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# HEALTH INSURANCE IN INDIA

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**Abstract:** *The basic aim of this Paper is to bring the readers, insurance professionals, insured and general public about the Health Insurance In India. The health insurance becomes the one of the major portfolio of non-life insurers next to Motor Insurance accounting 30-35% of total premium of the entire business. This paper will focus on health insurance scenario at the world level with specific reference to Indian Health systems and Insurance. It describes the Health care systems and development of Health Insurance in India and its performance. This paper elaborate the performance of insurance Regulator – IRDA – controlling and monitoring health insurance in India and also discuss the various regulations brought by the regulator to protect the policyholders interest.*

*Further this paper gives a snapshot about the Health Insurance policy coverage, exclusions, conditions, and various types of health insurance policies available in the market. A deep analysis was made on the cashless treatment offered by the insurance companies and the same how being misused by the healthcare providers. Various grievances redress mechanism available to aggrieved insured also highlighted at the end.*

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## INTRODUCTION

The word health was derived from the word "hoelth" which means "soundness of the body. Illness causes because of various factors like imbalanced diets, environmental and personal hygiene. Imbalance of four fluids viz blood, yellow bile, black bile and phlegm causes the ill health.

As per WHO health is a state of complete physical, mental and social wellbeing and not merely the absence of disease. In modern society, the health of an individual is determined by three factors viz (1) Genetic Factor (2) Environmental Factor and (3) Lifestyles.

**Cause of death**

Non communicable diseases account for 53%percent of all deaths. Injuries and other causes 10% of deaths and communicable disease account for 37%. The negative effect of high (unchecked) industrial growth and the resulting pollution creates major health problems. WHO reports that 10% of the patients are affected due to medical errors.

**Health care Systems**

The health care system is having three stages (1) Primary health care (2) Secondary Health care (3) Tertiary Health care.

| Stages | Care Unit | Nature of care undertaken |
|---|---|---|
| **I** | Primary health care | This is the first point of treatment. The physician may be family doctor. Patient treated as outpatient. If needed referral will be made for further treatment. Located in all villages |
| **II** | Secondary Health care | It is outpatient and Inpatient care Unit. Consists of Specialist of Heart, General, Ortho, Surgery, Operation theatre and qualified paramedical staff. Located in Taluk Places. |
| **III** | Territory Healthcare | This is specialized care unit for major surgery and ailment. All types of care undertaken here. All facilities and equipment available. Located in District places |
| | | This is specialty care unit for a particular ailment or surgery. Mostly located in State capitals and/or Metro cities. |

## HEALTH SYSTEM MODELS OPERATING IN THE WORLD

A. **Beveridge Model or Single Payer systems: -** Under this system health care is provided and financed by a single payer it the Government through taxes. Many but

not all hospital and clinics are owned by the Government. Countries like Great Britain, Spain, Italy, Portugal, New Zealand, and Greece following this system.

B. **Bismarck Model / employed based or Multi Payer system:-–** Unlike single payer system there are a number organization paying for health care. This model followed in 'Germany, France, and Japan etc.

C. **The National Health Insurance or Managed competition** Model – this is combination above mentioned two models. It used private sector providers but the payment comes from Government run insurance companies that every citizen pays into.

D. **The Out of pocket model: -** Health care are taken care by the families by incurring expenses from their pocket. This system mostly underfunded and do not offer comprehensive care.

E. **Composite Model:-–** The health care model in USA is a mix of all the above models.

**Table – 1 : COMPOSITION OF WORLD HEALTH EXPENDITURE**

| | | | |
|---|---|---|---|
| **a.** | **Private insurance** | **-** | **18%** |
| **b.** | **Government Spending (excluding social insurance)** | **-** | **35%** |
| **c.** | **Social insurance** | **-** | **25%** |
| **d.** | **Others** | **-** | **4%** |
| **e.** | **Out of pockets expenses** | **-** | **18%** |

*Source : National Health Accounts who 2010*

**Table – 2 : WORLD HEALTH EXPENDITURE – AT A GLANCE (TOTAL % OF GDP)**

| Country / Year | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| Afghanistan | 8.5 | 8.1 | 8.5 | 8.1 |
| Austria | 11.1 | 10.9 | 11.1 | 11 |
| Australia | 9.0 | 9.2 | 9.4 | 9.4 |
| Bangladesh | 3.5 | 3.6 | 3.5 | 3.7 |
| Bhutan | 5.2 | 4.8 | 3.6 | 3.6 |
| Brazil | 9.0 | 9.2 | 9.5 | 9.7 |
| Costa Rica | 9.7 | 10.2 | 10.1 | 9.9 |
| Cuba | 10.6 | 10.6 | 8.6 | 8.8 |
| China | 5 | 5.1 | 5.4 | 5.6 |
| France | 11.6 | 11.5 | 11.6 | 11.7 |
| Germany | 11.6 | 11.2 | 11.3 | 11.3 |
| India | 3.8 | 3.8 | 3.8 | 4 |
| Japan | 9.6 | 10.1 | 10.3 | 10.3 |
| Mauritius | 5.2 | 5 | 4.8 | 4.8 |
| Nepal | 5.9 | 6.1 | 5.5 | 6 |

| | | | | |
|---|---|---|---|---|
| Pakistan | 3 | 3 | 2.8 | 2.8 |
| Silence | 3.4 | 3.3 | 3.1 | 3.2 |
| UK | 9.4 | 9.2 | 9.3 | 9.1 |
| USA | 17.1 | 17.1 | 17 | 17.1 |
| TUVALU | 16.8 | 18.5 | 15 | 19.7 |
| Switzerland | 10.9 | 11.1 | 114 | 11.5 |
| Spain | 9.6 | 9.4 | 9.3 | 8.9 |

Source: WHO global health expenditure database2010

**Table – 3 : WORLD – SHARE OF PUBLIC AND PRIVATE SECTOR AND OUT OF POCKET SPENDING ON HEALTH CARE 2005**

| Countries | Public expenditure as % of total expenditure on health | Private expenditure as % of total expenditure on health | Out-of-pocket spending as % of total expenditure on health |
|---|---|---|---|
| Bangladesh | 29.1 | 70.9 | 62.6 |
| Brazil | 44.1 | 55.9 | 30.5 |
| China | 38.8 | 61.2 | 53.2 |
| India | 21.9 | 78.1 | 71.1 |
| Indonesia | 46.6 | 53.4 | 35.5 |
| Mexico | 45.5 | 54.5 | 51.2 |
| Pakistan | 17.5 | 82.5 | 80.9 |
| Sri Lanka | 46.2 | 53.8 | 46.3 |
| South-East Asia | 29.0 | 71.0 | 64.2 |

*Source : WHO global health expenditure database 2010*

## HEALTH CARE IN INDIA

Right to health is not included as a fundamental right in our constitution. It is included in the Directive principles of State policy wherein it directs the States to be responsible to take care of health of their people. As per Supreme Court decision in CESC Ltd vs. Subash Chandra Bose where in the SC relied on international instruments and concluded that the right to health is fundamental right. It went further and observed that health is not merely absence of sickness. "The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. 70% of health care expenses are paid from out of pocket expenses in India.

## HEALTH CARE DEVELOPMENT IN INDIA

Since 1948, the Central and State Government have implemented various measures to cater to health requirement of population; various councils established; numerous committees were formed; every five years has given importance of public health care.

In India, the first health policy was launched in 1983. In 2002, a comprehensive National Health policy was introduced. The highlights includes (a) Increase in health sector expenditure to 6% of GDP with 2% of GDP being g contributed as public health investment, by the year 2010 (2) Enforce the mandatory two year rural posting before the awarding of the graduate degree (3) need for an improvement in the ratio of nurses viz-a-viz doctors / beds (4) Revival of Primary Health care (5) establishment of fully equipped "hub-spoke trauma care networks in large urban agglomerations to reduce accident mortality (6) setting of private insurance instrument for increasing the scope of the coverage of secondary and tertiary sector.

In 2005, National Rural Health Mission was launched to carry out necessary architectural correction in the basic health care delivery system in Rural India. Further the $11^{th}$ and $12^{th}$ five year plans has given much importance to health care.

## INDIAN HEALTH CARE SYSTEM

At the gross root level Anganwadi workers, Trained Birth Attendant, Village Health Guide and Members of ASHA volunteers work as links between the population and the health system.

1. **Village level: –** sub-centres are the rural links established for every 5000 population (in case of hilly , tribal and backward areas is 3000) Managed by health worker – ANM.
2. **Primary health centre: –** is a referral unit for about 6 sub centers. PHC is established for every 30000 population (for a hilly, tribal and backward area is 20,000). PHS provides outpatient services and has 4-6 beds. They have one medical officer, 14 Para medical workers and other supporting staff.
3. **Community health centre (CHC)**:- First referral unit. For every Four PHCs, there will be on CHC. It must caters to every 1 lakh population with at least 30 beds, one operation theatre, x-ray machine, labour room and laboratory facilities. It should

have at least 4 specialists. As per Ministry of health report there are 1, 48,124 sub centers, 23887 PHC and 4809 CHCs in the country as on 2011.

4. **Employees State Insurance Scheme: -** In 1948 The employees State Insurance Act was passed to protect the factory workers. This is Central Government Scheme. The scheme is contributory scheme by the employer, employee and the state government. All workers earning wages up to Rs.15000/- pm is covered under the scheme. The scheme covers free comprehensive healthcare, maternity, disability benefit and loss of wages to sickness and employment related accidents.
5. **Central Government Health Insurance :-–** It was started in 1954 to take care of health care needs of Central government employees including pensioners and their family members. The membership contributions ranging from Rs.15 to Rs.150/- per month. It covers the comprehensive health care.
6. **Apart from the above the schemes**, as a measure of social security to the poor and socially backward people, the Central government has brought health care scheme with active participation of insurance companies called ***"Rashtriya Swasthiya Bima Yojana (RSBY)*** for the benefit of BPL families in the state. Later this scheme was covered above BPL families also. Under the scheme the family has to pay Rs.30 as administrative charges. The maximum sum insured is Rs.30, 000/- per family consisting of maximum 5 members. It is a floater policy hence the sum insured of Rs.30, 000/- float on the entire family. This system is totally cashless less system and totally paper less system. The bio-metric card issued by the insurer can be used in the designated hospitals on anywhere in India basis.
7. **Every State Government is having health care system** at Village level, Taluk level, District level and State Capital level for the benefit of common people. Apart from this system, some state government has tied up with insurance companies to provide health care for the poor and socially backward community. For example
   - Chief Minister Health Insurance in Tamil Nadu
   - Arogyasri in Andhra Pradesh and Karnataka
   - Yeshasvini in Karnataka
   - Rajiv Gandhi Health Insurance in Maharashtra
   - Modified RSBY in Punjab

8. **Private health care is more in India: -** Nearly 70-80% of health care needs are catered by Private players in India. This is ranging from the small nursing home to multi-specialty Hospitals.

**Table – 4 : Health expenditure in India: 2002-2009**

| Year | 2001-02 | | 2004-05 | | 2008-09 | |
|---|---|---|---|---|---|---|
| | % of Total | % of GDP | % of Total | % of GDP | % of Total | % of GDP |
| **Public Funds (Rs. Crores)** | 21439 | | 26313 | | 58681 | |
| | 20 | 0.9 | 20 | 0.8 | 27 | 1.1 |
| Central Government | 6719 | | 9067 | | | |
| | 6 | 0.3 | 7 | 0.3 | | |
| State Government | 13271 | | 16017 | | | |
| | 13 | 0.6 | 12 | 0.5 | | |
| Local Bodies | 1450 | | 1229 | | | |
| | 1 | 0.1 | 1 | 0.0 | | |
| **Private Funds (Rs Crores)** | 81710 | | 104414 | | 157394 | |
| | 77 | 3.6 | 78 | 3.3 | 72 | 3.0 |
| Households | 76094 | | 95154 | | | |
| | 72 | 3.3 | 71 | 3.0 | | |
| **External Flows (Rs.Crores)** | 2485 | | 3050 | | 3702 | |
| | 2 | 0.1 | 2 | 0.1 | 2 | 0.1 |
| **Total Health Expenditure (Cr.)** | 105634 | | 133776 | | 219777 | |
| | 100 | 4.6 | 100 | 4.2 | 100 | 4.1 |
| **Per Capita Health Expenditure (Rs.)** | 1016 | | 1228 | | 1904 | |

*Source : IC – 35 & 36 of Insurance Institute of India*

## ORIGIN OF HEALTH INSURANCE INDIA

Till 2000, general insurance markets comprised only by the four nationalized insurance companies. In 1981, a limited cover was devised to cover the individual and families and in 1984 overseas medical insurance was introduced to provide medical cover for Indians travelling abroad.

In 1990 all the public sector companies introduced a deferred insurance namely "Bhavishya Arogya Policy for the benefit of retired persons. The UIT has introduced Senior Citizen Unit Plan in 1993. Later in 1995 LIC has introduced an insurance cover called Asha Deep-II to

cover the four major diseases such as Cancer, Paralytic Stroke, Renal failure and Coronary Artery Disease. GIC has introduced a policy in 1996 for the weaker section of public called "Jan Arogya Bima Policy. After entry of private players in Health Insurance, India witnessed tremendous changes in its health insurance business not only in terms of premium growth but various types of health insurance coverage.

Today the Indian Insurance Markets has

- 5 specialized stand alone health insurance companies
- 24 general insurance companies providing health insurance covers
- 20 life insurance companies offering health insurance.

## PERFORMANCE OF INDIAN HEALTH INSURANCE COMPANIES (LIFE, NON-LIFE AND STANDALONE HEALTH INSURANCE COMPANIES)

**Table – 5 : Health – No. of Policies issued, Insured Members and Claims**

| Year | Number of Policies | Number of Members | Number of Claims | Premium (Rs. In Crs.) |
|---|---|---|---|---|
| 2003-2004* | 2265451 | 8361629 | 360088 | 944 |
| 2004-2005* | 2059449 | 8987239 | 555273 | 987 |
| 2005-2006* | 3828495 | 16345575 | 1016785 | 1947 |
| 2006-2007* | 3110475 | 17907430 | 1060047 | 2820 |
| 2007-2008* | 3790838 | 24121625 | 1436998 | 2758 |
| 2008-2009* | 4575725 | 32710604 | 2081297 | 3976 |
| 2009-2010** | 6884687 | 54893453 | 3263597 | 7803 |
| 2010-2011** | 7742076 | 52508111 | 3843285 | 10932 |

*NB: Member – Insured person(s) covered under the policy. 1. *Policies serviced by TPAs only. 2.**Figures of Policies serviced by TPAs and directly serviced by Insurers*

**Table – 6 : Health - Total Premium, Total Claim Paid and Claim Ratio**

| Period | Premium (Rs. In Crs.) | Claims paid (Rs. In Crs.) | Claims Paid Ratio % |
|---|---|---|---|
| 2003-2004* | 944 | 785 | 83% |
| 2004-2005* | 987 | 948 | 96% |
| 2005-2006* | 1947 | 1777 | 91% |
| 2006-2007* | 2820 | 2198 | 78% |
| 2007-2008* | 2758 | 2904 | 105% |
| 2008-2009* | 3976 | 4087 | 103% |
| 2009-2010** | 7803 | 7456 | 96% |
| 2010-2011** | 10932 | 10797 | 99% |

*NB: 1 *Policies serviced by TPAs only.*

*2 **Figures of Policies serviced by TPAs and directly serviced by Insurers*

**Table – 7 : Growth in health insurance premium collection** ( in Rs. Crores)

| Insurer | 2006-07 | 2007-08 | 2008-09 | 2009-10 | 2010-11 |
|---|---|---|---|---|---|
| Non-Life Private | 1223.99 | 1832.50 | 2266.30 | 2349.80 | 3031.48 |
| Non-Life Public | 1973.60 | 3136.50 | 3824.00 | 4883.30 | 6912.55 |
| Standalone Health Insurers | 11.16 | 155.94 | 535.09 | 1072.10 | 1535.70 |
| **Total** | **3208.70** | **5125.00** | **6625.50** | **8305.20** | **11479.70** |

**Table – 8 : POPULATION COVERED UNDER HEALTH INSURANCE**

| Schemes | Coverage in 2013-14 (in millions) |
|---|---|
| **Central Government** | |
| Employees State Insurance Scheme | 56 |
| Central Government Health Scheme | 3 |
| Rashtriya Swasthya Bima Yojana | 70 |
| **State Government** | |
| Tamil Nadu – Chief Minister Scheme | 70 |
| Karnataka _ Yeshasvini | 40 |
| Karnataka – Arokyasri | 1.4 |
| Andhra Pradesh – Arogyasri | 3 |
| **Total scheme sponsored by Government** | **243** |
| **Commercial insurers** | **55** |
| **Grand Total (includes others not listed above)** | **300** |

*Source : world bank, India : Office courtesy Jerry La forgia*

## HEALTH – REGULATORS

### 1. IRDA

**IRDA –** Insurance Regulatory and Development Authority of India which is Constitutional body established by Central Government by virtue of amending Insurance Act, 1938. IRDA Act, 1999 passed in during February 2000 which paved the way for creation of IRDA. Most of the powers hitherto vested with the Insurance Act, 1938 were passed to IRDA. IRDA is one of the stringent regulators in the world. IRDA Regulate the Insurance business – Life, Non-life, Health Insurance and Re-Insurance in India. IRDA has brought out various regulations such as policy holder's protection regulations, Health insurance regulations, TPA regulations etc to protect the interest of insured and manage and control the Indian Insurance Industry.

### 2. NATIONAL ACCREDITATION IN INDIA

National Accreditation Board for Hospital and Healthcare providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations. The board is structured to cater to much desired needs of the consumers and to set benchmarks for programme of health industry.

### 3. CLINICAL ESTABLISHMENT ACT

India have the Health policy and does not have Health Regulator as on date. Health care industry needs to be regulated for it proper conducts and growth in line with public policy. Clinical Establishments (Registration and Regulation) Act, 2010, has now been notified by the Union Government, on 28.2.2012 and it has come into force in Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim and All UU from 1.3.2012. This act stipulate the various norms to run a clinical establishment in India.

## KNOW YOUR HEALTH INSURANCE POLICY

Your health insurance policy contains the following information :-

| | |
|---|---|
| **Proposer** | The one who has submitted the proposal and paid the premium – either a single individual or Head of the Family |
| **Insured** | Those whose covered under the said policy |
| **Policy No.** | It is a Unique no. |
| **Period of Insurance** | The period of insurance coverage is available |
| **Sum Insured** | The maximum claim amount payable under the policy during the policy period. In case of floater policy, the entire sum insured will float on the family either any one or all can take avail the claim but up to the maximum sum insured at the policy |
| **Cumulative Bonus** | This is an additional sum insured offered by the insurer for the no claim period and added with the basic sum insured. |
| **Premium** | Amount payable to cover the risk |
| **Inception / date of first policy** | It will help to determine the cumulative bonus and waiting period and pre existing diseases. |
| **Nominee** | As per IRDA regulations, nominee should be recorded in the health policy |
| **Customer Information sheet** | It is in simple language and give details about the policy coverage, terms and conditions, procedures to be followed at the time of claims, settlement and renewals etc. |
| **Coverage** | It gives details about the policy coverage |
| **TPA** | Third Party Administrator who facilitate the claim process on behalf of the insurer |
| **Waiting Period** | The entire ailment are covered after 30 days from the inception of the policy, However certain diseases such as cataract, Hernia etc are covered after a specific waiting |

| | |
|---|---|
| | period. But accidental injuries cover immediately. |
| **Pre existing diseases** | Diseases existing before the commencement of policy are not covered. However in group insurance and tailor made insurance, pre existing diseases are covered after loading of premium. Even some insurance companies covers pre existing disease under Individual Health Insurance also |
| **Co-Pay** | The insured has to share certain portion of expenses as agreed in the policy |
| **Capping** | Some expenses like room rent, daily cash benefits and major operations are capped. In such cases, the insurance company will reimburse up to the limit specified in the policy |
| **Exclusions** | Certain diseases, ailment, treatment and expenses which are not covered under the policies are called exclusions |
| **Conditions** | The conditions may be express or implied conditions. Immediate claim intimation and submission of claims papers, sum insured enhancement and cancellations, renewal, disclosures are some of the conditions. |
| **Contributions** | If the insured has two policies, the insured can claim from either of the policy or claim at both the policies up to the ratable portion of the insurer. |
| **Definitions** | Detailed information |
| **Payment of claims** | It gives brief details of claim settlement procedures |

## HEALTH INSURANCE – HOW THE PREMIUM WORKED OUT

For the Individual health insurance and family health insurance, the industry claim average has taken to work out the basic premium. And then, the insurer will add their overhead cost with little margin of profit. The following are the factors for premium rating :-

1. Past claim history
2. Age
3. Family size
4. Sum insured
5. Existing illness
6. Demographic, sex and health providers availability (it is not followed in India)

For Group health insurance, the above factor will be taken for an Individual and multiplied by average no, of persons in the family and no. of families. The premium will be loaded for covering parents / dependents, removing caps, pregnancy and child birth, removing waiting period and covering pre existing diseases etc.

## HEALTH INSURANCE PRODUCTS AVAILABLE IN INDIAN MARKET

The following health insurance products are available in the market. This list only illustrative and not exhaustive

| Name of Policy | Brief Details of coverage |
|---|---|
| **Individual Health Insurance** | It is a basic Health insurance policy covers the individuals with lot of exclusions, conditions, capping, co-pay etc. |
| **Family Floater** | A single sum insured is floated on the entire family. Any one or all can avail the sum insured under the policy. |
| **Group Health Insurance** | Covers an entire group based on individual sum insured. This is just like individual group policy only |
| **Tailor made Group Health Insurance Policy** | It is just an open policy. Issued to Group only. Individual or single family sum insured. It will be on floater basis. All caps, exclusions, pre existing diseases and waiting period removed on payment of extra premium. Additional coverage like pregnancy also covered. |
| **Indemnity** | Under this types of polices expenses are reimbursed / paid on the happening of insured peril. Example Individual and group health policies |
| **Fixed Cash benefits policy** | Under these policies instead of incurring the expenses first and reimbursing, the insurer will pay the claim amount on conformity of diseases. Example critical illness policy – on diagnosing the illness, the insurer will pay the claim amount immediately and will not wait till the treatment over subject to policy terms and conditions. Every day cash benefit also such type of cover. |
| **Top up and Super Top up cover** | The insured may or may not require the basic health insurance cover. These policies have certain threshold limits. Once the claims crosses the threshold limits, the claims will be settled the over and above the threshold limits but within the sum insured. |
| **Long term cover** | In general insurance there is no long term health insurance coverage. However in life insurance has combo product which covers life and health insurance which has long term cover say up to 5 years. |
| **Overseas Health Insurance Policy** | If any resident Indian individuals / family visit to any foreign country for pleasure trips or business trips, they are covered under the Overseas health insurance policy. This policy only operates when the insured at overseas. |

## HEALTH INSURANCE - PORTABILITY

IRDAs Health Regulations 2013 has allowed the insured to port their health insurance coverage from one insurer to another insurer without losing the benefits he/she derived from the existing policy. The salient features and conditions are as follows :-

1. The insured has to approach the new insurer at least 45 days before the renewal date of his existing policy. The insurer is not liable to offer portability if the insured fails to intimate 45 days before expire of existing policy.
2. If the acceptance of portability is not received by the insured within stipulate time, at the request of the insured, the existing insurer should renew the policy at least for a month. If any reasons the insured is intended to continue the policy, the existing insurer should allow the same by charging the normal premium.
3. The policy holder should submit the portability form along with a proposal form to the new insurer.
4. On receipt of the portability application, the new insurers will seek the information from the existing insurer through the IRDA web portal.
5. The existing insurance company should provide the details within 7 working days through the IRDA portal failing the insurer will be penalized by IRDA
6. On receipt of the details within the stipulated above time line, the new insurer to intimate the insured within 15 days of receipt of such documents about accept or reject of the proposal. If he fails to do so within the stipulated time, then he does not have any ground to reject the proposal.
7. No levy of any additional loading or charges exclusively for the purpose of porting.
8. No commission is payable for a ported policy.
9. All individual and family floater policy can be ported excepted group and tailor made.

## ROLE OF VARIOUS AGENCIES IN HEALTH INSURANCE

### 1. IRDA

IRDA - Insurance Regulatory and Development Authority – is one of the stringent regulators in the world. IRDA regulates the insurance business in India. IRDA was formed in the year 1999 and start functioning from February 2000. The functions of IRDA includes, regulate the

Indian insurance market, licensing to various agencies such as insurers, brokers, agents, surveyors, TPAs and monitor their performance, issue various regulations on the subject matter, data collection and compiling, publishing the annual reports etc.

In Indian Insurance market, health insurance is having a major share after the motor insurance. Approximately the share of health insurance is between 25-30% of the entire portfolio of the insurer. All the insurance companies doing the health insurance – life and non-life – either as individual health insurance or as rider with other policies.

IRDA permitted all the insurance companies to do the health insurance business – life and non-life – either as individual health insurance or as rider with other policies. Initially the insurers has to file their product with the IRDA under file and use guidelines and get approved. Once the product is approved and placed in the market, the insurer has no right to withdraw the product without the prior approval of the IRDA

Apart from Life and Non-life Insurance companies, IRDA has permitted the following standalone Health Insurance Companies and their performance is encouraging.

1. Star Health and AlliedInsurance Company
2. Maxpupa Health Insurance Company
3. Religere Health Insurance company
4. Apollo Munich Re Health Insurance Company
5. Cigna TTK Health Insurance Company

## IRDA – REGULATIONS ON HEALTH INSURANCE – SALIENT FEATURES

1. Each and every insurer should file their product with the IRDA under File and Use guidelines and it should be approved by IRDA. Any subsequent revision or modifications should be effected with the prior approval of IRDA. The revision / modifications approved by the IRDA should be intimated to insured at least 3 months prior to the date of when such revision or modification comes into effect. The possibility a revision or modification of the terms of policy including the premium must be disclosed in the prospectus
2. Any approved product which is in the market at present, should not be withdrawn without the approval of the Authority. Insurer shall not compel the insured to migrate to other health insurance products, if it is to the disadvantage of the insured

3. No assignment of health policies is allowed. However Life-Health Combo product are allowed up to the limit of life cover.
4. Entry age is at least up to 65 years
5. An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the previous years.
6. Policy can be renewed with a grace period of 30 days from the date of renewal without break in policy but the coverage is not available for such period.
7. All health policies shall have a free look in period. The insured is allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.
8. Cost of pre-insurance health check up is allowed and such expenses will be reimbursable up to 50% by the insurer if the policy is accepted.
9. Option to migrate to suitable health insurance policy
10. The health insurance policy shall mandatorily contain all information such as renewal, coverage, minimum age, premium loading, enhancing sum insured, exclusions, cancellation and conditions.
11. Declaration shall only form part of the proposal from and shall not be included in the policy documents.
12. Every insured shall be provided with a Key Information Sheet setting out in a simple language briefly but clearly all the important features of the policy, its claims limits, disallowances.
13. All insurers shall settle claims including its rejection within 30 days of the receipt of the last necessary documents. Rejection should be by insurer and not by TPA
14. Penal inertest provision shall invariably be incorporating the policy documents as per the Regulation 9 (6) of Protection of Policyholders interest Regulations, 2002.
15. Portability of health insurance policies from one insurer to another.
16. The policy can be cancelled / not renewed only due to non- disclosure of material fact, fraudulent claim made and not by any other reasons.

## ROLE OF HEALTH INSURERS

Insurance companies – Life, Non-life and standalone health insurance companies has to offer various health insurance products individually and combining with other personal line

of products. The premium should charged be reasonable and adequate. Hassle free Claims settlement. Health product should be filed with the IRDA as per file and use guidelines. Once the product introduced in the market, insurers are not authorized to revise or modify the existing product without the approval of the authority. Effective and efficient grievances handling mechanism should be followed. Insurer cannot refuse any renewal because of frequent claims and over age. They have to appoint TPAs to serve the insured.

## ROLE OF TPA

TPA – Third Party Administrator are licensed by IRDA to act as Health Claim facilitator against remuneration by the insurers. The TPA will enter into agreement with insurance companies to facilitate (1) claim servicing of the client (2) Issuing identity card to the insured (3) providing the claim and disease data and analysis (4) tie-up with network hospitals etc. (5) Cost control.

Once the claim intimated to the TPA by the insured, TPA will issue the pre authorization letter to the tie-up hospital where the treatment to be taken. After the treatment but before the discharge, the hospital authorities will submit the soft copies of bills and reports to the TPA. The TPA will verify the bills and reports with the policy terms and conditions and the agreement between TPA and the hospital and approve the claims. The insured has to bear the expenses which are not covered under the policy and walk with free hand without settling the full amount of expenses.

When there is no tie-up hospital at the place of treatment taken and the insured want to take one particular hospital as per his choice then the cashless facility cannot be extended under those circumstances, the insured has to intimate the claim to the TPA first and submit the Bills after treatment and seek reimbursement from the TPA. TPA does not have any authority to dispute a claim or repudiate or reject a claim on its own but it should be done only by the insurer.

## ROLE OF HEALTH CARE PROVIDERS

The Health care provider is the one of the partner in the Healthcare system. He provides the healthcare to the insured persons. The healthcare provider may be tie-up with the TPA of the insured or he can provide the service directly to the insured.

If the healthcare provider has tie-up with the TPA then he has to extend the cashless facility to the TPA members. He has to give priority to the members of TPA. He has to charge the

rates as pre agreed with the TPA including the length of Stay at Hospital at pre agreed terms. He should not collect any money from the insured for admission and cost of medicines unless it is not covered under the scope of policy. They have to provide the necessary data to the TPA and insurer as and when required. They have to allow the insurer / TPA or its representative to visit the hospital any time including checking of records.

## HEALTH CODING

Medical coding is the transformation of verbal descriptions of disease, injuries and procedures into numeric or alphanumeric representation. There are three types of coding in health namely (1) Diagnostic codes – used for medical diagnosis, signs and symptoms (2) Procedural codes – used to identify the special health intervention given by the medical practitioner to the patient and (3) Pharmaceutical codes.

## USE OF MEDICAL CODING

The health insurance industry is deriving lot of benefits from the use of medical coding not only for the internal use and for the external use also. The internal use includes product pricing, claims management, provider management and underwriting the risk, The external use includes types of disease prevailing in that particular area, treatment facilities available and how the health care can be improved in those neglected area etc.

## HEALTH CODING IN INDIA

Recently the IRDA issued various regulations on Health coding in India. In Indian health market CPT and ICD 10 PCS are most commonly used as Procedure Codes. The Regulator and IIB has made mandatory compliance of ICD – 10 PCS Diagnosis code for all health insurance reports

## FRAUD AND ABUSE IN HEALTH INSURANCE

### FRAUD

There is no specific definition for insurance fraud under the Indian Penal Code but there are various sections which deal with forgery, cheating, impersonation, falsification of documents etc. However the Indian Contract, u/s 17 defines the fraud as “Fraud means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agents, with intent to deceive another party thereto his agents, or to induce him to enter into the contract (a) The suggestion as a fact, of that which is not true, by one who does not believe it to be true ; (b) the active concealment of a fact by one

having knowledge or belief of the fact (c) a promise made without any intention of performing it (d) Any other act committed to deceive ; (e) any such act or omission as the law specifically declare to be fraudulent.

Fraud and Abuse is common in insurance industry also. Around 10-15% are fraud claims. Every year Indian insurance industry looses around Rs.2000 crores in this head. In India there is no special law for insurance fraud as in developed countries. Low penalties and inefficiency of the insurance companies to fight with the fraud and take legal actions and insiders involvement increases the fraud.

**ABUSE**

Abuse is the result of unethical and inconsistent business practices followed by the Healthcare providers with and without the active support of the insured for their personal gains to ruin the insurers. Fraud and Abuse are one and same but there is a silver line different between them. Ex. If a customer filed a false claim is Fraud whereas the customer submitted his exaggerate medical expenses with the help of hospital authorities and seeking reimbursement is abuse.

**HOW THE FRAUD AND ABUSE EATING THE INSURANCE INDUSTRY EARNING**

During 2002, IRDA – the Insurance Regulator – licensed and permitted the Third Party Administrator to facilitate the health insurance claims for the benefit of the insured. Accordingly each and every insurer appointed TPAs to facilitate the insurance claims. There are two types of claim process (1) Cashless Treatment and (2) Reimbursement claims. Under the cashless treatment method, the insured can take treatment at any tie-up hospitals of TPA and take cashless treatment up to his eligible sum insured with the prior approval of the TPA. Under reimbursement method, the insured has to incur the expenses first and get reimbursed from the insurer through the TPA.

The novel schemes is getting spoiled by the health providers with their own connivance and gloving hands with the insured. The following statistics will reveal the increase of medical expenses after introducing the cashless facility.

**Table – 9 : Disease wise claim severity Analysis for 2009-09 and 2009-10**

| Sl. No. | Diseases | Excess paid for cashless over reimbursement – in % | |
|---|---|---|---|
| | | 2008-2009 | 2009-2010 |
| 1 | Arthropathies | 70% | 132% |
| 2 | Malformation/deformation | 93% | 76% |

| | | | |
|---|---|---|---|
| 3 | Accident | 62% | 50% |
| 4 | Injury | 61% | 73% |
| 5 | Perinatal conditions | 61% | 65% |
| 6 | Pregnancy | 47% | 49% |

A study was conducted by IIB to find out variation in claim severity and medicine expenses between major hospital groups and other hospitals for the year 2009-10 and the findings are as follows :-

**Table – 10 : Study on Major Hospital Group expenses**

| Sl. No. | Hospital | Claim severity in excess compare to industry average - % | Medical expenses - % of excess for cashless over reimbursement |
|---|---|---|---|
| 1 | A | 77.29 | 42 |
| 2 | B | 82.10 | 103 |
| 3 | C | 54.30 | 51 |
| 4 | D | 31.68 | 73 |
| 5 | E | 81.61 | 111 |

**Table – 11 : COMPARISON OF LENGTH OF STAY Cashless Vs Reimbursement**

| Sl. No. | Disease | Average length of stay in the hospital | | | | | |
|---|---|---|---|---|---|---|---|
| | | HOSPITAL 'A' | | HOSPITAL 'B' | | HOSPITAL 'D' | |
| | | cashless | Reimb | cashless | Reimb | cashless | Reimb |
| 1 | Accident | 9 | 2 | 7 | 3 | 3 | 11 |
| 2 | Arthropathis | 34 | 37 | 30 | 63 | 32 | 31 |
| 3 | Malformation/deformation | 11 | 21 | 30 | 11 | 45 | 30 |
| 4 | Pregnancy | 24 | 27 | 15 | 25 | 26 | 4 |
| 5 | Injury | 29 | 19 | 27 | 32 | 21 | 23 |

**Table – 12 : CITY WISE CLAIM SEVERITY ANALYSIS**

| Sl. No. | Name of the City | Excess % paid for cashless over reimbursement | |
|---|---|---|---|
| | | 2008-09 | 2009-10 |
| 1 | Bangalore | 89 | 82 |
| 2 | Hyderabad | 89 | 82 |
| 3 | Pune | 89 | 80 |
| 4 | Chennai | 37 | 51 |
| 5 | Ahmadabad | -6 | 62 |

## GRIEVANCES REDRESSAL MECHANISM

The health insurance policy holders having the following grievances mechanism to redress the grievances. IRDAs Policyholders Protection Regulations, 2002 clearly specify the duties of the insurer to redress the grievances of the insured.

| Authority | Whom should the insured first to approach |
|---|---|
| **Insurance Company** | The insured can first approach the policy issuing office for any grievances for redressal. If the Branch has failed to redress the grievances, he can approach their Divisional Office / Regional Office / Head Office subsequently.<br>Each and every Insurance company is having online grievances redressal portal. The insured can lodge the grievances through portal. The complaints are monitored strictly and regularly. Issues are solved quickly and get response about the issue |
| **IRDA** | IRDA is having a online grievances portal. If the insurance company fails to respond the grievances within a stipulated period, the insured can escalate the issue to IRDA. IRDA will send the grievances to the insurance company and call for their feedback. |
| **Ombudsman** | All grievances on personal line of business are accepted by ombudsman which is a statutory body as per the Insurance Act 1938. Ombudsman authorize to entertain the claim up to Rs.20,000. Aggrieved insured can approach to redress his grievances. Ombudsman binds the insurer and insured. |
| **Consumer Forum** | The aggrieved insured can approach the Consumer Forums such as District Forum, State Forum and National Forum. District forum is authorized to accept the grievances upto Rs.20 lakhs. The State Forum and National Forum having limits of Rs.20 lakhs to Rs.1 crore and above 1 crore respectively. Both the forum is appellate authority. |
| **High Court / Supreme court** | The aggrieved insured can approach the High Court and Supreme court after exhausting all the above. |

## CONCLUSION

The Indian Health Insurance has growing a greater fast then other insurance portfolio. Now it has reached 30% of entire portfolio of the non-life insurance companies. Standalone health insurance companies and life insurance companies share on health insurance also showing a stupendous growth on premium, no. of policies issued and no. of life covered. The growth is due to most of the young generation and employer want to cover their employees' health. But the Loss Ratio on health insurance is more than the premium. The present ratio is around 130 – 135 which is certainly alarming the industry and regulator. The reason for increasing ICR one is no health regulator in India and second one is abuse and fraud. Indian Insurance Industry should take concrete steps to set up a constitutional

authority to regulate the health providers and bring stringent laws to curb the health insurance frauds.

## REFERENCES:

1. IRDA Annual report
2. Insurance Information Bureau Reports
3. Insurance Institute of India – IC 35 & 36\
4. Report from WHO
5. Reports from various journals