CHAPTER III

THEORETICAL BACKGROUND
CHAPTER III

THEORETICAL BACKGROUND

This chapter explains in depth the concept which includes Evolution of Insurance, General Insurance, Health Insurance in India, About IRDA Regulations for health insurance, Growth of Health Insurance in India, Public and private health insurance companies, Future of Health Insurance.

3.1 EVOLUTION OF INSURANCE

Human life is open to risks which are uncertain at various degrees. All risk cannot be avoided or certain risk may be beyond the capacity of an individual to bear. But they can be handled or minimized through the best concept known as insurance. “Insurance affects everything and everything affects insurance” is a well known quote. The word insurance origins from the word ‘insure’ which means to protect. In Rigveda, reference was made for insurance as Yogakshema which indicates to well being and security of people. Hummurabi and Manu’s codes quote the provision for sharing future losses. Insurance is the secure in the event of damage or loss to either life or property as per the agreement made between the insurer and insured but not as per the actual amount of premium or contribution paid.

In ancient times insurance refers to pooling of resources that could be re-distributed in times of natural calamities such as fire, floods, epidemics etc. This concept is the root for the modern health insurance market. In olden days there was a concept of ‘piruvu’ which means contributing some amount from all the families in that village to a family having a sick person. The word insurance means ‘to protect’.
The meaning of health insurance is protecting the health of the people against medical expenditure for the existing and for the future.

Insurance is defined as a co-operative device to spread the loss covered by a particular risk over a number of persons who are exposed to it and who agree to ensure themselves against the risk. Mowbray and Blan Chard define insurance as “A social device for eliminating or reducing the cost to society of certain types of risk.” W.A. Dinsdale defines insurance as “A device for transfer of risks of individual entities to an insurer, who agrees for a consideration (called premium) to assume to a specified extent losses suffered by the insured.” Insurance is a financial arrangement by the insurance company which guarantees or compensates for specified loss, damages or illness in return for a specified payment of premium.

**Origin of Insurance**

The concept of insurance was initialized in the 14\(^{th}\) century. The references of insurance were also identified in Babylonia, France and Rome. The beginning of the insurance industry took place in the UK at Lloyd’s coffee shop where it was used as a tool for protection against financial loss of sea hazards involved in foreign trade. Marine insurance is the oldest form of insurance followed by life insurance and fire insurance. Fire insurance was started in Germany in the 16\(^{th}\) century and during the same period life insurance was started first in England. In 1653, the first life was insured by Mr. William Gybbons. In 1866 in England, a major fire broke out in which 85 percent of the houses and properties were destroyed. After this disaster fire insurance came into existence.

**Insurance in India**

In 1818, a British Company – Oriental Life Insurance was set up as the first insurance firm in India which was followed by Bombay Assurance Company in 1823. Some of the European insurance companies considered only European life and for Indians they charged 20% above the normal premium as Indians were treated as
‘sub-standard’. In 1871 Bombay Mutual Life Assurance Society was established which came out with policies for Indians at a nominal premium rate. In the year 1912 Life Insurance Act was enacted and a major transition of Indian insurance took place in 1956 with the nationalization of life insurance business in India.

3.2 GENERAL INSURANCE CORPORATION OF INDIA (GIC)

General insurance travelled to India from UK. General Insurance business was transacted by British and other foreign insurance companies through their agencies in India. The first general insurance company was Triton Insurance Company Ltd was established in Calcutta in 1850 was controlled by British. In 1907, the first general insurance company The Mercantile Insurance Company was established by Indians. Till independence 40 percent of the share was held by British and other foreign countries.

Based on General Insurance Business (Nationalization) Act 1971, GIC was registered as a company under the Indian Companies Act 1956 in November 1972. GIC was incorporated as a holding company to look after non-life insurance business. In Jan 1973, all 107 private companies both Indian and foreign transacting general insurance business in India merged with one of the four subsidiary companies of GIC as National Insurance Company, New India Assurance Company, Oriental Insurance Company and united India Insurance Company. GIC has wide international operations. In 1988, GIC started its wholly owned subsidiary, India International Private Ltd., in Singapore, which has become a leading insurer in the Singapore market.

General Insurance products and services are being offered as package policies offering a combination of the covers in various ways. There are package policies specially designed for householders, shopkeepers, industrialists, agriculturists, entrepreneurs, employees and for professionals such as doctors, engineers, chartered accountants etc. GICs also offer tailor-made policies based on the personal requirements of the customers. A suitable general insurance cover is an
absolute essential for every family. An individual can be provided with a suitable insurance cover against personal accidents. A Health Insurance policy can provide financial relief and lowering of mental agony to an individual undergoing medical treatment on account of a disease or an injury.

![Fig 3.1 – Classification of Insurance](image)

3.3 ORIGIN OF HEALTH INSURANCE

The English word ‘Health’ comes from the old English word hale, meaning “wholeness, a being whole, sound or well”. World Health Organization (WHO) in 1948 has defined health as “a state of complete physical, mental & social well being and merely the absence of disease of infirmity”.

Health care is a diagnosis, treatment and prevention of disease, illness, injury and other physical and mental impairments in human beings. The healthcare varies across individuals, groups and countries which are influenced by social and economic conditions and health plans of that country. Health care is regarded as an important determinant in promoting the general physical and mental health and well-being of people around the world.

Health Insurance was originally started in Germany in early 1883-84, when compulsory accident and sickness insurance was initiated by Otto Von Bismarck. During 1880s Britain faced the fear of spread of diseases from its colonies and neighbouring countries, and initiated the process of quarantine. The same was adopted by Great Britain, France, Chile, the Soviet Union and other nations after the First World War. Many social forum and political parties showed their involvement in public health and organized meetings, and pamphlets on health needs were issued to create awareness among the public about health care.

Before independence in India, health care was based on voluntary work. Since ancient times traditional practitioners of health care have contributed to the medicinal needs of society. Acute knowledge in the medicinal properties of plants and herbs were passed on from one generation to another to be used for treatment. The colonial rule and the dominance of the British changed the scenario. Prior to independence the healthcare in India was in shambles with a large number of deaths and spread of infectious diseases. It was a common practice for villagers to take a ‘piruvu’ (a collection) to support a household with a sick patient.

Insurance as an organized form of commercial and financial activity, made it beginning in India as early as 1818. The first insurance legislation of the British government which was enacted in 1870 and a subsequent enactment in 1909 had no jurisdiction on the activities of the insurers transacting business in India. In 1912 the life insurance corporation Act was enacted. In the long history of Indian Insurance, the first major transition took place in 1956 with the nationalization of life insurance
business in India. This was followed by the nationalization of the General Insurance Industry in 1971.

The history of Health Insurance in India trace back to 1923 when the Workmen’s Compensation Act was passed. During 1948 the ESI Act was passed and in the year 1999, with the passing of IRDA Act marked the beginning of a new era for Indian Health Insurance which gave way to international players investing in the Indian Health Insurance Market by teaming up with the local companies. Health Insurance Policies were first introduced in 1986 when the Indian Insurance Industry was nationalized.

The Government set up a committee in 1993 under the chairmanship of R.N. Malhotra, former Governor of RBI (Reserve Bank of India), to propose recommendations for initiation and implementation of reforms in the Indian insurance sector. The objective of setting up this committee was to complement the pace of reforms initiated in the financial sector. The committee submitted its report in 1994 wherein it was recommended that the private sector be permitted to enter the Indian insurance sector. It also recommended the participation of foreign companies by allowing them to enter into an MOU (Memorandum of Understanding) by floating Indian companies, preferably a joint venture with Indian partners.

There are various methods which are used by the common man for financing the overall health care expenditure. The basic structure which gives the flowchart of how health expenditure is financed in India. The structure states how people spend for their health issues whether they are under the government or public funding having options of government or social security or external sources like aids. In case of private financing options are out of pockets or private health insurance schemes or external sources.
3.4 HEALTH INSURANCE IN INDIA

Health insurance is one of the growing sectors in the Indian insurance industry. This area has seen a tremendous growth since 2010. Health insurance has also contributed around 5% of the total healthcare market. The Indian Health Insurance Scenario is a mix of mandatory social Health Insurance, Voluntary Private Health Insurance and Community Based Health Insurance. Health Insurance is a minor player in Health ecosystem. Health Insurance Sector is one of the fast growing sectors in India and there are various Health care Insurance products being launched in India. The base of health insurance products is mediclaim which was introduced in the year 1986. Modifications are made in the product and are launched as new product.
Government or State-based Systems

Government or state-based systems includes CGHS (Central Government Health Scheme) and ESIS (Employees State Insurance Scheme). The above schemes are run by member-based organizations which cover about 5% of the population in different ways. CGHS was started in the year 1954 covering nearly 2.3 lacs of population. It provides benefits to both employer and employees. All employees of the central government (current and retired), semi-government organizations, judges, MPs, freedom fighters, Ex Governors and Presidents and journalists are beneficiaries of this scheme. The main objective of bringing out this scheme was to provide complete medical care to the central government employees.

The benefits also include outpatient’s facilities, preventive and primitive care in dispensaries. Inpatient facilities in both government hospitals and approved private hospitals are also covered. For example, central government employees can take treatment at Global Hospital which is approved by the CGHS. The scheme is
mainly funded through Central Government funds, with premium ranging from Rs.15 to Rs.150 per month on their salary scales. The coverage of this scheme has extended its services to non-allopathic system of medicines like homeopathy, Ayurveda, Yunani, Sidha system, Yoga. The main components of this scheme are dispensary services, hospitalization, specialist consultation services and health education to the general public i.e. beneficiaries.

The Employees State Insurance Act was passed in 1948. This scheme gives protection to employees against loss of wages due to inability to work due to sickness, disability, maternity and death due to employment injury. This scheme provides cash benefits, preventive and health education and medical benefits. It covers the employees and their family members without any charges for the services provided by them. The beneficiaries of this scheme are factory sector employees whose incomes are less than Rs.7,500 per month. People working in mines and plantations, or an organization offering health benefits as good as or better than ESIS, are specifically excluded.

The service is extended to service establishments like shops, hotels, restaurants, cinema houses and road transport and news paper printing etc. The monthly wage limit for enrolment in the ESIS is Rs.6,500 with a prepayment contribution in the form of a payroll tax of 1.75% by employees, 4.75% of employee’s wages to be paid by the employers and 12.5% of the total expenses to be borne by the state governments. The scheme is managed and financed by the employees’ state insurance corporation through the state governments, with total expenditure of Rs 3,300 million or Rs 400 per capita insured person.

In the recent years, various state governments have initiated health insurance coverage schemes. This initiative has made the public to get automatically covered under the government health insurance scheme. Tamil Nadu, Andhra Pradesh, Karnataka, Goa and Kerala are some of the states to introduce this scheme.
Tamil Nadu government has come out with a comprehensive health insurance scheme to people for medical and surgical procedures whose annual income is below Rs.72,000. This scheme was introduced by joining hands with United India insurance company-a public sector. The features of the policy are cashless hospitalization facility for certain ailments. The scheme covers up to Rs.100000 per family under floater scheme for 950 medical procedures. The new scheme gives priority to government hospitals than in private hospitals. Certain types of treatments are permitted only in government hospitals and exclusive areas will be earmarked in the government hospitals which are identified under the scheme.

In the year 2000, Andhra Pradesh government implemented the Aarogya Raksha Scheme to increase the utilization of permanent methods of family planning by covering the health risks of the acceptors. All people living below the poverty line and those who accept permanent methods of family planning were eligible to be covered under the scheme. Government pays a premium of Rs.75 per acceptor. The benefits include hospitalization costs up to Rs.4,000 per year for the acceptor and for his two children for a period of five years from the date of family planning operation. The hospital bills were directly reimbursed by the New India Assurance Company.

The Government of Goa joined hands with New India Assurance Company in 1988 and developed a medical reimbursement scheme. The scheme can be availed by all permanent residents of Goa with an income below Rs.50000 per annum for hospitalization care which was not available within the government system. The overall limit was Rs.30000 for the insured person for a period of one year.

Government of Karnataka with UNDP has launched on health insurance in two blocks in the year 2002. The main objective of the project was to develop and test a model of community health financing for rural community which would
increase the access to medical care of the poor. The beneficiaries are the entire population of these blocks. The premium was charged Rs.30 per person per year.

Government of Kerala has also planned to launch a pilot project of health insurance for the families living below the poverty line. The scheme would be associated with a government insurance company. The premium to be collected Rs.250 plus 5 per cent tax. The maximum benefit per family would be Rs.20,000. The benefits includes hospitalization coverage, deliveries involving surgical procedures. The scheme would be applicable 216 government hospitals across the state.

**Rashtriya Swasthya Bima Yojana**

RSBY was launched by Ministry of Labour and Employment, Government of India to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most of the diseases that require hospitalization. Government has also fixed the package for the hospitals for more complications. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding. RSBY provides the participating BPL household with freedom of choice between public and private hospitals. This makes the hospitals for collecting revenue from the people under this scheme. The scheme has been designed as a business model for a social sector scheme with incentives built for each stakeholder.
This business model design is conducive both in terms of expansion of the scheme as well as for its long run sustainability. The insurer is paid premium for each household enrolled for RSBY. Thus this motivates the insurer to enroll as many households as possible from the BPL list. This will result in better coverage of targeted beneficiaries. Hospitals are also provided with the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. Even public hospitals have the incentive to treat beneficiaries under RSBY as the money from the insurer will flow directly to the concerned public hospital which they can use for their own purposes. Insurers, in contrast, will monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims.

For the first time IT applications are being used for social sector scheme on such a large scale. Every beneficiary family is issued a biometric enabled smart card containing their fingerprints and photographs. All the hospitals empanelled under RSBY are IT enabled and connected to the server at the district level. This will ensure a smooth data flow regarding service utilization periodically.

**Market-based Systems (Private and Voluntary)**

There are many types of health insurance plans which are offered by private and public insurance companies. The need for private health insurance was for coverage for treatment in the private hospitals, coverage of services which are not included under social health insurance and coverage for co-payments in social health insurance. The aim of private health insurance was to enhance the maximum utilization of facilities provided to people subscribes the policy. Mediclaim policies or individual health plan covers the hospitalization expenses for 24 hours including hospital bed, surgeon’s fees, operation theatre charges etc. under the mediclaim policy around 2.5 million population are covered.

Mediclaim is considered as the model for the health insurance plans followed by other plans like family floater plan. Under this plan, the sum insured can be availed for all or any member of the family and not for a single person. The
other plans are critical illness plan, senior citizen health plan etc. certain regulations are also to be implemented in the private health insurance sector with regard to guidelines for development of products, standardized restrictions on exclusions, pricing of products and controlling charges and reimbursements.

**Community-based Health Insurance**

Health insurance scheme are usually targeted for low-income populations. This scheme was initiated to support the individual members from taking up the financial burden of hospitalization. It can be termed as Micro Health Insurance schemes. There are three types of community health insurance schemes in India.

The main objective of community based health insurance is to protect the poor people from financial burden for medical expenditure and to provide them health care facilities from the nearby hospitals in the surrounding locality. These are targeted at low-income populations and the nature of the communities around from people living in the same town or district to members of work cooperative or micro-finance groups. Organizations like ACCORD, RAHA, SEWA etc are based in rural or semi urban areas working among the poor.

### 3.5 IRDA ACT, 1999

On the recommendation of Malhotra Committee, the IRDA Act was passed on 1999. The Principle responsibility of IRDA were

- Framing various regulations governing the activities of the insurance companies and corporation-both Indian and Indian companies with foreign business partners.
- Discharging the responsibility of controller of insurance in opening offices, licensing intermediaries etc.
- Monitoring the activities of the Tariff Advisory Committee (TAC).
IRDA – Health Insurance Regulations 2013

The committee examined the health insurance regulations to implement the changes to reflect the suggestions. The committee also discussed the need to amend or modify the regulations to details in the regulations to guidelines and clarify with respect to the following:

1. Change in the definition of Health Insurance Business in keeping with the amendment to the insurance act;

2. Inclusion of new definitions – pilot product, AYUSH, health savings account product.

3. For health plus life combi-the term cover only restriction needs to be removed for life products.

4. ‘File and use’ needs to be replaced by ‘product clearance’ as it would subsume use and file (for group products).

5. Assignment needs to be restricted to only benefit policies- PA and critical illness.

6. Clause 12(d) of the regulations needs to be modified to reflect that while a TPA cannot reject or repudiate a claim, settlement of claims may be made by TPAs subject to following detailed guidelines issued by the insurers for the various products.

7. The regulations should enable prescription of standards, protocols and benchmarks for providers in the network.

Health plus Life Combi Product means combination of life insurance cover of a life insurance company and a health insurance cover offered by non-life or standalone health insurance companies.
Definitions:

Pilot Product – pilot products are short term innovative constructs, which enable insurers to gauge market reaction to new ideas and innovation.

Health Savings Account - health savings account is a long term, retail health insurance product which enables policyholders to create a contingency fund to be used to pay for future health expenses.

Policyholder’s Protection Regulations

Some important Matters to be stated in Health Insurance Policy

- The name of the policyholder and the names of each covered beneficiary.
- Date of birth of the insured, age, address for correspondence, email id and contact number.
- The period of insurance and the first date of the first policy where insurance is without break.
- The sum insured.
- The pre-existing disease (PED) waiting period, if applicable.
- Specific waiting periods as applicable.
- Free health check-up, when applicable, if any.
- The premium paid, policy period, terms conditions exclusions and warranties.
- Action to be taken on the occurrence of a claim for cashless and reimbursement options separately.
Details of TPA, their local and national address, their toll free number, website details.

Grievance contact nos. of both insurer and TPA.

Obligations of the insured in proper disclosure and timely intimations.

Free look period facility and portability conditions.

Policy migration facility and conditions where applicable.

Renewability conditions.

Premium revision and or loading conditions.

Provision for cancellation of the policy as per health regulation.

Proforma for communication to insurer/TPA.

Address of policy issuing office, Head Office and grievance department with email ids, website address of the insurer and links to guidance sites therein.

Ombudsman service details with address and contact numbers of local ombudsman.

3.6 GROWTH OF HEALTH INSURANCE IN INDIA

Based on the various medical services and medical expenses, people make their option to subscribe health insurance policy. The growing general insurance business has forced the insurance sector to concentrate on health insurance business. Health insurance segment has become reputed in the recent period which has lots of opportunities for better growth and has recorded an increase of 22% 2013-2014. Health insurance has also become an important factor for life insurance business.
This has made the life insurance companies to launch health insurance policies which suit the policyholders.

According to IRDA annual report 2013-14, the gross health insurance premium collected by non-life insurance companies was Rs.17495 crores during 2013-14 which was 13.21% more as compared with the premium collected Rs. 11031 crores during 2010-11.

Health insurance business in India is categorized under group health insurance, government sponsored health insurance, private health insurance and Stand-Alone Health Insurance companies. IRDA encourages more stand alone health insurance companies. As per the IRDA annual report 2013-14, the group insurance has the major share of 46% of the gross health insurance premium followed by individual health insurance contributing 42% and 12% contribution from the government. While comparing with the past four years, it is revealed that the contribution of group insurance is the same but increase in the individual health insurance from 35% to 42%.

Government contribution shows a decline of 8% from 20% in 2010-11 to 12% in 2013-14. The annual report reveals that health insurance industry has distributed nearly one crore health insurance policies covering a total Indian population of 21.62crore. Government sponsored health insurance policies has contributed the maximum of 72% followed by the group insurance and individual health insurance policies of 13%. The claim ratio shows 97% in 2013-2014 which has increased comparing with 90% in the past three years.

At present union funded insurance schemes cover an estimated population of 181 million through employee state insurance scheme (ESIS) – 60 million; central Government Health Scheme (CGHS – 3 million) and Rashtriya Swasthya Bima Yojana (RSBY – 118 million). 110 million people in the south Indian states which include 70 million in Andhra Pradesh, 35 million in Tamil Nadu and 5 million in
Karnataka who are covered under the state government health insurance schemes. The above schemes are covered only for in patient care.

According to IRDA report Maharashtra, Tamil Nadu, Karnataka and Delhi are the top four states or union territory with respect to share of health insurance premium. Tamil Nadu stands the second in the health insurance premium with 11% share. People in Tamil Nadu have more awareness towards health insurance and are interested in subscribing health insurance policies under government sponsored health insurance policies or private or group health policies. Based on the distribution channel, it is revealed that insurance agents contribute the major part in the health insurance products with 36% followed by direct sale or internet sale contribute 32%. Only 1.73 lakhs health policies are sold through online marketing.

The 12th five year plan and the NHM’s framework for implementation to undertake universal health coverage (UHC) in each state which will show path for implementing the same all over the country in the future. Goal of Universal Health Coverage is to ensure that all people obtain the health services they need without suffering financial difficulties while paying for the same. This can be minimized by a well organized system for financing health services and a sufficient capacity of well-trained motivated health workers.

The National Rural Health Mission was launched by the government of India in the year 2005 to provide accessible, affordable and quality health care to the rural population who are below the poverty line. But the UHC has to be adequately funded and well planned by the team of organizations. The team includes World Health Organization (WHO) country office in India and 10 organizations includes DFID, GIZ, ILO, UNAIDS, UNDP, UNFPA, UNICEF, USAID and the World Bank joined hands together to promote Universal Health Coverage in India.
3.7 PUBLIC AND PRIVATE HEALTH INSURANCE COMPANIES IN INDIA

There are four public sector players in the country with health insurance policies – United India Insurance Company Ltd, National Insurance Company Ltd, New India Assurance Company Ltd and Oriental Insurance Company Ltd. The main advantage in availing a policy from a public insurance company is lower premium for the same coverage compared with private health insurance companies. All the public health insurance companies deal with group insurance policy, family floater and individual insurance policies. According to IRDA report, the four public sector non-life insurance companies has major contribution of 62% towards health insurance business and private health insurance companies has contributed to the extent of 26% and the 12% contribution from the stand-alone health insurance companies. All these share of contribution towards health insurance remains the same for the past four years.

With the opening up of private health insurance sector in India, it is very clear that health insurance industry had boomed and people got aware of health insurance. As per IRDA Report, there are 21 private insurance companies in India. There are many advantages of private health insurance companies like flexible health policies and prices. They have launched many comprehensive packages at nominal prices. Health plans are designed as per the requirements of the customers with lower premium. ICICI Lombard General Insurance company received the award for “The best Recommended Company” of the year 2013. They had been ranked one for the customer satisfaction. The claim processes of private health insurance companies are easy and faster. Even private insurance companies face certain disadvantages such as coverage of risk for poor people, disabled and senior citizens would be rejected. They prepare the exclusions for their product design. They concentrate only on a particular targeted section of people.
As on 31st March 2014, IRDA has sanctioned licenses to five insurance companies for operating as standalone health insurance companies. The companies are Star Health and Allied Insurance Company Ltd, Apollo Munich Health Insurance Company Ltd, Max Bupa Health Insurance Company Ltd, Religare Health Insurance Company Ltd and Cigna TTK Health Insurance Company Ltd. Star health and allied insurance company was the first to be granted license followed by Apollo munich health insurance. During 2013-14, the gross premium collected by these companies were Rs. 2245 crore as compared with Rs.1726 crore in the previous year 2012-13. It shows a increase of 30%. The claim ratio of these companies was 66.06% during 2013-14 as compared with the previous year 2012-13 as 61.49%.

Star Health and Allied Insurance Company Ltd offers mediclaim, personal accident policy and travel insurance. They have been awarded “Claim Service Company of the Year 2014” among 28 General Insurance Companies for their Customer-friendly direct claim settlement.

Apollo Munich Health Insurance Company is a Joint Venture between Apollo Hospital Groups and German based Munich Health. The company offers tailor made health policies to Individuals, Family, Senior Citizens and for Corporate.

Max Bupa Health Insurance Company is a joint venture between Max India Limited and Bupa Finance PLC, UK. The company has gained a reputation in the insurance sector that they are the right company selection for the health insurance.

Religare Health Insurance Company was promoted by Fortis Hospitals and Religare Enterprises, Corporation Bank and Union Bank of India are the major shareholders. Regigare is known as a Specialist in health insurance products.

Cigna TTK is a joint venture between Cigna a global insurance company and TTK Group. They offer health insurance plans for individuals and family.
Types of Plans provided by public and private health insurance companies

Individual Policy

Individual policy covers the health of the individual i.e., single person only. The individual enters into an agreement with the health insurance company (insurer) for a period of one year. It is a legal document and valid for only one year. The policyholder can renew the policy before the expiry of the tenure to enjoy the benefits provided by the insurance company without any break. Individual policy cannot be transferred to any other person. If the policyholder wants to change the insurance company, then he cannot continue with the bonus or benefits during renewal.

Family Floater Health Policy

Family Floater Health Insurance Policy provides health coverage to the entire family under a single sum Insured. The policy covers the hospitalization expenses with regard to illness or diseases/injury by the insured person and that it cannot exceed the sum insured for that family as given the policy document. This policy is also for one year and has to be renewed before the expiry of the policy for continued benefits and bonus.

Critical Illness Plan

This scheme provides financial assistance to the insured under a serious ailment like cancer or stroke. Every coverage has a list of ailments between 9 to 12 of them. The insured can be covered along with a life insurance cover as a rider or this can be availed as a standalone policy from life insurer or non-life insurer. If critical illness occurs, it pays the entire sum insured and terminates and can happen only once for any particular illness. But to get the money, the insured has to survive for 30 successive days after the diagnosis. The policy is covered for 10-20 years if
covered as rider under life insurance cover and if under non-life cover it is for 1-5 years.

**Senior Citizen Health Plan**

Health insurance plan for senior citizens is very much necessary as they would be planning to retire and live on pension or on interest from their savings. A sudden medical emergency can result in financial crisis. Senior citizen health plans are for the age group of 60-80 years. The plan can be renewed lifelong or up to the age of 90. They have a fixed coverage of Rs.1,00,000 or Rs. 2,00,000. Under this plan many treatment are excluded from the plan. Under this plan they also have the option to attach a critical illness plan rider. The plan benefits includes hospitalization expenses, day care expenses which arises of special usage of equipments like chemotherapy or dialysis etc, medical expenses prior and post hospitalization, ambulance charges and certain pre-existing diseases subject to certain terms and conditions of the insurer.

**Pre-existing Diseases**

Pre-existing condition is a medical condition or disease that existed before obtaining health insurance policy, and it is significant, because the insurance companies do not cover such pre-existing conditions, within 48 months of prior to the 1st policy. It means, pre-existing conditions can be considered for payment after completion of 48 months of continuous insurance cover. Also in general certain diseases are excluded and are put on waiting period of one year. There are standard exclusions which are not covered under any type health plans.
Permanent Exclusions

Insurance companies are not liable under any circumstances, for any claim in connection with or with regard to any of the following permanent exclusions and any other exclusion specified in the schedule of insurance certificate.

- Addictive conditions and disorders - Treatment related to addictive conditions and disorders, or from any kind of substance abuse or misuse including alcohol abuse or misuse

- Ageing and puberty - Treatment to relieve symptoms caused by ageing, puberty, or other natural physiological cause, such as menopause and hearing loss caused by maturing or ageing.

- Artificial life maintenance - Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

- Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

- Conflict and disaster - Treatment for any illness or injury resulting from nuclear or chemical contamination, war, riot, revolution, acts of terrorism or any similar event (other than natural disaster or calamity

- Congenital conditions - Treatment for any Congenital Anomaly.
- Convalescence and Rehabilitation
- Cosmetic surgery
- Dental/oral treatment
- Drugs and dressings for Out-patient or take-home use
- Eyesight
- Experimental treatment
- Health hydros, nature cure, wellness clinics etc.
- HIV and AIDS
- Hereditary conditions
- Non-allopathic treatment
- Psychiatric and Psychosomatic Conditions
- Obesity
- Out-patient Treatment
- Reproductive medicine - Birth control & Assisted reproduction
- Self-inflicted injuries, Sexual problems and gender issues
- Sexually transmitted diseases
- Sleep disorders, Speech disorders, Treatment for developmental problems.
- Unrecognised physician or Hospital, Treatment received outside India
- Unlawful Activity

**Third Party Administrator (TPA)**

The Insurance Regulatory and Development Authority of India (IRDA) defines TPA as a Third Party Administrator who, for the time being, is licensed by the Authority, and is engaged, for a fee or remuneration, in the agreement with an insurance company, for the provision of health services. TPA was introduced by the IRDA in 2001. TPA (Third Party Administrator) is an organization which involves in processing the claim for health insurance companies. It is an outsourcing for insurers for claim processing. An insurance company goes to TPAs for managing its claim processing by providing network. Mainly TPAs also handle employees benefit plans and retirement plans. With a team of manpower and technology, TPAs are able to handle the claim in a professional manner and also it is very much cost effective.
3.8 **FUTURE OF HEALTH INSURANCE**

The way ahead for health insurance is very prospective. Two decades back health insurance was slowly introduced in the market. But now the health insurance sector is the number one in the general insurance business. One more area for the insurers to satisfy the policyholders are through humanitarian approach with new product development and while settling the claims.

Many support groups are functioning to take care of the children affected with genetic disorder like MPS support group which was inaugurated by Fetal Care Research Foundation by Dr. Suresh, Director, Mediscan and Dr. Sujatha Jagadeesh, Genetic Counseling. The group is supporting the family members with free multi specialty clinic every year for the regular follow up of children at one roof with all pediatric specialists. They also provide the diagnosis at free of cost, consultations like surgeons at free of cost. Also they get financial assistance from both government and corporate bodies to build a corpus fund. They are also working to get medical coverage for the children affected with genetic disorder for the frequent medical expenses of the affected. But insurance companies are not showing interest with the same. Initiatives are also taken by parents for the same.

In the days to come, it will become a period of biological revolutions which is going to affect every sphere of human activity. Comparing with other developed or middle income countries, the contribution from government budget is much higher. For the economic development of our country, insurance industry should be strengthened. Indian insurance industry is generally considered for tax saving purpose. Life Insurance Corporation dominates the insurance sector. People don’t see the insurance industry as the benefits provided by them. Indian population merely 2% to 3% is covered under health insurance.

The reason is they consider health insurance policies as burden of paying premium when they are keeping good health. With the entry of private players along with foreign expertise, Indian Insurance has become vibrant. Growth of Indian Health Insurance Industry is immense and the potential market for health insurance
is high. In India only 2% of total expenditure is funded by public or social health insurance while 18% is funded by government budget.

**Conclusion**

As DNHP 2015 has stated that the primary aim of NHP was to clarify, strengthen and prioritize the role of government in financing healthcare, prevention of diseases and legislation for health. The document has stated that health is a fundamental right to all citizens whose denial is punishable by law and the government is made responsible for the same. So analysis has been done in chapter IV to find out awareness level of policyholder, satisfaction level and problem faced by them so that a new product can be developed which is better than the existing one and also covers the children affected with genetic disorder.

There is an increase in gap in health related outcomes between rich and the poor in developing countries like India. This gap restricts the poor people to contribute to the economy. Direct out of pocket payments can push the people into indebtedness or to poverty. The Planning Commission of India accepts that out of pocket expenditure to pay for health care is a growing problem in India. Around 30 per cent in rural India did not go for treatment due to financial problem and 20 per cent were untreated because of financial problem.

Health Insurance can protect them from the financial burden during the medical requirements. There is a growing awareness among the public for better health care and also to get the best health care from the best medical providers. People look for the best insurance providers who can satisfy them with the policy and the benefits, and the extent they are covered under the various Health insurance schemes.