. On the other hand, if the numbers insured are large and the NGO is confident of managing the funds, then it is advisable to take the risk. Currently, the provider model and the mutual model are legally not acceptable to the IRDA if they are operated as an 'insurance'. So organisations running such a programme should call it by a different name, e.g. a health fund.

If the NGO/CBO is taking the risk, it is necessary that it should:

- Be a registered body.
- Have the ability to manage accounts, manage the funds.
- Have social skills in marketing the product.
- Have a history of auditing its accounts regularly.
- Should be able to collect enough premium to meet the costs of the claims, the administrative costs and keep some money aside as reserve.

9. How does one Administer the Scheme?

Apart from premium collection and processing claims and reimbursements, a CHI has many other administrative functions such as:

1. Creating insurance awareness among the community. This is a very important and often neglected activity. This is best done by the NGO through its network of staff and contacts in the community. It is not a one-time activity, but should be a regular activity to keep reinforcing the message.
2. Negotiating with the insurance company and with the providers. Again a neglected but important activity. Ideally this should be done by the NGO as the community may not have the capacity or the power base to do it.
3. Monitoring the scheme. This is again a technical job and usually should be left to the NGO which has the technical capacity. Some of the indicators that need be monitored are given in the Appendix.
4. Managing risk. Putting in place measures to prevent moral hazard, adverse selection and cost escalation. Again this will fall on the NGO, which has the capacity to do this activity.
5. The NGO should ensure that there is a mechanism to deal with complaints. An independent body should be set up that will accept complaints and look into them.
6. Feedback to the community about the performance of the CHI is an important activity that needs to be done, at least annually.

Details of the administrative function and their distribution between the community and the NGOs are given in Table 3. While both the community and the NGO should share the administrative burden, one should not put too much burden on the community. Remember that they do not have too many technical skills and are also vulnerable because of their economic status. One needs to have a balance.

For administering a CHI, the NGO has to have the following skills:

- Social skills – To be able to discuss with the community about MHI and get them involved at all levels of functioning.
- Technical skills – To understand the risk management of an MHI. Also should be able to negotiate with the hospitals/insurance companies.
- Accounting skills – To be able to monitor the income, the expenses, make projections for the future and be able to calculate possible premiums for the future.

10. Processing Claims and Reimbursements

The entire CHI should ideally be a third-party payment mechanism (cashless system). The providers (hospitals) should discharge the patient and should then claim the necessary bills from the insurer (NGO/insurance company). The main question is – how does the hospital protect its interests? The hospital will be worried about the following possibilities:

- A genuine patient from household A is admitted and incurs a bill of Rs 8000 which is below the upper limit of Rs 10,000. Another patient from the same household is admitted later and incurs a bill of Rs 6,000. While this is still below the upper limit, the combination of the two bills means that the hospital will only be reimbursed Rs. 10,000 of the Rs 14,000 incurred. Unless the hospital is very sharp and has a good MIS, it may miss this and end up losing Rs 4000. One simple way out is for the hospital to enter the details of the bills in the insurance card, so at the time of admission, it is clear to all concerned how much money is in balance.
- A genuine insured patient is admitted and incurs a bill of Rs 15,000. The patient claims that he does not have the money (Rs 5000) to pay the extra amount above the upper limit. In such a case, the hospital may have to forego the money, the only consolation being that they are foregoing Rs 5000 and not Rs 15,000. Such instances can also be brought to the notice of the NGO which can then try and raise money from other sources for this situation.
- A patient uses unfair means to get admitted. Here the NGO has to play an active role in monitoring frauds and ensuring that only genuine patients get admitted.

One way of reassuring the hospital is by advancing a certain corpus to the hospital. The latter withdraws from the corpus on a monthly basis, the claim amount. When the corpus is depleted, the hospital submits the list of claims to the NGO and rebuilds the corpus.

The hospital should submit the claims to the NGO/insurance company and they in turn should reimburse the hospital directly as soon as possible. The NGO should coordinate this and ensure that there are no problems on either side.

To minimise the workload, the documents to be submitted by the hospital should be limited to a copy of the final bill and a copy of the discharge summary with the necessary clinical and laboratory details. The hospital will be open to audits by the

NGO/insurance company to check on the treatment given. As far as possible, the hospital should follow standard treatment guidelines and use generic medicines.

11. Risk Management

Managing risks is an unrecognised and much neglected aspect and probably responsible for the collapse of most CHIs. Several aspects of scheme design and management help in lessening the risk of making the scheme unviable. These involve controlling 'expenditures' and 'fraud'. The following list provides some ways of effective risk management:

- **Voluntary versus mandatory** – A health insurance that is mandatory and attracts a large number of members has a very high chance of success. It removes adverse selection and so increases the financial viability of the scheme. Unfortunately, very few CHIs are able to enforce this and so most MHIs are based on voluntary membership.
- **Enrolment unit** – It is common to have individuals as the enrolment unit. However, this encourages those who are sick or have the potential for illness (e.g. children or elderly or newly married women or people with chronic diseases) to join. This means that there is adverse selection, leading to the CHI becoming financially unviable. So it is always recommended to have a higher enrolment unit, e.g. at least a family. Even better would be all the members of an SHG, etc. But at least a family as the enrolment unit would ensure that people who are both healthy and sick will be enrolling. So there is some form of risk pooling.
- Remember that the **larger the risk pool**, the better the chances of success for the CHI because there is more risk sharing. Hence try and get as many members enrolled into the CHI. Small numbers like 500, 1000 members are not enough to run a CHI, unless one links up with an insurance company and allows for sharing risks with a larger pool.
- Having a **definite collecting period and a waiting period** will also help prevent adverse selection. This will have a positive impact on the viability of the MHI.
- A **referral system** is an important element that prevents moral hazard. This or a pre-authorisation system will ensure that only those who require care are admitted and treated.
- **Co-payments** can also help in reducing unnecessary admissions and treatment. However, care must be taken to ensure that the co-payments do not become a significant financial barrier. Co-payment could be in the form of co-insurance, deductibles or maximum limits. Each has its own advantages and disadvantages.

- **Provider payment mechanisms** like capitation or case-based payment are excellent mechanisms to reduce moral hazard. But they are complicated and require technical expertise. Hence they can be introduced at a later stage.
- **Preventing fraud** is an important measure. One way is to distribute photo ID cards to the enrolled families. However, this is very costly. Another way out is to use the social capital of the NGO staff to prevent fraud, e.g. patients may be asked to get a referral slip from a local NGO staff before getting admitted. So the hospital admits the patient only if he/she produces the insurance card and also the referral slip.

Other Aspects

Other than the steps mentioned above, there are some aspects of CHI that need to be in place for it to be successful and sustainable over the years.

Empowerment

This is an important yet neglected issue in a CHI. Most people think that CHI is simply a financial tool to finance healthcare. But CHI also has the potential to empower the local community so that they receive better quality healthcare. Some of the ways of this empowerment are:

- The community can be involved in the design and the development of the scheme. This will give them a sense of ownership and help them design something that is acceptable to them.
- The community should also share the responsibility of managing the scheme. This would range from administrative work to decision-making roles.
- The community can monitor the quality of care provided. While the technical quality may be beyond their understanding, it may be possible for them to influence the perceived quality of care. The community can demand better inter-personal services, special queues for the insured and better availability of medicines. All this can greatly improve the quality of care.
- Finally, when the community is consulted regularly, it will help in developing a scheme that is truly community owned.

Monitoring Equity – It is important not to forget equity issues in the efforts to implement the scheme. Are those with equal needs getting equal benefits? Are those with increased needs getting increased benefits? Are the richer subsidising the poor? These questions need to be asked at the beginning itself and monitored continuously.

Promoting Solidarity among the insured. This is specific to CHI – the ability to build on a base of solidarity. And to continue to build on this solidarity. One way of doing this is to give feedback to the community on a regular basis on what is happening in the scheme and how their money is being used to benefit the needy. This measure will definitely give people the sense of fulfilment that is necessary in promoting solidarity.

Building on the Foundation of Trust – This is the basis of all CHIs and should not be neglected. Trust includes issues of reliability of the management and confidence that the management is capable of managing the scheme. This needs to build up over time and sustain to ensure that the scheme continues.

Scaling up of the Scheme – It is not enough to limit the scheme to the target population. But measures should be continuously sought to see how new groups can be brought into the scheme and hence increase the risk pool, the number of insured and hence the viability of the scheme. Federating similar schemes is an easy way of scaling up. Or, creating a super insurance fund that will manage the funds of many CHIs can also introduce economies of scale while retaining the independence of management of the individual CHI.

Human Resources

It is essential to review the administrative functions of the scheme to know whether the organisation promoting the scheme needs to have additional staff or not. In the initial stages cost of human resources, especially that of technical experts and cost of capacity building is high. Small CHIs cannot be expected to bear these costs out of the premium fund. This should be financed from external resources if possible. One way of reducing this cost is to have a centre with the expertise that can then be shared by the various CHI schemes.

Capacity-building Measures Required

Learning from other schemes is one of the best ways of building capacity among the staff. Visits to and internships in other organisations with experience of running CHI can give ideas about practical management of CHI.

Apart from this, the skills and competencies mentioned in Table 4 will have to be systematically developed within the organisation. Frontline workers have to understand the concepts in insurance and have complete knowledge of the product and the scheme. They should never misguide or make empty promises to the community.

Financial management system and MIS in the organisation will have to be strengthened to manage the fund and scheme in an efficient and transparent manner.

Time Frame

We can say that CHI is a starting point for bringing in the weaker sections of the society into the formal health insurance system, ideally a social health insurance system (SHI). Or, it is a mechanism for client's control on the insurance system. CHI has the potential for promoting health and positive health behaviours, cost and fraud control, and building solidarity.

Thus, CHI can continue to run for decades either for the same clients or with newer members coming in its pool over the years, as the basic units in universal health insurance or SHI system.

Table 4: Various types of human resources required

Administrative function	Skills and competency required
Promotion of scheme, premium collection	Local language and communication skills, through knowledge of the scheme, trust and confidence of the community members
Negotiations with providers, fraud control	Medical technical and quality of healthcare knowledge, negotiation skills, courage of conviction
Negotiations with insurance agencies	Knowledge of insurance terms and procedures, negotiation skills
Claim screening, claim processing	Through knowledge of formats and procedures, computer literacy, use of MIS, diligence
Fund management	Financial management, investment knowledge, diligence
Planning and coordination	Leadership, communication and negotiation skills, analytical skills, decision making

Conclusions

The strength of CHIs lies in their relevance, affordability, reach, participatory design and management. Common weaknesses like small size, low negotiation power, weak financial management capacity can be overcome by developing federation structures and resource centres for supporting CHIs.

There are many NGO federations and SHG federations being promoted under various governmental and non-governmental programmes. These very structures can take on responsibilities for supporting CHIs and creating risk and resources-sharing mechanisms.

External development partners as well as central and state governments are now eager to support such initiatives to reach weaker sections of the community with insurance protection. Organisations and other stakeholders involved can in turn come together to further strengthen CHI systems and link these upward to a formal insurance system to develop a social health insurance mechanism.

At the end of it all, remember that CHI is a more equitable and empowering tool to help finance healthcare. IT IS NOT A MAGIC PILL TO SOLVE ALL THE PROBLEMS OF THE HEALTH SYSTEM. Financial management of health insurance is important but it should not divert the planners from the goal of CHI, namely, to improve access to healthcare and to protect the households.

Expanding the Employees' State Insurance Scheme (ESIS)

N. Devadasan and Somil Nagpal

Introduction

Health-financing models based on formal employment are widely prevalent and make up a significant source of health financing. This is in addition to the other sources of health financing through general government revenues and private insurance¹. These health financing mechanisms are recognised as powerful methods to ensure adequate financial protection for all against healthcare costs, and are compatible with the goal of fairness in financing².

In tax-funded systems, the population contributes indirectly via taxes, which then form part of the general revenues to be used in the provisioning of healthcare. In employment-based social health insurance systems, it is the employees and employers who pay in their contributions, with or without additional state support. These are then used in funding healthcare for the employees, sometimes also covering their dependents. Such employment-based contributions could take diverse forms, like a mandatory, earmarked, payroll-tax, or a voluntary, tax-deductible contribution to a health plan.

Internationally, many European nations' healthcare is financed by employee-based social health insurance. The employees and employers contribute to a 'sickness' fund. The contributions may range from 5 to 15% of the annual income. This sickness fund is used to finance the healthcare of the entire population – both employed and

¹ Savedoff, W. Tax-Based Financing for Health Systems: Options and Experiences. Discussion paper; WHO Geneva; 2004.

² Carrin, G. Community-based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives. Discussion paper; WHO Geneva; 2003.

unemployed. Germany, Belgium, France are examples from Europe, while Japan, Thailand and the Philippines are good examples from Asia. Further details are given in Appendix 4.

In India, various forms of employment-based health coverage already exist, such as the widely recognised Employees' State Insurance Scheme (ESIS) for employees in the formal sector, the Central Government Health Scheme for serving and retired civil servants, the schemes for serving and retired employees of the Armed Forces, Railways, Paramilitary forces and other government organisations, and the various health coverage schemes and benefits provided by banks, insurers, other public sector companies, and the private sector employers³. Together, they make up about 7% of the total health expenditure in the country. We shall now take a closer look at these models, especially at ESIS, and whether employment-based health insurance models are suitable for India.

Objectives of ESIS

Employment-based insurance schemes aim at:

- Ensuring adequate financial protection for all
- Reducing adverse selection
- Providing cross-subsidisation
- Effectively pooling health risks, bringing in efficiencies from bulk purchasing of health services.

The Employees' State Insurance Scheme

Employees' State Insurance Scheme (ESIS), one of the oldest health insurance schemes in India, is aimed at targeting the formal sector to provide a social security mechanism for the lower paid industrial workers. Established vide the ESIS Act in 1948, the scheme gives both cash and medical benefits to the employees of factories and service establishments who earn less than a specified wage ceiling, currently capped at Rs 7500 per month. All eligible members must contribute a share based on their wages (currently 1.75% of wages, but exempt for those earning less than Rs 40 per day) while the employer contributes a larger share (currently 4.75% of wages of all eligible employees, including the low paid ones). The state government also contributes a minimum fixed amount. The scheme is managed by the Employees'

³ Mahal. A. Sakthivel, S. Nagpal, S. National Health Accounts for India. Background Papers – National Commission on Macroeconomics and Health, New Delhi; 2005.

State Insurance Corporation (ESIC), a statutory body established under the Union Ministry of Labour, comprising representatives from the ministries of labour, health and employees' federation.

Benefits under ESIS

These include:

- free, comprehensive healthcare at ESIS facilities
- cash compensation for loss of wages due to illness
- maternity benefits
- disability benefits
- survivorship and funeral expenses in the event of death of the worker.

Healthcare includes preventive, promotive, curative and rehabilitative services. ESIS has its own dispensaries, hospitals and medical staff. It also empanels select private practitioners to provide medical care to its beneficiaries. Patients requiring treatment from specialists not available at the ESIS hospitals can receive it at the speciality facilities, with the ESIS reimbursing the expenses.

Presently, the scheme is spread over 677 centres in 25 states and Union territories across India, covering 7.8 million employees and more than 25 million beneficiaries⁴. One main limitation of the scheme is its coverage. Currently the scheme is mainly aimed at the low-paid, non-supervisory industrial worker.

Expansions

In this chapter, we propose that the formal sector can be covered by expanding the ESIS. It could lead to many advantages as listed below:

1. Such an expansion would build upon an existing scheme which already has in place legal mandate and provisions, structures to collect the contributions, provider networks, claim settlement and payment mechanisms and a management body. It could be easier to scale up this structure than to create a new one, thus saving time and effort.
2. In the ESIS the current scope of risk pooling is only between the healthy and the sick. All the beneficiaries are low-paid industrial workers and their dependents and so there is no risk sharing between the rich and the poor. Expanding coverage would bring larger numbers and all classes of wage earners into the risk pool.

⁴ <http://esic.nic.in/> accessed on 08.09.2004.

3. A large purchaser and provider of health services like the ESIS could be a more efficient mechanism of financing the health needs in the formal sector than prevalent modes of out-of-pocket payments by individuals or the smaller group insurance plans purchased for employees by their employers. For universal coverage of healthcare, more funds would need to be generated in a more organised manner, for the health service needs of the covered population. By providing a social insurance mechanism for the formal sector, these funds can be utilised in a more efficient manner.
4. There is a growing demand for medical insurance and risk protection for health needs, even among those earning well. The ESIS with its long years of experience, its healthcare institutions, statutory sanction and government backing would gain more credibility and accountability.
5. Expanding the scope of ESIS will allow existing hospitals, facilities and human resources of ESIS to be better utilised. Enhancing the scope of the scheme will help to bring down administrative costs of ESIS.
6. As higher paid workers are enrolled into the scheme, the same percentage of wages will get converted into higher contributions in rupee terms, raising the average rupee contributions per member of the scheme. This increased contribution provides the scope to improve upon the benefit package or to reduce costs of the scheme in percentage terms.

Pre requisites for Expansion of the ESIS

Before considering expansion of the scope of ESIS, the following pre-requisites will need to be addressed:

- To create widespread consensus on this matter. Large industrial houses, chambers of commerce and federations of industry should be involved. The main advantages which could be highlighted to them are: social security for their human resources, ease of administration of health benefit schemes, standardisation of coverage, etc. They will also have to be assured that the quality of services and accessibility of services shall receive due attention in this expansion. Efforts will also be needed to reassure the industry that rather than being a 'payroll tax' without any direct returns, this scheme is an important mechanism for social security and staff welfare for employees in the formal sector.
- To convince the ministries of commerce, etc. about the rationale of the scheme. This move would be associated with a marginal increase in input costs and would have some impact on the cost of Indian goods in the international market. At a time when the USP of India is its cheaply produced products and services,

expanding the ESIS might reduce this competitive edge. On the other hand, this can also be taken as the actual cost of production even now. So far the industrial houses have been benefiting by passing on this cost, either to their employees or to the government, and this scheme only makes them partially share the burden of healthcare of at least their employees. Last but not least, this can also actually be a tool to enhance the productivity of the employees by keeping them healthy.

- The employees' associations and unions must not regard this arrangement as a diversion of their members' funds. Rather, they should be convinced of the benefits for their members as such a move would increase the funds into the ESIS and provide better quality of care for them.
- Once a consensus has been reached, suitable amendments will need to be made in the current ESI Act to include necessary changes. The Central Act could be amended in a manner which allows the individual states to expand the scope of the ESI scheme according to their local requirements, without compromising on the scheme's basic principles.
- Some of the main changes that need to be considered for revision in the Act include:
 - ◆ Establishing the ESIC as an autonomous body, with independent management.
 - ◆ Removing the wage ceiling limits for eligibility.
 - ◆ Identifying the establishments that are eligible (along the lines of the EPF) or empowering the states to expand the list of covered establishments.
 - ◆ Strengthening the capacity and powers of the ESIC to
 - ◆ Collect dues from the establishments including penal provisions for defaulting establishments or those not disclosing the true numbers/wages of their employees.
 - ◆ Contract with and purchase care from private providers. Already, ESIS uses various payment mechanisms, including prospective payment mechanisms, and enabling provisions will help ESIC to control costs and keep care accessible.
 - ◆ Purchase re-insurance from public or private insurance companies. This will limit the exposure of the scheme and keep its costs predictable.

An expanded ESIS will improve its capacity to provide good health insurance through a mix of its own facilities, facilities taken over for administration from PSUs and other employers hitherto running their own facilities for their employees, as well as by purchasing good quality care from providers.

Beneficiaries in an Expanded ESIS

Currently the ESIS only insures the low-paid industrial workers who are working in

- Power-using non-seasonal factories and employing 10 or more persons
- Non-power using factories and employing 20 or more employees
- Service establishments like shops, hotels, restaurants, cinema, road transport and newspaper establishments employing 20 or more persons.

It is recommended that the coverage of the ESIS is expanded in an incremental manner, e.g. in the initial phase, the scheme could be expanded within the existing ESIS-covered establishments to cover all the staff (including those who are earning more than Rs 7500 per month) and their dependents. In the next phase, an expansion to other establishments not presently covered by ESIS could be undertaken, while reducing the minimum number of employees required to be within the scope of the scheme. In the final phase, the rest of the formal sector, including contract workers, construction workers, the self employed, etc. could be covered by the scheme.

The eligibility criteria until Phase II could be all permanent employees in these establishments, along the lines of provident fund contributions. Retired employees can continue to remain in the scheme if they contribute a fixed amount, depending upon the last salary drawn. All dependents (to be defined) are to be eligible for the benefits. In Phase III, the eligibility criteria would need to be further relaxed for the sake of contractual workers holding contracts longer than a defined period, say 3 months.

The first phase would contribute greatly to an increase in the number of members, as most of the higher-paid, or white collar workers would be covered. This would take care of a constant complaint of the ESIS – that when an employee gets a raise in pay, it disbars him/her from the ESIS and its benefits. At the same time, it is clear that the higher paid workers presently do not see any benefit in contributing to the ESIS. In the last decade or so, while the scope of ESIS has been expanded from those earning from Rs 3000 per month to Rs 7500 per month, the utilisation of services continues to be made mainly by those belonging to the lower income strata within the covered groups. Thus, despite contributing higher amounts per month, the relatively higher paid workers seem not to be availing of the ESIS benefits to the same extent as the lower-paid workers. This could be the reason for the income surpluses in the scheme in recent years. However, by covering all the staff members, risk-protection and risk-pooling for all is taken care of, and all employees continue to benefit throughout their employment period and even after.

Covering all employees has another advantage. Presently, under the Act, to opt out of ESIS, any establishment needs to show a better coverage already existing for its employees and to seek specific exemption from ESIS. Thus, even if an establishment chooses not to be covered by ESIS, adequate health coverage of all its employees would continue to be ensured.

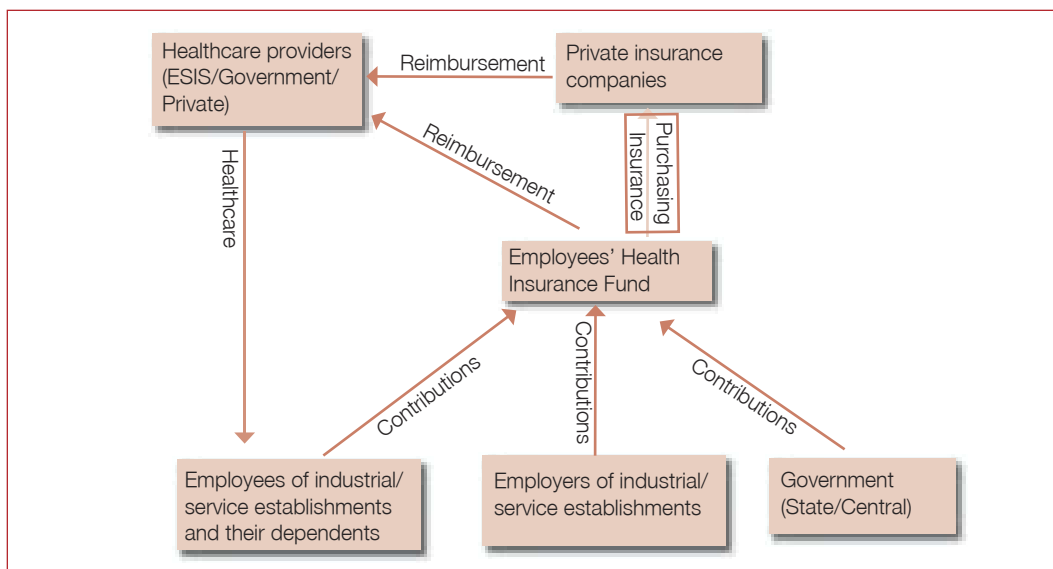
The risk pooling effect is greater when funds are pooled across establishments, e.g. if the IT industry contributions are pooled with that of a small factory. If managed properly, there would be money transfer from the better-off to the poor workers and their dependents. On the other hand, this could also be interpreted by the higher-paid workers as an additional ‘tax’ on their wages, if they do not see any advantages from their contribution.

Design of the ESIS

A proposed design of the expanded ESIS could look like what has been shown in Figure 1.

- The employees, their employers and the government would contribute to a common pool called, for the purpose of this paper, Employees’ Health Insurance Fund (EHIF). The fund represents the pooled contributions of all employees across all establishments participating in the scheme, and is the corpus which would be utilised to provide the benefits under the scheme.

Figure 1: Proposed design of the expanded ESIS



- To provide an element of choice and help facilitate the process of consensus for the expansion of the scheme, the employees could be provided with three options as regards their health coverage: to enrol with the ESIS, to enrol with a private health insurance scheme, or to remain in the institutions' healthcare scheme (in the case of those institutions that provide their own health services for its employees). The incentive to choose ESIS rather than the private health insurance would be the lower premium and the higher coverage offered by the ESIS as compared to the private health insurance. Thus, enrolees would opt for non-ESIS insurers only if these alternative insurers give them better coverage or better quality of services than ESIS. Competition would also inspire the ESIS to provide better services so that it does not lose the enrolees to competing insurance companies.
- Employers with existing health facilities could either continue with the same or hand them over to ESIS for administration. The ESIS could then use these facilities for any of its beneficiaries. If the employers choose to continue with their own facilities, and to opt out of the ESIS, they would still need to contribute the difference of the contribution they would otherwise be paying into the EHIF, and the equivalent risk-adjusted average premium amount which EHIF would have paid to any of the private insurance schemes for covering all the employees of the establishment. Also, the employers must ensure better coverage than ESIS to be able to opt out. Such an arrangement prevents misutilisation, ensures comprehensive coverage for employees, yet lets employers choose to run their own facilities, if they so desire.
- If the employee enrolls in the ESIS and requires care, he/she can receive care at any of the empanelled hospitals or providers of the scheme, and the provider will be reimbursed or otherwise paid by the EHIF. On the other hand, if the employee enrolls in a private health insurance scheme, and requires care, he/she will be subject to the policy conditions and coverage provided by the insurance company.
- Even for enrolees of the ESIS, there could be a provision for purchasing add-on or supplementary covers from private insurers, which could provide them with services that are not part of the standard ESIS benefit package. This could include, for example, stay in special/private wards, where the difference between the costs of the general ward and the special ward could then be paid by the insurer providing the supplementary cover. The availability of this choice will also ensure that the higher-paid workers can avail of high-end or non-essential services if they so desire, by purchasing the appropriate

add-on insurance covers over and above the contributions they make to the ESIS, and the availability of this option will help achieve industry and employees' consensus.

The Insurer for the Expanded ESIS

The Employees' State Insurance Corporation (ESIC) will be the main insurer of the scheme. It will provide certain products for the employees. Those employees who are not satisfied with these products could purchase insurance from private insurance companies. However, the payment of premia for this purchase would be through the ESIC, so that it can calculate the applicable premium, make sure that all the employees of the institution are insured, and that the contributions from the employers and the governments into the EHIF are being collected at the appropriate time.

The role of ESIC would include:

- Providing health insurance
- Purchasing healthcare from providers in a larger way
- Managing employer health facilities
- Paying for alternative health insurance cover from insurance companies. This requires that the capacity of the ESIC be enhanced.

The ESIC can reinsure with the GIC or other appropriate reinsurer(s) to protect its fund. Along with good fund management, this should ensure that there are enough resources to provide good quality care to all the employees in the formal sector. Currently, the ESIC's credibility is low, and it is seen as a bureaucratic organisation that responds more to its own needs than of the employees. This image has to change, for which professional managers (finance managers, health managers, actuaries, human resource managers, etc.) need to be enrolled to manage the EHIF and the provider network.

Premiums and Contributions for the Expanded ESIS

Source of Contribution:

Contributions to the ESIS will be from four basic sources:

- (i) the employees
- (ii) the employers
- (iii) the state government
- (iv) the central government. The government contributions will be mainly to fill in the gaps, if any, and will be subject to limits. The government would also, as

it does now, continue to contribute to the provision of health insurance in an invisible manner by doing away with income taxes (individual and corporate) for all contributions made into the fund.

Current rates of contribution

At present, the employees contribute at the current rate of 1.75% of their payroll. This percentage share could be retained, or with higher expected contributions and favourable claim experience, be reduced marginally. The employee contribution will be deducted at source by the employers and transferred to the EHIF on a monthly/quarterly basis. Similarly, the employer's contribution (of 4.75% as at present, or a lesser amount as decided) will also be added to the amount deducted at source and transferred to the EHIF. These contributions will be the core funding mechanism for the EHIF. The ESIC will use its MIS and its field machinery to ensure that all the enrolled employees in the establishments are contributing. Special cells for this can be formed and provided with punitive powers to enforce the legislation, including levying fines on defaulters.

At the end of the year, after the accounts are closed and audited, any deficit in the EHIF will be made good by the government in a ratio of 2:1 (state: centre). However, there will be an upper limit to this to control the spending. The premia can also be suitably revised to prevent a recurrence of the deficit.

This contribution into the EHIF will ensure that the employee receives the standard set of ESIS benefits as described below. However, if an employee wants greater coverage, high-end or higher benefits, he/she can subscribe to add-on or supplementary covers by paying an additional premium or contribution. Such covers can be provided by both ESIC and private insurance companies, and the employee can select from a variety of products and insurers. This approach ensures that the employee gets all the information at one site and is able to make an informed decision. At the same time, the insurance companies have to incur less cost in marketing as most of their products will be available for the individual customer at the point of need.

Who will join the scheme?

Being a mandatory insurance, all employees will have to join and contribute to the scheme. However, in case both husband and wife are in the workforce, a policy decision will need to be taken; in certain countries, both spouses continue to pay

their premia, while another policy option could be that only one need contribute. In the latter case, on presenting an appropriate certificate, the lower-paid spouse can be exempted from contributing towards the ESIC. However, this has to be renewed every year to prevent fraud.

Concept of solidarity

The contributions will continue to be income-rated, ensuring some form of equity. Those who earn more will contribute more, and will cross-subsidise those who earn less. However, for this the concept of solidarity needs to be built up, else there will be tremendous opposition to such a move.

Insurance card

All the enrolees will be issued an insurance card, which not only identifies the covered individuals and their eligibility for cover, but ideally serves as a smart card that can be swiped at any of the empanelled dispensaries/hospitals, ensuring a cashless health cover for the enrolees. Only employees of those establishments who have contributed to the ESIC in the previous quarter will be eligible to use the benefits, while for others, the card will initially warn of default status and after two quarters also lead to the cashless facility being temporarily withdrawn. Only after the defaulting establishment pays up its dues will the employees be eligible to lodge their claims for reimbursement. This mechanism can be another check on defaulting institutions, while also not depriving the employees of cover, as their own contribution is likely to have been deducted by the employer on time. The smart card will have all the details of the employee, his/her dependents and the institution that he/she works in. It will include a photograph of their family, and perhaps some biometric identifiers such as fingerprints coded and embedded electronically in the card chip. This will help minimise fraud due to impersonation to a large extent.

Contribution record

The contribution records will be maintained in a transparent manner, and will be available for viewing at a website. This will enable all the stakeholders – government, insurance companies, employees and employers – to review the status of their contributions. Separate accounts will be maintained at the establishments for the ESIC contributions and prior to being paid into the EHIF, this corpus will not be used for any other purposes as is the wont with many of the social security contributions.

The Benefit Package

This is an important factor for the success of this scheme and includes medical as well as cash benefits to enrolees.

Cash benefits

These are an important component of the total claim cost incurred by the ESIS, and an important social security mechanism for employees at the lower end of the wage spectrum. However, they may not be as relevant for the higher paid workers. At this stage, the policy maker has three options, namely:

- To separate the system for cash benefits from the health benefits/health insurance component. Contributions received from employers will be distributed into these two parts and separately administered for persons drawing wages up to Rs. 7500 per month. The contributions in terms of percentage of wages could then be lower for higher-paid workers who are not eligible for any cash benefits.
- To reduce premiums for all employees while making all the cash benefits available only to those who earn less than Rs 7500 per month.
- A ceiling on the daily cash benefit, basing it on the wage drawn by an employee earning up to Rs 7500 per month.

In each of these options, all those presently receiving the cash benefits continue to do so unaffected, while there is still scope for cutting down premiums.

The higher-paid workers may not value the cash benefits vis-à-vis the higher contributions required for the same, and there may not be much point providing them with this cover. So their cover could be limited only to the other three benefits, i.e. medical benefits, maternity benefits and disability benefits.

Medical benefits

In the healthcare component, currently the employees receive the following benefits: *Promotive care* – for all.

- The ESIC will develop materials and inform employees and employers on healthy lifestyles.
- Employees will be encouraged to give up smoking, allocate some time for physical exercise, encouraged to eat a healthy diet, etc. Employers will be educated and encouraged to adopt safe industrial practises so that accidents and exposure to occupational hazards are minimised.

- The workers as well as the management will be made more aware about pertinent industrial hazards.

The ESIC will thus endeavour to reduce illness on all counts through a special unit staffed by experts in communication, media, occupational health, etc.

Preventive care – for all the employees and their dependents, including

- antenatal check-ups for pregnant women
- routine immunisation services for those eligible
- annual medical check-ups for the staff and screening programmes.

Curative care – OP

- For all the employees and their dependents, provided at ESIS hospital OPDs, ESIS dispensaries and empanelled dispensaries.
- Doctors will be empanelled based on pre-specified criteria to provide OP care for the insured.
- Over a long term, a gatekeeper function through a system of registration with a ‘family doctor’ can be developed to reduce the costs of healthcare as it will ensure that illnesses are treated at the appropriate level.

The smart card will identify the insured and control fraud.

Curative care – IP care.

- This will need to undergo certain changes from the system prevalent presently.
- All insured patients will be eligible for the standard package consisting of meeting hospital expenses for most conditions, up to a maximum of, say, Rs 200,000 per family per year.
- The only exclusions could be cosmetic surgeries, spectacles, dental prosthesis, etc.
- Admissions will be in empanelled, pre-contracted hospitals and ESIS’s own facilities.
- The facility available would be a semi-private room in the ESIS hospital and a general ward in the empanelled hospital.
- Co-payments will be required for those availing of facilities in non-empanelled hospitals in emergency conditions, as a cost-control mechanism and to prevent moral hazard.

Those who find that this package is inadequate for their needs can subscribe on additional payment to an appropriate add-on cover from ESIS or a private health

insurance company, which will provide various additional benefits as per their needs, like coverage in higher classes of rooms, greater annual ceilings, annual executive health check-ups, etc.

To avail of IP care, the patient must be referred from an empanelled dispensary. This will reduce moral hazard and also reduce costs. One of the basic documents required would be a referral letter explaining why the patient could not be treated at the primary level and required care at the secondary or tertiary level. This needs to be monitored strictly to ensure that there is no fraud in the system.

One important consideration for the policy maker at this stage would be to provide mechanisms for portability of the coverage across employers and perhaps also during brief periods of unemployment. This will ensure that the employees do not lose benefits when they change their employers. One basic requirement for this would be a unique beneficiary identification number that is used by the employee. Once allotted, this could remain constant even when employers change. Also, the scheme could provide for a limited period, say three months, of continued cover even after formal employment ceases for the beneficiary. The beneficiary information is shared by employers on a monthly basis and the intimation of cessation of employment would, in any case, be delayed by up to one month due to such a reporting cycle.

The Provider Network for the Expanded ESIS

This is another crucial element for the success of this scheme. If the ESIC can ensure credible healthcare at reasonable costs, it will ensure an acceptable and sustainable healthcare programme. To this end, the ESIC should negotiate with the providers and enforce appropriate conditions in the interest of its beneficiaries. One of the first activities of the ESIC would be to empanel dispensaries and hospitals. The criteria for this will evolve over time, but some illustrative guidelines are given in Box 1.

Similar pre-qualification criteria can be developed by the ESIS for the dispensaries as well. All hospitals meeting the specified criteria and agreeing to ESIS conditions will be eligible to enrol under the ESIS.

However, the ESIS hospitals must change their mode of operations. Currently they are financed by the ESIC and the staff are paid a fixed salary, leaving little

incentive for them to perform. Once this expanded ESIS is in force, these hospitals could become independent trust hospitals which will have to compete for patients along with the private hospitals. They would however still have certain preference of beneficiaries, e.g. a higher class of rooms will be available to beneficiaries in ESI facilities. They could also admit non-ESI patients and charge market-determined rates from them, improving utilisation of their facilities. These steps will help them become more efficient and patient-friendly. Also, it would help to provide a scope of incentives and disincentives to staff based on individual and collective performance.

The ESIC should also ensure that there are adequate hospitals/dispensaries empanelled within the area where its beneficiaries are located. Norms for this are suggested above and can be developed as per local needs and national and international guidelines.

Once the hospitals/dispensaries are empanelled, the ESIC should immediately develop standard treatment guidelines for common diseases. Based on this, the costing for each procedure could be worked out by the ESIC management team. This will help develop tariffs for inpatient procedures and for contracting with private providers. These tariffs could be a flat rate, i.e. Rs X for a normal delivery, Rs Y for a Caesarean section, or could be based on location, e.g. metro and non-metro tariffs. This will prevent costs going up and be easier to administer.

Next, the ESIC would monitor whether these hospitals are adhering to the aforementioned guidelines and providing quality services to its beneficiaries. For example, ESIC could check if the patients are being prescribed generic medicines, the treatment is as per the standard treatment guidelines, the billing is as per the contracted tariffs and so on. This is an important activity for which a separate monitoring cell needs to be set up. Supervising the hospitals, helping them implement the guidelines, empowering the hospitals to influence the prescribing pattern of the doctors, all this and more will be part of the activities of the ESIC, as provider-level reform will need to complement reform of the financing system for optimum effect.

Box 1: Criteria for empanelling a hospital

The hospital should:

- Be registered with the local administration and under other relevant legislation.
- Have appropriate numbers of resident medical officer (allopathic or ayurvedic or homeopathic or siddha or Unani) available round the clock.
- Have facilities to admit at least 10 patients at a time.
- Have at least 3 qualified nurses (or nursing assistants), at least one for each shift.
- Have its own pharmacy, or access to an independent pharmacy that will supply medicines to the patients.
- Have its own laboratory or access to an independent laboratory where investigations will be done on a credit basis for the insured patients.
- Be willing to use generic medicines for the treatment of the insured patients.
- Be willing to incorporate standard treatment guidelines for the treatment of the insured patients.
- Be willing to provide cashless services to the insured patients.
- Not charge any money from the patient (except for specified co-insurance, as applicable). All services (medicines, investigations and consumables) will be supplied by the hospital.
- Accept the tariff rate developed by the ESIC.
- Maintain adequate records and registers (e.g. IP register, OT register, Labour room register, pharmacy register, accounts register) as per the prescribed format.
- Allow inspection of its records by prescribed representatives of the ESIC.
- Be willing to change its treatment practices if some indicators (e.g. infection rates, (Caesarean rates, admission rates, investigation rates, etc.) are found to be higher than average.
- Be willing to submit claims as per the requirements.
- Be willing to wait for at least 30 days for reimbursements.
- In the event of any fraud, bear the cost of the fraudulent bills.

Administration of the Insurance Programme

The ESIC, with its long experience in administering an insurance programme, already has the administrative capacity to manage such a scheme yet certain changes are required to be made in its current administrative role. For example, it needs to:

- **Create awareness among the employees.** Especially as more employees join the scheme and later more institutions join the scheme. Creative efforts using modern media should be used to focus on the positive impact of having health insurance.

This should also build on the message of solidarity and the steps required to be taken to use the benefits. This will be an ongoing activity and the centre will be staffed by experienced media/communications people.

- **Collect premiums in a more proactive manner** to ensure that all the institutions and their employees are covered by the ESIS.
- **Identify and negotiate with the providers.** This is a new task requiring considerable technical, managerial and social skills. The negotiators should have knowledge about medicine and treatment regimes and should be able to convince the hospital management to follow the ESIC guidelines.
- **Process claims and reimbursements rapidly.** For this decentralised offices should be given the responsibility of managing the funds and issuing cheques. Computers will help prevent and detect frauds, and will also have provisions for audit trials.
- **Provide feedback to the employees and employers in a regular manner.** Annually, the ESIC should give each establishment a summary report indicating the contribution inflow from their institution and the benefit outflow – in rupee as well as service terms. This is an important measure for enhancing the credibility of the ESIC and will in turn ensure that the membership in the ESIC is increased in relation to the private insurance companies.
- **Keep accounts of the entire operations.** The ESIC has been doing this and should not face any problems here.
- **Monitor the important process and output indicators.** A detailed list is given in the Annexure. The MIS is an important tool which will play a vital role in managing the scheme. Good data and analysis can help the manager detect fraud, moral hazard, cost escalation, etc. This requires that good data be generated and an experienced team analyses this data.

The ESIC should also consider support and grievance redressal mechanisms through 24x7 call centres to ensure that patients are given their due hearing and appropriate information. There could also be an online information and email support mechanism offering the same service. Such a proactive and customer-friendly approach will not only improve their credibility but also enhance the quality of services.

The entire ESIC should have a dynamic management structure comprising important stakeholders, e.g. representatives from the government, the employees, the employers and the health profession. Working committees should meet regularly

to monitor the scheme. Decision making in terms of claims and reimbursements, empanelling hospitals, negotiating with employers, etc. should be standardised and then decentralised as much as possible, to minimise bureaucratic delays.

Claims and Reimbursements

Claims and reimbursements will be handled by the ESIC. All hospitals/dispensaries with claims will submit them to ESIC on a monthly basis to the regional office of the ESIC, which, after checking the validity of the bills, will clear them within one month. This last point is important for the ESIC to be a credible insurer and a credible payer for its bulk purchase of services.

The ESIC already has administrative departments but till now they have mostly looked at accounts. Now they must add technical scrutiny to this job description, using protocols like *Appropriate Evaluation Protocols* to check whether the treatment provided is appropriate and relevant for the symptoms and diagnosis. Such mechanisms will ensure that the providers are regulated strictly.

From the beginning it must clear that a cashless system of reimbursement will be followed. The hospitals will have to take some risk in this system, of their claims being reduced or denied. The focus will be on the patient who will benefit from this measure. Also, with smart ID cards, the risk of fraud, charging over the upper limit, etc. is totally minimised.

Computerised data at all levels will help in accessing and processing information quickly. Software for this purpose can easily be developed or customised. Once this is in place, the performance of the scheme is likely to improve. More important, these indicators ensure adequate focus on the patients and outputs vis-à-vis people.

Human Resources

While the ESIC already has ample staff to manage most of their operations, to cope with the expansion, they would need more personnel, especially technical people who could for example, help it develop standard treatment guidelines, review the claims, conduct medical audits, negotiate with providers, etc. or communication experts to develop and implement a media campaign, quality experts to continuously monitor the patient satisfaction and make the necessary changes, analysts to review regularly the data inflow and support informed decisions and so on. While most of them can

be contracted or engaged as consultants, some may need to be regular employees of the ESIC. For this the ESIC needs not only to employ more people, but to build the capacity of existing staff. Exposure visits to social health insurance schemes in Europe and Asia could be a beginning. Thailand is near enough and similar to our country's situation.

Conclusions

All the aforementioned measures proposed in the new scheme of things at ESIS have two important implications: one, that the ESIC will need to make radical changes in its current style of functioning. Two, that the government has the political will to carry out these reforms. We may ask – why should the policy-maker consider such a drastic step? The main reason is that this is one big step towards universal coverage. Currently, most of the formal sector employees are uninsured. Those who are insured are at the mercy of individual insurance companies. If ESIC can provide them with a good product and can insist on everybody getting insured, the chances are that a large proportion of the Indian population will enjoy the benefits of health security. Given that this segment today uses 30% of public funds for its healthcare, this measure will ensure that the rich pay for their health services and release funds and resources for the benefit of the poor.

ESIC, with its existing network of offices and its demonstrated capacity to manage a health insurance programme, is well suited to implement this mandatory social health insurance programme. However, the ESIC must first undergo a change in its functioning and image. People often regard it as a bureaucracy-ridden and corrupt body, whose main task is to issue sick leave. It has to shift from this to being a competent insurer committed to providing good services for its beneficiaries. While the task may seem difficult, it is not impossible. There are plenty of examples of how public sector companies have made an effort and achieved a tremendous turn around with proper management and incentive structures.

One way forward could be to try out some pilots and learn from them. The policy makers have to realise that this is a long process, and that time is on our side. Rather than rushing through reforms and encountering internal and external resistance, it is advisable to proceed in a phased manner and bring about changes incrementally. Proceeding towards universal coverage by first covering the formal sector employees is a big step in that direction. A large, employment-based insurance model is probably the best policy option if universal coverage is the

ultimate goal. This could then provide the framework for extending the coverage to the informal sector, as other countries worldwide have done.

Employment-based schemes are long-term in nature, often extending through the working life of the individual into his retirement years. They resemble other long-term, social security-related schemes like pension schemes. Some schemes could have provision for the cover even during periods of unemployment or when employers change.

Extending Private Health Insurance

M.S. Pillai

Introduction

Development of health insurance is one of the goals of the government health strategy and is a stated view of the IRDA. With healthcare costs increasing in India and the expanding need for healthcare services, private health insurance is developing as a necessity. With governments subsidising premiums for those who are below the poverty line (BPL), there is a need to focus on the formal sector which primarily comprises the middle class and the upper class and who form about 30% of India's population. While some people of this section have benefits through their employers or through voluntarily purchased 'Mediclaime' policies, a large strata is still uncovered by any form of health insurance.

Currently this group resorts to out-of-pocket (OOP) payments when they access healthcare. However, this is an inefficient manner of paying for healthcare. To minimise this, it would be helpful if the government and other relevant agencies also promote health insurance among the middle and upper class.

Actually, the industry has been trying to promote health insurance, but not with much confidence, as they are afraid of the 'loss-making portfolio' tag that health insurance carries with it. This document tries to develop a focused approach to private health insurance and clearly states some of the pre-requisites that insurance companies and the government need to put in place if they want to profitably tap this huge market and improve coverage from the current 1% of the population.

The Objectives of Private Health Insurance (PHI)

The objective of private health insurance is to improve access to affordable, quality healthcare through policies that cover a major portion of their healthcare spending.

PHI aims at spreading the reach of health insurance in the country and enhancing the market share of health insurance in health financing by developing specific insurance schemes for the formal sector.

Covering the middle and upper class with health insurance also will have equity considerations. NSSO data from the 52nd round clearly shows that the upper quintile of the population consumes about 30% of public funds earmarked for healthcare. Introducing health insurance could release these resources for the poorer sections of society.

Box 1: Characteristics of the current private health insurance products

The existing products of the general insurance companies have some differences but they largely share the following characteristics.

- All of them are hospitalisation policies with add-ons like 'critical care' cover.
- Most of them are indemnity policies, though there has been a recent move towards cashless systems.
- Individuals and groups are canvassed through agents and distributors whose main responsibility is to market the product. Third-party administrators, who are supposed to service the product, usually limit themselves to administering claims and reimbursements.
- The requirements for a hospital to be empanelled are very basic – usually 25 beds. There is limited control on quality and costs.
- The premiums are risk rated – decided on the basis of the age of the insured and the pre-existing illnesses. The pricing of the premium is based on inadequate data resulting in either under-pricing or over-pricing.
- The benefit package has several exclusions and the coverage is to the limit of sum insured. Administration is difficult.
- Purchase of individual health insurance largely driven by tax benefits.
- There is definitely a gap between the people's expectations and the products offered.
- According to data offered by the insurance companies, the claims ratio is about 120%, resulting in losses for the insurance companies. This is due to a combination of reasons, poor pricing, adverse selection, over utilisation and over billing, and fraud.

Currently a large section of the middle and upper classes is not covered by any form of health insurance. Promoting private health insurance in this group would not only improve access to quality care, but would also have equity implications.

Contextual Issues

Currently we have most of the requirements to implement a successful private health insurance programme (Figure 1). While most of them are effective, there are some (shaded) that are not perfect and need to be looked into to improve the effective implementation of a private health insurance programme.

The government has accepted the importance of protecting its citizens through a risk pooling mechanism. The people also are affected because of high medical costs and would like to insure themselves against unfavourable events. The employers are also interested in protecting the health of their employees, as it enhances productivity. While the insurance companies are being effectively regulated through the IRDA, there is unfortunately very little regulation of the health sector. This is one of the weakest points in the Indian health insurance scenario. Today there are twelve insurance companies that provide health insurance, supported by 25 TPAs. The health insurance products being currently offered by these players are unprofitable and there is a need to improve pricing and its quality. Some of the main characteristics of the existing products are given in Box 1. Currently there is a network of agents and distributors, especially in the urban areas to market the products. In India, we have a mix of public and private healthcare providers, most of whom provide healthcare of questionable quality. This healthcare is also priced very highly, and usually not related to actual costs.

Due to all the above-mentioned problems, there is very limited reach of private health insurance among the middle and upper class. Data shows that only about 9 million out of an estimated 300 million have enrolled with 'Mediclaime' policies.

The Way Forward

Given the current problems with private health insurance and its limited reach, an improved approach to widening the reach of private health insurance in our country is proposed. The main emphasis would be on:

- Improving the quality of the products
- Developing an efficient pricing model
- Using different channels to reach out to the community
- Regulating the services so that quality is ensured and costs are contained.

Table 1: Insurer Distribution Plan

Channel	Formal Sector		
	Low Income* (< 1 lakh per year)	Middle Income (1–3 lakh per year)	High Income (> 3 lakh per year)
Insurer's agency force	✓	✓	
Bank/Financial institution tie-ups	✓	✓	✓
Brokers		✓	✓
Branch network		✓	✓
Corporate agents			✓
Affinity groups		✓	✓
E-channel			✓
NGOs and voluntary associations	✓	✓	

* Income refers to annual household income.

The Pre requisites

Before initiating any new steps, some pre-requisites need to be in place. These are explained below:

- Basic information for health insurance should be available. This would include:
 - ♦ List of ailments that the target population usually suffers from. Regionwise, age and genderwise.
 - ♦ Data on frequency of various illnesses in the above-mentioned population.
 - ♦ Data on the average quantity of services used for each illness.
 - ♦ Data on the unit cost for treating the above list of illnesses for two or three levels of hospitals.

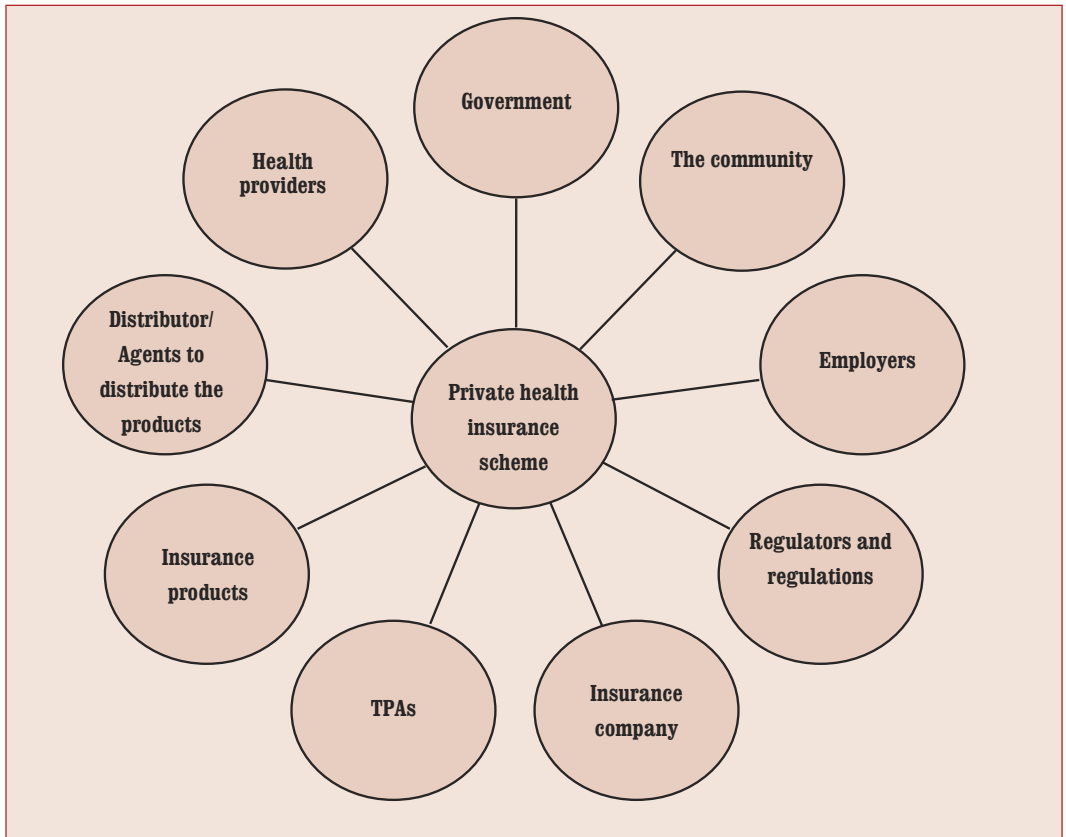
Currently one will have to depend on limited company-specific available data or that provided by the individual TPAs.

- List of providers in a region.
- Provider regulation mechanism.

The Target Community

As per recent estimates, there are about 175 million in our country who can be considered as the target population for private health insurance. They are the people who have the purchasing power and a need for health insurance.

Figure 1: The various ingredients in a private health insurance scheme



Currently most of this group is given the option of subscribing to health insurance on a voluntary basis. We suggest that the approach should be more strategic, approaching the employees of the corporate sector, the government sector and even the voluntary sector and enrolling them. Later, even employees in shops and establishments can be enrolled. While enrolling, both the employee and his/her dependents should be enrolled, thereby enhancing the coverage substantially.

Marketing of the Product

The insurer needs to map various subgroups within the target population and accordingly make the distribution plan through intermediaries, as shown in Table 2.

Changing the Design of the Current Schemes

The current design has lot of scope for improvement by integrating the service provided to the end customer. With an agent selling the product, TPAs issuing the identity

cards, insurance companies sending the papers, empanelled hospitals providing healthcare and claiming the costs and the TPAs administering the reimbursements, there are very few obvious links between these stakeholders. On the other hand, we propose a more coherent design, wherein the TPA is the 'human face' of the entire health insurance. Agents linked with the TPA will sell the product and will deliver the identity card and the policy papers to the insured. At the time of illness, this person will facilitate admission and interact with the hospital for processing the claims. This increases the credibility of the insurance company and the product and makes it more acceptable to the community.

An Acceptable Benefit Package

With the aim of providing an optimal health solution to the end user suiting his specific requirements, we suggest considerable modification in the benefit package, to make it more acceptable. The modification of the terms and conditions and development of new products on an ongoing basis are essential to maintain consumer interest and increase the numbers covered in the scheme.

Some product options have been suggested keeping in view the different target segments.

Basic Scheme: For an annual sum insured of Rs 50,000 and Rs 100,000 per person

Coverage: Including hospitalisation expenses as an inpatient for more than 24 hours. This will cover boarding expenses in semi-private rooms (limited to 0.5% of sum insured per day), physician's expenses, surgeon's fees, OT charges, laboratory expenses and cost of drugs and related appliances. Also included would be the cost of pre-hospitalisation for 7 days and post-hospitalisation for 30 days.

The age group under this coverage will be 3 months to 75 years. Medical screening before accepting the cover would be compulsory for individuals above 45 years, if enrolling on an individual basis. If enrolling on a group basis (more than 100), there would be no need for screening.

There is no cover for outpatient expenses and pre-existing conditions would be covered after a period of 3 consecutive years of renewal.

There will be a co-payment of 10% by the insured on each and every claim.

This scheme will be available to individuals and groups with a discount structure for family and group sizes.

Optimal Scheme: For an annual sum insured between Rs 100,000 to Rs 500,000 per person

This scheme will have a wider cover along with a higher sum insured range. Besides the benefits under the basic scheme, the optimal scheme would cover day-care procedures and out-patient care, up to specified limits, which will depend upon the sum insured. Maternity benefit and critical illness cover are the additional benefits for which the premium will be loaded.

	Benefits	Upper limits	Conditions
1	Hospitalisation expenses	100% of SI	After a waiting period of 30 days. Room rent restricted to 0.5% of sum insured.
2	Day-care procedures	20% of SI	After a waiting period of 30 days.
3	Out-patient care	1% of SI	After a waiting period of 30 days.
4	Maternity benefit	5% of SI	Two-year waiting period with one maternity covered in policy lifetime.
5	Dental Treatment	0.5% of SI	After a waiting period of 30 days.
6	Wellness programme/ Health Check-up	Network Hospitals	After two years of policy continuation.
7	Hospital Cash	0.2% per day	After a waiting period of 30 days.
	Critical illness rider	20% of SI	In addition to the available SI under 1–7.

	Benefits	Upper limits	Conditions
1	Hospitalisation expenses	100% of SI	After a waiting period of 30 days. Room rent limited to 0.5% of sum insured
2	Day-care procedures	20% of SI	After a waiting period of 30 days.
3	Out-patient care	1% of SI	After a waiting period of 30 days.
4	Maternity benefit	5% of SI	Two year waiting period with one maternity covered in policy lifetime
5	Critical illness rider	20% of SI	In addition to the available SI under 1-4

The basic product should be provided by all insurance companies. They are, of course, free to add other elements of coverage and riders, e.g. a personal accident element, a life component or coverage for transportation.

Enhanced Scheme: For an annual sum insured between Rs 500,000 to Rs 1,000,000 per person

The Enhanced scheme in addition to the basic and optimal schemes would cover dental care, wellness care and health check-ups after the second year and hospital cash benefit limited to 0.20% per day.

In case of dental care, out-patient care will be covered up to 0.5% of the Sum insured, while 100% of the cost of accidental injury treatment, up to the maximum policy limits will be covered.

Wellness programme will be covered as two broad components – lifestyle health risk assessment and targeted support programmes. The lifestyle health risk assessment is a comprehensive questionnaire designed to identify the health status of individuals. The results of the assessment will allow developing targeted support programmes for them as per their requirement. However, the wellness benefit will be available only to beneficiaries of group insurance and if the families are covered.

Managing and Calculating the Premium

How much would such a package cost? Back of the envelope calculations indicate that the premiums will be as follows:

Basic Scheme	:	1% to 4% of sum insured based on age distribution.
Optimal scheme	:	2% to 4.5% of sum insured.
Enhanced Scheme	:	3% to 5% of sum insured.

The pricing should be continuously compared with that of the competition and actuarial modelling.

A more accurate figure can be available if one uses the 'Premium' software in the accompanying CD. With basic figures of morbidity and the benefits, one can easily calculate the approximate premium.

Premium Collection and Accounting

Premium needs to be given by the insured or his family member on the basis of the scheme chosen. The insured will have the choice of having his premium collected by the agent/broker/NGO facilitator/Employer/e-channel for final deposit in the designated banks/accounts of the insurers.

Table 2: Benefits under the suggested scheme

Basic	Optimal	Enhanced
Rs 50,000 – Rs 100,000 sum insured per person per year.	Rs.100,000 – Rs 500,000 sum insured per person per year.	Rs.500,000 – Rs 1,000,000 sum insured per person per year.
		Optimal plus Dental care Deluxe room Pre-existing conditions (after 3 years of continuous renewals).
	Basic, plus Daycare procedures (20% of SI) Outpatient care (1% of SI) Maternity benefit (5% of SI) Health check-up Single room	Basic, plus Daycare (20% of SI) procedures Outpatient care (1% of SI) Maternity benefit (5% of SI) Health check-up Single room
Hospitalisation expenses more than 24 hours. Coverage includes room boarding expenses (0.5% of SI), physician's expenses, surgeon's fees, OT charges, surgical appliances, cost of drugs and pre- & post- hospitalisation expenses.	Hospitalisation expenses more than 24 hours. Coverage includes room boarding expenses (0.5% of SI), physician's expenses, surgeon's fees, OT charges, surgical appliances, maternity, cost of drugs and pre- & post- hospitalisation expenses.	Hospitalisation expenses more than 24 hours. Coverage includes room boarding expenses (0.5% of SI), physician's expenses, surgeon's fees, OT charges, surgical appliances, maternity, cost of drugs and pre- & post- hospitalisation expenses.
There will be a co-payment of 10% by the insured on each and every claim.		
Pre-existing conditions would be covered after a fixed period of consecutive renewals.		

The scheme hopes to provide easy collection mechanisms with monthly/quarterly/half-yearly options. This needs to have a back-to-back pan-India arrangement with a number of banks with adequate reach. The consumers will be informed about the policy terms and conditions from the same channel. The policy copy will later be delivered to him through a centralised processing centre. This process can be made more effective with the increasing role of technology.

Premium would be collected by the insurance company as a single annual premium. Provisions can be made for collection of premium as instalments where an agency like the employer pays the full premium in advance and collects the instalments from the employee. If the employer is not willing to take on this responsibility, then the insurance company can collect the premium in instalments, but with a small mark-up to cover the administrative expenses.

Provider Network

The key issue in the health insurance framework is that among the stakeholders, the provider network is least regulated. Healthcare service delivery at the provider end of the chain is a very important part of the health insurance process. The lack of adequate regulation regarding pricing and delivery influences the financials of various other stakeholders in the health insurance market. It affects the insurers in terms of pricing of the health insurance policies and its sustainability of schemes, profitability and the consumers directly in terms of affordability and availability of services.

The providers will be a network of hospitals, nursing homes, laboratories, pharmacies and specific empanelled doctors providing healthcare services to the insured population. These providers are currently concentrated in metros and mini metros and will be from the private sector. While the current tendency is for the insurance companies to have an exhaustive list of providers, we recommend that this be limited to good providers who are distributed effectively to cover the geographical areas. The insured would need to be educated about the importance of quality rather than quantity.

The select Third-Party Administrators (TPAs) will negotiate for better quality of care and cost-control mechanisms. The strength of the TPA will be based on the volume of business that the TPA will place with the provider network. Providers are interested in this as they get confirmed purchase of their services, which helps them to compete in the market.

The main focus on negotiations, in order of priority will be:

- Quality of care, based on standard treatment protocols.
- Pricing based on diagnosis related groups (DRGs) or case-based groups.
- Establishing a cashless system.
- Use of essential drugs.
- Special conditions for the insured patients, e.g. separate line, fast track consultation, minimum administrative load.

The scheme will help patients to use the facilities through empanelled providers. They can also get themselves treated at the non-network hospitals where they will not get cashless facility. Some of the prerequisites for the overall working of this scheme and the accreditation of these providers are:

The providers need to be **classified into specific categories** according to their basic facilities, quality of care and standards.

Table 3: Fixing the price as per category of provider

Procedure	City Category	Provider type	Price
Disease X	Cat A	Type 1	
Disease X	Cat A	Type 2	
Disease X	Cat A	Type 3	
Disease X	Cat B	Type 1	
Disease X	Cat B	Type 2	
Disease X	Cat B	Type 3	
Disease X	Cat C	Type 1	
Disease X	Cat C	Type 2	
Disease X	Cat C	Type 3	

From the point of view of the insurance industry, **accreditation** is one of the important ingredients of the health insurance business model. Globally, accreditation of hospitals is based on three broad models: (i) availability of basic health facilities including standards related to the number of personnel, space, standards of equipments and other facilities; (ii) rankings based on quality of care, (iii) the accessibility and acceptability of the provider to the customer, which makes the health system accountable.

In India, in the past certain standards have been laid down by the Bureau of Indian Standards and National Institute of Health and Family Welfare for facilities and equipments based on the number of beds. The Ministry of Tourism and Ministry of Family Welfare have jointly set up a task force with sub committees to look into issues of accreditation of hospitals and standardisation of services. The Government of India along with CII is also working on the accreditation of hospitals. Work is progressing on developing minimum quality standards for all hospitals and development of price bands corresponding to various specialised areas of services.

The Quality Council of India (QCI) is ready with the proposed structure of National Accreditation Board for Hospitals and Healthcare service providers (NABH). The proposed Indian criteria for assessment of hospitals by NABH will be based on organisational and clinical governance, operational management, focus on patients, clinical services and human resources. The inputs on accreditation standards are available in a draft stage and will be reviewed by the technical committee of the proposed NABH. Once these are in place and certain time frames set for hospitals/providers to meet the defined standards and different levels/grades of accreditation indicate the quality of service delivery, the linkage with the insurance market would be evident.

To have consistency and standardisation of pricing of the products, **standard treatment guidelines** need to be negotiated with the providers. As the prices of these procedures vary from location to location, separate rates need to be negotiated with these providers, as shown in Table 3.

For consumers to be satisfied with the insurance company, quality healthcare services at a suitable price by the provider should be available to them. Increase in price by the provider will result in increased price of insurance cover for the consumer, thereby having a direct impact on him. Regulating the provider will be critical to the success of developing health insurance market in India.

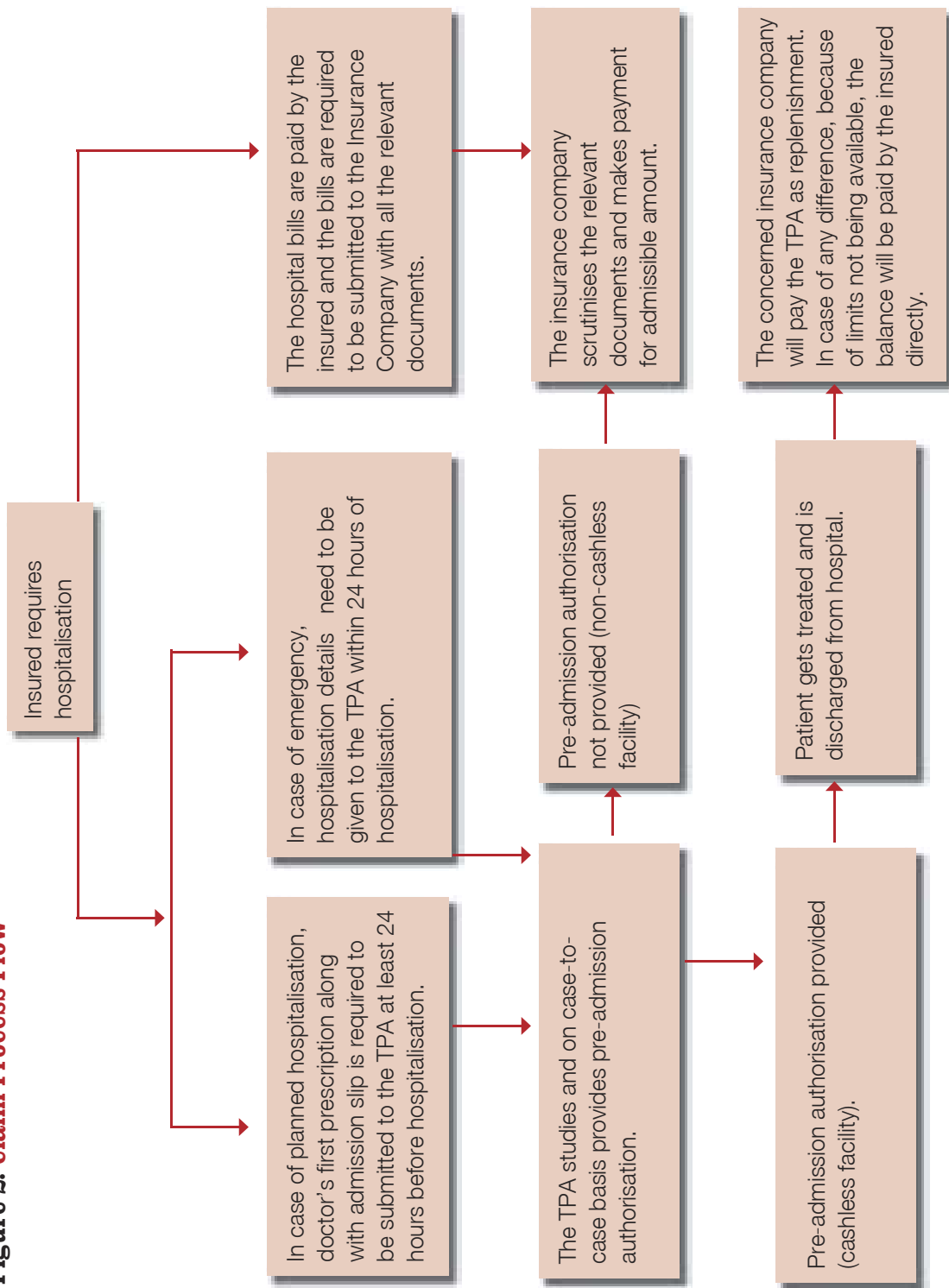
The TPA should also have the freedom to visit the provider and conduct medical audits, AEPs, and review the data.

Considering these factors, there is *need for an institution to regulate the provider network*. It should cover the current framework governing the providers, their accreditation and monitor the price and standard of care and its suitability.

Claims Servicing and Settlement

The provider network will be predefined. The claimants can avail of a cashless benefit from the empanelled hospitals in the network subject to the limits of the cover that are provided. In case the insured seeks care from a non-network hospital, the patient will have to pay the bills and claim reimbursement from the company. The details are given in Figure 2.

Figure 2: Claim Process Flow



Here the TPA and the insurance company will have to ensure that the reimbursements to the hospitals are done within a previously agreed time period. Otherwise, this will result in loss of credibility.

Management Information Systems (MIS)

Data will have to be maintained on the insured population, providers (both network and non-network hospitals) and claimants. This will include:

- Age and gender-wise summary of those covered.
- Number and amount of claims paid and outstanding.
- Details of claims: Age gender wise, geographical, location wise, disease wise.
- Cost of treatment under different heads, viz. consultation, medicines, procedures, investigations.
- Details about the providers.
- Details of health facilities and personnel. This will also include hospital PAN number, doctor's registration number with Medical Council.
- Room charges, cost of treatment (surgeon fees, OT charges, miscellaneous).
- Number of days of stay for different ailments.

The providers will have to follow the coding systems and standards prescribed, like Diagnosis codes, ICD 10; Procedure codes, Service/Revenue codes, clinical observation codes and explanation of benefits codes. This is in line with the recommendations made in the IRDA report on data collection.

Grievance Redressal

According to the current regulations, every insurer should have in place proper procedures and effective mechanisms to deal with complaints and grievances of policyholders efficiently. This information has to be communicated to the policyholder along with the policy document. Most companies provide for procedure and defined escalation process to deal with grievances. Consumers also have the option of taking any service deficiency issue with consumer forums available in every district.

Administration of the Scheme by Third-Party Administrators (TPA)

Though TPAs seem to have made a poor impression, they still are an efficient strategy to administer the scheme. So it would be advisable for us to use them for this purpose. In this document, we suggest that they have some additional roles.

TPA is an IRDA-licensed organisation, providing a range of health insurance-related services to the policyholders on behalf of the insurer and acting as a link between the insurer and the provider. These include:

For the policyholders, assistance in:

- Marketing and selling the products to specific customer groups
- Enrolment and all associated procedures
- Hospitalisation
- Claims settlement and management
- Information sharing and customer service.

For the insurance company, contribution to:

- Developing a provider network
- Assistance in negotiating healthcare charges and quality with providers
- Claims control
- Support to MIS.

Spreading Information

An essential factor for expanding the scope of private health insurance is educating and making the customer more aware of the benefits of health insurance. Given the low level of awareness in the country, there is a need for industry-specific awareness campaigns with pooling in of resources by the insurers. The campaign, on the lines of various social campaigns needs to be consistently continued over a time frame of over two years. The popularity of private health insurance in India will depend largely on the spreading of information in a simple manner through the right medium. For the basic scheme the ideal communication medium would be the television while for the optimal and enhanced versions, print, television and e-channel are suggested.

Human Resources

The human resource requirement will be personnel with a good understanding of all aspects of the health insurance market. Insurers may be required to recruit doctors, paramedical staff, healthcare assistants, and administrative staff to manage the health insurance scheme.

This will be required both at the underwriting of health business and claims settlement stage. The numbers required will depend on the volume of business.

One of the issues in India is availability of qualified staff with the knowledge of the business. There are no specific training and capacity-building organisations relating to the area of health insurance. This institution needs to be developed so that the interested resources can qualify themselves by passing relevant examinations, as is the case in some advanced countries (e.g. the US). This will develop a pool of resources, which can be used effectively in the second phase of development of the health insurance market.

Conclusions

The strength of this scheme as regards structure, organisation and delivery is that it moves a step forward in terms of offering optimal coverage to the end user. It may promote a wider coverage both in terms of geography and numbers. The sustainability will depend on the review and monitoring process in terms of service, policy conditions and pricing.

However, the scheme may be affected by the impact of provider behaviour on adequacy of the pricing. This can be seen from the recent developments wherein several important providers in a major metro city have been excluded from the network of public sector companies because of the inconsistency in the pricing of their services.

At the present moment the regulatory framework for the insurers and TPAs is in place and changes are expected for standalone health companies. What is required is the regulation of the provider network, which has to be taken up by the government.

The growth of private health insurance would, to a large extent, be influenced by the consistent thrust on this business by insurers. The funds for the scheme are to be provided by the insured whose contributions will form the pool and to some extent a subsidy for the basic scheme can be considered by the local governments.

The financial development of this scheme will depend on how much risk the individual insurance companies can take and the position and priority that health insurance has in their business model. It is quite clear that it does represent a huge opportunity, which no company can afford to ignore.

Medical Savings Account (MSA)

Somil Nagpal, Richa N. Gautam and P. Singh

Introduction

Medical Savings Accounts (MSAs) are not a new concept in international health-financing models. For over two decades in Singapore, and for over a decade in China, MSAs have proven to be a better choice than other models of Health Insurance. In South Africa, they are the most popular type of private health insurance¹. India too has had its own MSA-type model in health insurance², which has been marketed by the public sector insurers as 'Bhavishya Arogya'.

In Medical Savings Accounts, there exists an individual (or family) account in which insurance contributions are deposited, and out of which the individual (or family) concerned makes expenditure on health. In these accounts, funds which have not been utilised by the beneficiary can accumulate and be used later; they do not lapse. In theory, MSAs can be used as such, but in practice they are usually accompanied by a high-deductible or catastrophic health insurance, which protects beneficiaries from major illnesses. The catastrophic cover protects from expenses which could be beyond what their MSAs could protect them from, or could wipe out their savings in their MSAs³.

Objective

MSAs act as a demand-side approach to reduce healthcare consumption⁴. Experience shows that they can cut costs, increase competition and reduce unnecessary public

¹ Gratzner, D. It's time to consider Medical Savings Accounts. CMAJ, July 23, 2002.

² Insurance Institute of India. General Insurance (IC-34). I.I.I., Mumbai, India, 2000.

³ HealthInsurance.info. Medical Savings Accounts (MSAs). Internet.

⁴ Shortt, S E D. Medical Savings Accounts in publicly funded healthcare systems: enthusiasm versus evidence. CMAJ, 2002; 167(2): 159–162.

spending. Another advantage which could be useful for India particularly, is that MSAs can also encourage people who have not been covered earlier to join the health insurance pool⁵. In theory, people using their MSAs to make payments for the healthcare services that they receive, would be wiser consumers.

There are two advantages in introducing MSAs in India:

1. It would attract the young, healthy individuals, to join the pool of insured persons. As MSAs would need to also be accompanied by a catastrophic risk cover, the pool of health insurance beneficiaries, because of the addition of the MSA beneficiaries to it, would be larger and healthier. It would thus provide better risk sharing.
2. MSAs would have cost advantages: one, the administrative overheads of routing claims through an insurance pool are minimised, as payments are settled directly by the beneficiary or with minimal processing required on the part of the organisation maintaining the MSA. Two, the moral hazard associated with health insurance is also likely to be reduced.

The first benefit of reduction in administrative costs could, however, be offset by the fact that the buying of services in a managed-care environment is administered by expert, large buyers of services who have greater bargaining power with healthcare providers than individuals. In India, however, as this bargaining power of health insurance companies or even the Third Party Administrators is yet to develop in a big way, cost advantages of this bulk buying of services are very few. On the other hand, centralised buying of services for the catastrophic cover could actually raise the bargaining power of insurers, as is proposed later in this model.

Time Frame of MSAs

Medical Savings Accounts are long-term accounts, preferably life-long and inheritable ones. Thus, individuals can build up their medical savings from a young age, when accumulations in the account will be larger than the need to use these accounts for health-related expenditures. In this way, these accounts are similar to other long-term, social security-related savings, like the pension savings.

Design of MSAs: the International Experience

International experience with MSAs is limited to a few countries, including Singapore, China, and to some extent, South Africa, the US and Hong Kong.

⁵ Zurich Financial Services. Medical savings accounts— a counterweight to lopsided healthcare? Internet, 2005.

Singapore has had the longest experience in implementing MSAs, which were launched in April 1984. Known as 'Medisave', these interest-bearing accounts are administered by the Central Provident Fund (CPF). Currently the contribution into these accounts is about 6 to 8% of wages, tax-deductible, and shared between the employer and the employee. In addition, the Government also provides targeted subsidies – open dormitory-style wards (or General Wards) receive the highest public subsidy while 1–2 bedded wards (similar to private and semi-private wards that we have) receive no public subsidy⁶.

China piloted MSAs in two cities, Zhenjiang and Jiujiang, in December 1994. Although there are local variations in the Chinese model, contributions are pooled from employers and employees, and allocated to individual MSAs and into a social insurance pool. Once the funds in the individual accounts are over, there is an additional deductible of 5% of annual wages, beyond which the social pool is available with a co-payment by the beneficiary. Only drugs registered in the programme's Essential Drugs List are reimbursed by the social pool⁷.

In the United States, MSAs are voluntary and have had limited acceptance. They are available in two forms: (i) Archer MSAs are available since 1997, for the self-employed and for those employed in small firms, (ii) Medicare MSAs are available as an option to Medicare enrollees, again since 1997. However, the US experience with MSAs is limited.

In South Africa, MSAs are one form of voluntary, private health insurance, and have been available since the deregulation of the insurance industry in 1994, along with indemnity and HMO models. The MSAs have become the most popular type of private health insurance, and covered 4.6 million people in 2000. There is also limited information about cost-saving having been achieved through this model⁸.

Medical Savings Accounts: the Indian Experience

Although most people do not know about it, Bhavishya Arogya has been around in India for several years now⁹. Against an upfront, one-time premium payment,

⁶ Cheong, L. Medical Savings Accounts in Singapore: The Impact of Medisave and Income on Healthcare Expenditure. Center for Primary Care and Outcomes Research, Stanford University, 2004.

⁷ Hanvoravongchai, P. Medical Savings Accounts: Lessons Learned from Limited International Experience. WHO, Geneva, 2002.

⁸ Matisson, S. Medical Savings Accounts in South Africa. Report 234. National centre for policy analysis, Dallas, 2000.

⁹ Insurance Institute of India. General Insurance (IC-34). I.I.I., Mumbai, India, 2000.

the insured person receives a hospitalisation indemnity benefit after reaching a pre-selected vesting age (minimum being 55 years, to be chosen at the time of availing the policy). The total reimbursement available to the insured person is also limited up to the pre-specified sum insured. There are no exclusions for pre-existing diseases. If the policyholder dies, funds lying in the account (as calculated according to policy terms), are available to the nominee. The plan is tax-deductible under section 80D of the Income Tax act, enjoying the same tax benefit as the more widely known Mediclaim policies. The number of policies sold under this plan is quite low.

A Voluntary MSA model for India and its Advantages

There are many advantages for India in considering MSAs as an option. Introduction of MSAs, even as a voluntary model, will help increase the spread of health insurance in the country through the linked catastrophic health insurance cover. MSA, by its very nature, is an attractive option for the young and the healthy, as this group has low healthcare expenses and members of this group are in a better position to accumulate funds in their MSAs. Once this group decides to go in for MSAs, which comes with the linked catastrophic cover, the pool of persons insured in the catastrophic health insurance cover will be younger and healthier.

The absence of solidarity is criticised by many as a drawback of the MSA option, but the demographic characteristics of India, which is biased towards the young, provide some element of solidarity in the MSA model, with the young joining the catastrophic cover pool. It is also important to note, especially in view of the experience with Bhavishya Arogya, that a voluntary MSA model may not attract a large number of persons to subscribe to MSAs, as would be possible under a payroll-based model, described below.

A Payroll-based MSA Model for India and its Advantages

The advantages of MSA as a model for payroll-based health insurance schemes in countries like India are many.

- The payroll-based MSA schemes in India would allow easier administration and a large pool of insured persons.
- The linked catastrophic cover would provide solidarity and also serve as a social security mechanism.
- The community's visible and immediate need of outpatient care is met by the MSA.

- The linked catastrophic cover provides greater security. Even though its advantages may not be immediately clear to the community, it remains a very important risk protection mechanism.

In such an MSA model, a percentage of wages/emoluments of the organised workforce, to be shared by the employer and the employee in a defined proportion, would feed into the health insurance system. A part of this premium would go towards the catastrophic health insurance cover, while the rest would remain in individual MSAs.

In principle, the sources of financing for a payroll-based MSA are the same as that in the ESIS – the cost is shared by the employer and the employee. The difference is that the individuals themselves (not a corporation) would utilise a large part of this fund, and these funds in the hands of individuals would be allowed to accumulate. The mechanisms to collect the premia from employers and employees already exist in the country. However, unlike ESIS where only low-paid workers are covered, this option using MSAs would apply to all employed persons, regardless of income.

The catastrophic health insurance would provide a safety net, so that episodes of illness involving a high financial burden are taken on by the pool. The catastrophic cover component would offer a limited, basic health insurance cover for illnesses requiring hospitalisation (with exceptions for non-essential surgeries like cosmetic surgeries) to all enrollees. To attract persons with higher income, who would also end up with larger balances in their MSAs (as the contribution is based on a percentage of income, which is higher in their case) there is the choice of buying additional health insurance using funds from their MSA. These could provide them facilities like private wards or deluxe rooms, not available in the basic catastrophic cover.

Contextual Issues and Pre requisites

A committed implementing agency, in an environment of wider health sector reforms, is critical for ensuring greatest impact of a widespread health-financing initiative, including this proposed model. Introducing MSA-based health insurance will not, by itself, solve all problems with availability, accessibility and affordability of quality healthcare. Rather than looking at health insurance models as a cure for all evils in the health system, the focus has to be on a multi-pronged health reforms initiative, of which health insurance is one important component.

Introduction of MSAs would need the following pre-requisites for best impact over a long term:

- A continuation of tax incentives for subscribing to MSAs, where all health insurance and MSA contributions are deductible from income up to a specified limit. All expenses on preventive and curative care, health insurance premia and other permissible health-related expenses as defined by the regulator, for self and dependents, do not attract any taxation on withdrawal from the account.
- A regulatory agency for the sector, and the required institutional structures for such a scheme, which could include MSA fund managers. The unutilised funds lying in MSAs would be invested by these fund managers, as per the guidelines issued by the regulator, on the lines of similar fund management practices in vogue for pension, mutual fund, insurance and other financial products. The portability of these unutilised funds could also be envisaged by the regulator, though a lock-in period may become necessary so that MSA fund managers can apportion enrolment and other initial costs over a period of time and thus keep their administrative costs under control.
- A system for enrolment and identification of insured persons and settlement of their expenses, e.g. issuing smart cards or identification-cum-payment cards. The merchant categorisation practices which are already practised in the payment card industry would help identify which transactions are health related¹⁰. This would provide considerable ease in determining eligibility of payments which could be made from MSAs, this being an important aspect of MSA regulation.
- Reforms in provider payment mechanisms, including negotiated or contracted schedules of charges for procedures plus prospective provider payment mechanism, for the catastrophic health insurance cover. This could be managed by a Centralised Contracting organisation jointly established by the insurers to take this up on their behalf.
- A continuation of public providers of healthcare like PHCs, CHCs and government hospitals, where outpatient care would continue to be available at a low cost.

The Target Community

Being a wage or payroll-based scheme, the target community for the MSA model can be the employees of all organisations which employ over a specified number of persons, and the dependents of these employees. This number of employed persons

¹⁰ Visa - Merchant Category Codes for IRS Form MISC 1099 Reporting. Internet- http://usa.visa.com/download/corporate/resources/mcc_booklet.pdf

could be 10–20 or so, similar to what has already been successfully managed under the ESIS. Later, the limit could be brought down in stages, finally down to 1 employee, so that all organisations including the self-employed persons can be covered under the scheme. However, unlike ESIS there shall be no upper ceiling on income in the MSA model, therefore higher paid professionals will also be covered and accumulate contributions in their MSAs.

The target community is socially and economically heterogeneous. This provides some element of subsidy from the rich to the poor and from the healthy to the sick, in terms of a wider base for the catastrophic insurance cover and lowering of premia. However, the MSAs of lower paid workers will accumulate smaller balances, which is a limitation but is still better than there being no risk protection available at all. Also, the operation of the catastrophic cover will commence earlier for lower paid workers, as the deductible for this cover will also be low in the case of these persons, being defined in terms of annual wages or annual contribution to MSA.

For the higher paid workers, whose monthly contributions are high, the premia for the catastrophic cover will form a smaller fraction of their total contribution towards the MSA. This will help them accumulate higher balances in their MSAs, and they can use these funds to buy additional insurance for inpatient services in keeping with their health service expectations. The accumulated MSA balances will also help them incur health-related outpatient expenditure as per their choice and discretion. It might also help them in being cautious in availing of such services as they are decreasing their own account balances. The tax-benefits of this model should give them sufficient incentive so that they do not see this wage contribution as an additional ‘tax’, as a large portion of the money remains with them to be used as they wish, with the only requirement being that the same be health related.

In a voluntary MSA scenario, insurers will need to market these policies as an option available to employers, having additional benefits compared to the existing group Medisave covers. Many employers, as an HR measure, are in favour of getting group health insurance products for their employees, instead of managing medical benefits themselves. Of course, this voluntary model cannot have a market that would make this scheme a near-universal health insurance option. On the other hand, in a mandatory MSA scenario, the market situation would be much like the existing market for gratuity products, where the organisations need to provide for gratuity as laid down by legislation, but are free to choose their providers

from amongst the organisations competing for the same¹¹. Thus, the various MSA schemes could similarly compete to market their health insurance products and services to organisations.

The Insurers

The existing general insurance companies can themselves develop, market and administer these MSA-based products, after developing some more competencies in retail fund management and in electronic payments, in addition to their expected competencies in medical networks, provider payment systems, health claim processing and cost-control methods.

Alternatively, these existing health insurers could link up with other fund managers for the MSA fund management, e.g. with Banks, Mutual Funds, Provident funds, etc. and only provide services for the catastrophic cover on their own.

The Providers

Both private and public healthcare providers are eligible to be paid for their services from the MSA. However, it is important that the MSA scheme negotiates with the providers for costs, quality of care and benefits, particularly for the services paid from the linked catastrophic cover.

In order to keep premia at affordable levels for the vast majority of insured persons, various cost-control methods need to be adopted. Controlling claim costs would require contracting with providers for procedure-based or Diagnosis Related Groups (DRG)-based reimbursement systems, or perhaps even prospective provider payment mechanisms, although the latter are not easy to implement in the inpatient setting. In a mandatory model, where the purchasing power of the MSA system would be very high, accreditation of providers could be a pre-requisite for enrolling in the network, encouraging widespread accreditation of providers and the consequent control over quality of services.

However, contracting of providers would also mean that the choice of providers would be restricted for the insured persons, though all public providers and perhaps many private providers would be available. The basic services under the catastrophic cover will provide only for non luxury, shared wards, and will exclude cosmetic surgeries and certain other

¹¹ Life Insurance Corporation of India. Internet- http://www.licindia.com/group_schemes_003.htm

low-priority procedures. The providers may be required to follow a prescribed Essential Drugs List (EDL) and to prescribe drugs only by their generic names.

A deductible shall apply for the catastrophic cover, but this could be fixed, depending on the wage/monthly MSA contribution of the insured person. In this manner, the deductible will be small for a low-paid employee, and substantially higher for a highly paid worker.

The Benefit Package

The MSA balances can provide funds for all health-related expenses – including outpatient, inpatient, preventive and promotive, rehabilitative – depending upon availability of adequate funds in the MSA.

- Outpatient services – can be financed from the individual MSA.
- Inpatient services – up to a maximum of three times the monthly wages or some other limit to be decided by the MSA, depending on the profile of the subscribers – to be financed by the individual MSA.
- Catastrophic services – defined as an admission for an acute episode of illness and costing more than three times the monthly wage or higher than a fixed amount, say, Rs. 20,000 per episode. This could be reimbursed by the catastrophic health insurance component of the MSA. So the patient does not have to dip into the MSA for very large expenses and deplete his MSA. The patient can pay the stipulated deductible of 'X%' of the bill, which can be used from MSA.
- Chronic patients – can be financed from the individual MSA up to a pre-specified limit per year, and costs beyond the same to be paid from catastrophic cover with a co-payment from the MSA.
- Exclusions – interventions for cosmetic purposes, spectacles, contact lenses, hearing aids, etc.

The procedures covered would need to be according to analysis of data available with insurance companies, TPAs and other available sources at present. The benefit package would include coverage for all important cardiovascular, cardiothoracic, gastrointestinal and neurological surgeries, as well as select eye, ENT, gynaecological and orthopaedic surgeries. It will also need to include high-cost medical conditions requiring hospitalisation, including myocardial infarction, cerebral stroke, etc. and for major injuries, malignancies and other high-cost conditions like chronic renal failure requiring dialysis. The lists drawn by schemes like Yeshasvini can be a starting point for the same.

However, beneficiaries can choose greater coverage of the excluded conditions and procedures, and of paying for higher classes of beds/rooms, through supplementary health insurance policies purchased using their MSA funds. This choice, however, will be linked with a high co-payment to maintain cost-controls and to prevent inflationary pressures on health costs.

By payment of suitable additional premium for additional insurance cover over and above the catastrophic cover, facilities like single-occupancy wards and certain other excluded services can be made available to the insured persons. However, this would require a co-payment, say 25%, in addition to the higher insurance premium, both of which can be paid from the MSA.

Insured persons looking for care outside the contracted provider network may be offered limited reimbursement, fixed at the amount specified for the procedure within the contracted provider network. The remaining expenditure can come out of the MSA, or by a supplementary health insurance with a high co-payment which the beneficiary may have subscribed to.

Outpatient care is to be taken from providers of choice, and to be borne by the MSA, though the model looks at a continuation of low-cost outpatient care being available from public providers of care.

Wherever required, standard EDL drugs will be available to be purchased at low prices using the MSA funds. When the electronic payment systems are in place, these transactions would be cashless, and the MSA would stand electronically debited.

Premium and Contribution

At present, the ESIS, which is a similar scheme for the organised sector, collects 6.5% of wages (divided into 4.75% by the employer and 1.75% by the employee) for employees earning up to Rs. 7500 per month. From this group, the average annual premium received by ESIS is about Rs. 2800 per employee, the calculation being based on a total contribution of about Rs. 2000 crore from about 71 lakh employees in 2003–04¹². Assuming that a similar contribution of 6–7% is collected under the

¹² Employees State Insurance Corporation, India. Internet- www.esic.nic.in

MSA model, this contribution of Rs. 3000 per year or so shall be available from even this group earning below Rs. 1 lakh per year.

The catastrophic insurance cover may be structured to cost in the range of Rs. 300 or so per person per year, so that the low-paid employee and his dependents get 25–30% of the total contribution for the catastrophic cover. The rest will be available to him as his MSA for using OPD and other services. In addition, this group could have a safety net (in the nature of a fund/grant) provided by the government, like the one in Singapore.

For the higher income group (earning above Rs. 1 lakh per year), the allocation for the catastrophic cover may be kept at 20–25% of the monthly contribution (which in turn is the same standard 6–7% of wages). The rest could be allocated into individual MSAs. The maximum money going into the catastrophic cover may also be fixed at an absolute sum, say Rs. 10,000 per employee or Rs. 3000 per beneficiary. This high contribution to the catastrophic cover from the higher income group provides a cross-subsidy to the lower-income group. However, this cross-subsidisation will fail if insurers are allowed to choose or cherry-pick the organisations where they provide cover. Thus, a mechanism of ‘Equalisation Fund’¹³ maintains this cross-subsidy, regardless of who actually services these two different groups. The balance contribution is available to the individual employee as his MSA, to be used as per his own choice and discretion on health-related expenses.

If the MSA holder dies, the funds lying in his MSA should be inheritable, and can be merged into the MSA of his nominee/ legal heir without being taxed. If the nominee/ legal heir does not have an MSA, there may be some tax on the MSA balance, and the remaining funds can be utilised by the heirs as they wish, not necessarily in health-related expenses.

Contributions will be collected electronically or through remittance from the employers, collectively for all the employees in the organisation.

¹³ To prevent cream-skimming by insurers, a mechanism of equalisation premia could be introduced, where the premium charged from, for example, younger and higher paid individuals would include a buffer which partially subsidizes the premia payable by elderly and/or lower paid individuals. The equalisation premium is pooled and provided to insurers in the proportion of such elderly insured persons covered by them.

Claims and Reimbursements

To keep administrative costs low, the catastrophic insurance looks at a minimisation of the claims received for processing and reimbursement. This utilises the following mechanisms:

- Contracted network of providers providing cashless facilities to beneficiaries
- Specified list of eligible conditions and procedures
- Pre-agreed rates for reimbursement according to procedures or DRGs
- Centralised provider contracting and claim processing agencies, which will help prevent duplication of enrolment efforts, minimise administrative costs and will enhance the collective bargaining power of the insurers with providers.

The MSA funds will minimise administrative costs by using electronic payments at eligible health service outlets for payments being made from MSAs. These services will be subject to verification or audit at intervals by the claim-processing agencies to make sure that the services provided are genuine.

The scheme will need a lot of initial effort and investment on contracting with providers and also in issuing debit cards (or, until such time that debit cards cannot be introduced, any other identification cards) to all beneficiaries before it can be carried out. This one-time effort will ensure that subsequent costs of the scheme, both in terms of claims and administration, are low.

The contracting of providers will be to a centralised contracting agency collectively established by the health insurers and the regulator, and will not depend on the specific insurer providing the cover. This will lessen duplication of efforts to build a network, and increase the bargaining power of the insurers. If they do not tie up with the centralised contracting agency, providers will lose a large potential volume of all the insurers together. The centralised contracting agency will also monitor accreditation of the provider, quality of services and grievance-redressal of providers and beneficiaries.

Claims from providers regarding the catastrophic cover, on a periodical basis, will be forwarded to a centralised claim processing agency, again established collectively by the insurers and the regulator. This agency will process all claims received from insurers regardless of the insurer providing the cover, and the final claim costs paid out will be recovered by this agency from the respective insurers.

Administration and Management

Considering the complex and largely unexplored nature of a large-scale health insurance model for the country, it is important to have adequate regulatory infrastructure to help formulate policies and monitor the market, and make suitable changes in the system as implementation experience becomes available. The IRDA is best suited for this but requires increased capacity.

The Medical Savings Accounts are long-term investments with multiple withdrawals. These could be managed by Banking Institutions, Mutual Funds or Pension Funds, etc. which already have expertise in retail fund management and perhaps also in electronic payments. An ideal case model for MSA payments would be where all payments made out of MSAs are electronic, through debit cards. The unutilised funds lying in MSAs could be invested by the fund managers, as per the guidelines issued by the regulator, on the lines of similar fund management practices for pension, mutual fund, insurance and other financial products.

The catastrophic health insurance pool would need to be managed by a health insurance company, or preferably multiple health insurance companies, with good expertise in medical networks, provider payment systems, health claim processing and cost-control methods. To prevent misutilisation by insurers, a mechanism of equalisation premia could be introduced. Here the premium charged from, for example, younger and higher paid individuals would partially subsidise the premia payable by the elderly and/or lower paid individuals. The equalisation premium is pooled and provided to insurers in the proportion of elderly insured persons covered by them. This could be extended to other identified groups which are otherwise unattractive to insurers and could become victims of cream skimming by insurers.

Management Information Systems

A large insurance effort as proposed in this model requires a good amount of data, at the time of planning the scheme as well as on an ongoing basis. Data will be available with the centralised contracting and processing agencies, to be used by the regulator and by the insurers in designing and improving upon the scheme further, and to take care of any left out inadequacies. However, care will also need to be taken that health-related data of individuals is kept confidential and is not used against them for pricing of policies. For this purpose, administration of identifiable data should be only with the regulator, while collective data can be made available to insurers for planning their products.

Conclusions

The Medical Savings Account model, linked with a catastrophic health insurance cover, is a workable model for Indian conditions. In India, the various criticisms of an MSA model, and the perceived disadvantages of the MSA model (like lack of solidarity, no collective bargaining power with providers) are perhaps not very relevant. However, substantial preparation and investment in terms of time, effort, planning and piloting should be made before it is launched. Like any other health insurance model, this is only a financing reform, and for greatest impact, it should be part of a multi-faceted health system reform initiative.

Appendix 1

A Glossary of Health Insurance Terms

Compiled by Sunil Nandraj and Sreedevi Lakshmi Kutty

Actuary: A mathematician who specialises in estimating risks, rates, premiums, and other factors for insurance companies.

Actuarial analysis: The technique of calculating the insurance premium and the reserves required, using actuarial methods. This involves mathematical modeling using the life expectancy of the population, the frequency of hospitalisation, the costs of healthcare, etc. All insurance company premiums are usually based on actuarial analysis, but in India, because of the lack of adequate data, this analysis is based on a weak foundation.

Administrative costs: Costs related to the operations of the health insurance. This includes costs incurred in marketing the scheme, in premium collection, in claims processing, in quality assurance and underwriting fees. In India, the insurance companies load the premium by about 20% to cover these costs.

Adverse selection: It occurs when those who anticipate needing healthcare choose to buy insurance more often than others. It is because insurance suppliers lack full information about the risk of individual insured persons. Adverse selection may result from the tendency among patients to seek or continue insurance coverage to a greater extent than healthy people. An example of adverse selection is when only the baby in a family is insured. This is done because the family knows that the chances of the baby falling ill are higher. Adverse selection needs to be prevented, else it affects the financial sustainability of the insurance programme. It can be controlled to a certain degree by making the insurance mandatory and/or by enlarging the subscription unit, e.g. the entire family is insured rather than an individual.

Age limits: Stipulated minimum and maximum ages below and above which the insurance company will not accept applications or may not renew policies. Most Mediclaim policies in India have age limits of 3 months to 70 years.

Agent: An insurance company representative, licensed by the regulator, who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Ambulatory care: Medical services that are provided on an outpatient (non-hospitalised) basis, services may include diagnosis, treatment, and rehabilitation.

Association group: A group formed by members of a trade or a professional association for group insurance under one master health insurance contract.

Asymmetry of information: The situation where two people in a transaction have different amounts of relevant information. For example, in a health insurance transaction, the insured knows best about his health status. Asymmetry may allow the agent more information to practise opportunistic behaviour, e.g. a patient with diabetes will suppress the information, so that he can avail of a lower premium.

Beneficiary: A person who is eligible to receive, or is receiving, benefits from an insurance policy. Beneficiaries usually include both people who have contracted for benefits for both themselves and their eligible dependents. (See also *subscriber*)

Benefits: Benefits are the sum of money received by an insured or an assignee (e.g. a hospital) as reimbursement for medical costs incurred due to illness. Benefits may also be in the form of health services received. These benefits are in lieu of a premium paid to an insurance provider.

Blanket medical expense: A provision that entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Brochure (also called certificate of coverage): The booklet showing the complete details of a plan's benefits, limitations (or limited benefits), exclusions, and definitions. The brochure is a plan's contractual statement of benefits.

Cap: A limit of the benefit amount that an insurance company will pay. The cap may be an overall maximum, such as a maximum of Rs 10,000 per patient per year, or may apply to specific services, such as a cap of Rs 500 per year for outpatient services.

Capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person treated, regardless of the actual cost of the services provided, e.g. Rs 2000 for normal delivery.

Catastrophic insurance: A 'top-up' insurance (or re-insurance) to cover individual cases with severe or prolonged illnesses resulting in very high costs. (See also *co-payments*).

Catastrophic limit: A benefit feature to limit the amount you would have to pay in a calendar year if you or your family incurred large and unusual medical bills. This is the opposite of the 'cap'. Here the beneficiary pays a certain amount of the bill. The insurance company pays any amount above that.

Cherry picking: A practice by private insurance companies of offering medical insurance to individuals they believe to be healthy while denying coverage to those they believe to be unhealthy (see also *cream skimming*).

Claim: A request to an insurer by an insured person (or by the provider of a good or service on behalf of the insured individual) for payment of benefits according to the terms of an insurance policy.

Claim amount: It is the amount/benefit payable by the insurer under a policy on a claim occurrence.

Co-insurance: A cost-sharing provision of a health insurance policy that requires the insured beneficiary to pay a percentage of the cost of covered services. The rest is then paid by the insurance company, e.g. the beneficiary pays 10% of the bill, the rest 90% is reimbursed by the insurer. (See also *co-payments*, *cost sharing* and *deductibles*)

Collection period: A definite period during which the insurance premium is collected.

Community financing: Ways of raising money that are organised and controlled by communities themselves. Contributions may also be provided in the form of materials and community or individual labour.

Community rating: A method of establishing premiums for health insurance based on the average cost of actual or anticipated healthcare used by all the subscribers

in a specific geographic area or industry. Community ratings do not vary for different groups or subgroups of subscribers or according to such variables as the particular group's claims experience, age, sex, or health status. It is usually a flat rate applicable to all the members of the insurance programme.

Compulsory insurance: An insurance programme in which legislation defines the population covered, benefits, the conditions of eligibility, and the sources of funds. An insurance plan may be compulsory only for an employer or for individuals as well. Any universal public plan is necessarily compulsory regarding the payment of taxes (which support the plan), and thus not optional for the individual.

Contributory: A group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan.

Co-payment: A type of cost-sharing arrangement whereby insured or covered persons pay a specific, flat amount per unit of service or time and the insurer pays the rest. The co-payment is incurred at the time that the service is rendered. Unlike co-insurance (see above), which involves payment of some percentage of the total cost, the co-payment does not vary according to the cost of a service. E.g. the insured beneficiary pays the first Rs 100, the rest of the bill is reimbursed by the insurer. (See also *co-insurance*, *cost sharing* and *deductibles*)

Cost-sharing: Sharing the costs of providing a particular type of healthcare between the patient and agencies such as the provider of care and the employer of the patient. The main aim of this is to reduce frivolous/small claims.

Coverage: The guarantee against specific losses provided under the terms of an insurance policy. Frequently used interchangeably with benefits or protection, coverage is the extent of insurance afforded by a policy. It also often means insurance or an insurance contract.

Cream-skimming: A process whereby an insurer tries to insure the most healthy individuals in order to increase profits. Cream-skimming can make it difficult or impossible for individuals with high risks, e.g. children, elderly, etc. to purchase private insurance.

Declination: The insurer's refusal to insure an individual after careful evaluation of the application for insurance and any other pertinent factors.

Deductible: The amount of money an insured person must pay ‘at the front end’ before the insurer will pay. In health insurance with a Rs 1000 deductible, the insured must pay any medical bill under Rs 1000 in its entirety, and the first Rs 1000 when the total is over that amount. The reason for introducing this concept into healthcare coverage is primarily to discourage ‘unnecessary’ use of services, and also to reduce insurance premiums, since all claims have a minimum amount, which the insurer will be spared on every claim. (See also *co-insurance*, *cost sharing* and *co-payments*).

Diagnosis-Related Groups (DRGs): System that reimburses healthcare providers fixed amounts for all care given in connection with standard diagnostic categories.

Dread (or specified) disease insurance: Insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis, and spinal meningitis.

Eligibility conditions: Conditions that insured persons must meet in order to be entitled to the benefits of the scheme. These include a maximum duration of benefits (the time during which the insured may receive benefits); a qualifying period (a minimum period of contributions before the insured person or dependents can qualify for benefits); and a waiting period (the time an insured person has to wait before qualifying for specific benefits).

Eligibility period: A specified length of time, frequently ninety days up to one year, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Evidence of insurability: Any statement of proof of a person’s physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions: Specific conditions listed in an insurance or medical care policy that are not covered by benefit payments. Common exclusions include pre-existing conditions, such as heart disease, diabetes, hypertension, or asthma which began before the policy was in effect. Because of exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage either for a particular disease or in general. Sometimes conditions are excluded only for a

defined period after coverage begins, such as nine months for pregnancy or one year for illnesses. Exclusions are often permanent in health insurance coverage for individuals and temporary (e.g., one year) for small group insurance. They are uncommon in large group plans that are capable of absorbing extra risk.

Experience rating: The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Ex gratia: A payment made where there is no legal liability.

Family policy: A policy that insures both the policyholder and his or her immediate dependents (usually spouse and children).

Fee schedule: A listing of accepted charges or established allowances for specific medical or dental procedures. It usually represents either a physician's or a third party's standard or maximum charges for the listed procedures.

Fee-for-service: A method of charging whereby a physician or other practitioner bills each visit or service rendered. E.g. separate fees for consultation, medicines, laboratory, procedures, etc. This is the usual method of billing by the majority of India's private physicians. Under a fee-for-service payment system, expenditures increase not only if fees go up, but also if charges are made for more units of service or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or prepayment systems, whereby payments do not change according to the number of services actually used or if none is used.

Grace period: A specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues. (The premium can be paid without any late fees.)

Group contract: A contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Group insurance: Any insurance plan under which a group of employees (and their dependents), or members of a similar homogeneous group, are insured under a

single policy that is issued to an employer or the group itself. Group health insurance is usually rated based on experience (except for small groups, all of which are given the same rate by an insurance company). Group coverage is less expensive than comparable individual insurance, in part because an employed population tends to be healthier than the general population, and in part because of lower administrative costs, particularly in marketing and billing). Note that a policyholder or insured is the employer or group, not the individual employees or group members.

Health insurance: A financial instrument that, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of their contributions. These are primarily used to meet the costs of the benefits.

Health maintenance organisation (HMO): An organisation that provides a wide range of healthcare services for a specified group at a fixed periodic payment (similar to a premium). The main advantage of an HMO is that it has an inherent interest in keeping costs low.

Health sector: The part of the economy which is involved in activities intended to improve health. The term may be used to mean health services but it is often used synonymously with the term health system, to cover both health services and health-related activities.

Home nursing care: Skilled care in the home provided by a nurse. The care generally must be ordered by a physician, is usually limited to a specified number of hours per day and visits per year, and does not include homemaking services of any kind.

Hospice care: A coordinated programme at home and/or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialised team under the direction of a licensed or certified hospice-care facility or agency.

Hospital indemnity: A form of health insurance that provides a stipulated daily, weekly, or monthly indemnity during hospital confinement. The indemnity is payable without regard to the actual expense of hospital confinement.

Indemnity: Benefits in the form of cash payments rather than services. In most cases, after the provider of a service has billed the patient in the usual way, the insured person submits to the insurance company proof that he/she has paid the necessary bills. He/she is then reimbursed by the company for the amount of covered costs and makes up the difference him/herself. In some instances, the service provider may complete the necessary forms and submit them to the insurance company directly for reimbursement, thereafter billing the patient for costs that are not covered.

Individual insurance: Policies that provide protection to the policyholder and/or his or her family. Sometimes called 'personal insurance', as distinct from group and blanket insurance.

Inpatient services: The care provided while a bed patient in a covered facility.

Insurance company: Any company primarily engaged in the business of furnishing insurance protection to the public.

Insurance: The contractual relationship that exists when one party (the insurer) agrees to reimburse another (the insured) for loss caused by designated contingencies. The contract refers to insurance policy, the consideration is a premium, the loss is the risk, and the contingency is a hazard or peril. Insurance is a formal social device for reducing the risk of losses to individuals by spreading the risk among groups.

Insuring clause: The clause that sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Insured: A person covered by an insurance policy, to whom protection is provided under the policy terms.

Lapse: Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Limitations (or Limited Benefits): Statements in a brochure showing services or supplies that are not fully covered, only partially paid by a plan, or covered only if the service or supply provided meets certain specified criteria, e.g. pre-authorisation for surgery.

Limited policy: A contract that covers only certain specified diseases or accidents.
Loading costs: Administrative and other costs associated with underwriting an insurance policy. (*See also loading factor*).

Loading factor (or load): The percentage of total premiums used for administrative costs, profits, and all items other than medical benefits.

Long-term care: The range of maintenance and health services to the chronically ill or physically or mentally disabled. Services may be provided on an inpatient (for example, rehabilitation facility, nursing, etc.).

Managed care: Healthcare systems that integrate the financing and delivery of appropriate healthcare services to covered individuals by arrangements with selected providers to furnish a comprehensive set of healthcare services, explicit standards for selection of healthcare providers, formal programmes for ongoing quality assurance and utilisation review and significant financial incentives for members to use providers and procedures associated with the plan.

Manual rate: The premium developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Maternity care: Prenatal and postnatal care and delivery by a covered hospital, physician, or other covered practitioner, including, in many cases, nurse midwives.

Minimum group: The least number of employees permitted to effect a group for insurance purposes. The purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Moral hazard: The tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured. Can be classified into 'supply side Moral Hazard' (when the doctor provides unnecessary care because the patient is insured) or 'demand side Moral Hazard' (when the patient demands unnecessary care because he is insured).

Morbidity: The incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

No claims bonus: A reduction in the premium of an insurance policy effected through an increase in risk cover offered, because no claims have been made on it in the past years.

Non contributory: A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. All eligible employees must be insured.

Out-of-pocket payments or costs: Costs borne directly by a patient who lacks insurance benefits; sometimes called direct costs. Unless covered by insurance, they include patient payments under cost-sharing provisions.

Outpatient services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Overheads: The costs pertaining to general services (e.g. administration) which do not necessarily arise from the operation of a given programme.

Payroll deduction: A specific amount withheld from the earnings of an employee to finance a benefit. Payroll deductions may come in the form of a set payroll tax or a required payment for a benefit, such as a group health insurance premium.

Policy: The legal document issued to the policyholder that outlines the conditions and terms of the insurance; also called the 'policy contract' or the 'contract'.

Policyholder: A person who pays a premium to an insurance company in exchange for the insurance protection provided by a policy of insurance.

Pre admission certification: A procedure whereby the insured or his doctor is required to contact the insurance company before admission to a hospital, and get the latter's permission.

Pre existing condition: 'An injury that occurs, a disease that is contracted, or a physical condition which existed prior to the issuance of a health insurance policy. Such conditions usually result in an exclusion from coverage under an insurance policy due to costs of care for the condition.

Premium: The amount of money or consideration paid by an insured person or policyholder (or on his or her behalf) to an insurer or third party for coverage under an insurance policy. Premiums are related to the actuarial value of the benefits provided by the policy, plus a loading fee to cover administrative costs, profit, etc. Premiums are paid for coverage whether or not benefits are actually used. They should not be confused with cost-sharing mechanisms, such as co-payments and deductibles, which are paid only if benefits are actually used.

Private health insurance: Health insurance that is sold by either by commercial firms or non profit-making organisations to individuals or groups. Such insurance is voluntary for the individual or group as a whole (though it may be compulsory for members of the group).

Provider: A person or institution which physically delivers healthcare goods and services, e.g. a hospital or a doctor.

Referral: The practice of sending a patient to another practitioner or to another programme for services or consultation, which the referring source is not prepared or qualified to provide.

Regulation: The intervention of government in the healthcare or health insurance market in order to control entry into or change/monitor the behaviour of participants in that marketplace through specific rules.

Reimbursement: Payment by an insurance scheme to a healthcare provider, or to insured persons, as a refund for all or part of fees for services.

Reinsurance: The acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.
Renewal: Continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Rider: A document that amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage, or in any other way amend the original contract.

Risk: Any chance of loss.

Schedule: A list of coverages or amounts concerning things or persons insured.

Self-insurance (Self-insured plan): A programme for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial insurers.

Skimming: The practice in health programmes and insurance companies that are paid for on a prepayment or capitation basis of seeking to enrol only the healthiest people as a way of controlling programme costs. This is possible since the income of a programme or company is constant whether or not services are actually used. Skimming is also called creaming and contrasts sharply with adverse selection (see above).

Social health insurance: An insurance scheme set up and controlled by government or public agencies to provide protection against sickness. Social insurance is usually compulsory for the whole population or for certain group. The contributions are usually from payroll deductions of employed citizens, but the benefits are usually for the entire population.

Stop loss: The quantitative level up to which an insurer is liable for costs, beyond which risk is passed on to a re-insurer. Stop-loss clauses usually cover either overly large single claims or excessively high aggregate claims of any one member within a defined period.

Substandard risk: An individual who, because of a health history or physical limitations, does not measure up to the qualifications of a standard risk.

Third-party administration: Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Third-party payer: Any organisation, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. The individual generally pays a premium for such coverage in all private and in some public programmes and the organisation then pays bills on his/her behalf. Such payments are called third-party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party),

and the organisation paying for it (the third party). (See also *service benefits* and *indemnity benefits*.)

Time limit: The period of time during which a notice of claim or proof of loss must be filed.

Underwriter: The term as generally used applies either to: (a) a company that receives the premiums and accepts the responsibility for the fulfillment of the policy contract, or (b) the company employee who decides whether or not the company should assume a particular risk.

Underwriting: The process by which an insurer determines whether or not to accept an insurance application and on what basis/terms it will be accepted.

Uninsurable risk: One not acceptable for insurance due to excessive risk.

Universal coverage: Coverage of all the citizens of a country under a particular insurance scheme or variety of schemes.

Utmost good faith: A duty imposed on both parties to an insurance contract. The legal duty implies full disclosure of all facts material to the contract during negotiations of the contract.

Waiting period: The period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overall coverage has commenced (see exclusions). Some policies will not pay maternity benefits, for example, until nine months after the policy has been in force. Another common waiting period occurs in group insurance that is offered through a place of employment, whereby coverage may not start until an employee has been with a firm more than 30 days.

Waiver of premium: A provision included in some policies that exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract.

Waiver: An agreement attached to a policy that exempts from coverage certain disabilities or injuries that are normally covered by the policy.

Indicators for Monitoring a Health Insurance Programme

Indicator	Definition	Monthly	Annual
Coverage rate	Number of people enrolled in a defined population		+
Penetration rate	Number of people enrolled from among the target population		+
Distribution rate	Number of people enrolled per distributor		+
Enrolment trend	Trend over the years		+
Renewal rate	The number of people who are renewing their membership		+
Member satisfaction	The number of members who are satisfied with the services	+	
Insurance card rate	The number of members with an insurance card		+
Quality of claims	The number of claims with the proper documents at the first instance	+	
Utilisation rate	The number of members who fell sick and required care	+	
Claims rate	The number of members who fell sick, and have claimed insurance benefits for their illness episode	+	
Reimbursement rate	The number of members who have been reimbursed their claims	+	
Median medical costs	The median costs of hospital bills	+	
Referral rate	The number of patients who were referred	+	
Quick ratio	The ratio between the liquid assets and the liabilities	+	
Administrative expenses ratio	The ration between the administrative expenses and the total expenses		+

Appendix 3

Measures to improve the Universal Health Insurance Scheme

Current scheme	Changes suggested
Targeted at the BPL families only	Open up this scheme to all, but give the subsidy only to the BPL families.
Not clear how to identify BPL families	Use existing BPL cards to identify the BPL families, even if they are not foolproof.
Premium Individuals: Rs 365 of which Rs 200 is subsidised Family of five: Rs 548 of which Rs 300 is subsidised Family of seven: Rs 730 of which Rs 400 is subsidised	Allow APL families to enrol by paying the full premium, while the BPL families need to pay only Rs 165 / Rs 248 / Rs 400. Anybody with families more than 7 members can be charged at the flat rate of 'family of seven'. This will encourage larger families.
Definition of family is very restrictive, e.g. husband, wife, three dependent children or dependent parents	Remove these restrictions and allow any member sharing the same kitchen to be part of the family.
Covers only from 3 months to 65 years	Should have a 'womb to tomb' policy. From birth till death. No exclusions on the basis of age.
Covers only hospitalisation	Hospitalisation + OP expenses for 5 visits per person per year with a ceiling of Rs 100 per visit.
There are various limits under each category of hospitalisation, e.g. Boarding charges Rs 150 per person per day, Consultation fees up to Rs 4500, Medicines up to Rs 4500, etc.	Remove all these limitations. Just a maximum flat rate of Rs 20,000 per hospitalisation or Rs 30,000 for a family in a year.
Standard Mediclaim exclusions exist	Most exclusions should be removed as they are not acceptable to the community. Cost of spectacles should be reimbursed at a flat rate of Rs 500 per pair. Maternity cover should be provided at a flat rate of Rs 2500 per delivery. Retain exclusions only for aesthetic surgeries (which will be a rare event among BPL families anyway).

(Contd.....)

(Contd.....)

Current scheme	Changes suggested
This is a reimbursement model, where the patient has to pay upfront and get reimbursed later from the insurance company	Introduce a cashless system, so that patients do not have to pay for the services rendered.
Personal accident cover up to Rs 25,000 if the earning head of the family is injured in an accident	Retain.
Loss of wages cover of Rs 50 per day of hospitalisation in case the head of the household is hospitalised. Up to a maximum of 15 days	Change to – if anybody is hospitalised.
Definition of hospital	Any hospital/nursing home with at least 5 beds. But should be empanelled by the insurance company/administrator of the scheme. Medical practitioners with a formal medical degree can be empanelled for OP care.
There is no negotiation with the hospitals for prices	This needs to be negotiated with the empanelled hospitals, so that costs are kept under control.
No effort to inform/educate the community about the scheme	More efforts by the insurance company to educate the public.
There is no incentive to renew the policy	No claim bonus should be provided to the families.
The insurance company's role has been to develop the product. They do not market it and are reluctant to administer it	The insurance company should take on the responsibility of administering the product, along with local NGOs or local governments or state governments.
Currently only public sector companies are allowed to market this product	Allow any registered insurance company to market the product.

International Experience with Employee-based Health Insurance

In **Germany**, over 90% of residents receive healthcare through the statutory health insurance, which functions through non-profit sickness funds that collect premiums from members and pay healthcare providers according to pre-negotiated agreements. Employers and employees contribute equally in the premiums, which in the first half of the 1990s averaged between 12 and 13% of a worker's gross earnings up to the income ceiling¹. Premiums are set according to earnings rather than risk and are not affected by a member's marital status, family size, or health. The 'sickness' funds are used to purchase healthcare for the entire population, not just the employed and their dependents.

France has a system of employment-based public health insurance that now covers everybody in the nation. There are three healthcare funds: a main one covering most workers, one for the self-employed and one for agricultural workers. The funds are mandatory, no one may opt out, and they're not allowed to compete with each other nor micromanage care. This insurance system covers around 75% of all health costs in the country, the rest being met through out-of-pocket payments and supplementary insurance companies. About 85% of the French also have some form of add-on private insurance, which pays for the various procedures and equipment the public insurance doesn't wholly cover².

Japan achieved universal health coverage in 1961 through the National Health Insurance Act. Large employers (with 700+ employees) are required to operate insurance plans for workers and their dependents, called 'Society-managed insurance' and cover 26% of Japan's population. Employees and dependents in smaller companies (less than 700 workers) are automatically enrolled in the government 'small business national health plan' covering about 30% of Japan and is paid for both by payroll taxes and general fund revenue. The third category of insurance is the 'Citizens insurance programme', covering the retired and the self-employed, and

¹ Internet. Country Reports – Germany – Health Insurance. www.countryreports.org accessed on 18.4.06.

² Klein E. Health of Nations France. http://ezraklein.typepad.com/blog/health_of_nations/index.html. Internet. 2005.

is administered by municipal governments, financed through compulsory premia on the self-employed, contributions from the other two programmes and general tax revenues.

In **Chile**³, employees have to make a mandatory payment of 7% of their wages, which could then be used to contribute for health insurance coverage from the public-sector National Health Fund (Fonasa) established to administer the SHI scheme, or through the private sector insurers (Isapres). About 67% of the population is enrolled with Fonasa, while 20% are covered under some 40,000 private plans with 18 licensed, private Isapres. Both schemes are regulated by the Superintendence of Isapres, under the Ministry of Health (Government of Chile).

In **Thailand**⁴, the Social Security Scheme resembles the existing ESI scheme in India. It is a mandatory, tripartite contribution scheme, where costs are shared by the employers, employees and the government at the rate of 1% of wages each, and offers social security to formal sector employees (establishments with >10 employees), covering about 7% of the population. It also has a system for cash benefits for loss of wages due to illness.

³ Rao, K.S. Health Insurance in India. Background Papers. National Commission on Macroeconomics and Health, New Delhi, 2005.

⁴ Health Systems Research Institute. Health Insurance Systems in Thailand. Report on the 8th International Social Health Insurance Seminar, Thailand, 2002.

Some Private Health Insurance Schemes for the Poor

Name of scheme	Insurance company offering the scheme	Eligibility criteria	Annual Premium	Benefit package	Remarks
Mediclaim	All Insurance companies	3 months to 80 years	Depends on the age, the risk and the benefit package. The minimum is Rs 201.	Includes cover for hospital expenses only. For Rs 201, the maximum limit is Rs 15,000.	Existing diseases and maternity are excluded. Cashless system only if linked with TPA.
Universal Health Insurance Scheme	All GIC companies	3 months to 80 years	Rs 248 for a family of 5.	Hospital expenses up to a maximum of Rs 15,000 per patient and Rs 30,000 per family of 5.	Limited only to BPL families. Exclusions like in a Mediclaim policy.
Jan Arogya	All GIC companies	3 months to 80 years	Age rated. < 45 years Rs 70. Special family premiums.	Hospital expenses up to a maximum of Rs 5,000 per patient per year.	Exclusions like in a Mediclaim policy.
Rural Women's Package	All GIC companies	Women between 18 and 65 years	Rs 93 for women member and Rs 146 for women plus family.	Hospital expenses up to a maximum of Rs 5,000 per patient per year. Plus life cover up to 15,000.	Only for SHG women members and their families (children not included).

Tribal Health Insurance	Royal Sundaram Alliance + CCORD	0–60 years. Tribals only.	Rs 30 per person per year.	Hospital expenses up to a maximum of Rs 3000 per year.	No exclusions.
SEWA health insurance	ICICI Lombard + SEWA	18–58 years.	Rs 42 per person per year.	Hospital expenses up to a maximum of Rs 2,000 per year.	Exclusions similar to Mediclaim policy.
Karuna Trust Health Insurance scheme	NIC + Karuna Trust.	0 – 60 years.	Rs 20 per person per year.	Hospital expenses up to a maximum of Rs 2,500 per year.	No exclusions. Includes loss of wages. Uses the government health system.
Shakti Health Shield	WWA + Royal Sundaram Alliance.	0 – 60 years.	Rs 125 for < 45 Rs 65 for children.	Hospital expenses up to a maximum of Rs 7,000.	Maternity included.

Useful Links

List of websites for further information on community health insurance

Community health insurance in India	http://www.comhealthins.org
ILO – STEP	http://www.ilo.org/public/english/protection/socsec/step/
PHR Plus	http://www.phrplus.org/cbhf.html
USAID	http://www.usaidmicro.org/default.asp
Micro health insurance	http://www.microhealthinsurance-india.org/content/index_eng.html
Yeshasvini	http://www.yeshasvini.org/_holding.htm
Vimo Sewa	http://www.sewainsurance.org/
ACCORD	www.ashwini.org

Health insurance

<http://www.irdaindia.org/>

<http://www.genevaassociation.org/>

<http://www.issa.int/engl/homef.htm>

Further reading (all available at the website – www.comhealthins.org)

Dr. N. Devadasan et al. – An overview of community health insurance in India. EPW. 2004.

Dr. N. Devadasan et al. – The landscape of community health insurance in India. Health Policy. 2006.

Dr. N. Devadasan et al. – Community health insurance in India: a compilation of 10 case studies. FWWB 2005.

Rajeev Ahuja et al. – Health insurance for the poor. EPW. 2004.

Dr. Kent Ranson et al. – How to design a community based health insurance scheme. World Bank. 2003.

ILO – India: an inventory of micro insurance schemes. ILO. 2005.

ILO – Insurance products provided by insurance companies to the disadvantaged groups in India. ILO. 2005.

About the Authors

Dr. N. Devadasan, Institute of Public Health, Bangalore	<i>A doctor who worked for more than ten years with tribal populations in a remote corner of India, Dr. Devadasan, along with his wife helped to set up an entire health system for this impoverished group, financed partly by a health insurance mechanism. Here his interest in health insurance was kindled. After a three-year stint with the WHO, he is currently conducting extensive research and training in community health insurance with the Institute of Tropical Medicine, Antwerp, Belgium. Dr. Devadasan has authored many articles and books and is a consultant to various State governments on health insurance.</i>
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All views expressed in this manual are those of the authors in their personal capacity and do not reflect those of the organisations to which they belong.

Institute of Public Health

The Institute of Public Health is an initiative by a few public health professionals in an effort to make a difference to the current health scenario in our country. We believe that there are enough resources and technology available to change the health status of our citizens, all we need are the people to do it, the knowledge and the skills and most important — the motivation.

This is why our focus is on building capacity and Training is one of our main activities. We train health professionals, managers and the community; anybody who can make a positive difference in their region. The training does not just provide knowledge. We also support the individuals/organisations to put their new knowledge and skills into practice — a form of ‘hand holding’. Most important, our training is focused on the end user of health services — the community, the individual, the patient. Therefore every single training programme will be centred on this fundamental core.

Along with capacity building, we need to have an evidence-based public health. Currently data on most health-related topics in India does not exist or is not easily available. We hope that by conducting a health systems research, especially applied research, we shall be able to generate this evidence. Evidence that can be used to answer many questions that trouble our planners and policy makers. This in turn will enable them to develop appropriate and effective policies that will help the common person. Thus research and advocacy will go hand in hand.

And who are our faculty? In this era of computers and telecommunications, we do not believe in having a centralised, top-heavy cadre of academicians. Rather, we draw on existing experts from the field. These ‘experience experts’ assist us when necessary. A core team at Bangalore coordinates this process and provides the necessary direction.

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