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Journal

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"There is no pill for every ill but there is a bill for every pill"

Dr. B.M.Hegde's Sole Mantra for a healthy you and a healthier society.

भारतीय बीमा विनियामक और विकास प्राधिकरण

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Publisher's Page

Demographic studies throughout the world show that there is an increase in the ageing population across the world. This can be attributed to increased life expectancy globally. By 2025, it is estimated that there would be population increase of about 1 billion, of which about 300 million would be of age 65 years and above. Along with the increased awareness amongst the citizens of the world for the need to be in a good health, the above mentioned demographic trend has created the need for health care service innovation to deliver sustainable long term care. India is no exception to this trend.

People across the world, are being introduced to sedentary lifestyle changes that may lead to incidence of costly morbidity conditions which cause diseases of Affluence.These diseases have become a major threat, accounting for 38 million global deaths annually of which a significant part is from middle/ low income countries making it crucial to have sufficient health insurance.The medical treatment costs across the world have gone up and most of the health care spending in the Indian context is Out of the Pocket expenditure. This eats into the savings accumulated for meeting important long term financial objectives.Health Insurance not only addresses the ever rising health care costs but also would serve as a wise financial plan, that safeguards one's savings and investments, as they need not be liquidated during emergencies out of sheer lack of choice.

The Insurance sector was opened for private participation in 2000, and IRDAI has been making suitable Regulations and taking other measures from time to time with a view to ensure protection of the interests of the policy holders and orderly growth of the Insurance sector.

On July 12th, 2016, IRDAI has notified a revised Health Insurance Regulations. The Regulations primarily intend to achieve the following main objectives:

- General Insurers or Health Insurers are permitted to offer pilot products to give scope for innovation.
- To encourage the Wellness and preventive habits of the policyholder's.
- Health Insurers can offer Combi-Plans: which could be a hybrid of Health and any Life Plan to further enable Insurers to leverage on the strengths of each other.
- Allow insurance companies to offer Loan/ Credit Linked Group Health / Personal Accident Insurance products to enable the insured to repay the loan in case the insured falls ill and is not able to repay the loan.
- Encourage renewal by simplifying the renewal procedures
- To provide a permanent identity card (Smart Cards) to avail cashless facility which is valid as long as the policy is renewed with the company.

In a nutshell, the Authority's constant endeavor is to bring greater accountability of insurers internally, to encourage innovation in product design,to promote wellness habits among the policyholders, to create a policyholder friendly environment and to bring about robust growth of the Health Insurance sector.

T.S. Vijayan

प्रकाशक का संदेश

विश्व भर में जनसांख्यिकीय अध्ययन यह दर्शाता है कि सारी दुनिया में वयोवृद्ध लोगों की संख्या में वृद्धि हो रही है। इसके लिए वैश्विक तौर पर बढ़ी हुई प्रत्याशित आयु को कारण माना जा सकता है। यह अनुमान है कि 2025 तक जनसंख्या में लगभग 1 बिलियन की बढ़ोतरी होगी, जिसमें से लगभग 300 मिलियन 65 वर्ष और उससे अधिक आयु के होंगे। अच्छे स्वास्थ्य में होने की आवश्यकता के लिए दुनिया के नागरिकों के बीच बढ़ती हुई जागरूकता के साथ, उपर्युक्त जनसांख्यिकीय प्रवृत्ति ने स्वास्थ्य रक्षा सेवाओं में नवोन्मेषण की आवश्यकता को जन्म दिया है, जिससे धारणीय दीर्घकालिक रक्षा प्रदान की जा सके। इस प्रवृत्ति के विषय में भारत अपवाद नहीं है।

दुनिया भर के लोग स्थानबद्ध जीवन-शैली के परिवर्तनों के प्रति परिचित हो रहे हैं, जो विभिन्न महँगी अस्वस्थता-दर की परिस्थितियों के घटित होने के लिए मार्ग प्रशस्त कर सकती हैं , जो समृद्धि की बीमारी का कारण बनता है । ये बीमारियां एक प्रमुख संकट बन गई हैं, जो वार्षिक रूप से वैश्विक तौर पर 38 मिलियन लोगों की मृत्यु का कारण हैं जिसमें से एक उल्लेखनीय अंश मध्यम/ निम्न आय वाले देशों का है जो पर्याप्त स्वास्थ्य बीमा की व्यवस्था करने के लिए अत्यंतअत्यंत अत्यंत महत्वपूर्ण परिस्थिति का निर्माण करता है। विश्व भर में डॉक्टरी चिकित्सा की लागतें बढ़ गई हैं तथा भारतीय संदर्भ में अधिकांश स्वास्थ्य रक्षा व्यय व्यक्ति के द्वारा स्वयं अपनी जेब से वहन किया जानेवाला व्यय है। यह महत्वपूर्ण दीर्घकालिक उद्देश्यों को पूरा करने के लिए संचित बचत को हड़प लेता है। स्वास्थ्य बीमा न केवल बढ़ती स्वास्थ्य देखभाल लागतों को ही ध्यान रखता है बल्कि एक अच्छा वित्तीय योजना के रूप में भी काम करता है, जो किसी की बचत और निवेश को सुरक्षित रखता है, क्योंकि केवल विकल्प के अभाव के कारण उत्पन्न होनेवाली आपात स्थितियों के दौरान इन्हें परिसमाप्त करने की आवश्यकता नहीं होती।

बीमा क्षेत्र को निजी सहभागिता के लिए 2000 में खोला गया था, तथा पॉलिसीधारकों के हितों की रक्षा करने और बीमा क्षेत्र की सुव्यवस्थित वृद्धि को सुनिश्चित करने की दृष्टि से आईआरडीएआई समय-समय पर उपयुक्त विनियम बना रहा है तथा अन्य उपाय कर रहा है।

12 जुलाई 2016 को आईआरडीएआई ने संशोधित स्वास्थ्य बीमा विनियम अधिसूचित किये हैं । उक्त विनियमों का उद्देश्य प्राथमिक रूप से निम्नलिखित मुख्य लक्ष्यों को प्राप्त करना हैः

1. नवोन्मेषण का अवसर देने हेतु स्वास्थ्य बीमा कंपनियों से सामान्य बीमा कंपनियों तक को अब एक सीमित अवधि के लिए प्रायोगिक उत्पादों की पेशकश करने की अनुमति दी गई है।

2. पॉलिसीधारक की तंदुरुस्ती और रोगनिरोधीआदतों को प्रोत्साहित करने के लिए।

3. स्वास्थ्य बीमा कंपनी कॉम्बी-योजनाएँ प्रस्तावित कर सकते हैं: कॉम्बी योजनाएँ स्वास्थ्य और किसी जीवन योजना का मिश्रण हो सकती हैं जो बीमाकर्ताओं को एक दूसरे की शक्ति से उन्नयन करने के लिए आगे और समर्थ बनाएँगे।

4. बीमा कंपनियों को ऋण / साख से संबद्ध सामूहिक स्वास्थ्य / वैयक्तिक दुर्घटना बीमा उत्पादों की पेशकश करने के लिए अनुमति देता है ताकि बीमाकृत के बीमार पड़ने पर और ऋण चुकाने में सक्षम नहीं होने की स्थिति में बीमाकृत को ऋण चुकाने में सक्षम बनाया जा सके ।

5. **नवीनीकरण प्रक्रियाओं को सरल बनाकर नवीनीकरण को प्रोत्साहित करना**

6. नकदी रहित सुविधा का लाभ उठाने के लिए एक स्थायी पहचान पत्र (**स्मार्ट कार्ड**) प्रदान करना जो तब तक वैध होगा जब तक पॉलिसी का नवीकरण कंपनी के पास कराया जाएगा।

संक्षेप में, प्राधिकरण का निरंतर प्रयास आंतरिक रूप से बीमाकर्ताओं का अधिकाधिक उत्तरदायित्व सुनिश्चित करने, उत्पाद अभिकल्पन में नवोन्मेषण को प्रोत्साहित करने, पॉलिसी धारकों में पूर्ण स्वास्थ्य आदतों को बढ़ावा देने, पॉलिसीधारक के लिए अनुकूल परिवेश का निर्माण करने तथा स्वास्थ्य बीमा क्षेत्र के सुदृढ़ विकास लाने के लिए है।

टी.एस. विजयन
अध्यक्ष

Inside

COVER STORY

ISSUE FOCUS

THINKING CAP

From the Editor

Going the Distance

"It is health that is real wealth and not pieces of gold and silver"- *said Mahatma Gandhi.*

It is a profound truth because only a healthy mind with a healthy body can appreciate the value of any possession be it physical, mental or spiritual. The increased income levels & modern technology brought a sea of changes in the lifestyle of people. Diverse food habits, work profiles, the increased uncertainty about the periodicity of sickness or life itself and the ever increasing medical costs have all contributed to the Health Insurance gaining prominence. Health insurance, which remained highly underdeveloped and less significant segment of the insurance product portfolios, is now emerging as a major tool to manage financial needs of people seeking health services. However, there are still lots of issues and challenges that need to be addressed by the regulator as well as the health insurance industry in India.

This edition tries to bring out such issues/challenges and also various ideas from industry experts to address them.

This edition focuses on-

- *single mantra of "positive thinking" to maintain good health*
- *reasons for Under Penetration of Health Insurance in India and various policy interventions by IRDAI to address the same*
- *how digitization of the insurance ecosystem can lead to a simplified experience for both the insurers and the customers*
- *the huge scope for innovation in the health insurance sector*
- *the need on part of all the stakeholders in working towards the healing of pain points across the value chain*
- *basics and fundamentals of health insurance*
- *various customer engagement models that could be adopted and their efficacy in addressing the issues*
- *the need for creating an efficient health care system to alleviate the burden of high levels of Out of the pocket expenditure*
- *the need to have a relook into the existing structure of Indian Health Insurance sector*
- *the significance of understanding the customer needs by the insurers*

The issues and challenges that the Health Insurance industry is facing must be holistically addressed to make it a sustainable and a well rendered sector.

Let us all wish for the day when India would also be considered one amongst the other nations that has a scientifically planned Health Insurance sector in place which is both efficient and effective in addressing the needs of the citizens of the country.

"Health insurance is like a knife. In the surgeon's hand it can save the patient, while in the hands of the quack, it can kill"

- J. Anita

BEWARE!! IRDAI does not sell Insurance

The public are hereby cautioned regarding the following:

- **Some of you must be receiving phone calls from persons claiming to be employees of Insurance Regulatory and Development Authority of India (IRDAI) and trying to sell insurance policies or offering some 'benefits'.**

Please note that IRDAI does not sell or promote any company's insurance product or offer any 'benefit'.

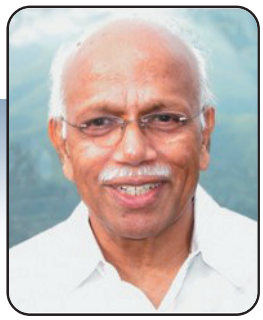
- **IRDAI regulates the activities of insurance companies to protect the interests of the general public and insurance policyholders.**

Report to the nearest police station and file FIR if:

- **Any person approaches you claiming to be IRDAI employee for sale of insurance products or offering any 'benefit',**
- **Any unlicensed intermediaries or unregistered insurers try to sell insurance products.**

Health is environmental

Dr. BM Hegde presses upon the paramountcy of a healthy mind in creating a healthy environment. He opines that "Its not what you eat but what eats you (your thoughts) that kills you!"



- Dr. BM Hegde

We have been depending too much on reductionist science to believe that health and diseases are basically controlled by our genes. This myth has now been blown apart and our genes, if anything, have very little to do with our evolution and even with our existence. Also, we now know that we can even change our genetic pattern, if needed, by *our environment*. Our life style changes, can change even our genetic pattern. This has been recently proved in the case of killer diseases of old age.

If one is healthy and well at a given point in time it is just a chance; if one, on the other hand is ill and suffering it is also a chance! No science can predict either of these events, with any degree of certainty! Doctors have been predicting the unpredictable future of patients for generations based on some phenotypic features called *risk factors*. A very large prospective study, followed up for 25 long years, has shown that there are no "*risk factors*" as far as human diseases are concerned. The said MRFIT study, did further show that the so called "risk factors" could be controlled by drugs or surgery but the risk, if it is there, still works itself successfully!

With the onset of quantum wisdom, we have been now able to comprehend much more than what we could grasp with our five senses. Quantum world view opens a new vista in human physiology where we can get a wider holographic view of human life at a given point in time. So called *life style management* also gets a new meaning in quantum world view. In the old Einstein-Newtonian world view, life style changes are simply work, sleep, food, exercise, stress reduction, the physical environments like air, water, earth, weather etc. in addition to the medical money spinners like hypertension, diabetes, obesity etc. Although this has made a dent in the morbidity pattern, they did not make a huge difference. In addition, the powerful drugs used to control the risk factors have brought in their wake many adverse drug reactions, some of them being even fatal.

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In the new world view, human mind assumes special significance. Reductionist science does not take the mind into considerations seriously although some fringe studies

did show some mental altered states like depression and frustration leading to serious illnesses. The main line medicine is yet to give importance to the mind as it is not yet sure where the mind is. The Canadian Neurosurgeon Wilder Penfield in his elaborate reductionist studies put the mind inside the brain but later realised his mistake and in 1971 admitted that the mind cannot be confined to a small organ like the brain. Mind is our *consciousness*-the canvas on which our thoughts are projected. Consciousness is fundamental and all else will have to arise from consciousness, wrote Max Planck! Matter and energy being the two faces of the same coin, the human body becomes an illusion of the human mind. In view of this new scientific awareness, the real environment for our healthy living or even for recovery from any illness should be the human mind.

A healthy mind is an insurance against diseases and is a tool in reversing disease processes. Our mind is at work in every disease situation, from common cold to cancer. In the latter case the cancer cells, "aimless, jobless wandering cells" that have mutated to survive a hostile environment in our bodies, urgently need a conducive environment to remodel and survive. Our reductionist idea of early cancer detection (a big business move for the cancer industry) is a fraud, as these wandering cells have gone far and wide, long before the cancer can be clinically detected. **Hence there is nothing called "early" cancer detection**. Sometimes the secondaries come up before the primary cancer shows up! It is imperative that people understand the significance of a healthy mind to be physically healthy. For the lay person what should be the meaning of a "healthy mind"?

Healthy mind is a mind filled with "enthusiasm to work and enthusiasm to be compassionate." This all-encompassing definition covers all parts of health. The words are chosen carefully. Enthusiasm is not just wanting to do a thing but a compulsive motivation to do that. Enthusiasm to work is the love for work-***want to work and NOT have to work!*** Similarly, enthusiasm to be compassionate is a compulsive urge to be of some use to someone, almost always, nay to be universally compassionate. If one follows these two mottos in life, there is no room for any negative thoughts in the mind like hatred, jealousy, superego, anger, pride, and greed (that too Wall Street greed!). These are the real risk factors for all major killer diseases!

In the true sense of the word, the real environment for the

Healthy mind is a mind filled with "enthusiasm to work and enthusiasm to be compassionate." Enthusiasm is not just wanting to do a thing but a compulsive motivation to do that. Enthusiasm to work is the love for work-***want to work and NOT have to work!***

human wellness and illnesses is the human mind. Rest of the conventionally acclaimed risk factors are not the real environment although they do contribute to the final outcome. Genetics has given place to epigenetics. Human mind sits in the driving seat in human affairs which can even alter the gene penetrance. Charles Darwin and Gregory Mendel have been given an undeservedly exalted position in medical textbooks although the neo Darwinists still want to hang on to their coat strings as there is money in genetic profiling, genetic engineering, stem cell research, dead body and cord blood preservation etc. Charles Darwin himself, in his old age and, before him, his own grandfather Erasmus Darwin and Lamarck have clearly said that the environment is more important than the genes in human evolution. The new

science of evolutionary biology has strongly reiterated that truth.

Like people who search for the God inside mud and stone structures, these scientists have been searching for the real environment in BP, sugar, cholesterol, tummy girth etc. which is far outside the real environment of the human mind. Our future generation at least should have the benefit of this truth. We have to bring forth a generation of our youth with a healthy mind. In that direction real education takes the cake. Today, education is aimed at making a wealthy career for the child. That is not education. The real education is to make a healthy mind out of every child and not just a wealthy career. If every Indian child develops a healthy mind with enthusiasm to work and enthusiasm to be compassionate, all our societal ills like terrorism, laziness, crime, rape etc. will vanish without any effort on our part. Can I hope that the powers that be, would change the base of education policy, which would lay the foundation for a healthy mind in every child?

"21st century illiterate is one who cannot unlearn the wrong things that he has learnt and relearn the right things."

Dr. BM Hegde,
hegdebm@gmail.com

Biography of Dr. BM hegde

"People's Doctor" **Padma Bhushan Dr. Belle Monappa Hegde** well known as Dr.**B. M. Hegde** was born on August 18, 1938, in Pangala near Udupi. This exemplary soul has many feathers to his cap of outstanding glories. He is an amazing Cardiologist, Medical scientist, inspirational orator, author of several books and an able administrator.

He is highly regarded for his Philanthropic activities. He is one of the rare doctors who instead of prescribing medical tests and dozens of drugs, advises on a healthy life style and says "***Enough medicine is already in our body. The day we understand real science, we will stop reaching out to drugs, sit in tranquil and the body will cure for itself. "***

Dr. B M Hegdewas honored with ***Padma Bhushan*** *award in 2010, one of India's highest civilian awards. He has been a deserving recipient of various national and international awards for his outstanding contributions in medical field. Some of them being the Dr. B. C. Roy Award in 1999, Dr. J C Bose award for life science research and highly recognized pride of India award from United States of America.*

It is a privilege to present to our readers, the interesting insights from this inspirational personality....

Academic milestones:·

FAMS – National Academy of Medical Sciences, New Delhi – 2002

- FRCPI – Royal College of Physicians, Dublin (Honorary Fellowship Conferred for Distinction) – 1999
- FRCPE – Royal College of Physicians, Edinburgh – 1986
- FRCPG – Royal College of Physicians and Surgeons, Glasgow – 1985
- FACC – American College of Cardiology, Bethesda Md. – 1984
- FRCP – Royal College of Physicians, London – 1981
- MRCP – Royal Colleges of Physicians, UK – 1969
- MD – King George's Medical College, University of Lucknow – 1962-64
- MBBS – Stanley Medical College, Madras University – 1956-60

Health Insurance architecture in India: Challenges ahead

Mr. Pankaj Nawani sanguinely opines that a balance established between the objectives of Health Insurance and the mechanisms to regulate the overall costs of delivery would go a long way in ensuring that the sector not only grows expeditiously but withal would achieve its social and commercial purposes.

- Pankaj Nawani

It would be safe to say that if at all there was a country suited for the expansion of health insurance it would be India. Firstly, the tropical climate and poor public sanitation makes it a haven for spread of bacterial diseases like Typhoid, Hepatitis etc. Secondly we have high pollution levels, particularly in cities, which can lead to spread of endemic diseases like cancer and respiratory disorders. Thirdly, we have poor levels of awareness, poverty and a culture which does not lay much emphasis on physical fitness. In this overall scenario it is interesting to note the pattern of expenditure on health care and what it might suggest for the future of health insurance in the country. According to a Mckinsey study India spends 4% of its GDP on health care [1]. Of this roughly 9% is financed by insurance arrangement, 30% is financed by public expense (Government and NGO's) and rest 61% is self financed. This level of self financing is bound to have negative consequences. In 2004, when the health insurance penetration was 1%, 7% of Indian households fell below poverty line on account of catastrophic health insurance [2].

Last decade and a half has seen very rapid expansion of health insurance coverage in India. In 2003-04 the total premium for health insurance in India was 1370 cr which has risen in FY 2016 to 21000 cr. This is a CAGR of nearly 30%, making health insurance the fastest growing segment in the Indian Insurance sector. The number of lives has also risen from 2 cr to 29 cr. [3] A big part of this expansion has been driven by public initiatives like National Rural Health Mission (NHRM) and health schemes like Rashtirya Swasthya Bima Yojana(RSBY), Janani Surakasha Yojana(JSY) launched by central and state governments. These programs today provide health insurance cover ranging from Rs. 30,000 to Rs 200,000 to around 21 cr people. Over and above government schemes, 5 cr workers are covered by employer provided group health insurance schemes while another 2.5 cr have individual health insurance policy coverage.

According to a Mckinsey study India spends 4% of its GDP on health care [1]. Of this roughly 9% is financed by insurance arrangement, 30% is financed by public expense (Government and NGO's) and rest 61% is self financed. This level of self financing is bound to have negative consequences.

While the expansion of health insurance coverage is a step in right direction, health insurance is not the end in its own self. The purpose of health insurance has to be to increase the quality of health care as well as alleviate the financial distress associated with medical expenses. When considered in this light the overall impact of health insurance coverage has been a bit of a mixed bag. On the one hand there have been remarkable improvements in access to health care particularly in rural sector. The percentage of institutional births has increased in India by 15% in last 10 years with a corresponding decline in percentage of home births. Also Health Insurance coverage is associated with a 17% increase in probability of being admitted in hospital[2]. Clearly the access to healthcare has improved with expansion of health insurance.

However on the aspect of mitigating financial distress, health insurance has not had the requisite impact. After a decade of health insurance expansion, the percentage of households which fall below poverty levels, on account of catastrophic health expenses is still 7% [2]. When one takes into account the increase in population the absolute number of distressed households has actually risen from 70 million to 88 million. The percentage share of out of pocket (OOP) expense in overall healthcare has come down only marginally from 68% to 62% and in absolute terms the OOP expense has risen sharply over last ten years. Data shows that households are increasingly relying on their incomes to fund health care expense. While customers are in distress, the health insurance industry as a whole isn't in pink of health either. While the growth in customer base and premium has been phenomenal, the claims ratios have deteoriated from 94% in 2010 to 101% in FY15[4].

The bulk of expansion in health insurance coverage in last 10 years has come from government supported schemes and they deserve credit for making health care accessible to millions. It is truly one of the most under appreciated achievements of our nation.

Clearly the social objective of a secure society with a reasonable healthcare availability to all will require both modifications to existing healthcare financing methods as well as newer forms of financing which supplement the existing healthcare infrastructure. I would like to list out the same in following sections

1. Government funded health schemes: The bulk of expansion in health insurance coverage in last 10 years has come from government supported schemes and they deserve credit for making health care accessible to millions. It is truly one of the most underappreciated achievements of our nation. However NSO survey data gives us glimpse of both success and limitations of the current structure. While the proportion of people who did not access medical facilities due to financial constraints has fallen by a whopping 80% between 2004-2014[2], the schemes have not impacted out of pocket expense and financial burden. Kerala and Andhra, with some of the highest health insurance coverage, report highest amounts of distress on account of medical expenses. This according to some experts hints at changing nature of medical care where expenses which are not hospital related and thus not covered in insurance are becoming increasing part of overall expense. This view is also supported by rising share of non communicable diseases like cancer, heart ailments which require disease management expenses. There might be a case to review the focus on health insurance schemes in some states with more focus on mitigating catastrophic health expense and its consequences. However what holds true for Kerala will not hold true for Bihar or Jharkhand where increasing the access to healthcare should continue to be the primary goal. In short government schemes have done a great job but now might be the time to change track and adopt differentiated measures.

2. Employee State Insurance Corporation: Established in 1948 Employee State Insurance Corporation (ESIC) was designed as a health benefits scheme for organized sector workers. As of today ESIC cover is mandatory for employees earning below Rs. 21000 per month and covers 8 cr people. In theory ESIC replicates the benefits of mid 20th century Western European worker but it in practice falls woefully short. For 8 cr people, ESIC provides 20,000 beds giving a bed density (per thousand) of 0.25[4]. WHO recommended bed density is 3.5 [1]. The doctor availability for ESIC subscribers is 0.1 per thousand in ESIC hospitals when for India this figure stands at 0.6, this despite subscribers contributing 6.5% of their wages (4.75% employer contribution plus 1.75% employee contribution). For a person earning 21,000 per month this works out to be annual premium of 16,380!!

ESIC has got the basic philosophy right. Worldwide experience has shown that employers are the most potent and cost effective agents to mobilize savings in support of public goods like health and retirement. Over past 60 years ESIC has set up extensive infrastructure to enroll subscribers and given the steady shift in employment patterns where increasing proportion of workers are being employed in organized sector, such an infrastructure could be of great value. However reforms in choosing insurance providers similar to the ones already enacted in government scheme, where the subscriber has been empowered to choose the healthcare provider, are needed in helping ESIC attain its objectives of ensuring healthcare delivery for organized sector labor. Given that ESIC collected 14000 cr in FY 15contributions [4], the market opportunity for health insurers could indeed be very big.

3. Employer provided group health insurance: Apart from government schemes and ESIC, employer provided health insurance is the bulwark of health coverage in India. It accounts for 44% of total health insurance premiums and covers 5cr individuals. However this segment suffers from very poor claims ratios (116%) [3]which are even worse than government schemes. This is clearly not sustainable and is beginning to have an impact on market. Private players have largely exited the group health market. Health insurance costs continue to rise for employers. It is well known among recruiters that employer provided benefits like insurance play a very limited role, if any, in attracting or retaining talent. With such adverse ratios and rising health insurance premiums, financial controllers in companies are beginning to question the need for such benefits. In FY 11 premium per covered member in group health schemes was Rs. 2204 which in FY 15 has come down to Rs. 1840[3] indicating static or maybe even falling levels of group health cover. This has happened even as the healthcare costs in last 5 years have nearly doubled.

In FY 11 premium per covered member in group health schemes was Rs. 2204 which in FY 15 has come down to Rs. 1840[3] indicating static or maybe even falling levels of group health cover. This has happened even as the healthcare costs in last 5 years have nearly doubled.

Were this important pillar of health insurance to wither away, it would be bad news for largely middle class employees for whom employer provided health insurance is often the only health insurance they have. Government focus and resources are in any case stretched on the extreme poor and rightly so. Government cannot step in for this class. The need of the hour is to reinvent the insurance benefit in this segment in such a way that the costs for employers are controlled while the effectiveness for employees increases. One way to do it would be to re-orient the employer provided health insurance to exclusively preventing catastrophic health out of pocket expenses.

Employees should be encouraged to have a basic health policy of their own with employer provided health policy kicking in only after a certain point. It is here that insurers and benefits brokers, with some innovative products and marketing, can virtually remake and expand this market profitably.

4. Individual health insurance: Individual health insurance has increasingly become important in health insurance landscape of the country. From 35% of overall market in FY 11, it now comprises 44% and has relatively healthy claims ratios of 81% [4].However most of this business comes from the traditional indemnity based products. Given the ability to assess risk and modulate service delivery individual health insurance needs to be at the cutting edge of health insurance ecosystem of India. As highlighted earlier the disease pattern of India is shifting increasingly to non communicable diseases which require much higher level of diagnostics, disease management systems etc. This opens up new horizons of growth for the industry to add products other than indemnity based insurance to its bucket. Another area of growth could come from the longer life spans and assisted living market. New developments in wearable and connected devices is making staying in touch with customer easy and less intrusive at the same time. This has important implication in managing risk and fraud in the health insurance category. Making the most of these emerging areas will require innovation from the industry.

While spread of health insurance is a step in right direction we would also be better served to review the direction we want to steer.

5. Introduce Health Savings Accounts: While spread of health insurance is a step in right direction we would also be better served to review the direction we want to steer. Health insurance suffers from a fundamental moral hazard in that the customer has little incentive to control the cost. The impact of this can be seen in United States where healthcare financing accounts for a crushing 18% of GDP. One way to control this moral hazard can be health savings accounts which are tax advantaged instruments which are used exclusively for healthcare related expenses. These operate in tandem with high deductible plans offered under other cover thus inverting the model by reducing the low ticket claims but protecting the customer from catastrophic health expenses. This model has been followed with great success in Singapore where health outcomes similar to US are achieved at expense of 4% of GDP. To begin with these types of account can be rolled out in organized sector workers and then once the mechanisms are established, they can be eventually rolled out to general populace.

In summary the overall objective of health insurance ecosystem in India should take into account needs and characteristics of the various segments in the country. The twin objectives of health insurance i.e improving access to health care as well as reducing catastrophic out of pocket expense, need to be balanced with mechanisms which help control the overall costs of delivery. Were this balance to be achieved, health insurance sector in India will not only grow fast, as indeed it has done in last 10 years, but also be able to fulfill its commercial and social objectives.

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Re-inventing customer engagement in health insurance

Mr. K M Srivathsan observes and brings forth the changing customer-Insurer interaction dynamics in Health Insurance sector, in the wake of a changing demography. He vouches for an archetype wherein all the stakeholders engage with each other in a holistic pattern, paving the way to an Incessant-Interaction Model rather than a mere Transaction-Interaction Model.

- Srivathsan Karanai Margan

Introduction

"*Panta Rhei*" or "everything flows", said the Greek philosopher Heraclitus, indicating the ever changing nature of world. There cannot be a better statement to synopsize the current scenario in the health care universe. Many tectonic shifts are occurring simultaneously, thereby disrupting all the stakeholders and challenging any form of inertia.

Self-financing for a major healthcare situation can be a financial tsunami to any family. Still it is paradoxical to note that, there is a low intake of health insurance in the Indian market, despite it being the best means for financing healthcare expenses and absorbing the financial shocks.

The ageing population and growth in non-communicable diseases (NCD) are changing the global disease burden thereby triggering a social, economic, and political challenge in the world. In addition to these, changes such as innovations in medical technology, all-pervasive digital connectedness which is enabled by mobility, internet-of-things (IOT), and cloud computing, growth of artificial intelligence, and behavioral shift driven by the millennial generation are dynamically changing all frontiers of health care.

As healthcare and health insurance industries are closely related, the changes in one directly impacts the other. Due to the changes mentioned above, the products and services customers expect, factors that influence their decision making, the manner in which they interact and the digital-life they live through, all these are evolving and in a state of flux. This paper discusses some of these and the customer engagement model that the insurance industry is embracing.

Health care scenario and changing demography

The total healthcare expenditure in India is about 3.97% (2013) of the GDP, for an intimidating population of 1.25 billion (2013). The per capita expenditure on health in India is $54.3 (2010), whereas it pegged at $4,153 in the US. Without the support of any social security or national health care policy, this leaves a large portion of the expense to be borne by the individuals. Self-financing for a major healthcare situation can be a financial tsunami to any family. Still it is paradoxical to note that, there is a low intake of health insurance in the Indian market, despite it being the best means for financing

healthcare expenses and absorbing the financial shocks. However, in the recent years health insurance is showing signs of growth, yet the overall adoption rate is less than 17% (2014).

In India, health insurance plans with in-patient only coverage and indemnity type are being sold the most, whereas more than 75% of the healthcare expense is spent as out-of-pocket by the customers. Resonating the growing global concern about NCD, close to 50% of the in-patient admissions in India, are due to life-style or NCD. The share of NCD is expected to increase to over 75% of the overall disease burden by the year 2030. World Health Organization (WHO), has predicted that India is losing a big portion of its GDP due to premature mortality and morbidity from NCD.

Demographically India may be comfortably positioned today, with a population of 68.2% spread between the age group of 0-54 years. On analyzing this along with the fertility rate, the comfort evaporates, as alarm signs indicate a mammoth ageing problem in the future. The total fertility rate (TFR) per couple in India is 2.34 (2013) which is higher than the supposed replacement level fertility (RLF) of 2.1 per couple. (*RLF is defined as the rate at which a population replaces itself from one generation to the next*). The TFR in India, is on a steady decline from 3.14 (2000) and 2.53 (2010) and is predicted to slip below 2.1 by 2020. Even today, the RLF is lesser than the threshold of 2.1 in about 12 states in India, which points out that these states are already on the path of becoming top-heavy, in few decades from now. Lesson from across the globe showcases that, it is an unviable financial nightmare for governments to fund social security schemes in top-heavy populations.

Prevention of early mortality and increase in longevity are generally considered as signs of growth. This trend is now reflected across the globe due to technological advances in diagnosis and treatment, and better quality of drugs. The average life expectancy (LE) at birth in India is 68.3 (2015), which has been on a steady rise from 66 (2013) and 58 (1990). Optimistically, the increase in LE is expected to directly add into the Health Life Years (HLY) of an individual thereby maintaining or compressing the Disability-Adjusted Life Years (DALY) towards the end-of-life years. However, contrary to the belief, it is globally seen that the increase in LE, is in fact increasing the DALY instead of HLY.

It is globally a worrisome trend that NCDs such as cardio-vascular (heart attacks and stroke), cancers, chronic respiratory diseases (COPD, Asthma) and diabetes are growing rapidly because of urbanization, sedentary lifestyle, changing diets and

It is a serious cause of concern that the elderly population in India is expanding without the presence of a reliable support system that caters to their geriatric requirements.

rising obesity levels. WHO has mentioned that in India, about 61.2 million people are diabetics and 30% have high blood pressure, and the numbers are continuing to increase. The problem with NCDs is that after they are diagnosed, the patients live with the conditions for the rest of their lives. To worsen the condition, long-term uncontrolled presence of NCDs is seen to expose them to other co-morbidity conditions during the course of life. Obviously individuals with NCDs tend to incur long-term health care expenses through their advanced ages, which is a nightmare in retirement planning.

It is a serious cause of concern that the elderly population in India is expanding without the presence of a reliable support system that caters to their geriatric requirements. The collapse of joint or extended family system, which until the recent past was providing the needed financial and caregiving support, complicates the problem. The absence of a proper long-term-care and

terminal-care support exacerbates the issue further. Due to the collaborative impact of multiple factors such as collapse of traditional support system, population becoming top-heavy, expansion of morbidity and lack of a robust healthcare system, the society runs the risk of drifting towards You-are-On-Your-Own (YOYO) economy, in which all the responsibilities are shifted from the government to the individuals.

Customer Engagement based Business Models

Insurance industry has always been reactive with respect to customer interaction. Traditionally, interactions have been transactional in nature and mostly concentrated around just few customer touch-points such as policy renewal and claim payment. The ubiquity of smart-phones and IoT devices such as sensors and wearables, is now providing insurers with a 24x7 access to the hitherto unknown life-details of the customers. This has prompted insurers to move away from transactional interaction model to establishing a long term relationship with the customers by embracing a continuous engagement model. The core philosophy of insurance is seen to be changing from compensating financially after the occurrence of a risk event to partnering and collaborating with customers in risk prevention and life-continuity. Insurers are looking to make profits from reducing the risk by influencing behavior instead of the traditional approach in which profits were made from efficient pricing and underwriting. The pricing is done based on the value provided and the results achieved.

General or P&C insurers have been aggressive in adopting continuous engagement models, with auto insurers spearheading usage based insurance and telematics, and home insurers embracing IoT based sensors. The life and health insurers have remained a bit cautious to embrace the model due to the inherent complexity in the nature of business. So far, only few of them have implemented this model that focuses on the prolonged healthy living of the customers. These companies track health and lifestyle details of the customers, try to influence and modify their behavior to achieve the desired health results. The engagement activities and the value additions become prominent and the core risk cover in turn becomes invisible.

The core philosophy of insurance is seen to be changing from compensating financially after the occurrence of a risk event to partnering and collaborating with customers in risk prevention and life-continuity.

Medical studies point out that morbidity can be compressed to a shorter period before death, if the age of onset of the first chronic infirmity can be postponed. This is the most important reason that compels life and health insurers to consider the engagement model to interact with customers during the wellness or prodromal stages, to postpone or prevent the onset of NCDs. By doing so insurers hope to prevent huge amounts of future claim payouts.

By partnering with other network service providers and third parties such as device manufacturers, diagnostic centers, care providers, grocery stores, gyms etc., insurers can get a comprehensive understanding of lifestyle of the customers. By accessing the data from wearable devices and sensors, insurers can get details of customer's health parameters such as blood sugar, heart rate, sleep pattern, activity etc. Analyzing both the health and lifestyle details, insurance companies can micro-segment a customer based on wellness and disease life cycles, and launch an appropriate engagement program personalized for the individual customer. Customer is given personalized health goals which are tracked continuously. If any deviation is observed, the customer is

alerted and a correction course prescribed for modifying the health status in due course.

The engagement models by life and health insurers are only in the initial stages of evolution. Across the multiple health-stages such as wellness, prevention, diagnosis, therapy and control, the traditional approach by health insurers has remained skewed only towards therapy. With the emergence of the engagement model, wellness and prevention are slowly being recognized as important activities. As the model matures, it is expected that higher focus will be accorded to wellness, prevention and diagnosis. The indicative image below will help to understand the expected evolution of the engagement models across the various health stages.

Contrary to the popular belief, the engagement model is not a revolution but a natural evolution of the traditional model. In fact, the engagement model is now making insurers to look at a space they have traditionally neglected. To make a meaningful progress and create a positive impact in the health status of the overall population, engagement initiatives by just few life or health insurers will be inadequate. To achieve that, all the stakeholders in the healthcare landscape such as hospitals, insurers, third party administrators, device manufactures etc., should come together to create a holistic engagement ecosystem. Such an engagement ecosystem can be considered to be a revolution, as it will change the way businesses are conducted and how stakeholders interact with one another.

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Pioneers of the new model

Many auto insurers across the globe have been spreading the engagement model of conducting business. Due to the numerous implementations, usage based insurance, has evolved and matured in many forms such as pay-as-you-drive, pay-how-you-drive and manage-how-you-drive.

In life insurance, Discovery Vitality in partnership with other insurance companies has been pioneering wellness based engagement model across many countries. The program by Vitality incentivizes customer to improve their quality of life and reduce their long-term medical costs. For achieving wellness goals, customers are rewarded by getting access to a wide range-of-benefits that includes subscription to wellness facilities or discounts for purchasing healthy food.

Another life insurance company, AllLife, South Africa, offers insurance policies with death and disability cover,

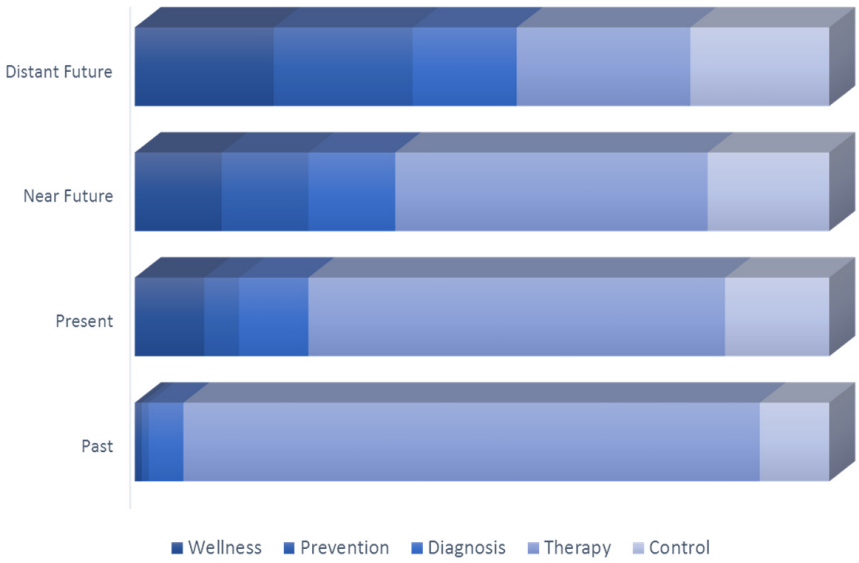

Figure 1 Evolution of Engagement across various Health-Stages

exclusively for at-risk customers with heath conditions of HIV positive or diabetes. On purchasing the policy, customer signs a contract to comply with an adherence program structured by the insurer. Customers are sent periodical reminders through-out the policy term to go through specific tests at authorized centers. If the customer fails to adhere to the stipulated levels of the parameter measured, a warning is given to maintain levels. If the customer fails to maintain the levels beyond a certain term or fails to go for a test within a specific period, payout benefits are reduced to accident cover and any disability benefit is suspended.

Since the health insurance contracts are for a short-term and payment is of reimbursement type, the adoption of engagement insurance in health insurance has been quite slow. However, health insurer like Oscar Health in the US, is attempting to change the landscape. Oscar Health offers care at a lower cost. The insurer provides an app to the customers that enables them to talk to a doctor anywhere, anytime free of cost, get a prescription, and keep track of their health history. Oscar partners with wearable device company Misfit and rewards healthy customers by linking their biometric information to their health insurance automatically. Customers get rewards in the form of premium discounts or gym memberships for staying active.

New breed of technology start-ups are mushrooming under the umbrella of HealthTech to create new solutions and tools to facilitate the engagement model. These companies cater to the specific requirements of the customers that fall across the intersection of various health-stages (Wellness, Prevention, Diagnosis, Therapy and Control) and the treatment path (Information, Assessment, Intervention, Monitoring and Coordination). Insurers could partner with them to offer innovative engagement solutions. To name a few, Stride Health, an online broker helps workers to find health coverage that is tailored to their needs. Shire, uses wearables to analyze the mood of a person based on the breathing pattern and provides real-time suggestions for relaxation. Pager, allows to summon a caregiver to any location either home or office of a person. Intendu, uses personalized and adaptive games for brain stimulation and rehabilitation of stroke patients. Babylon Health, a mobile health company provides virtual health service that includes health care consulting through mobile or tablet and allows doctors to diagnose with the help of live video conferencing.

The fundamental question that needs to be answered is, why should health insurers take an active central role in spearheading the engagement model while the other major stakeholders such as hospitals and the government remain passive.

Challenges and how to overcome them

In spite of various apparent benefits, there are few challenges for health insurers to adopt the engagement model.

Why Health Insurers?: The fundamental question that needs to be answered is, why should health insurers take an active central role in spearheading the engagement model while the other major stakeholders such as hospitals and the government remain passive. A rational answer to this question is – the hospitals interface with the patients only after the occurrence of the infirmity i.e. from Diagnosis, Therapy and Control stages, whereas, the health insurers are related to a customer right from the wellness stage. The association with the customer through-out all the health stages naturally makes health insurers a core and the perhaps the only stakeholder capable of playing a role in wellness and prevention.

Benefit Realization: It may be meaningful for a life insurance company to deploy the engagement model as the

contracts are for a long-term and by focusing on the wellbeing, life insurance companies may be able to postpone the mortality and thereby stand to gain in the long term. Although motor insurance contracts are for a short-term, the engagement models revolve around the driving pattern and driver behavior, and hence, the benefits of the programs are realizable by the insurers within the contract period by means of lower claim payouts. The problem for health insurance is that the nature of the contract is a mix of both. The contracts are for a short-term, but the engagement programs should be similar to that of life insurance companies focusing on the long term health benefits. With no immediate realizable benefits within the contract period and no guarantee of the policyholder persistency, the benefit realization becomes a challenge.

Zero incentive: In the existing health landscape, neither insurers nor hospitals, are incentivized for focusing on the long-term needs and involving in the wellbeing and preventive intervention activities. Few insurers and start-ups, are sporadically trying the engagement model to show service differentiation in the market. Since the model is in the nascent stages, changes in the behavioral patterns or health is yet to mature to the extent that it shows tangible benefits in reducing in the morbidity claim pay-outs. With the numbers of cost benefit saving still unclear, it may be difficult for insurers to sustain the business model if they have to invest on this model all by themselves with no additional cost loading on the policies.

In India, customers are generally seen to be satisfied with the benefit structure of the products, but highly dissatisfied with the services.

Quo Vadis?: All the stakeholders in the health ecosystem will be beneficiaries of the result oriented engagement model that focuses on prolonged wellness. Due to this, it should be mandated that they become co-partners in the engagement ecosystem. Regulations should evolve to encourage the health insurers to adopt multiple variants of such long-term engagement models. Various engagement programs depending on the age, type and stage of the disease should be structured. Appropriate network service providers and IoT devices should be included as a part of each program. A discount or reward based engagement model may work for enticing the customers to the program in the short-term. However, this may not work in the long-term as continuous discounting or rewarding may not be viable.

To overcome the financial burden, health insurers should be allowed to arrive at a structured price for each engagement program. For example the program for diabetes prevention at 30 years and that for diabetes control at 40 years would involve different activities and hence differently priced. So would be the programs for controlling high blood pressure or rehabilitation of a stroke victim or for ageing in-place. As all insurers become stakeholders, portability of the policy would not pose any problem as all the insurers would have access to the health records and engagement program details. This will enable the transferee company to enroll the customer and continue engagement in a similar program they offer.

The Indian elephant learns to dance:

In India, customers are generally seen to be satisfied with the benefit structure of the products, but highly dissatisfied with the services. While insurers in other geographies are experimenting new models of service with the adoption engagement models, India has remained a laggard with even poor product innovation.

The IRDA (Health Insurance) Regulations, 2016 has brought in the much anticipated breath of fresh air to the industry. Health insurers are now taking

As the Indian demography is showing signs of becoming top-heavy, if the NCD health scare is not contained with the widespread adoption of the engagement models, the UHC may be unachievable.

baby steps towards offering innovative products such as, products for senior citizens, reimbursement of out-patient expenses (Cigna TTK), restore and multiplier features (Apollo Munich), special coverage for dengue (Apollo Munich), diabetes specific products (Apollo Munich & Star Health), health plus life combi products (Star Health and India First Life Insurance). The regulation encourages launch of health package products and close-ended pilot products for risks which were not covered earlier. It also prompts insurers to embark on services for wellness and preventive aspects by offering health specific services with network service providers. This regulation propels a fundamental shift in the insurer-customer relationship and leads insurers towards the right path of product and service innovation.

Besides this, in compliance with the United Nations Sustainable Development Goals, India has agreed to achieve Universal Health Coverage (UHC) by the year 2030. UHC will be a government sponsored scheme that is funded by tax payments and increased spending on public health. UHC follows a model which is already prevalent in many geographies, where every citizen is to be covered for basic healthcare services. Insurers may need to innovate the products to cover benefits that are not offered by UHC. Implementing such a scheme will be a herculean task in India considering the size of the population, low healthcare spending and a frail healthcare infrastructure. As the Indian demography is showing signs of becoming top-heavy, if the NCD health scare is not contained with the widespread adoption of the engagement models, the UHC may be unachievable.

Conclusion:

The adoption of engagement models will bring in benefits to all the stakeholders in the long term. Insurers will benefit from the postponement of the onset of NCD and compression of morbidity resulting in low claim payouts. For network service providers or TPAs, it will be a new business opportunity to partner with the customers in executing healthy-living programs. Governments will be saved from funding crisis and the challenge of handling health catastrophes. In India, the healthcare infrastructure is already very fragile with the number of hospital beds per 1000 people being 0.9 (WHO Guideline: 3.5) and the number of doctors available per 1000 people being less than 1.8 (WHO Guideline: 2.5). As such even a slight increase in HLY will relieve the burden on hospitals immensely. Above all, it will be the customers who will be the prime beneficiaries with the extension of healthy life and active ageing.

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Emerging Health Insurance Sector – A Digital Approach for Tackling Issues and Challenges

Mr. Munish Daga enunciates the gargantuan scope for innovation in the Health Insurance sector in India and withal the potential of robust technology to leverage this scope and in untangling the Indian Health Insurance sector from the quagmires of antiquated methods of service handling and other lacunae.

- Munish Daga

Healthcare in India is in a state of transition where state governments as well as the government at the centre are launching several initiatives to make healthcare affordable and accessible to all. However, given the low penetration of health insurance in India, there is a huge scope for the sector to innovate and introduce best practices using robust technology as a backbone and make basic healthcare accessible to all citizens. The sector also offers huge scope for leveraging technology to standardize procedures and make delivery systems efficient thus ensuring reach, growth and profitability for the sector. With this approach, three key areas that need to be tackled are elaborated below:

Unfortunately today, health insurance has not been able to cater to the evolving needs of the end consumer on various accounts.

1) The Consumer Problem

As is true for any industry, the customer is king and customer satisfaction and loyalty is every business's goal for success. Likewise, for the health insurance ecosystem, meeting the policyholder's needs in terms of product and service is crucial as health insurance serves a crucial healthcare need. Unfortunately today, health insurance has not been able to cater to the evolving needs of the end consumer on various accounts. Unavailability of unbiased information with respect to purchasing a policy coupled with lack of informative and educative information that makes the consumer aware of utilization guidelines, aspects such as using the policy as cashless has crippled health insurance adoption in India.

When the policy is being utilized at the hospital, the consumer has to rely on the hospital staff to share information regarding the status of the claim, requirement for information, approvals, and rejections. Second, even with the current process of information exchange between the patient – the hospital – the payer, transparency is very low as all information is exchanged over e-mails, and FAX – non-electronic channels that have no scope for keeping the policyholder in the loop. Such

formats of claims exchange are also prone to errors, back and forth between insurance desks that result in longer turnaround times, where customer service too suffers. As a result, there is no transparency in the claims process overall, making it an unreliable method to adjudicate claims.

2) Link the Hospital

A key player in the healthcare chain is the provider – the hospital. Specifically, from a health insurance perspective, for the patient/policyholder, after the policy is bought, the hospital is the only touchpoint for them. The volume and scale at which insurance desks in hospitals process health insurance claims on a daily basis itself justify the need for a streamlined and simplified approach to claims processing that ensures a hassle-free experience for the hospital as well as the patient.

Scores of individuals waiting in queues at insurance desks in hospitals for a status update, long waiting times after the discharge in case of cashless insurance, and going back and forth with the insurer and the hospital are common problems that a customer faces. From the hospitals perspective, while they are dealing with multiple insurers to process claims for their patients, the claims exchange process is manual, where the insurance desk at the hospital e-mails the information to the payer and waits for a response. Take this into account for anywhere between 100 to 1000 and more claims that is the typical range in hospitals today, the problem becomes much clearer.

3) A large portion of healthcare remains unaddressed – outpatient

At this juncture, several experts in the industry suggest that going forward, the industry's agenda must expand its focus to include an outpatient health insurance cover to enable the utilization of primary and secondary healthcare, synonymous to the tertiary services that are currently being provided. The private sector today provides nearly 80% of outpatient care and about 60% of inpatient care. The public sector provides for about 20% of outpatient care and 40% of in-patient care. (Ministry of Health and Family Welfare, 2015). Fewer than 2.50 per cent of patients in any given year need hospital-based care, which implies that 97.5 per cent of all conditions would need to be dealt with at the primary-care level. (Mor & Kalita, 2014) Justifiably, there is a need to invest considerably in primary level healthcare within a framework that averts patients from hospital-based care unless

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required.

Here, awareness and education would play a key role in sensitizing the public about such a healthcare system, how they can access and utilize it.

Inadvertently, the challenges involved in providing a health cover for primary and secondary healthcare are severely different from that of tertiary. Service providers such as physicians, pharmacies, and diagnostic centres cater to a customer base much larger than that of the hospitals. Handling traffic on such a large scale would require a network of primary health facilities, that are adequately staffed, skilled and supported along with a reliable logistics support system on a strong technology framework. Certainly, given the challenge and need, upon

With technology, we have a better chance at reaching out to a larger populace, especially those in need. With technology, we have a better chance at simplification. So why not embrace the need of the hour?

this day and age, a technological framework that can support such a large volume of transactions for real-time response is one that is completely automated.

Addressing the issues and challenges - The role of technology

With its nimbleness to adapt and range of practical solutions, technology has the immense potential to dispel all existing discrepancies. The sector in question must gradually leverage this powerful tool, not only in the better implementation of the mission, but also in building a standardized support system that draws feedback and activates follow-up mechanisms.

The aim must be to develop an active interdependent relationship with technology as opposed to complete dependency. This relationship will serve the needs of all stake-holders, while also improving efficiency, transparency, and delivery of resources. Take for example the banking system. Today, irrespective of the type of transaction you make, every time you swipe your card, make a digital payment, or withdraw money from an ATM, you immediately get a SMS from your bank, and the same reflects in your bank account in real-time.

Similarly, across the 3 key challenges and issues elaborated on earlier, digitalization and standardization of practices can bring about significant changes in the claims exchange process:

For the consumer and the hospital: By implementing a technology framework which brings the provider and the payer on a single platform to exchange claims electronically, including reports and documents, that enables processing claims data at the click of a button would change the way health insurance is delivered to the consumer. Such a system can also include an automated message and email that is sent to the policyholder every time there is a change in the status of the claim – bringing in an unprecedented level of transparency in the entire cycle. Electronic data resulting from such claims exchange processes gives the hospital a single dashboard to view an entire months health insurance transactions, enables identification of trends, and streamlines financial data that can lend itself to analysis on a large scale. From the public's perspective, health insurance utility data can be used to understand and identify healthcare trends such as benchmarking the age groups at which individuals are diagnosed with diabetes, or identifying more frequent occurrences of diseases by geography. Electronic data can lend itself to research and predictive analysis in a much bigger way to work on solutions that can benefit the generations to come.

For outpatient health insurance: There is no question of delivering primary healthcare for the consumers without a digitized technology framework. A patient who visits a physician for fever or flu cannot wait for the payer to respond to an email for eligibility and adjudication. Linking a comprehensive healthcare policy with a database such as AADHAR ID can be one of the ways to deliver an outpatient health insurance scheme. The patient need only provide the AADHAR ID, and

the platform in the form of an app or only SMS updates can ensure that the consumer can use health insurance for primary healthcare.

To elaborate on how it would work - the patient walks in to the clinic, produces the ID, the physician enters the ID for eligibility, selects the ailment from a drop-down menu, administers treatment, clicks the button, the amount is deducted from the sum insured. Similarly, the pharmacy and the diagnostic centre can also be linked on this platform where the reports are shared digitally, medicines can be ordered through the platform and delivered home – a range of possibilities that ensure last mile delivery for the end consumer.

The use of technology also paves the way for other possibilities such as appointment scheduling, effective grievance redressal, case record maintenance which have not been possible earlier at primary care levels and can now be enabled by digitization. With technology, we have a better chance at reaching out to a larger populace, especially those in need. With technology, we have a better chance at simplification. So why not embrace the need of the hour?

The future: Moving towards a paperless health insurance experience

The health insurance sector is one area where we have to make much more progress towards becoming less paper and more electronic based. We are in an age where financial payments do not require paper, income tax returns filing and paying taxes does not require paper, statutory documents like Form 16, TDS deduction forms do not require paper but for payment of a health insurance claim there continues to be the need for paper and not just paper but lots of paper. We have to work towards enabling a technology platform and standard where this need is reduced significantly if not eliminated.

We, as an industry have to collaborate to make that happen because without the aggressive adoption of technology, best practices and creation of standards, rapid progress is very difficult.

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Health insurance in India: A study of consumer insights

Mr. K T Thomas reckons that the Insurers ought to apprehend what the consumers cogitate while exercising their purchase options so that they can align their services suitably which would create a system that is mutually beneficial.

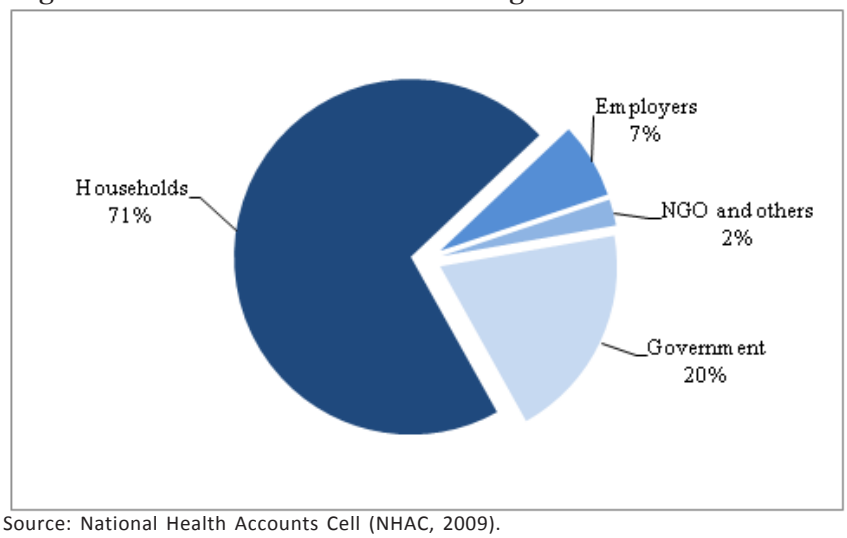
- Thomas KT, PhD

Introduction

India offers a wide variety of health care services to its population. On one hand there are the advanced hospitals and diagnostic centres in urban areas and in contrast the rural areas depend significantly on government health centres. Between these two extremes there are government hospitals, private hospitals, private practitioners, dispensaries and clinics (including Indian traditional medicine systems). In spite of health being a major government subject, majority of India's health infrastructure is in the private sector and more than 70% of health care expenses are met by consumers and not the government, as shown in Figure 1. Given this unbalanced mix of health care funding and low per capita income, medical costs are unaffordable for a majority of India's population.

In spite of health being a major government subject, majority of India's health infrastructure is in the private sector and more than 70% of health care expenses are met by consumers and not the government

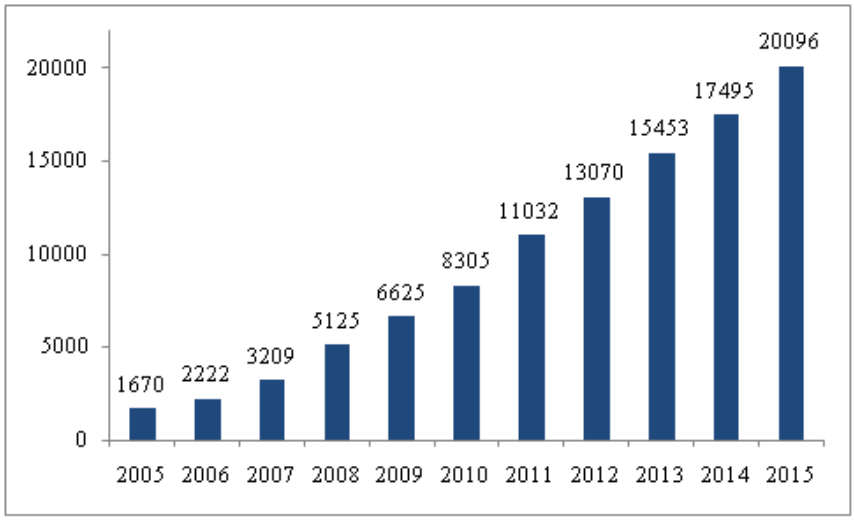
Figure 1: Source of healthcare funding in India



Source: National Health Accounts Cell (NHAC, 2009).

To address health care affordability, commercial health insurance was introduced in India by the government owned general insurers as a standardized annual indemnity product in mid 1980s. Today, with the increased liberalization of the insurance industry, many private players have entered the health insurance market

Figure 2: Health Insurance Premium Growth in India (Rs in Crores)



Source: IRDA, 2015

resulting in increased awareness and growth of health insurance, as shown in Figure 2.

Even as health insurance shows a steep growth, the majority of the health insurance members in India are still covered under employer programmes or welfare schemes. Currently only 18% (or around 22 crore) of the total population of India is covered under the various health insurance schemes (CBHI, 2015), with the majority covered under either government or employer programs (USAID, 2008) and commercial private health insurance has around 2.3% penetration of the country's population (IPH, 2009). An overview of health insurance sector is shown in Table 1.

Most of the insurers have now realized that group health coverage, even as it brings in revenue, is not a profitable model and have shifted their focus on to retail customers. While the retail market offers a large and profitable market, the segment has been a challenge due to limited research around consumer insights. It is hence imperative, that a study of consumer insights will help both health industry academicians and practitioners augment their knowledge of the consumer and will help establish the framework within which the consumers make their choices.

Table 1 – Health insurance industry in India – key parameters

Health insurance penetration (as a percentage of total population)	18%
Non-government (private) health insurance penetration (as a percentage of total population)	2.3%
Total number of firms providing health insurance products	20
Total industry health premium	Rs 20,096 Crores
Number of TPAs	30
Total number of claims processed by TPAs	51.2 Lakhs

Source: CBHI, 2015; IRDA 2015

Most of the insurers have now realized that group health coverage, even as it brings in revenue, is not a profitable model and have shifted their focus on to retail customers. While the retail market offers a large and profitable market, the segment has been a challenge due to limited research around consumer insights.

Methodology

The methodology of the research is briefly described below.

Literature Review. The IRDAI publishes an annual report which provides the snapshot of the performance of the health insurance industry (IRDA, 2015). In addition to the IRDAI, the Ministry of Health and Family Welfare, Government of India (MOHFW) provides a government-level view of health care, financing and health insurance (NCMH, 2005; NHAC, 2009; CBHI, 2015). Apart from these government sources, several global and Indian developmental organizations have published reports on health insurance in India. These include publications from USAID (USAID, 2008), Institute of Public Health (IPH, 2009), World Health Organization (WHO, 2012) and Public Health Foundation of India (Reddy et al., 2011). From a consumer research perspective, various authors have identified respondent age, education and gender (Marquis et al., 2006; Bawa and Verma, 2012; Hibbard et al., 2008) as being relevant to consumer preferences on health insurance. Other studies also identified awareness, availability and banking channels (USAID, 2008; NHAC, 2009) as key variables in health insurance penetration. Several other research studies have identified market related factors such as the brand name and presence (Isaacs, 1996; Robinson, 1999; Hung, 2008;), insurance benefits, choice and features (Davis et al., 1995; Tumlinson et al., 1997; Gates et al., 2000) as important to consumer's choice. The medical services provided (Long and Marquis, 1997; Hibbard and Jewett, 1997; Trude et al., 2006) and the related customer service aspects (Reidenbach and McClung 1999; Kim, Y. et al., 2008) also play an important role in consumer preferences.

Survey Methodology. A questionnaire was designed using a 5-point Likert scale and was conducted in the urban cities of Chennai and Coimbatore in Tamil Nadu. Tamil Nadu is representative of

Table 2: Health insurance - Respondent Insights

Response (%)	
Source of insurance	
Employer provided	18.1%
Self or family purchased	28.5%
Government provided	14.6%
Not applicable	38.8%
Primary reason for buying insurance	
To cover medical expenses	53.6%
Other reasons	46.4%
Purchasing role	
Needed medical coverage (patient)	45.2%
Other	54.8%
Awareness of the TPA role?	
Yes	58.8%
No	41.2%
Expected annual premium in Indian Rupees (INR)	
Up to 6,000	59.7%
More than 6,000	40.3%
Preferred buying channel	
Direct (Sales Representative)	43.0%
Internet/Phone	57.0%

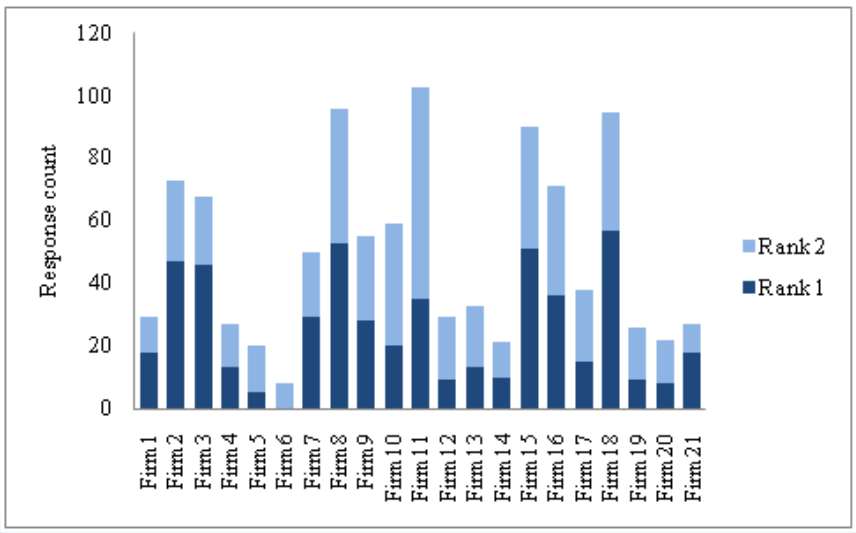
the national population behaviour with respect to health insurance usage, being amongst the top 5 states in submission of healthcare claims (IIB, 2011). The questionnaire was administered to 550 respondents and 520 responses were received. After screening these responses for missing and inconsistent responses, 495 valid responses were considered for analysis. The respondents were selected in a systematic random manner from the consumers (patients and care takers) of hospitalization services in tier-one tertiary hospitals.

Findings and Managerial Implications

As seen in Table 2, 38.8% of the respondents do not have any kind of health insurance. This is reflective of the fact that health expenses in India are met by patients from their own funds (out of pocket funds), even for expensive in-patient treatments. Retail insurance purchases are around 28%, which although appears higher than the national average and indicates the urban focus of the insurers.

Health insurers also face challenges because of the fundamental positioning of health insurance as a product category. Although health insurance is meant to defray medical expenses, close to half (46%) of the respondents indicate that they would purchase health insurance for other reasons (such as tax benefit, add on product and access to a good hospital network). This alters the core product concept and health insurers run the risk of their product being evaluated by consumers on aspects which are beyond their control and on parameters for which it has not been designed for.

Figure 3: Consumer's preference of insurance firm



Although health insurers pay significant fees to their TPAs, 41% of the consumers are not aware of the TPA role. This is a matter of concern for the insurers because the TPA is most often the first touch point with consumers in areas such as enrolment, claims settlement and customer service.

The other key insight is on purchasing role. Unlike many other service sectors, in health insurance the final consumer (patient) is not the actual buyer. The dynamics of social and family construct means health insurance market and the post-purchase customer service has to be viewed differently than in normal services.

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The final two sections in the table give the consumer perspective on premium he/she

Table 3: Consumer preferences when choosing a health insurer

	Average score (maximum 5)
Company attribute: Good hospital network	4.29
Benefit: Coverage benefit	4.27
Product offering : Wide choice	4.27
Operations aspect: Responsiveness	4.46
Customer service: Service at hospital	4.51

is willing to pay and the preferred channel. The response on premium amount clearly indicates that majority of consumers will balk at higher premium. Health insurers cannot afford to increase premium and will instead need to focus on eking better efficiencies in their business process to improve their profitability. In terms of purchasing channel, the key insight is the clear shift to technology enabled sales channels over traditional sales approaches.

The next finding is on the consumer's choice of insurance firm. Figure 3 shows that customers have discerned their preferred firms and some of the firms have clearly established themselves as preferred brands (i.e. ranked as first or second choice) for health insurance

Table 4: Summary of findings and managerial implication

Findings (Respondent insights)	Implications for health managers
Purchasing health insurance for non-medical reasons	Policy level directives and industry efforts are needed to educate consumers on health insurance role and benefits.
Purchaser of health insurance is not the final consumer of services	Understand the purchase process and purchasing roles and design products with end consumer in mind.
Respondent not aware of the TPA role	Educate consumers about the health insurance service value chain.
Preference for lower premium	Introduce cost-effective products to meet consumer price points.
Preference for Internet / telephone channels	Focus on technology-enabled channels in addition to direct sales models.
Clearly established brand preferences to build consumer loyalty.	Invest into brand visibility and brand values
Preference for good hospital network	Widen the choice of network providers through improved provider credentialing.
Preference for coverage benefit benefits.	Design products with appropriate coverage
Expects wide choice of products	Introduce products with varying risk and premium options.
Expects responsiveness from insurer Also streamline workflows and IT systems	Orient employees towards customer service. to improve responsiveness.
Expects good service at hospital	Continuous evaluation of hospitals to ensure exemplary customer service.

purchase.

The final set of findings is shown in Table 3. This table highlights the various aspects that consumers consider when choosing a health insurer. When compared to attributes such as brand image and branch locations, consumers have rated the presence of a good hospital network as the preferred attribute. In terms of benefit, the highest rating has been placed on coverage (medical benefits) than on cashless transaction and tax benefits. Consumers have also preferred a firm with wide product choice than cheaper products. In terms of operations, they prefer dealing with a firm whose employees are responsive and not surprisingly, in terms of customer service, they have rated the service at the hospital as most important.

The study has highlighted several consumer insights and the findings have several implications for health insurers and this has been summarized in Table 4 below. Health insurers can use the findings to identify the key challenges in the retail health insurance industry and deploy necessary strategies to address these.

Conclusions

Health insurance in India cannot be examined in a vacuum and the retail success of the industry depends on many environmental and regulatory factors. Even as health insurers turn their focus on to the retail markets, they need to address the inherent challenges in this segment. Insurers should make specific efforts to increase awareness amongst consumers, streamline the marketing message and improve the customer service experience, across the value chain. At a more strategic level the firms need to continually evaluate consumer insights which will be a key input in developing an effective retail marketing strategy and help create a more sustainable insurance model. As more retail consumers embrace health insurance services, this will enable the sector to grow and fulfill its social role of becoming a key contributor to the country's health policy.

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TECHNOLOGY TO BE A GAME CHANGER IN HEALTH INSURANCE

Mr. Antony Jacob asseverates that in the Indian Scenario, Health Insurance is the best financial tool for disentangling the Indian populace from the burden of high out of the pocket expenditures that they incur via health care spending. He also avouches the categorical role that technology could play in beefing up the quality of the customers' experience.

- Antony Jacob

Today India is on the brink of a paradigm shift. Indian industries and Indian citizens of every generation are awaiting an economic revival that will catapult the country to greater heights. It is apparent that a healthy population is essential for such rapid advancements to take place. An aware population about the changing dynamics of our lifestyles, a strong healthcare infrastructure and sufficient healthcare financing are the major components that keeps a nation healthy.

Healthcare challenges :

Unfortunately with communicable diseases like dengue, chikungunya etc. on rise, the burden of infectious diseases remains high in India. Adding to this, the burden of non-communicable diseases is also rapidly increasing. Besides changing lifestyles that cause conditions like diabetes and hypertension, the high level of pollution across Indian cities is acting as a catalyst for diseases such as cancer, chronic lung disease, and cardiovascular disease etc. With increasing urbanization and problems related to modern-day living in urban settings, about 50% of spending on in-patient beds is for lifestyle diseases. The advanced healthcare technology in our country is both a boon and a bane at the same time. On one hand healthcare providers now have cutting edge technology and processes to provide the best medical care to our people and on the other hand the same has put pressure on the price points to cause a high level of medical inflation. This is causing affordability problems for a common man to avail updated healthcare treatments. The cost of most common procedures like maternity, cataract, angioplasty, angiography etc. has increased in the range of 45-60% in the last few years. Alarmingly, around 80% of our population depends on personal out of pocket finances to fund their healthcare expenses. The same conclusion can be drawn from the low levels of penetration of health insurance in our country compared to the global penetration rate. This gives rise to a question - Is our economy leading in the right direction by depleting personal finances to avail healthcare services?

The advanced health care technology in our country is both a boon and a bane at the same time.

Role of Health Insurance: In such a financial crunch situation, the need for a robust healthcare financing model cannot be overstressed. Over the last few years, health insurance has evolved as the best financing tool to counter the rising healthcare costs. Creating products and services that meet people's needs are at the core of businesses, big and small. Determining latent needs and finding solutions to meet them is what successful companies do. Today, customer expectations are changing rapidly and are moving towards more personalization. It is thus important for service providers in every industry segment to track customer movement and buying patterns to create service value. The telecommunications, e-commerce and retail industries have created a perfect example of tracking its customers' movement and sending customized alerts. I believe that the healthcare industry and health insurance companies should also follow suit and develop technology-led communication tools to create long lasting relationships with customers. Together we should contemplate how to enhance customer engagement with the use of technology.

Digital Distribution : for a vast and populous country such as India, where insurance penetration is as low as 5%, providing affordable and quality healthcare to its 1.2 billion population remains a challenge even today. One of the main reasons for low penetration is the limited reach of the existing distribution channels; other causes include complex, traditional buying processes and after sales services. To combat this situation, the health insurance industry has started moving towards unique, disruptive and technology-driven distribution models to reach wide and deep into Tier 2 and 3 cities, while eliminating the need to have physical offices in cities and towns. With the help of technology, it is a win win situation for both agents and customers as it makes the buying process simple and quick. Consolidation of

Today, customer expectations are changing rapidly and are moving towards more personalization. It is thus important for service providers in every industry segment to track customer movements and buying patterns to create service value.

dataTechnology can be used to simplify the complex data and through analysis of this data, meaningful solutions can be created. Medical data, tech data, consumer trends etc. can help showcase trends in healthcare and what people prefer. Players in the healthcare and health insurance segments are taking best advantage of such information and build their laurels on fulfilling the consumer needs that emerge from it. The industry is working towards creating data analysis techniques to develop strong, innovative insurance covers that could help people mitigate every possible healthcare expense incurred during their lifetime.

Mobile-technology : India is expected to have over 500 million mobile internet users by 2017. The Indian smartphone market is enormous and there is widespread acceptance for mobile applications that simplify transactions such as bill payment, financial management and information aggregation, etc. Insurance as an industry is taking rapid strides in that direction with servicing portals that enable customers anytime access to their health insurance policy, locating the nearest hospital, checking claim status and getting other health related assistance from anywhere. So far, we have made great

Technology can uncomplicate and enhance customers' experience multifold. Health Insurance is aiming to take customer experience to the next level by making it more interconnected and seamless at the same time.

progress towards our aim of creating Apps that will help make all processes paperless – right from pre policy checkups to buying policies to claims settlement.

Hospital check-ins : Today, with technology we are able to determine the best possible route to take to our destination, book a hotel room, fight tickets, movie tickets, order our favorite dish, clothes, furniture etc. through the Internet or through Apps on our mobile phones. Insurance companies have started working on technology helping one find the best healthcare facility/ hospital/clinic in their area or city, do hospital check-ins in advance through app, wherein the room will be ready upon arrival at the hospital, doctor appointment will be sought and an attendant will be assigned. For planned treatment, people can also inform their insurer and complete pre authorization formalities through this App. Such an App is very helpful in saving precious time of a person going for medical treatment.

Digitization of Insurance ecosystem : Technology can uncomplicate and enhance customers' experience multifold. Health Insurance is aiming to take customer experience to the next level by making it more interconnected and seamless at the same time. A smart app containing one's medical history, treatments, as well as, medicines taken right from the day he/she bought health insurance, irrespective of the fact that a policyholder may have changed or continued with his/her initial insurer and can reveal the required information, with one touch could be the next in your mobile wallet. Such a smart app would also show policy benefits, exclusions, inclusions, sum insured and eligibility for related claims would then be instantaneous.

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Assuring Affordable Primary Health Care in a Digital Era

Mr. Ashok Kumar stipulates that the model of Pharmaceutical financing would be efficacious in alleviating the affliction of high level of Out of the pocket expenditure that goes into the health care needs of the people. He also spells out the need for a decentralized Health card administration system to render it effective.

- S N Ashok Kumar

In the year 1835, the state took responsibility for the health status of the Indian population, and established medical colleges, primary health centers, hospitals, etc. Much of it remained out of the reach for the majority then, and it continues to be so. In 1943, the Bhore committee made some important recommendations including development of the Primary Health Care centers (PHC) in India for delivery of basic health care. Seven decades later, the journey towards 'adequate health care for all' remains only partially fulfilled. In a populous county like India, access to healthcare continues to be constrained by lack of appropriate health care financing and health care delivery- beyond building well-manned PHCs. The latter can be addressed differently in a digital world. This paper revisits the need for financing primary health care and explores one possible model of financing along with digital delivery of health care needs.

For a country like India, improvement on the *Human Development Index* ranking (current rank -135) will be possible only with a robust health care financing model delivering services in a cost-efficient manner.

Pharmaceutical Financing

Hitherto, in India, health insurance has been made largely available for catastrophic illnesses – addressing secondary and/or tertiary care. However, nearly two-thirds of out-of-pocket (OOP) expenses are drug expenses which currently are not addressed by any healthcare financing model. For a country like India, improvement on the *Human Development Index* ranking (current rank -135) will be possible only with a robust health care financing model delivering services in a cost-efficient manner. It has been estimated that a good 2-3% of the total population ends up in poverty due to OOP. Expenditure on drugs (75% of total OOP) continues to remain the largest component of the OOP for both inpatient and outpatient care. It has also been estimated that this percentage is more or less same in both rural and urban areas (Garg etal, 2008). By way of bringing the missing piece -the pharma industry into the primary health care financing, through an effective pharmaceutical financing strategy one should be able to address OOP to a large extent.

Pharmaceutical financing needs to go beyond financing by way of controlling demand and ensuring supply at appropriate costing. This may be attempted in a model where *Health Cards* are made available to all citizens along with an optional layer of

optimal insurance cover which may include cover for dental and visual aids. Public financing through national and local government budgets needs significant support from appropriate private funding mechanism to ensure that health cards are sustainable in the long run. Insurance companies have attempted introducing products partially covering OOP but given their inability to control claim costs by incorporating appropriate cost control mechanisms-i.e. negotiated arrangements with pharma companies and prescribers- has limited growth of this segment or even withdrawal of such benefits. Therefore, in the view of the authors, it's best left to cost-efficient digital aggregators who have the ability to bring the pharma companies, prescribers, payors and patients in a single digital mobile platform. The pharma companies could be chosen by a bidding process for different categories of non essential drugs. Drugs supplied by pharma companies thus chosen can be financed by health companies administering *health cards* for an annual fee while the essential drugs can be financed through state and central budgets and made available to the consumer for a nominal or no cost depending on the socio-economic strata or geographic segmentation. The prescribers- we have chosen to use this word with an expectation that the Government would consider second layer of primary health care providers, namely, nurses, pharmacists, etc to prescribe medicines for primary health care- can be aggregated on this single mobile platform using all possible mobile solutions namely chat,call, IVR, SMS, video call,etc which can enable consultation, prescription, placing order for prescription, refilling and follow-up. The payors for optional covers- i.e. health insurance companies can be allowed to offer supplementary affordable insurance cover to users of *health cards* via a group insurance, and may even consider offering network discounts/ disease or case management services to those who can afford to pay additional premium. For those who cannot afford, the *health cards* could also be used to provide credit for secondary and tertiary care offered by both government and private hospitals. This will also allow the government to fund the running of its hospitals.

Health Card – Administration & Advantages

The *health cards* for a populous country like India is best administered at district or even taluk levels to allow participation of small and medium size pharma companies, and therefore keep the cost of health cards low. This will also help in mobilizing appropriate medicine at appropriate time given the fact that India has season and geography based disease patterns. Locally administered health cards can ensure easy

The *health cards* for a populous country like India is best administered at district or even taluk levels to allow participation of small and medium size pharma companies, and therefore keep the cost of health cards low.

enrollment of local health care providers which in turn can avoid any language barriers in a nationally administered scheme. A model of this kind will also help insurance companies to reduce:

i) *Skimming*- Method used by insurers to avoid insuring people at greatest risk

ii) *Claim Costs*- By bringing more local pharma and health care providers into the network and

iii) *Adverse Selection*- By adhering to basic insurance principle of large numbers.

The authors are hopeful that the digital age entrepreneurs will pick up this model and develop further/ implement efficiently with help from the state and central governments, regulators and other relevant stakeholders assuring affordable primary health care.

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Understanding Health Insurance

Mr. R. Venugopal refreshes the readers with the fundamentals of Health Insurance

- R.VENUGOPAL

Health Insurance appears to be the future of the insurance sector in India with more than 40% of the business coming from this portfolio in the General Insurance industry. The latest Insurance Act 2015 has recognized the Health Insurance as a standalone pillar of the industry and made the entry of the Foreign Players easy with 49% FDI possible.

The health awareness among the public too is rising day by day with a lot of people taking to organic food, regular visits to the Gyms as well as adopting Yoga, walking and jogging as hobbies and what not. The rising health expenditure compels people to purchase Health Insurance. Only in a healthy body, a healthy mind can exist is the new revelation among the people at large.

There is an excellent business prospect for this portfolio as only a small percentage of our population is covered by some kind of health cover- either provided by the Government or Employer or personally taken. Actually 71% of the medical expenditure in this country is borne by the individuals out of pocket without any scope for reimbursement. Illnesses impoverish 2.2% of India's population every year, driving them in to the BPL Category. There are more than 30 Players in the market providing more than 300 health products.

With all this humungous potential for growth available, the question arises: under this background what is the knowledge level of a common man about the Health Insurance?

With all this humungous potential for growth available, the question arises: under this background what is the knowledge level of a common man about the Health Insurance?

After six decades, now only majority of people are somewhat aware about life insurance that it is not just a 'death fund'. Are we going to take another few decades to comprehend Health insurance? Or shall we continue to live under the impression that if you take Health insurance, all our hospital costs will be reimbursed? Or can we order all the tests- whether required or not-because Health Insurance will take care?

The time has come to make the layman/ beginner understand the basic principles of Health insurance in a simple language. Hence I have tried to present the nuances of this subject in an easy-to-comprehend style for the benefit of students/ common public and ordinary people. For this purpose I have compiled the definitions and explanations from different books including the

publications of the Insurance Institute of India, IRDA Reports and newspaper clippings and other materials available in the public domain.

Some basic explanations about Health Insurance

The health care expenditure of the individuals being distributed by pooling their premium payments is the basic principle of this concept. So under Health insurance, the premium is collected from the individuals like life insurance and the health expenses are pooled together.

While the State and the Central Governments provide some health cover to their employees and pensioners, they also run a few schemes for the sake of the poor and the down trodden including the BPL Families. The following are those schemes:

- Employees' State Insurance Scheme
- Central Government Health Scheme- CGHS
- Rashtriya Swasthya Bima Yojana- RSBY.
- National Rural Health Mission

There are three parties involved under the Health cover- the insured, insurer and the health care provider.

The insured thinks that he/she can undergo all the medical tests- whether required or not- as there is the insurance to reimburse the cost. This is anti-selection.

The insurer suspects every person who comes for the health insurance thinking that there is every possibility of him/ her falling sick. So only the healthy, young people are preferred for insurance- which is called the 'cherry picking' or 'cream skimming'.

Both these ideas are wrong. There should be a balance as health insurance is again pooling of resources and sharing of expenses, as in the case of any insurance.

Different Health Insurance Products

Briefly these are the various health cover products:

1. Mediclaim- under this the hospitalization expenses are reimbursed- not 100% in all the cases. There is the principle of Indemnity with no scope for profit or gain out of an event. This is renewable every year with the premium changing, depending up on the health conditions of the individual.
2. Health Insurance Products provided by a few Life Insurers, where there is an income benefit payable on the happening of a certain event, whether the assured has actually spent so much amount or not. These schemes are normally for a few years with the premium remaining unchanged.
3. Personal Accident coverage where both the death and the partial/ permanent disability of the assured is covered subject to certain conditions. This is either taken as a separate policy or as a Rider under an existing policy.
4. Critical Illness cover takes care of dreaded diseases like cancer, heart attack, coma or major organ failure. There is normally a lump sum amount payable on the diagnosis of a certain critical illness or on undergoing of certain procedures.
5. There are many benefits attached to the health policy like the Daily Hospital Cash Benefit covering the room charges, out patient coverage and other additional expenditure like the ambulance costs, stay cost of an attendant etc.
6. Investment Products on the lines of the Unit Linked Insurance Plans- ULIPs- are a recent addition, whereby the premium is divided as risk premium and the savings premium. The savings portion is utilized for purchasing Units.

7. Senior Citizen products cover the elderly people up to even age 90. These have some cost sharing provisions like co-payments and sub limits to keep the claims and also premiums lower. Co-payment involves sharing of the cost by the individual up to certain limit and sub-limits also have the provision of reimbursement of the medical expenditure only after a certain bar.

8. Micro-insurance products are mainly for rural and informal sectors like the poor and below poverty line people. IRDAI also has put some conditions of a certain number of percentages of policies to be procured compulsorily by every insurer. Normally the sum assured under this category is Rs 30000. NGOs take up these Plans as part of their social objective.

9. Overseas Medical Insurance Plans protecting contingencies occurring during international travel. These are also called Overseas Travel Plans covering other components like the loss of baggage, cover for flight cancellation etc.

10. Other Products like coverage for persons with HIV, Dental treatment etc.

Basic Underwriting conditions

Health insurance is based on the notion of morbidity which is the likelihood of occurrence of any illness thereby requiring hospitalization. This is mostly influenced by age and certain factors like the overweight, underweight, habits like smoking, drinking, past medical history, family history, occupation, gender, environment and residence etc.

The risk is assessed through standard morbidity charts whereby every risk is quantified and premiums are calculated accordingly.

The Principle of Utmost Good Faith, the bedrock for life insurance, operates here also and the prospect is supposed to reveal all the material facts for underwriting to the insurer.

Insurable interest is a must for taking health insurance.

Indemnity principle is the basis of a health cover and there is no scope of any profit or gain arising out of an event-excepting the Case of benefit Plans.

Contribution is applicable when there is more than one health policy from different companies covering the same illness. Here the loss is shared on the proportion that its insurance bears to the total amount of insurance.

Proximate cause is the cause of the loss or peril insured against and this is the dominant cause and accordingly the loss is reimbursed.

Like life insurance, the following documents are required for underwriting:

- Proposal form
- Age proof
- Income certificates
- Medical reports
- Confidential report of the sales personnel
- Process for medical and non medical underwriting
- Numerical rating method as in the case of life insurance

Health insurance is based on the notion of morbidity which is the likelihood of occurrence of any illness thereby requiring hospitalization. This is mostly influenced by age and certain factors like the overweight, underweight, habits like smoking, drinking, past medical history, family history, occupation, gender, environment and residence etc.

- Underwriting decisions are similar like life insurance- accept at Standard rates, accept with extra premium, postpone the cover, decline the risk and impose restrictive clauses.
- Group Health Insurance is underwritten mainly on the Law of Averages and the parameters like the Type of Group, Group size, composition of the Group in terms of sex, age, single or multiple locations, income levels, employee turn over rate, death and disease strains in the group for the last few years etc.
- Other Groups like the Unions, Trusts, Societies, Professional Groups and Unorganized Labor are also underwritten on the basis of the size of the Group, risk of adverse selection, Persistency of members in the group etc.

Conclusion

The main purpose of educating the common man on the salient features of Health Insurance has been achieved.

The different details of various Health policies have been left unsaid, because each insurance company follows its own rules and regulations. They can be seen from the relevant websites. Only broad details and rationale have been explained.

IRDAI maintains the Insurance Information Bureau which is a Body for collection and dissemination of reliable and accurate numeric and statistical data. This includes information regarding the prevalent diseases, treatments given etc through the Third Party Administrators- TPAs- who are processing the claims and helping in the fast settlement of claims both to the policyholders as well as payment to the hospitals of their medical expenditure bills.

IRDAI has also taken the historic step of **Portability of Health Insurance from October 1, 2011** from one insurance company to another, if the customer is not satisfied with the services of the insurance company.

The Author is a retired Executive Director of LIC of India

Addressing Health Insurance Penetration in India

Mr. Anoop Singh emphasizes the momentous role that digitization of the insurance ecosystem could play in filling the lacunae facing the Health Insurance sector in India. He also cites various policy interventions taken up by the Insurance Regulator in that direction.

- Anoop Singh

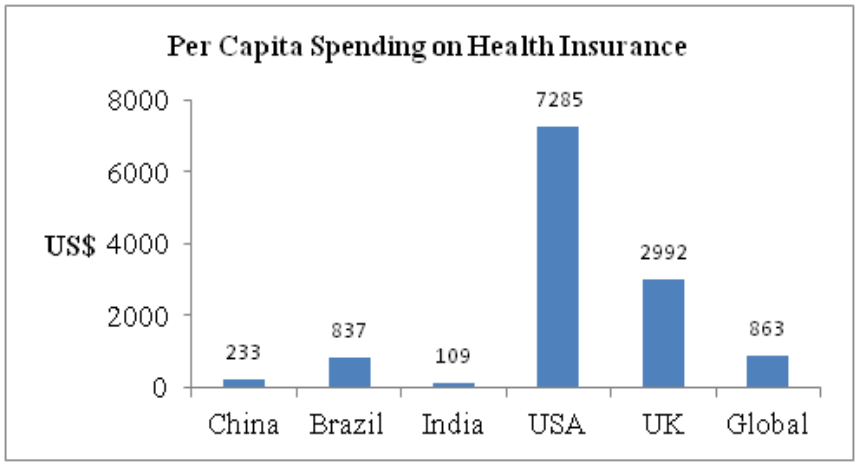
At the beginning of the millennium, a study by the World Bank (2001) noted that at least 24% of all people hospitalized in India in a single year slipped below the poverty line because they were hospitalized. The unfortunate truth, and biggest motivation to augment base-level health insurance, is that a large number of people in our country borrow money or sell assets to pay for their hospitalization expenses/ medical treatment.

Under-penetration of Health Insurance

Over a decade and a half later, despite all the developments in the sector, health insurance is still under-penetrated. As things stand, less than one fifth of Indians are covered under health insurance[1]. Further, even those covered by some form of health insurance scheme are inadequately insured. A study on out-of-pocket healthcare expenditure in India points out that 70% of healthcare expenses incurred by Indians are from their pockets, of which 70% is spent on medicines alone, leading to impoverishment and indebtedness[2]. Another study concludes that around 95% of middle-class Indians lack adequate health insurance to cover some of the most common procedures and ailments in the country; consumers above 45 years of age, who are at a higher risk of health problems and closer to retirement, are the least prepared for emergencies as they are under-insured by an average of 69%[3].

Further, although it is one of the fastest growing segments of the Indian insurance sector, with health insurance premiums registering a compounded annual growth rate (CAGR) of 32% between 2005 and 2013, per capita spending on health insurance still lags behind comparable emerging economies and the

Fig 1: Per Capita Spending on Health Insurance



Source: WHO, World Health Statistics, 2010

world[4] (see Fig. 1).

IRDAI Policy intervention

Some measures initiated by the Insurance Regulatory and Development Authority of India (IRDAI) to drive demand and supply include:

A) New Health Insurance Regulations-2016

(A positive step forward from Health Insurance Regulations-2013 towards building a progressive and stable industry)

1. Introducing the 'Use-and-File' process for Group products: Group products have a higher level of customization as compared to Retail products. Customers expected product features which best suited their requirements and employee (or member) needs, this was making the product structure complex and dated very soon. The concept of 'Use & File' (U&F) was introduced to meet this requirement of the market

Accordingly, an insurer has to get an approval from an internal committee (PMC) and provide a filing docket to the authority. Insurer is allowed to market the product and the authority can clarify or withdraw the U&F facility from an insurer if violation of regulation or guidance is observed.

2. Allowing pilot products This has allowed insurers to test the market under "Pilot product". Maximum duration for these products will be 5 years, post which either they should be converted to normal product or withdrawn. Insurers are also allowed to withdraw such products before 5 year period under certain conditions.

The motivation behind this recommendation was that in order to develop innovative products that cater to the needs of various categories of customers, an insurer should have the freedom to experiment with, test and then refine its products before finalisation. If this is not encouraged, insurers were unlikely to move out of their comfort zone and continue to issue only a limited range of predictable products.

To ensure that a larger number of potential clients are served, especially due to the immense ethnic, economic and demographic diversity in India, insurers required more flexibility to tailor their products to their consumers' needs, after studying their response to various products. Allowing pilot products would also promote better modernization and relevance of products.

3. Promotion of holistic health: India is a nation with a long and rich heritage of alternative medicine. Many consider these alternative forms of medicine as being more holistic and mainstream research has begun to endorse these beliefs. To stay ahead of the times and to broaden the scope of treatments covered, in 2013, the authority issued guidelines that allow insurers to cover non-allopathic treatment or AYUSH (Ayurveda, Unani, Sidha and Homeopathy).

To ensure that a larger number of potential clients are served, especially due to the immense ethnic, economic and demographic diversity in India, insurers required more flexibility to tailor their products to their consumers' needs, after studying their response to various products.

To promote preventive health care and wellness, insurers have been allowed to offer discounts on the renewal premiums in case of demonstrated improvement in health. The insurer must, however, disclose upfront the parameters to measure improvement in health in the product prospectus. Once offered at the time of filing the prospectus, such benefits cannot be withdrawn without a valid reason.

Further, insurers can now encourage and cross-sell outpatient consultations and/or treatment, pharmaceuticals or health check-ups offered by their network providers (hospitals and clinical establishments).

4. Towards building trust: Through the standardization of definitions, claim forms and lists of exclusions, the authority has

created a heightened level of confidence amongst potential purchasers of insurance. They now realise that irrespective of which issuer they approach, the basic terms of the policy will remain transparent.

B) Open Architecture in Distribution

1. Multi Corporate Agency – Banks, with their captive customer base, ready infrastructure and opportunities for cross-selling, have become ideal conduits for insurance products. As corporate agents to insurers, they were initially only allowed to sell insurance policies of only one insurer from the same line of business. With the amendments to the guidelines on open architecture in insurance distribution, corporate agents can now represent up to three life/ general/health insurers. This open architecture will go a long way towards offering potential customers all over the country a greater choice of products.

2. Insurance Marketing Firms – Towards introducing additional distribution channels, in 2015, the IRDAI formalised regulations for the setting up of Insurance Marketing Firms (IMFs). These entities are allowed to market insurance policies along with other regulated financial products that they distribute, such as mutual funds and NPS accounts. To safeguard the interests of customers, the remuneration of IMF salespersons is not commission-based but rather a fixed amount, with the option of a performance incentive.

In this era of digitization, the authority has taken the pragmatic step of introducing the concept of Insurance Web Aggregators.

3. Point of Sales (PoS) Persons – In a move that could reduce distribution costs in the general insurance space and simultaneously increase insurance penetration and insurance density, the guidelines for Point of Sales (PoS) persons permits anyone who has passed their matriculate exam and cleared the training requirement and exam conducted by National Institute of Electronics and Information Technology (NIELIT), to become a PoS and market simple and pre-underwritten policies for motor, personal accident, travel and home insurance. This will not only give people in the hinterlands an opportunity to secure gainful employment but also spread the insurance umbrella further.

4. Introduction of Web aggregators– In this era of digitization, the authority has taken the pragmatic step of introducing the concept of Insurance Web Aggregators. These entities compile and provide information about insurance policies of various companies on their website. Their primary motive is to provide accurate information to potential buyers. The role and duties of such aggregators are defined in detail in the Insurance Regulatory and Development Authority (Web Aggregators) Regulations, 2013.

In addition to enhancing transparency in the industry, web aggregators have made the whole process of decision making with regard to insurance products more convenient for busy buyers.

C) Guidelines to facilitate promotion of Digital Business

1. Insurance Repository – As a 'first of its kind' insurance service initiative in the world, the Insurance Repository System was introduced by the authority with the intention of improving services to policy holders as well as augmenting insurance penetration. This service allows subscribers to buy and store their policies in a dematerialised form (as e-policies). Beyond eliminating the risks of storage and loss, this facility provides convenience and safety to customers. Most importantly, e-policies are more economical to issue and service as compared to traditional paper policies. This feature could give a boost to the distribution and issue of low-ticket policies to marginal customers and thereby increase insurance penetration.

With all these initiatives undertaken in recent times, the IRDAI has infused further

transparency in the way the industry functions. The impetus on innovation alongside the mandating of minimum pay-outs and product information, facilitating a menu of offerings across health insurance products, portability and easy withdrawal of pilot products have also rendered safety to consumers and flexibility to insurers. By balancing customer protection with the commercial interests of the insurers and creating dynamic market conditions in the health insurance ecosystem, the authority has encouraged insurers to innovate and compete. The end result is bound to be a larger, more robust spread of health insurance products.

In a country with a land mass area of 3.3 million square kilometres and a population of 1.25 billion people, the biggest hurdle that suppliers of health insurance, both government and private, face is 'reach'. With the advent of digitization, and specifically the passing of the Aadhaar (Targeted Delivery of Financial and Other Subsidies, Benefits and Services) Bill, 2016, our nation seems all set to leap over this hurdle.

The role of digitization in insurance penetration

There are a number of ways in which consumers of insurance benefit from the internet, social networking and digitization revolution. It has made comparative information on prices and features of various products more easily available. Further, due to open interactives, various combinations of premium rates and coverage limits can be easily viewed, with and without various chosen frills and add-ons. Advice and feedback is also freely available from web aggregators who are completely neutral and unbiased sources, while satisfied and unsatisfied customers are also able to share their opinion with a larger universe of potential customers through blogs and other social networking channels. Most importantly, the internet offers seamless and hassle free purchase, renewal and claim processes in addition to ease of record-keeping and overall convenience in terms of payment. All these facilitators go a long way in building trust, enhancing affordability and widening coverage.

At another level, insurers can use digitization to study consumer behaviour in greater detail. This could impact all aspects of health insurance, right from the structuring of new products to the understanding of propensities to purchase, which in turn could enable insurers to bring more suitable products to the market and thereby augment inclusion.

Last, but not the least, in a country with a land mass area of 3.3 million square kilometres and a population of 1.25 billion people, the biggest hurdle that suppliers of health insurance, both government and private, face is 'reach'. With the advent of digitization, and specifically the passing of the Aadhaar (Targeted Delivery of Financial and Other Subsidies, Benefits and Services) Bill, 2016, our nation seems all set to leap over this hurdle. While the main purpose of this Bill is to improve the delivery of subsidies and targeting of recipients, the second round of benefits will come in the form of a database of statistics and broad financial status comprising the entire county.

(Footnotes)

[1] Central Bureau of Health Intelligence, National Health Profile, 2015

[2] Pharmacoeconomics: Open Access, paper titled 'Increasing Out-Of-Pocket Health Care Expenditure in India-Due to Supply or Demand?

[3] BigDecisions.com, a leading personal finance advice platform

[4] WHO, World Health Statistics, 2010

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REMOVING THE PAIN POINTS IN HEALTH INSURANCE

Mr. P C James presses upon the exigency on part of the insurers to overhaul the whole gamut of health insurance processes in ways that could heal if not expunge the pain points across the value chain of the sector. He brings out the concept of Treating Customers Fairly (TCF), at all points of contact with the service provider, by the service provider so as to make their whole interaction hassle free and joyful.

- P.C. James

Anyone having concern for social and economic welfare is convinced about the need of good health in human lives. To achieve good health, the care and cure involved must be affordable and accessible to all. Health care is steadily moving up the value chain in removing diseases and disabilities of people through higher levels of skills and technology. This trend, though welcome, puts cost pressures on those who seek treatments. The cost factor of medical treatments has made health financing a critical part of the health system. Financing of health can be done through many ways as seen in practice across various countries, but an increasingly accepted approach recognises that as major health incidents/ catastrophes are risk based and random, health care can be financed through risk based health insurance.

Despite all regulations and oversight health insurance is a service that is prone to generate pain points to those who avail it and face claims.

It is a necessary part of social duty that health financing has to be universalised. In India, this initiative has been pushed by the government by offering tax incentives to the well to do and by arranging subsidised mass insurance to the poorer sections. In addition, health insurance, has been formally given a special place in the insurance sector, by categorising it in the Insurance Act as a separate insurance segment and throwing it open to all insurers whether life, non-life or standalone Health Insurers to spread its benefit to the whole population. The Regulator in turn has been ensuring that the portfolio is well regulated and insurers offer real service and protection to all consumers who are increasingly flocking to enrol into health insurance schemes, whether they be individual or family, group or mass insurance.

Despite all regulations and oversight health insurance is a service that is prone to generate pain points to those who avail it and face claims. This was foreseen by the Regulator almost as soon as the sector was opened up, and the Third-Party Administration concept was introduced. TPAs were licensed to ensure that every insured is guided by the TPA in obtaining seamless care. More importantly, by ensuring TPA service the regulator ensured that cashless claim settlement, which is critical in catastrophic health claims, becomes the standard practice in health insurance. However, because of

the rapid growth of health insurance and the evolving nature of treatments and policy coverage there are issues that trouble consumers in the care receiving value chain. These can be examined across the various processes involved.

Sales and Advice Phase

1. In the search for a proper health insurance coverage, the information and advice phase is very important. Consumers face confusion in this area owing to the wide range of products and prices, terms and conditions. A standard recognition platform may have to be evolved first within a company and then across the industry. Sales practices of the companies and intermediaries need to ensure that fair comparisons are given. The information given should be transparent and the customer must be offered oral, written and website based information as well as enough time to internalise the value proposition. So, high pressure selling and rapid and uncomprehending form signing have to be eliminated as they are forms of misselling. Such actions must face warnings and even penalties if consumers have faced financial losses owing to gaps in covers and benefits. To help consumers to prove the wrong doing, regulations would have to ensure that advice given is made in writing.
2. Treating customers fairly (TCF) is a concept that is gaining currency and hence in the highly personalised and emotional area of health insurance, the advice part of selling has to be sensitive to the needs and lifecycle position of the customer, without prejudice to the insurer's right of full disclosure and avoidance of adverse selection and moral hazard/fraud.
3. As part of TCF it is necessary as per regulation to ensure that a copy of the proposal is handed over to the customer and acknowledgement obtained. This is also beneficial for the insurer in case the insurer need to prove any element of adverse selection, moral hazard , fraud and non-cooperation by the insured.
4. Rejection of proposal or limiting the policy benefits are silent areas in service failures and the use of any technical excuse cannot be used to deny or limit benefits in the policy. Denial of cover, delay and rejection of claims are the biggest dangers for consumers and insurers will have to explain and justify each and every such incident to the consumer citing fundamental reasons of non-insurability. There was a classic case where a couple travelling overseas from the age of 40 every year with no claims for 20 years. When they came to take the policy at the age of 60, they were refused insurance because the cover from the age of 60 cannot be automatically given and needs permission from higher office and someone callously rejected it. On a fundamental insurability basis the couple would be the most insurable couple because of their long no claim record which eliminates almost all traces of moral hazard and fraud.

Policy Issuance and Renewal Phase

5. Policy documents must be issued correctly with all clauses and conditions as well as the consequent TPA

Treating customers fairly (TCF) is a concept that is gaining currency and hence in the highly personalised and emotional area of health insurance

documents must be issued and delivered to the customer in the time prescribed. This is not often not done and puts the customer to uncertainties and fears of coverage gaps and service failures.

6. The right of the insured to have the 'free look' benefit must be respected and even encouraged to get the loyalty of the customer to the insurance concept as insurance is a complex credence product. Every insured has the right to receive the policy copy almost immediately after the policy is taken. Unless the policy wording with all conditions and terms are received the free-look benefit becomes useless.
7. Renewal of the policy on time and without break is another right that has to be encouraged to avoid disputes. It is important for both the insurer's intermediary and employee to understand that health insurance, though a renewable annual contract, is in fact a lifetime protection and need to be renewed without fail. Giving this value to the consumer is the essence of health insurance protection, especially as the risk increases with age and therefore gaps in cover can be seen as failure in renewal service.
8. Seamless transition of the policy is to be proactively helped by the insurer and the intermediary at critical transition times such when getting a job and moving from parental family insurance to one's own insurance, or when getting married, and most important when retiring and having to move from group insurance to an individual insurance.
9. Another major pain point is the gradual erosion of the value of health insurance owing to the relentless rise of health inflation. Hence at every renewal there must be a supportive guidance to encourage increase in sum insured based on inflation and also based on the higher income that the insured may be getting in the earning age coupled with expectation of treatment at a higher order hospital.
10. Persons on the move must be given service seamlessly wherever they re-settle and those who travel frequently need to be provided service for unforeseen health contingencies, in a manner similar to travel insurance.
11. Change in age, place of residence, persons entering or exiting the policy, increase in sum insured, benefits, no claim bonus etc. need to be recorded in the policy and transparently conveyed to the insured at least electronically and the record must be orderly available with the insurer to send to TPA as health insurance is claim (frequency) prone.

Another major pain point is the gradual erosion of the value of health insurance owing to the relentless rise of health inflation.

Claim Phase

12. Claims are bound to happen in health insurance as health insurance is a frequency risk. Current statistics indicate that approximately 9 persons claim out of 100 persons insured in a year. Claim frequency was less a decade ago. This steady rise triggers a claim ratio that can cause loading in premium costs and eventually make health insurance unsustainable. Health inflation coupled with increasing frequency of claims is a fact and therefore the rise in premium rates is inevitable. The insuring public need to be made aware of the cost push in insurance by joint action on the part of

insurers as a service.

13. Since there is a resistance against rise in premium from all concerned, the shorter route to contain claim costs is in trimming claim amounts. Here the insured can feel short changed and cheated and most pain points lie in the delay, the trimming or denial of claimed amounts.
14. Clever manipulation of sub-limits and other limitations and conditions can be made to suddenly remove the benefit before the eyes of the customer. Instances have been reported where certain illnesses have a waiting period of one year, but at the time of claim in the second year, the insurer points to a two year mortarium in the policy.
15. From the time of admission till discharge all parties concerned must adhere to standard terms for diseases and insurance terms so that all can talk in the same language and accept an outcome which is transparent. Disease terms should not change merely because its common term is excluded in the policy. Insurers have no quarrel with any disease but only with it not being a sudden and unforeseen contingency.
16. All the parties concerned in a health claim, namely the hospital, the TPA, the patient and the insurer face difficulties from the admission stage itself because the documentation and practices adopted are not seamless and clear to all. Very often the patients are forced to deposit advance payments awaiting cashless confirmation.
17. Documentation practices need standardisation as the patient is unclear about the process. Trained persons are not available at the hospital end to take care of documentation and billing in such a manner that the TPA and insurer can process and pass the claim quickly.
18. The insurance terms and conditions are many times interpreted and understood so subjectively that the insurance service given can send shudders to observers, not to speak of the helpless patient's representatives. One can hear anecdotes of cases such as the TPA representative refusing to pay because the dead body of the patient, whose expenses are being processed, has been sent for cremation.
19. It is also a fact that insurers and TPAs tend to look at all health claims in the same manner. There is a wide variety of claims such as emergency and elective treatments, accidents and critical illness treatments, surgical and non-surgical etc. It therefore becomes very shocking when treatment elements of critical illnesses such as cancer are refused citing a clause such as genetic conditions, when the patient is 63 and was having the policy for more than 10 years before the illness has been diagnosed.
20. Similarly insurers have to know what is a not excluded because some term in the policy excludes the generic condition. A very common example in the earlier years was the denial of claims for ectopic pregnancy which is a life threatening accidental emergency, merely because pregnancy and

The insurance terms and conditions are many times interpreted and understood so subjectively that the insurance service given can send shudders to observers, not to speak of the helpless patient's representatives.

> Exercise and weight balancing and other health promoting activities must be incentivised in taxes, premiums, and other innovations that make people look to their health with all round motivation.

child birth is excluded in the policy.

21. Delay in settlement of claims is a bane though it is seen on paper that claims are settled in 30 days. The tussle between hospitals and TPAs/Insurers is at the cost of patients. Hospitals also claim that crores of rupees are pending for payment straining their financial position. Anecdotal evidence claims that hospitals have to write off substantial amounts due to unpaid claims which TPAs and Insurers deny. So, there is a credibility gap which do not help the cause of insurance.

Health insurance world-wide is known for shifting costs – consumers to pools and insurers, which is legitimate and where not covered consumers to hospitals and hospitals to insurers etc. Insurers themselves want to shave costs and shift costs to insureds in the name of deductible and co-pay, which is legitimate when reasonable and by underpayments and rejections which is objectionable leaving the hospitals and patients to fend for themselves. Therefore, it may be seen that no stakeholder in the health insurance value chain is happy. So a need arises that health insurance processes be recast in such a manner that the pain across the system can be looked at and reduced or eliminated. The corner stones of health insurance templates need to be revisited and all stakeholders need to be convinced of some of the foundational requirements of successful health insurance.

1. Health disasters are risks in the pure sense of the word with due modification that it affects human beings. It is or can be qualified by subjectivity, frequency, complexity, period based costs, emotional feelings of those affected and so on. Morbidity and the variety of treatment approaches and levels of sophistication can make the costs non-transparent.
2. Hence containing costs is the critical core of health insurance to make premiums viable and affordable. In the race for offering benefits to those with more risk such as the aged it is possible that premium rates will go up forcing those young and without health risks to feel the ill wind of adverse selection, and slowly leave the system, which starts a vicious cycle of claim free people leaving and those with claims entering, making the industry unviable.
3. Therefore there is every need to price risks properly and put boundaries to risks that insurers can carry, and the residual risks must be put on to the governments and the tax payers as their burden for the social welfare costs of those who are not insurable in the normal sense because of the catastrophic nature of their illness or disability either on the frequency side or severity side or both. For this there could be pools formed with contributions from the government and the care givers to pay for the certainties concerned in the care to be given so that insurers can finance the uncertain parts of the care costs.
4. Reducing the burden of disease is a national priority and hence all stakeholders must make the larger population take care of the growing disease burden by laws and good practices to reduce pollution and toxic

contents in the air, water and food. Food that are unnecessarily rich in sugar or any other substance harmful to long term health must be moderated. Exercise and weight balancing and other health promoting activities must be incentivised in taxes, premiums, and other innovations that make people look to their health with all round motivation.

5. Health promotion will reduce costs on the part of the insured, hospital quality and adherence to standards can moderate costs on their part, insurers need to pare their management costs and commissions to give a higher return in claims to the insuring public. Government must reduce taxes , levies and also proffer subsidies where the premium costs based on risk make certain segments uninsurable.
6. Regulations must not breach the fundamentals of insurance such as allowing people to enter health insurance, at an age, when in other countries at that age people migrate to government supported insurance. Regulations at one time allowed two claim pay-outs for one incident of illness, which goes all against the principle of proximate cause and incentivised underinsurance and moral hazard, because two claim amounts can be got for one incident of illness. Break in insurance is condoned far too long when insurers can electronically remind customers regularly as the policy period is reaching renewal zone and so on.
7. TPA services must look to insured's ease of benefitting from the protection and their getting a wide variety of support to obtain the right advice and even where to take a second opinion so that unnecessary surgeries and costly medicines and treatments are avoided to the detriment of the system.
8. Insurers have the dominant responsibility to health insurance to ensure responsible risk based insurance, provide services directly or through TPAs to upgrade the benefit and welfare orientation of the system because it is an essential livelihood need for any citizen.

(The author is Director of Insure-Edge a 'lead by knowledge'/education promoting organisation)

The Author is the Director of "Insure-Edge" a lead by Knowledge/Education promoting organization.

In the Air

JULY 2016

1. **IRDAI/RI/18/130/2016: IRDAI (Obligation cession to Indian Re-insurers) Notification, 2016**

   IRDAI has notified that the percentage cessions of the sum insured on each General Insurance Policy to be reinsured with the Indian Reinsurer shall be 5% in respect of insurance during the year 1st April, 2016 to 31st March 2017 (except for government sponsored health insurance schemes, wherein it would be made 'NIL').

2. **IRDAI/SDD/MISC/CIR/135/07/2016: Operationalization of Central KYC Records Registry (CKYCR)**

   The Circular has directed all the insurance companies to upload all records of KYC on Central KYC Records Registry (CKYCR) in order to facilitate Banks/Financial Institutions with KYC related information of customers, so as to avoid multiplicity of undertaking KYC by Banks/Financial Institutions.

3. **IRDA/INT/CIR/PSP/139/07/2016: Addition of Products for sale through Point of Salesperson (POS)**

   The circular gives the list of additional products which can be solicited and marketed through POS.

4. **IRDA/INT/CIR/CSC/138/07/2016: Addition of Products for sale through CSC-SPV**

   The circular gives the list of certain additional products which can be solicited and marketed through CSC-SPV

5. **IRDA/INT/CIR/T&E/136/07/2016: Harmonization of training and examination requirements for various channels of distribution**

   The circular deals with the revised training and examination requirements of various distribution channels (i.e, Insurance agents, Insurance brokers and Other insurance intermediaries namely Corporate agents, web aggregators, Insurance Marketing Firm, CSC-SPV, Point of Salesperson (PoS)).

6. **IRDAI/Reg./21/133/2016: Insurance Regulatory and Development Authority of India Staff (Officers and Other Employees) Regulations, 2016**

   These regulations have defined the terms and conditions of service of Officers and other employees of the Insurance Regulatory and Development Authority of India.

7. **IRDA/HLT/REG/CIR/150/07/2016: Guidelines on Product Filing in Health Insurance Business**

   These Guidelines deal with the product filing procedures for products relating to Health Insurance Business for compliance by all Insurers and TPAs, as may be applicable, in terms of various provisions of the IRDAI (Health Insurance) Regulations, 2016.

8. **IRDA/HLT/REG/CIR/146/07/2016: Guidelines on Standardization in Health Insurance.**

   These guidelines have been issued to ensure that certain basic terminology being used in Health Insurance policies are given standard definitions so that prospects and insureds are able to understand them without ambiguity.

9. **IRDAI/Reg/17/129/2016: Insurance Regulatory and**

Development Authority of India (Health Insurance) Regulations, 2016

This regulation replaces earlier Health Insurance Regulation, 2013. This regulation brings in certain new features like pilot products, wellness programmes etc.to facilitate in better products and services to the policyholders and to bring in robust growth of health insurance sector.

AUGUST – 2016

10. **IRDA/CAGTS/CIR/MSL/152/08/2016: Complaints of Mis-selling /Unfair Business Practices by Banks/NBFCs**

This circular gives the specific details of IRDAI (Corporate Agents) Regulations, 2015 brought out by the Authority to curb mis-selling/unfair business practices.

11. **F. No. IRDAI/Reg/20/132/2016: IRDAI (Registration of Indian Insurance Companies) (Eighth Amendment) Regulations, 2016**

An additional provision w.r.t to Indian promoter and /or Indian investor who are regulated by RBI, SEBI and /or NHB is inserted.

12. **IRDA/F&A/GDL/LSTD/154/08/2016: IRDAI (Listed Indian Insurance Companies) Guidelines, 2016**

These Guidelines would be applicable to all insurers that have listed their shares or are in the process of getting their shares listed on the stock exchanges in relation to transfer or proposed transfer of shares.

13. **IRDA/F&A/GDL/LSTD/154/08/2016: Guidelines on Remuneration of Non-Executive Directors and Managing Director /Chief Executive Officer / Whole-time Directors of Insurers**

These guidelines deal with the remuneration of Non-Executive Directors and Managing Director / Chief Executive Officer / Whole-time Directors of Insurers.

14. **IRDA/INT/CIR/CSC/159/08/2016: Clarification - Addition of Products for sale through CSC-SPV.**

The circular provides certain clarification on CSC-SPV marketing Government sponsored Insurance Schemes without any sum insured limit.

15. **RDA/INT/CIR/POS/158/08/2016: Clarification - Addition of Products for sale through POS**

The circular provides certain clarification on POS marketing Government sponsored Insurance Schemes without any sum insured limit.

16. **IRDA/F&A/DP/IPO/2016-17: Exposure Draft on Discussion Paper on "Listing of Indian Insurance Companies"**

This paper discusses on the proposal that the insurance companies having completed 8 years of operations in case of general/re-insurance and ten years of operations in case of life insurance can go for mandatory public listing.

17. **213/IRDAI/HLT/Gen/Reg/2015-16: Exposure Draft on IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2016**

This draft regulation intends to ensure that the insurers follow prudent practices on management of risks arising out of outsourcing with a view to prevent negative systemic impact and to protect the interests of policyholders.

18. **Ver 02 AUGUST, 2016: Guidelines on Preparation of Investment Returns**

These guidelines are issued to streamline the reporting system

19. **F. No. IRDAI/Reg/22/134/2016.: IRDAI (Investment) Regulations, 2016**

These regulations prescribe the investment norms of the insurance companies.

SEPTEMBER, 2016

20. **Exposure Draft - Amendment to Regulation 3(5) of IRDAI (Issuance of e-insurance policies)**

It deals with the process for issuance of e-insurance policies where e-proposal form shall carry his/her electronic signature.

21. Exposure Draft Amendment to Regulations 16(c), 28(2),28(5) and 28(7) of IRDAIs (Regulation and operations of Branch Offices of Foreign Reinsurers other than Lloyds) Regulations,2015

This regulation allows branch offices of foreign reinsurers to outsource some of the functions such as investment. The amendments propose to make investment functions co-synchronous with the **IRDAI (Investment) Regulations,2016.**

22. IRDA/SUR/MISC/CIR/180/09/2016: Clarifications on Transitory provisions under section 64UM (3) read with Regulation 27 of the IRDAI (Insurance surveyors and loss Assessors) Regulations, 2015

The circular advises that the surveyors holding a valid license prior to the commencement of Insurance Laws (Amendment) Act 2015 and falling under regulation 27, shall be allotted work based on the respective Insurer's methodology for appointment of surveyors, utilization of surveyors and allotment of survey jobs, during the interregnum period of three years.

23. IRDA/CIR/LIFE/09/16/182: Settlement of Death Claims

The circular directs all Life Insurers to maintain separate classification of records of death claims

24. IRDA/SUR/MISC/CIR/183/09/2016: On-line examination for Surveyors and Loss Assessors

This circular talks about conducting of on-line examination, for grant of license for Surveyors and Loss Assessors, from the next financial year i.e. FY 2017-18.

25. Exposure Draft: IRDAI (Registration of Insurance Marketing Firm) (First Amendment) Regulations, 2016

This Draft proposes various amendments based on receipt of feedback and recommendations from the stakeholders and insurers.

26. Exposure Draft: IRDAI (Insurance Surveyors and Loss Assessors) (First Amendment) Regulations, 2016

This Draft proposes various amendments, such as acquisition of qualifications from AICTE, approved institutions and qualification by existing surveyors, based on various representations and grievances received from the surveyors.

OCTOBER,2016

27. RDA/INT/CIR/MI/197/10/2016: Products for the sale through Micro Insurance Agents

This circular allows, Government insurance schemes such as Pradhan Mantri Fasal Bima Yojana (PMFBY), Weather Based Crop Insurance Scheme (WBCIS) & Coconut Palm Insurance Scheme (CPIS) (without any limit on sum insured) covering the non-loanee farmers, to be solicited and marketed by Micro Insurance Agents.

28. IRDA/NL/CIR/RIN/201/10/2016: Quality of Data filed for online allotment of Filing Reference Number (FRN) to the Cross Border Reinsurer

This circular advises all the insurers to strictly ensure filling of all data fields in information sheet while filing the CBR details for auto generation of Filing Reference Number (FRN)

29. IRDA/IT/CIR/MISC/216/10/2016: Formation of Working Groups to come out with Comprehensive framework for Cyber Security in Insurance sector

This circular enables listed insurance companies to meet the disclosures requirements of SEBI under LODR Regulations, 2015. These requirements do not in any manner, modify the disclosure

requirements or the manner of preparation of financial statements as required Insurance Act, 1938, the IRDAI Act, 1999 and the Regulations framed thereunder.

30. Public Notice: National Centre for Financial Education (NCFE) - 'National Financial Literacy Assessment Test' (NFLAT) – 2016-17 for the students of Classes VI, VII, VIII, IX and X

With the aim to spread financial literacy, IRDAI as a member of National Centre for Financial Education (NCFE), invited all school students from classes VI to X to participate in the National Financial Literacy Assessment Test (NCFE-NFLAT 2016-17) being conducted through Online and Offline mode for school students of class 6th to 10th standard.

31. IRDA/NL/CIR/MISC/214/10/2016: Delay in claim intimation/ documents submission

In this circular, the Authority directs all insurer to comply with Section 34(1) of the Insurance Act, 1938 whenever there is a delay in claim intimation and document submission.

32. IRDA/NL/CIR/MISC/214/10/2016: Formation of working groups to come out with comprehensive framework for cyber security in insurance sector

In this circular, it has been decided to form two separate working groups for life and non-life sector (including health) comprising of CIOs of insurers to discuss and decide on the issues related cyber security.

33. IRDA/IT/CIR/MISC/215/10/2016: Cyber Security Framework

This circular is about beefing up of Authority's efforts on a comprehensive cyber security framework for Insurance sector of India in the wake of recent cyber-attacks and also implement appropriate mechanism to mitigate cyber risks. Accordingly, Insurers have been requested to submit the present status and the future plan of action on cyber security framework.

NOVEMBER – 2016

34. 01/11/2016: POLICY HOLDER COMPLAINTS REGISTRATION FORM

Policy holder complaint registration form is enclosed.

35. 01/11/2016: Cell for redressal of grievances of Policyholders

The details of how and when the policyholder can approach the grievance redressal cell are given.

36. IRDA/LIFE/MISC/CIR/ 221/11/2016: Spurious Phone Calls and Fictitious/ Fraudulent offers – Modification in Circular Provisions

It has been directed that all Life Insurers shall flash on their Home Page of their websites, the Public Notices issued by IRDAI cautioning general public about spurious calls and fictitious offers.

37. IRDA/LIFE/ORD/GLD/223/11/2016: Guidelines on Point of Sales Person – Life Insurance

As per the guideline, every "Point of Sales Person" shall be identified either by his Aadhaar Card Number or by his PAN Card shall be at least 18 years' age completed and shall have educational qualification of 10th standard pass.

38. IRDA/LIFE/ORD/GLD/222/11/2016: Guidelines on Point of Sales Person – Life Insurance

These Guidelines shall be applicable to the products offered by Life Insurers proposed to be sold through "**Point of Sales Persons".** Certain Category/Nature of Products to be offered under POS - Life Insurance have been indicated in the guidelines.

39. IRDA/LIFE/CIR/MISC/228/11/2016: Submission of Life Insurance Data to IIB.

This Circular directs all the life insurers to submit data to IIB only on yearly basis and not on half yearly basis.

40. IRDAI/NL/GDL/RIN/231/11/2016:

Operational guidelines for Foreign Reinsurers' Branches

As per the guidelines, the foreign reinsurers' branches are required to comply with the various provisions IRDAI Investment Regulations, 2016, subsequent amendments and related circulars and guidelines issued from time to time.

41. IRDAI/HLT/REG/CIR/219/11/2016: Clarifications in respect of the provisions of IRDAI (Third Party Administrators - Health Services) Regulations, 2016

42. IRDA/ACTL/CIR/ULIP/236/11/2016: Extension of grace period for payment of renewal premium of life insurance policies in light of recent demonetization

The Authority extends the grace period by an additional 30 days for all the Policies issued by life insurers the premium/s of which fell/falls due on or after 8th November, 2016 till 31st December, 2016

43. IRDAI/CIR/F&I/INV/239/11 /2016-17: Investment

This circular mentions that Insurers can invest in additional Tier-I (Base-III complaints) perpetual bonds ATI Bonds rating of ATI bonds shall not be less than "' AA"

DECEMBER – 2016

44. IRDA/Reg./24/136/2016: IRDAI (Registration and Operations of Branch Offices of Foreign Reinsurers other than Lloyd's) (Second Amendment) Regulations, 2016

This amendment deals about the modified norms for registration of branch offices of foreign Reinsurers

45. IRDA/ BRK/ CIR/ NO /243/ 12/ 2016: Filing of Returns for Foreign to Foreign Reinsurance Transactions

The circular advised that the reinsurance/ Composite Insurance Broking Companies to file a return with the Authority in the prescribed format within 45 days of end of the half-year beginning from the financial year 2016-17.

46. IRDAI/LIFE/CIR/ADV/255/12/2016: Filing of Health Insurance Advertisements by Life Insurers

This circular advised all the life insurers to file advertisements pertaining to Health Products and combined advertisements for Health and Life products with Health Department of the Authority through BAP portal.

47. IRDA/HLT/GDL/CIR/257/12/2016: Clarification to Guidelines on Standardization in Health Insurance

This circular extended time limit up to 31st March, 2017 for registration of Network Providers in the Hospital Registry, ROHINI, maintained by Insurance Information Bureau (IIB).

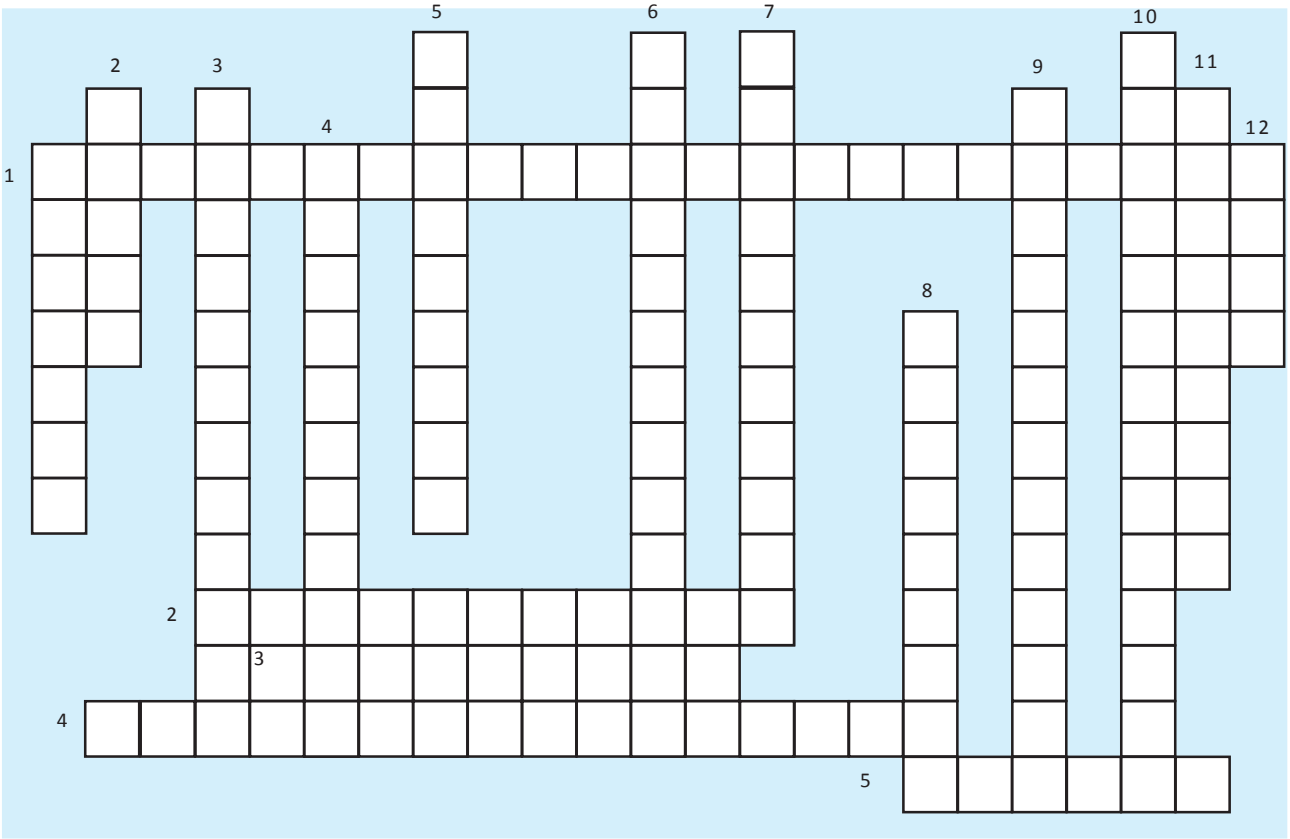
48. IRDA/F&A/CIR/ACTS/ 262/12/2016: Report of the Implementation Group of Ind AS in Insurance Sector

This circular directed that insurers/insurance companies are required to prepare Indian Accounting Standards (Ind AS) based on financial statements for accounting periods beginning from April 1, 2018 onwards with comparatives for the periods ending 31st March 2018 or thereafter.

49. IRDA/BRK/MISC/CIR/260/12/2016: Online System for obtaining prior approval and intimation regarding governance issues of Broking Companies.

The circular reaffirms to all the Brokers that submission of application for licensing of new brokers, renewal of registrations, related fees or information/prior approval for changes shall be accepted through on-line mode.

CROSS WORD



CLUES

Across:

1. Company/ Organisation (TPA) holding IRDA Licence to Process Claims (Corporate/ Ratail) as on Out Sourcing entity of the Insurance Company.
2. Insurance for Insurers
3. The Condition of being diseased
4. Active Processof becoming aware of and making choices towards a healthy & Fulfilling Life.
5. Rating - Evaluation or Assesment of a thing / entity.

Down

1. Type of insurance system to comply with the Sharia Laws.
2. Government health insurance scheme.
3. Day to day healthcare given by a health care provider.
4. Insurance Premium as a Percentage of GDP of a Country.
5. Relative incidence of death within a particular group categorized according to age or some other factors.
6. Part of the insurance claim to be paid by the insured.
7. Splitting of risk among multiple parties.
8. Facility provided at network hospitals for payment of hospital bills.
9. A Financial incentive for individuals that purchase goods in multiple units or large quantities.
10. Situations where persons with most dangerous life styles or careers are the most likely to buy insurance policies.
11. Fixed amount paid by the patient to the company before the patient receives service from the physician.
12. A Government run health insurance scheme.

Solutions will be published in the next edition

LIFE INSURANCE COUNCIL

Summary of New Business Performance of Life Insurers for the Period ended Dec-16 (Provisional)

		PREMIUM IN Rs CRORES					NO. OF POLICIES AND SCHEMES				
Sr.no	Particulars	For the Month Dec-16	Upto the Month Dec-16	For the Month Dec-15	Upto the Month Dec-15	YTD Variation in %	For the Month Dec-16	Upto the Month Dec-16	For the Month Dec-15	Upto the Month Dec-15	YTD Variation in %
1	Individual Single Premium	1626.96	20980.75	1532.88	8672.03	141.94 %	128454	1125780	121548	872782	28.99 %
2	Individual Non Single Premium	4968.01	30886.82	4221.34	26671.07	15.81 %	1923393	14704735	2427907	15699006	-6.33 %
3	Group Single Premium	5884.44	58122.85	4652.37	45013.96	29.12 %	273	2293	180	1498	53.07 %
4	Group Non Single Premium	532.99	6426.57	620.22	5230.67	22.86 %	2927	21501	2457	23394	-8.09 %
5	Grand Total	13012.39	116417.00	11026.82	85587.73	36.02 %	2055047	15854309	2552092	16596680	-4.47 %

LIFE INSURANCE COUNCIL

Detailed New Business Performance of Life Insurers for the Period ended Dec-16 (Provisional)

		PREMIUM IN Rs CRORES					NO. OF POLICIES AND SCHEMES				
Sr.no	Particulars	For the Month Dec-16	Upto the Month Dec-16	For the Month Dec-15	Upto the Month Dec-15	YTD Variation in %	For the Month Dec-16	Upto the Month Dec-16	For the Month Dec-15	Upto the Month Dec-15	YTD Variation in %
1	AEGON LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.14	1.32	0.14	1.41	-6.87 %	7	1468	3	201	630.35 %
	Individual Non Single Premium	7.85	45.21	10.07	85.68	-47.23 %	3625	20638	3670	31981	-35.47 %
	Group Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Group Non Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Grand Total	7.99	46.53	10.21	87.09	-46.57 %	3632	22106	3673	32182	-31.31 %
2	AVIVA LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.30	4.39	0.34	4.54	-3.41 %	112	771	2400	2622	-70.59 %
	Individual Non Single Premium	10.37	74.36	7.69	105.50	-29.52 %	2936	14627	2430	26030	-43.81 %
	Group Single Premium	0.00	0.09	0.00	0.05	70.84 %	0	1	0	0	∞
	Group Non Single Premium	0.97	33.50	8.99	94.47	-64.54 %	0	14	2	36	-61.11 %
	Grand Total	11.64	112.33	17.02	204.56	-45.09 %	3048	15413	4832	28688	-46.27 %
3	BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	5.43	39.53	18.35	147.75	-73.25 %	233	1834	1141	10270	-82.14 %
	Individual Non Single Premium	122.37	619.19	70.49	387.09	59.96 %	24483	165672	19531	155191	6.75 %
	Group Single Premium	38.34	811.18	54.02	662.93	22.36 %	5	40	6	44	-9.09 %
	Group Non Single Premium	146.28	673.51	48.85	474.04	42.08 %	10	97	10	112	-13.39 %
	Grand Total	312.43	2143.40	191.72	1671.80	28.21 %	24731	167643	20688	165617	1.22 %
4	BHARTI AXA LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.43	6.71	0.21	2.86	134.58 %	9	150	31	525	-71.43 %
	Individual Non Single Premium	41.97	263.68	42.10	237.65	10.95 %	10158	67274	9784	57942	16.11 %
	Group Single Premium	16.74	162.84	16.96	119.29	36.51 %	2	3	0	1	200.00 %
	Group Non Single Premium	-0.05	0.00	0.00	0.00	∞	-1	0	0	0	∞
	Grand Total	59.09	433.23	59.26	359.80	20.41 %	10168	67427	9815	58468	15.32 %
5	BIRLA SUN LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	4.38	28.25	2.72	23.49	20.27 %	99	720	101	631	14.10 %
	Individual Non Single Premium	130.68	521.27	67.42	403.27	29.26 %	29815	184788	23617	173654	6.41 %
	Group Single Premium	3.79	15.83	0.87	8.99	76.15 %	2	4	0	5	-20.00 %
	Group Non Single Premium	49.17	1135.14	29.02	835.11	35.93 %	49	354	37	373	-5.09 %
	Grand Total	188.03	1700.48	100.03	1270.85	33.81 %	29965	185866	23755	174663	6.41 %
6	CANARA HSBC ORIENTAL BANK OF COMMERCE LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.42	14.23	1.27	15.36	-7.35 %	8	112	9	85	31.76 %
	Individual Non Single Premium	74.32	333.68	33.34	251.38	32.74 %	9837	54396	7785	42609	27.66 %
	Group Single Premium	66.08	302.77	21.79	171.60	76.43 %	0	16	2	18	-11.11 %
	Group Non Single Premium	0.31	2.37	0.09	1.56	52.44 %	0	0	0	0	∞
	Grand Total	141.12	653.05	56.49	439.90	48.45 %	9845	54524	7796	42712	27.65 %

7	DHFL PRAMERICA LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	4.59	26.64	2.98	9.23	188.79 %	249	2343	238	697	236.15 %
	Individual Non Single Premium	19.13	112.80	15.45	109.90	2.64 %	7012	41111	6029	38236	7.52 %
	Group Single Premium	48.31	435.33	46.97	383.22	13.60 %	52	372	31	142	161.97 %
	Group Non Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Grand Total	72.03	574.77	65.40	502.34	14.42 %	7313	43826	6298	39075	12.16 %
8	EDELWEISS TOKIO LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	4.03	11.55	0.60	3.09	274.26 %	58	291	26	392	-25.77 %
	Individual Non Single Premium	15.14	80.93	11.84	68.75	17.71 %	3955	23113	3354	20621	12.08 %
	Group Single Premium	1.08	11.55	2.78	11.16	3.54 %	0	0	1	2	-100.00 %
	Group Non Single Premium	0.74	21.19	0.43	7.49	183.01 %	9	72	3	63	14.29 %
	Grand Total	20.99	125.22	15.65	90.49	38.39 %	4022	23476	3384	21078	11.38 %
9	EXIDE LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	2.83	209.81	3.50	53.43	292.70 %	57	342	57	357	-4.20 %
	Individual Non Single Premium	53.48	378.36	46.64	307.96	22.86 %	16822	120891	18136	127527	-5.20 %
	Group Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Group Non Single Premium	3.60	34.63	27.98	59.80	-42.09 %	34	188	20	263	-28.52 %
	Grand Total	59.91	622.80	78.11	421.18	47.87 %	16913	121421	18213	128147	-5.25 %
10	FUTURE GENERAL INDIA LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.70	5.48	0.19	2.60	110.97 %	57	969	16	226	328.76 %
	Individual Non Single Premium	14.48	84.54	12.61	67.14	25.92 %	3555	23542	2970	17545	34.18 %
	Group Single Premium	1.05	13.46	0.00	0.01	191169.74 %	0	4	0	1	300.00 %
	Group Non Single Premium	11.16	130.42	1.39	76.15	71.27 %	6	59	6	71	-16.90 %
	Grand Total	27.40	233.90	14.19	145.89	60.32 %	3618	24574	2992	17843	37.72 %
11	HDFC LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	42.83	397.70	25.80	232.33	71.18 %	40923	184013	19187	175530	4.83 %
	Individual Non Single Premium	258.00	1995.58	308.87	2037.40	-2.05 %	57939	505480	74521	559324	-9.63 %
	Group Single Premium	396.80	2987.82	125.95	1619.41	84.50 %	93	547	62	431	26.91 %
	Group Non Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Grand Total	697.64	5381.10	460.62	3889.14	38.36 %	98955	690040	93770	735285	-6.15 %
12	ICICI PRUDENTIAL LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	56.80	440.93	50.69	247.53	78.13 %	2449	24307	3466	12141	100.21 %
	Individual Non Single Premium	734.42	4232.41	479.42	3318.87	27.53 %	69287	452589	54668	360922	25.40 %
	Group Single Premium	36.10	629.27	29.22	1196.73	-47.42 %	58	534	32	254	110.24 %
	Group Non Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Grand Total	827.32	5302.61	559.33	4763.13	11.33 %	71794	477430	58166	373317	27.89 %
13	IDBI FEDERAL LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	39.53	139.86	15.09	134.17	4.24 %	1780	7899	847	7558	4.51 %
	Individual Non Single Premium	48.00	235.22	36.68	199.31	18.02 %	12640	68657	10488	66997	2.48 %
	Group Single Premium	8.05	113.10	3.80	50.15	125.52 %	3	43	3	68	-36.76 %
	Group Non Single Premium	0.07	2.59	0.48	6.16	-58.00 %	0	0	0	0	∞
	Grand Total	95.65	490.76	56.05	389.79	25.91 %	14423	76599	11338	74623	2.65 %
14	INDIAFIRST LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.37	7.39	0.66	17.23	-57.08 %	38	319	48	678	-52.95 %
	Individual Non Single Premium	36.49	205.87	20.16	107.49	91.53 %	9175	73114	8426	53446	36.80 %
	Group Single Premium	87.67	978.63	57.84	828.85	18.07 %	0	28	2	34	-17.65 %
	Group Non Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Grand Total	124.52	1191.89	78.66	953.56	24.99 %	9213	73461	8476	54158	35.64 %
15	KOTAK MAHINDRA OLD MUTUAL LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	24.07	111.54	13.19	60.42	84.62 %	2014	19426	2650	16947	14.63 %
	Individual Non Single Premium	126.68	610.96	101.28	536.25	13.93 %	26769	139854	23279	130744	6.97 %
	Group Single Premium	30.05	407.21	35.46	312.20	30.43 %	5	57	6	37	54.05 %
	Group Non Single Premium	66.03	548.03	38.84	379.68	44.34 %	77	741	44	632	17.25 %
	Grand Total	246.83	1677.75	188.78	1288.55	30.20 %	28865	160078	25979	148360	7.90 %

16	MAX LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	95.58	496.66	67.48	365.21	35.99 %	87	506	61	650	-22.15 %
	Individual Non Single Premium	296.51	1539.57	213.52	1220.01	26.19 %	52996	303100	47887	300656	0.81 %
	Group Single Premium	22.62	196.36	23.48	155.17	26.55 %	0	33	0	30	10.00 %
	Group Non Single Premium	2.29	51.11	1.68	22.07	131.60 %	5	343	23	302	13.58 %
	Grand Total	417.00	2283.71	306.15	1762.46	29.57 %	53088	303982	47971	301638	0.78 %
17	PNB METLIFE LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	3.31	13.58	1.12	6.28	116.32 %	65	305	40	203	50.25 %
	Individual Non Single Premium	111.04	633.47	112.36	595.49	6.38 %	21167	141954	28935	167702	-15.35 %
	Group Single Premium	7.09	36.25	3.98	20.74	74.75 %	0	0	0	0	∞
	Group Non Single Premium	1.50	39.55	4.99	35.84	10.36 %	14	134	15	280	-52.14 %
	Grand Total	122.93	722.84	122.45	658.35	9.80 %	21246	142393	28990	168185	-15.34 %
18	RELIANCE NIPPON LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	2.07	17.20	0.83	14.12	21.82 %	104	746	75	733	1.77 %
	Individual Non Single Premium	71.84	443.72	88.00	604.92	-26.65 %	23712	181933	32712	250278	-27.31 %
	Group Single Premium	3.02	56.85	4.10	69.18	-17.82 %	4	100	12	128	-21.88 %
	Group Non Single Premium	3.39	207.92	51.92	498.06	-58.25 %	2	28	6	66	-57.58 %
	Grand Total	80.32	725.70	144.84	1186.28	-38.83 %	23822	182807	32805	251205	-27.23 %
19	SAHARA INDIA LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	2.50	12.18	4.08	11.37	7.19 %	426	2440	751	2281	6.97 %
	Individual Non Single Premium	0.90	6.71	1.30	7.20	-6.77 %	673	5980	1540	8575	-30.26 %
	Group Single Premium	0.00	0.00	0.00	0.00	∞	0	0	0	0	∞
	Group Non Single Premium	0.00	0.00	0.00	0.35	-100.00 %	0	0	0	2	-100.00 %
	Grand Total	3.41	18.89	5.38	18.91	-0.10 %	1099	8420	2291	10858	-22.45 %
20	SBI LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	66.97	412.29	100.64	523.66	-21.27 %	2108	17535	4533	25656	-31.65 %
	Individual Non Single Premium	767.71	3682.01	685.98	2636.75	39.64 %	128150	828737	191517	823143	0.68 %
	Group Single Premium	107.32	2658.74	156.94	1038.55	156.00 %	0	43	11	57	-24.56 %
	Group Non Single Premium	25.82	187.93	19.29	324.93	-42.16 %	100	462	55	265	74.34 %
	Grand Total	967.83	6940.97	962.86	4523.89	53.43 %	130358	846777	196116	849121	-0.28 %
21	SHRIRAM LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	10.53	40.77	6.69	29.08	40.21 %	556	2675	472	2795	-4.29 %
	Individual Non Single Premium	40.03	247.55	38.62	236.44	4.70 %	18511	131669	25923	182783	-27.96 %
	Group Single Premium	10.19	133.85	21.83	137.29	-2.51 %	0	5	0	6	-16.67 %
	Group Non Single Premium	7.51	82.49	5.33	37.96	117.32 %	12	112	12	107	4.67 %
	Grand Total	68.26	504.66	72.48	440.77	14.49 %	19079	134461	26407	185691	-27.59 %
22	STAR UNION DAI-ICHI LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	12.60	39.32	2.32	64.74	-39.26 %	278	1115	137	3081	-63.81 %
	Individual Non Single Premium	69.74	321.63	39.08	220.96	45.56 %	12696	71592	8549	56302	27.16 %
	Group Single Premium	1.91	15.30	2.28	19.12	-19.96 %	0	1	0	2	-50.00 %
	Group Non Single Premium	0.77	8.06	4.86	188.74	-95.73 %	1	8	4	67	-88.06 %
	Grand Total	85.02	384.31	48.55	493.56	-22.14 %	12975	72716	8690	59452	22.31 %
23	TATA AIA LIFE INSURANCE COMPANY LIMITED										
	Individual Single Premium	0.49	3.09	0.52	8.44	-63.41 %	11	97	17	270	-64.07 %
	Individual Non Single Premium	111.84	571.21	67.74	308.14	85.37 %	17899	104535	14684	75064	39.26 %
	Group Single Premium	0.00	0.12	0.16	5.61	-97.92 %	0	0	0	1	-100.00 %
	Group Non Single Premium	1.40	47.30	20.47	87.85	-46.16 %	5	75	14	85	-11.76 %
	Grand Total	113.73	621.71	88.89	410.03	51.62 %	17915	104707	14715	75420	38.83 %
	PRIVATE										
	Individual Single Premium	380.92	2480.40	319.43	1978.30	25.38 %	51728	270383	36306	264529	2.21 %
	Individual Non Single Premium	3163.00	17239.92	2510.67	14053.54	22.67 %	563812	3725246	620435	3727272	-0.05 %
	Group Single Premium	886.21	9966.55	608.44	6810.23	46.35 %	224	1831	168	1261	45.20 %
	Group Non Single Premium	320.96	3205.73	264.62	3130.24	2.41 %	323	2687	251	2724	-1.36 %
	PRIVATE TOTAL	4751.09	32892.60	3703.15	25972.31	26.64 %	616087	4000147	657160	3995786	0.11 %
24	LIFE INSURANCE CORPORATION OF INDIA										
	Individual Single Premium	1246.04	18500.35	1213.45	6693.73	176.38 %	76726	855397	85242	608253	40.63 %
	Individual Non Single Premium	1805.01	13646.90	1710.67	12617.53	8.16 %	1359581	10979489	1807472	11971734	-8.29 %
	Group Single Premium	4998.23	48156.30	4043.93	38203.73	26.05 %	49	462	12	237	94.94 %
	Group Non Single Premium	212.02	3220.84	355.61	2100.43	53.34 %	2604	18814	2206	20670	-8.98 %
	Grand Total	8261.31	83524.39	7323.67	59615.41	40.11 %	1438960	11854162	1894932	12600894	-5.93 %
	GRAND TOTAL	13012.39	116417.00	11026.82	85587.73	36.02 %	2055047	15854309	2552092	16596680	-4.47 %

MONTHLY BUSINESS FIGURES - NON LIFE

Ref: December, 2016 **Date:** 19-01-2017

GROSS DIRECT PREMIUM UNDERWRITTEN FOR AND UPTO THE MONTH OF DECEMBER 2016

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

FLASH FIGURES -- NON LIFE INSURERS

GROSS DIRECT PREMIUM UNDERWRITTEN FOR AND UPTO THE MONTH OF DECEMBER, 2016

(` crore)

INSURER	DECEMBER		APRIL- DECEMBER		MARKET SHARE UPTO December , 2016	GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2016-17	2015-16*	2016-17	2015-16*		
Royal Sundaram	176.66	136.58	1637.42	1210.35	1.79	35.28
Tata-AIG	359.38	228.46	3175.30	2222.75	3.47	42.85
Reliance General	276.46	214.79	3169.46	2151.69	3.46	47.30
IFFCO-Tokio	396.74	277.88	3480.33	2653.27	3.80	31.17
ICICI-lombard	795.45	625.69	8059.29	6021.96	8.81	33.83
Bajaj Allianz	715.28	439.01	5387.59	4112.10	5.89	31.02
HDFC ERGO General	419.83	297.57	3964.46	2407.85	4.33	64.65
Cholamandalam	250.53	212.39	2218.89	1698.04	2.42	30.67
Future Generali	111.61	122.03	1252.36	1118.27	1.37	11.99
Universal Sompo	130.94	74.48	808.33	597.68	0.88	35.24
Shriram General	156.40	140.12	1331.24	1204.65	1.45	10.51
Bharti AXA General	102.58	93.20	978.42	971.14	1.07	0.75
Raheja QBE	4.44	2.45	40.64	18.87	0.04	115.38
SBI General	210.01	174.53	1788.20	1327.01	1.95	34.75
HDFC General (**Formerly Known as L&T General**)	21.94	43.31	279.67	321.76	0.31	-13.08
Magma HDI	30.94	29.70	288.72	288.63	0.32	0.03
Liberty	38.68	29.06	424.34	300.93	0.46	41.01
Kotak Mahindra#	9.83	0.00	51.46	0.00	0.06	0.00
Private Sector Gen. Insurers Total	**4207.70**	**3141.25**	**38336.11**	**28626.95**	**41.89**	**33.92**
Star Health & Allied Insurance	284.42	186.77	1814.68	1302.49	1.98	39.32
Apollo MUNICH	111.50	75.37	744.27	578.99	0.81	28.55
Max BUPA	53.21	42.67	400.51	325.27	0.44	23.13
Religare	66.74	40.31	472.36	342.68	0.52	37.84
Cigna TTK	20.81	37.76	149.93	96.65	0.16	55.13
Aditya Birla Health **	30.97	0.00	33.53	0.00	0.04	NA
Stand-alone Pvt Health Insurers	**567.65**	**382.88**	**3615.27**	**2646.09**	**3.95**	**36.63**
New India	1850.24	1369.45	14032.55	11133.80	15.33	**26.04**
National	986.61	964.25	10109.41	8827.15	11.05	**14.53**
United India	1047.10	963.69	11678.53	8838.22	12.76	**32.14**
Oriental	763.14	731.16	7774.04	6176.43	8.49	**25.87**

3/31/2017 MONTHLY BUSINESS FIGURES - NON LIFE

Public Sector Insurers Total	**4647.09**	**4028.55**	**43594.53**	**34975.60**	**47.63**	**24.64**
ECGC	115.26	114.33	870.81	935.97	0.95	-6.96
AIC	222.53	110.37	5102.77	2691.40	5.58	89.60
Specialized PSU Insurers	**337.80**	**224.70**	**5973.58**	**3627.37**	**6.53**	**64.68**
PRIVATE TOTAL	**4775.35**	**3524.13**	**41951.39**	**31273.04**	**45.84**	**34.15**
PUBLIC TOTAL	**4984.88**	**4253.25**	**49568.11**	**38602.97**	**54.16**	**28.40**
GRAND TOTAL	**9760.23**	**7777.38**	**91519.50**	**69876.01**	**100.00**	**30.97**

Note: Compiled on the basis of data submitted by the Insurance companies

* Figures revised by insurance companies

 # Commenced operations in Dec 2015

**** commenced operations in October 2016**

SNAPSHOT OF LIFE INSURANCE INDUSTRY AS AT 31.12.2016

The Life Insurance Sector procured Rs.**116417.00** crore First Year Premium with a growth of 36.02% as at the end of 31st December, 2016. LIC procured Rs 83524.39 Cr with a growth of 40.11% where as Private Sector procured Rs 32892.60 Cr posting a growth of 26.64%. Public and Private sector both posted a growth in Individual and Group NB premium.

The number of individual policies has shown a decrease of 5.92% by public sector and growth of 0.1% by private sector and overall decline of 4.47%. In the case of lives covered under group schemes, private sector has shown a growth (by 26.00%) and public sector has shown a decline (by 7.40%). Overall, there is a growth of 14.53% in the total number of lives covered under group policies.

The share of Annuity (16.91%) segment has shown a growth whereas Life (53.85%), Pension (29.13%) and Health (0.10%) segments have shown a decline in their share out of overall business when compared to last year's performance. The individual pension business showed a growth both in terms of number of policies and premium for private sector where as the public sector showed a decline in both premium and policies. Group Pension premium has a growth of 24.39% for public sector and 56.45% for private sector. However, the share of individual pension premium out of the total pension premium remains at just around 3.3%.

The number of individual agents* in life insurance sector stood at 20,54,141 with a net increase of 37,576 (1.9%) for the period. There is a net addition of 1,291 (0.1%) agents in private sector which has ended up with a total of 9,56,296 agents while there is a net addition of 36,285 (3.4%) in case of LIC which closed the month of December 2016 with a total of 10,97,845 individual agents.

(* Source data is from Life Council's MIS for the month of December, 2016)

Analysis of ULIP business:

The Life Insurance Industry has procured Linked Premium of Rs.12956.82 crore as at 31st December, 2016 as against Rs. 11417.17 crore for the corresponding period of previous year showing a growth of 13.49%.

LIC has an insignificant linked premium of Rs.14.21 crore.

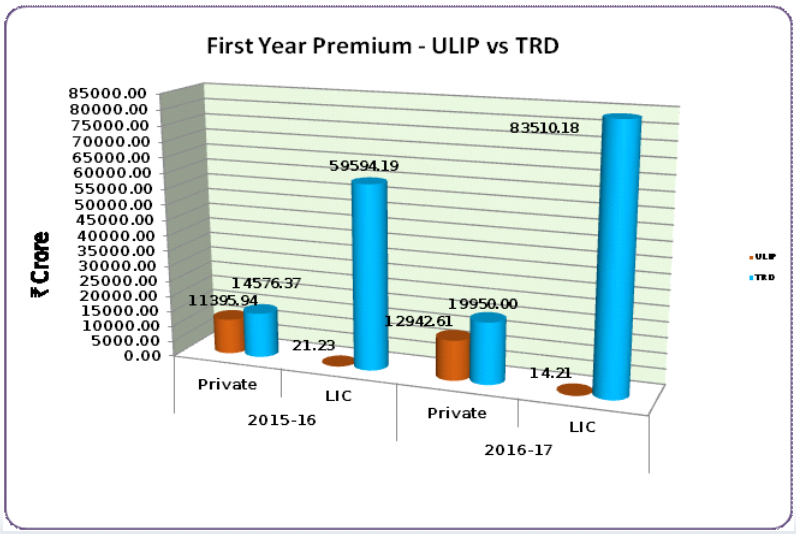
Private players have collected linked Premium of Rs.12942.61 crore (PY Rs.11395.94 crore) with a growth of 13.57%.

Analysis of Traditional Business:

The Life Insurance Industry has procured Non-Linked Premium of Rs.103460.18 crore as at 31st December, 2016 as against Rs.74170.56 crore for the same corresponding period of previous year. It shows a growth of 39.49%.

LIC's Premium is Rs.83510.18 crore (PY Rs. 59594.19 crore), a growth of 40.13%.

Private players have collected Non-Linked Premium of Rs.19950.00 crore (PY Rs.14576.37 crore), an increase of 36.87%.



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   c) Line spacing: Double
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Policyholder Servicing Turn Around Times

Policy Service	Maximum Turn Around Time
Processing of Proposal and communication of decisions including requirements/ issue of Policy/Cancellations	15 days
Issuing copy of proposal form	30 days
Response by the insurer on post policy issue service related requests such as change in address/nomination/ assignment of policy etc.	10 days
LIFE INSURANCE	
Surrender value/Annuity/Pension processing	10 days
Maturity Claim/Survival Benefit/Death claim without investigation	30 days
Raising claim requirements after lodging the claim	15 days
Death Claim Settlement / Repudiation with investigation requirements	6 months
GENERAL INSURANCE	
Appointment of Surveyor	3 days
Survey Report Submission	30 days
Insurer seeking addendum report	15 days
Offer of settlement/rejection of claim after receiving first / addendum survey report	30 days
GRIEVANCES	
Acknowledging a Grievance	3 days
Resolving a Grievance	15 days

Some Important Insurance Related Websites

	Insurance Related Resources	
1	Insurance Regulatory and Development Authority of India (IRDAI)	www.irdai.gov.in
2	IRDAI Consumer Education Website	www.policyholder.gov.in
3	Insurance Information Bureau (IIB)	www.iib.gov.in
4	IRDAI Agency Licensing Portal	www.irdaonline.org
5	Integrated Grievance Management System (IGMS)	www.igms.irda.gov.in
6	Mobile Application to Compare ULIPs	www.m.irda.gov.in
	Insurance Education Institutions	
1	Institute of Insurance and Risk Management (IIRM)	www.iirmworld.org.in
2	Insurance Institute of India (III)	www.insuranceinstituteofindia.com
3	Institute of Actuaries of India (IAI)	www.actuariesindia.org
4	National Insurance Academy (NIA)	www.niapune.com
	International Resources	
1	International Association of Insurance Supervisors	www.iaisweb.org
2	National Association of Insurance Commissioners	www.naic.org
3	International Gateway for Financial Education	www.financial-education.org
	Other Resources	
1	Governing Body of Insurance Council (GBIC)	www.gbic.co.in
2	General Insurance Council	www.gicouncil.in
3	Life Insurance Council	www.lifeinscouncil.org
4	Insurance Brokers Association of India (IBAI)	www.ibai.org

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