Critical Appraisal of Micro Health Insurance Laws

This article critically reviews the laws (and rules thereof) related to micro health insurance, with special reference to the rural and social sector obligations of insurers and the regulations governing the sector, including those of third-party administrators. The underlying perspective is to serve those who are dependent on the informal economy for their livelihood and for whom expenses on health are a major burden.

ALEX GEORGE

Private expenditure constitutes 78.7 per cent of health expenditure in India. As high as 98.5 per cent of this is out of pocket expenditure [WHO 2005; World Bank 2005]. Health insurance coverage in India is variously estimated by researchers to be between 3 per cent and 10 per cent of the population, consisting mainly of employees in the organised sector and their families [Rao 2005; Devadasan et al 2005; Gupta and Trivedi 2005]. On the contrary workers in the informal sector of the economy, constituting 93.3 per cent of the workforce [Gupta and Trivedi 2005] and their families and an overwhelming part of the population do not have any coverage, except a few schemes of non-governmental organisations (NGOs).

The government of India, in union budgets 2003-04 and 2004-05, introduced a major initiative to subsidise health insurance coverage for the poor. But these schemes run by the four public sector general insurance companies have not been able to reach out to the poor. In 2003-04, the schemes reached only 11,408 BPL families till May 2004; in the second year, they reached only around 34,000 families till January 31, 2005 and have an extremely low claims ratio [GoI 2003-04; GoI 2004-05; Rao 2005].

There are a few NGO and community-based organisation (CBO) initiatives to provide health insurance to the poor such as the Voluntary Health Services (VHS) and Action for Community Organisation, Rehabilitation and Development (ACCORD) in Tamil Nadu, Yashaswini and Karuna Trust in Karnataka, Vimo-SEWA in Gujarat, Raigarh Ambikapur Health Association (RAHA) in Chhattisgarh, the Students Health Home in West Bengal, PREM in Orissa, etc, [Devadasan et al 2004; Gupta and Trivedi 2004; George 2006]. These schemes and similar others are referred to as "community health insurance" or "micro-insurance" schemes.

Definitions and Law

Atim defines "health mutuelles", i e, community health insurance as: any voluntary non-profit insurance scheme formed on the basis of the ethic of mutual aid, solidarity and the collective pooling of health risks in which members participate effectively in its management and functioning [Atim 1998]. Micro-insurance, which refers to community health insurance, has come to be used to denote micro health insurance as the latter is perceived

to be more cumbersome [Dror 2001]. "The term micro-insurance has been suggested to distinguish community-funded health insurance schemes both from other insurance activities at the level of communities or from non-insurance community-based health schemes" [Dror and Jacquier 1999]. Dror clarifies that micro refers to the small size of a group or volume of transactions and also to the locus of operations at the lowest level of social organisation, just above the family [Dror 2001].

The Insurance Regulatory and Development Authority (IRDA) of India in its Micro-Insurance Regulations 2005, Section 2 (d) includes health insurance as only one of the different types of "general micro-insurance", which covers also belongings such as hut, livestock, tools or instruments and personal accidents [IRDA 2005c]. Its Section 2 (e) covers health insurance also under "life micro-insurance". Given this broader legal definition of micro-insurance in India it has become necessary to use the more distinctive term micro health insurance even though it is longer.

Rural and Social Obligations

Schedule I of the IRDA Act has amended the Indian Insurance Act 1938 and added Section 32 B, which instructs every insurer to undertake a certain percentage of life and general insurance business in the rural and social sectors, as specified by the authority. Section 32 C of the Act clarifies that to discharge the obligations under 32 B, the insurers should provide life and general insurance policies to persons residing in rural areas, workers in unorganised and informal sectors, economically vulnerable or backward classes of society or other categories as may be prescribed. As per the IRDA (2005b), rural sector means places or areas classified as "rural" by the latest decennial Census of India. Social sector includes unorganised sector, informal sector, economically vulnerable or backward classes and other categories of persons in rural as well as urban areas.

According to this regulation, "Unorganised sector includes self-employed workers such as agricultural labourers, bidi workers, brick kiln workers, carpenters, cobblers, construction workers, fishermen, 'hamals', handicraft artisans, handloom and khadi workers, lady tailors, leather and tannery workers, papad makers, powerloom workers, physically handicapped self-employed persons, primary milk producers, rickshaw pullers, 'safai karamcharis', salt growers, sericulture workers, sugarcane cutters, tendu leaf collectors, toddy tappers, vegetable vendors, washerwomen, working women in hills, or such other categories of persons" [IRDA 2005b]. Many categories of workers specified above work for employers and are not self-employed. Therefore this section could be reformulated to reflect both types of employment.

The regulation defines informal sector to include small-scale, self-employed workers at a low level of organisation and technology, with the primary objective of generating employment and income, with heterogeneous activities like retail trade, transport, repair and maintenance, construction, personal and domestic services and manufacturing, which are labour-intensive and having often unwritten/informal employer-employee relationship.

General insurers who have begun operations after the commencement of the IRDA Act 1999, are expected to raise 2 per cent and 3 per cent of their gross premium income "written direct" in the first and second years, from the rural areas. This percentage is increased to 5 per cent from the third year onwards and is to be maintained at that level subject to future changes in the rule made by IRDA [IRDA 2005b]. Since health insurance is marketed in India mainly as a general insurance product, this specification applies to it. However, fixing the obligation to rural areas to a percentage of premium income is likely to lead to an inequitous spread of insurance in rural areas as a small number of large policies from the well-to-do can make up the necessary percentage, without touching the rural poor at all. Life insurers on the contrary are expected to raise 7 per cent and 9 per cent of their total policies from rural areas in the first and second years and 16 per cent in the fifth year.

All insurers (life and general) who began business after the commencement of the IRDA Act 1999 are also expected to contract a certain number of policies each year from the social sector. They are supposed to insure 5,000, 7,500, 10,000, 15,000 and 20,000 lives in the first, second, third fourth and fifth years respectively [IRDA 2005b]. Instead of this number specification, which is just a token, IRDA should have insisted on a percentage of policies from the social sectors to make the social obligation meaningful.

The regulations also mention that these levels currently fixed for newly starting insurance companies, will be reviewed every five years. With regard to the existing insurers the regulation states that their levels for rural and social sector

obligations will be fixed in discussion with them.

Micro-Insurance Regulations

The main thrust of IRDA's Micro-Insurance Regulations 2005 is to make NGOs, self-help groups (SHGs) and micro-finance institutions (MFIs), which are currently involved in micro-insurance, into agents of insurance companies, who are the "insurers" under these rules. As per its section 2 (d), a "general micro-insurance product" means any health insurance contract, any contract covering the belongings such as hut, livestock, tools, instruments or any personal accident contract, either on individual or group basis, as per terms stated in its Schedule I. Health insurance contracts can be also issued for a term varying from one to seven years as per the plan mentioned in Schedule II as a "life micro-insurance product". Section 2 (g) stipulates that a micro-insurance policy means an insurance policy sold under a plan, which has been specifically approved by IRDA as a micro-insurance product.

Section 2 (f) reduces NGOs, SHGs and MFIs, currently working in health insurance independently, into agents of the "insurers", i e, for profit insurance companies in the private and public sectors. It defines a micro-insurance agent as: "a non-governmental organisation, self-help group or micro-finance institution who is appointed by an insurer to act as a micro-insurance agent for distribution of micro-insurance products". IRDA therefore wants to institute a mere principal-agent relationship between the two, making independent community insuring rather illegitimate. The intention appears to be to shape the micro-insurance market to suit the insurance companies. This is also reflected in the insurance plans put forward by these regulations in Schedules I and II, which is dealt with later.

Explanations given in the Regulations about NGOs and SHGs are almost ditto, which reflect a very poor understanding of both. An NGO is defined as "a non-profit organisation registered as a society under any law, and has been working at least for three years with marginalised groups, with proven track record, clearly stated aims and objectives, transparency and accountability as outlined in memorandum, rules, by-laws or regulation as the case may be, and demonstrates involvement of committed people". The only difference from this made in the definition of SHG is that it should be any informal group of 10 to 20 or more persons, with all the other clauses on NGOs just added on. Even the self-help component of SHGs, for which they are constituted and is relevant for various micro-insurance operations, is not reflected in the definition. The terms "marginalised groups", "proven track record", "clearly stated aims and objectives" and "involvement of committed people" are left abstract in both the definitions, which can lead to various kinds of interpretations. For example it is not specified, which are the marginalised groups. Proven track record in what? Is merely stating the aims and objectives clearly enough? What are those aims and objectives expected to be?

The regulations see NGOs, SHGs and MFIs only as a marketing link to the people to canvass policies and as an aid in administration as mentioned in Section 5 (3). According to Section 5 (4), a micro-insurance agent can be terminated without notice if the agent engages in misconduct/indiscipline or fraud. On the contrary the agent has to give a notice of three months to the insurer before cancelling his contract. The regulation does not explain the words "indiscipline" and "misconduct" either. It is the insurer, who is to ensure that the agent follows the code of conduct, thereby reducing the agent to the status of an employee.

It is mentioned in Section 2 (c) with reference to the family plans mentioned in Schedules I and II, that only the first three children will be insured under the plans. This clause is too restrictive. Provisions should be made to insure all children and not only the first three, for which a higher premium can be collected, not exactly proportionate to the increase in number as a larger pool always contributes to spreading risk. Age specification at entry under the individual and family plans in Schedules I and II is left to the discretion of the insurers. This could lead to under five-year old children, women in the reproductive years and the aged getting totally eliminated from the schemes.

The MI regulations offer a commission of 10 per cent and 20 per cent of premium respectively for single premium and non-single premium life policies and 15 per cent for non-life policies to the agent. Subject to these limits the insurer is allowed to decide on group insurance products. On the contrary group insurance products should be offered a higher

commission than individual policies as they offer a large pool.

Regulations on TPA – Health

Third party administrators (TPA) will be relevant only for those micro health insurance schemes, which function as agents of insurance companies in the public and private sectors. But since the IRDA in its above-mentioned Micro-Insurance Regulations 2005 promotes this kind of schemes, in future TPAs will have a role to play with regard to micro health insurance schemes also. As per Section 2 (e) of the Third Party Administrators – Health Services Regulations of IRDA 2001, TPA is licensed by the authority and engaged for a fee or remuneration by an insurance company for the provision of health services. Only joint stock companies registered under the Indian Companies Act 1956 and having a paid-up and working capital of Rs 1 crore each are eligible to apply for licence as TPAs.

As per Section 21 (c) of these regulations, the TPA should disclose the details of the services it is authorised to render, which are stated in its agreement with the insurance company. Section 2 (f) instructs TPAs to render necessary assistance specified under the agreement and advise the policyholders, claimants or beneficiaries in complying with the requirements for settling claims with the insurance companies. According to Section 2 (e), they are also supposed to obtain all necessary documents pertaining to insurance claims, which arise from insurance contracts. Thus their role is that of intermediaries between the policyholders, insurance companies and health providers. However, the current trend in India of private corporate hospitals themselves starting TPAs and of TPAs starting health delivery networks run counter to this [Rao 2005; Gupta et al 2004]. While even independent TPAs can collude with health providers resulting in cost escalation, this current trend would make it worse. The TPA Regulation 2001 does not rule out private hospitals from setting up their own TPAs or vice versa. In fact its Section 2(e) gives a contrary impression since "provision of health services" is mentioned as one of the purposes for which a TPA is licensed and appointed.

For the policyholders one of the main advantages of TPAs is the cash-free arrangement at the point of health delivery. On the other hand, it is observed that the four public sector insurance companies raised their premium by 6 per cent, apparently to accommodate cost escalation due to appointing TPAs [Gupta et al 2004]. In the US health insurance system, which is organised through TPAs, administrative costs are 25 per cent to 30 per cent as compared to 3 per cent in Canada [Rao 2005]. It is estimated that "administrative waste" among private insurers consumes 17 per cent of US healthcare spending [Webster 2006].

TPAs in India are currently offered a commission of 5.5 per cent as per IRDA specification, which they consider low. In addition, they have expressed disinterest in handling the universal health insurance scheme for the BPL population as they are of the view that their costs in reaching out, educating them and processing their claims will be higher [Rao 2005].

Conclusion

Fixing the obligation to rural areas to a percentage of the policies sold instead of the premium income and ensuring that at least a certain part of these policies are sold to the categories mentioned under social sector obligations can ensure some amount of equity in access to health insurance in rural areas. Regarding social sector obligations, instead of the small number of policies, which is presently specified, IRDA should insist on a certain percentage of policies to be sold to various categories of social sectors to make this obligation more responsive to Indian conditions, with 93 per cent of the workforce in the informal sector and their dependent families having no coverage.

It is true that the civil society organisations, which conduct their own micro-health insurance schemes, need more accountability and transparency in their functioning. Constituting a separate authority to regulate micro-insurance schemes with the participation in its management of informal sector trade unions, cooperatives, women's organisations, SHGs, NGOs, CBOs, etc, who are better informed and sensitive to the needs of the micro-insurance sector, will enhance the development of this sector and also ensure transparency and accountability. Channelising the union government's subsidy under the universal health insurance, through the schemes registered and monitored by the proposed authority is likely to increase the reach of this initiative targeted for the BPL population.

The proposed authority should reduce the capital adequacy for registering micro-health insurance organisations to a level proportionate to the membership, benefit package, claims ratios, cost per member and administrative costs of such schemes. Some large schemes could then register themselves as micro-insurance organisations, and the medium and small schemes could federate among themselves. Capital adequacy required under the IRDA Act for life and general insurance companies now is a whopping Rs 100 crore!

The option to join as an agent of the insurance companies should be left to the management and members of micro health insurance schemes. In the event of their choosing to join on a principal-agent basis, there should be plans offered by the companies, which do not exclude women in the reproductive age group, children and the aged, and offer inpatient and outpatient care, diagnostics and surgical care.

If the micro-insurance schemes which are presently operating without any tie-up with insurance companies are allowed to continue most of them will not require the services of TPAs as their size of business is not economical for their intervention. If in case they need TPAs as in the case of the very large Yashaswini scheme in Karnataka [ILO 2006], such schemes will be hiring them in the capacity of insurers and therefore will have better control over their activities. If there is still a need for TPA to manage the micro-health insurance schemes there should be differential norms for their registration, commensurate to the size of business.

The government and IRDA might like to take into consideration these suggestions while formulating the new laws to introduce priority sector insurance to serve the poor. EPW

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