CHAPTER – III
ROLE OF HEALTH INSURANCE MARKET IN INDIA

3.1 Introduction

Healthcare Insurance or Health Insurance is a contract between a policyholder and a third-party payer or Government. The objective of the program is to reimburse the policyholder for all or a portion of the cost of medically necessary treatment or preventive care provided by healthcare Professionals. Health insurance (popularly known as Medical Insurance or Mediclaim) protects us against any financial constraints arising on account of a medical emergency. It sometimes includes disability and long term medical needs. In Mediclaim, insured pay a premium and in return the insurer commits to pay a predetermined sum of money to meet the claims. Health insurance is new in the Indian context and is slowly catching up with the consumers. Consumers understand the objective of health insurance and its offering to cover the ever rising medical expenses. Health insurance is available to both individual and groups. However, the premium for the individual policy is costlier than that of the group policy. An individual is the owner of his personal policy. Whereas in group plans, the sponsor is the owner of the policy and the registered members are covered by the policy. Insured can take advantage of group health insurance to overcome the shortage of their individual insurance. People with no policy or are uninsurable due to one or the other reason can take good advantage of the group plans and be covered. Insurance is perceived by a common man as a risk protection measure. In India, health insurance is provided mainly in the form of mediclaim policy to individuals or groups, association or corporate bodies.

- The mediclaim policy covers hospitalcare and domiciliary hospitalization expenditure.

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Health Insurance is available to persons between the ages of 5 years and 80 years. Children between 3 months and 5 years of age can be covered provided one or both parents are covered concurrently.³

Health insurance in a narrow sense would be an individual or group purchasing healthcare coverage in advance by paying a fee called premium. In its broader sense, it would be an arrangement that helps to defer, delay, reduce or altogether avoid paying for healthcare incurred by individuals and households.

### 3.2 Forms of Health Insurance Coverage in India

There are various forms of health coverage in India. Based on ownership the existing health insurance schemes can be broadly divided into four categories. They are Voluntary Health Insurance Schemes or Private-For-Profit Schemes, Employer-Based Schemes, Insurance offered by NGOs / Community Based Health Insurance and Mandatory Health Insurance Schemes or Government Run Schemes (namely ESIS, CGHS).

#### 3.2.1 Voluntary Health Insurance Schemes or Private-for-Profit Schemes

In private insurance, buyers are willing to pay the premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to the third-party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer’s income. In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes. The Life Insurance Corporation offers Ashadeep Plan II and Jeevan Asha Plan II. The General Insurance Corporation offers Personal

Accident policy, Jan Arogya policy, Mediclaim policy, Overseas Mediclaim policy, Cancer Insurance policy and Critical Illness policy.

Of the various schemes offered by public or private sector health insurance companies, mediclaim is the main product of the GIC. The year 1999 marked the beginning of a new era for health insurance in the Indian context. With the passing of the Insurance Regulatory Development Authority Bill (IRDA), the insurance sector was opened to private and foreign participation, thereby paving the way for the entry of private health insurance companies. The Bill also facilitated the establishment of an authority to protect the interests of the insurance holders by regulating, promoting and ensuring orderly growth of the insurance industry. The bill allows foreign promoters to hold paid up capital of up to 26 percent in an Indian company.

3.2.2 Employer based Insurance Schemes

In employer-based health insurance is purchased by employers for their employees. It is financed through employer or joint employer-employee contributions. This type of insurance is currently subsidized in part by the federal government through tax exclusions for employer contributions to employee health insurance plans. Existing evidence suggests that rather than helping to contain healthcare costs, employer-based health insurance may be partly responsible for their present escalation. There are several government and private employers such as Railway and Armed force and public sector enterprises that run their own health services for employees and families.

3.2.3 Insurance Offered by Non - Government Organizations / Community-based Health Insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premium is usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with the adverse selection because of a large number of high-risk members since premiums are not based on the assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have an adverse effect on the ability of the
insurance fund to meet the cost of benefits. Community-based schemes are typically targeted at poorer populations living in communities. Members of communities are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package and oral locating the schemes.

3.2.4 Social Insurance or Mandatory Health Insurance Schemes or Government Run Schemes (namely the ESIS, CGHS)

Social insurance is an earmarked fund set up by the government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income rather than related to health risk. The benefit packages are standardized and contributions are earmarked for spending on health services. The government-run schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS).

Central Government Health Scheme (CGHS)

Since 1954, all employees of the Central Government (present and retired) some autonomous and semi-government organizations, Member of Parliament, Judges, Freedom fighters and Journalist are covered under the Central Government Health Scheme (CGHS). This scheme was designed to replace the cumbersome and expensive system of reimbursements. It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities and preventive and promotive care in dispensaries. Inpatient facilities in government hospitals and approved private hospitals are also covered. This scheme is mainly funded through Central Government funds, based on salary scales. The coverage of this scheme has grown substantially with provision for the non-allopathic systems of medicine as well as for allopathy.⁴

⁴ Rahul Agarwal, “Identifying Awareness, Preferences and Consumption Patterns in the City of Jaipur”, 2008-2010, pp.1-93.
Employee and State Insurance Scheme (ESIS)

The enactment of the Employee State Insurance Act in 1948 led to the formulation of the Employee State Insurance Scheme. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. Medical care is also provided to employees and their family members without fee for service. Originally, the ESIS scheme covered all power-using non-seasonal factories employing ten or more people. Later, it was extended to cover employees working in all non-power using factories with twenty or more persons. The existing wage limit for coverage under the Act is Rs.21,000/- per month (w.e.f. 01/01/2017).

3.2.5 Other Government Initiatives

Apart from the government-run schemes, social security benefits for the disadvantaged groups can be availed of, under the provisions of the Maternity Benefit (Amendment) Act 1995, Workmen’s Compensation (Amendment) Act 1984, Plantation Labour Act 1951, Mines Labour Welfare Fund Act 1946, Beedi Workers Welfare Fund Act 1976 and building and other construction workers (Regulation of Employment and Conditions of Service) Act, 1996. The Government of India has also undertaken initiatives to address issues relating to access to public health systems especially for the vulnerable sections of the society. The National Health Policy (NHP) 2002 acknowledges this and aims to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services. Ensuring more equitable access to health services across the social and geographical expanse of the country is the main objective of the policy. It also seeks to increase the aggregate public health investment through the increased contribution from the Central as well as State Governments and encourages the setting up of private insurance instruments for increasing the scope of coverage of the secondary and tertiary sector under private health insurance packages. The National Population Policy (NPP) 2000, envisages the establishment of a family welfare-linked health

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5 http://www.esic.nic.in
insurance plan. As per this plan, couples living below the poverty line who undergo sterilization with not more than two living children would be eligible for insurance.\(^6\)

### 3.3 The Health Insurance Market in India

The Indian Health Insurance market has evolved in a little over the two decades since the first Health insurance product was launched a way to back in 1986. Mediclaim insurance, as it was first known has witnessed quite a few changes. Though it may not have been comprehensive and has been modified three times, it remains the longest running health insurance product in India. It has been a dominant product. Most of the health insurance products subsequently launched carry more than 50 percent of its feature. Any Health Insurance product in the Indian market is still identified as mediclaim.\(^7\) General Insurers have a number of standard health policies covering hospitalization expenses for individuals and their families. Hospitalization expenses are payable under the standard health policies and characterized by the common features such as waiting period for commonly occurring diseases and coverage of pre-existing diseases with loading. Some policies even differential rating for hospitalization claims in different parts of the country. Sometimes disease wise payouts are also specified in these policies. Covers specifically for the senior citizen category have also been devised by a few insurers, though this is viewed as a claim prone segment and therefore not targeted aggressively.

Critical illness policies and cancer policies are also available in the market, and payments are made under this scheme for contracting the specified illness. Hospital cash plans, top-up or surplus insurance covers with deductibles, disease-specific policies and travel related health policies are also quite popular. There are also some economically priced policies with limited benefits for the underprivileged sections of society such as the universal health insurance policy, marketed by the public sector insurers.\(^8\) The present Indian Health Insurance companies are classified as Figure 3.1

\(^6\) ibid 4
General health insurance companies are non-life insurance companies, including a number of public and private health providers. The coverage in the public and private sector is provided by several types of insurers including employers that self-insure.

Standalone health insurers - companies that focus on only one line of business are set to grow on the back of rising medical costs and heavy dependence on private medical care. In India five are standalone health insurance players. These are Star Health and Allied Insurance, Apollo Munich Health Insurance, Max Bupa Health Insurance, Religare Health Insurance, and Cigna TTK.  

Life Insurance Corporation providing health plan LIC's Jeevan Arogya is a unique non-participating non-linked plan which provides health insurance cover against certain specified health risks and provides with timely support in case of medical emergencies and helps the family remain financially independent in difficult times.

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3.4 Health Insurance – A Profitable Portfolio

In the words of Mr. C.S. Rao, Former Chairman, IRDA, “For the continued development of Health Insurance Market (in India) and also to protect the long-term insurance of the insured persons; there is a responsibility on all the stakeholders in the system for ensuring sustainability of health insurance.” Making the health insurance portfolio profitable would, therefore, require carrying out the different aspects of health portfolio which require remodeling and in suggesting corrective measures of different levels of implementation.

3.4.1 Use of Information Communication Technology (ICT) Tools in Medical Records

Paper based records are used in recording patient information by most doctors and at many hospitals. In the US, an adaptation of Electronic Medical Records (EMR) is incentivized and regulated under the Health Information and Accessibility Act. Insurance companies and other large medical institutions are heavily promoting the same. Within the constraints of privacy issues, increasing use of macro-data called from such electronically-stored data could greatly improve the way health insurance products are designed and priced. This could solve also difficulties faced by insurers in respect of obtaining the past medical history of individuals desiring insurance coverage were the rejection of claims has been disputed by the insured.

3.4.2 Utilizing New Underwriting Tools

Medical Underwriting is becoming more and more essential if insurance is to be done objectively and the health portfolio is to become viable. With regulatory norms ruling out rejection of renewal once the risk has been accepted, except on grounds of fraud or misrepresentation, it is vital that pre acceptance screening at the initial stage is intensive and reliable. An insurer would be required to utilize an analytical tool or underwriting guideline to develop the estimate of the impact of that medical condition will have future claim costs. The risk is scored assigned to the individual will be the deciding factor which will help the underwriter decide whether to accept or reject the coverage of the individual concerned.
3.4.3 Development of New Products with Viable Pricing

The employer based group health insurance market in the organized sector is fairly well penetrated and public policy initiatives now focus on the poor at the bottom of the economic pyramid. The expanding and viable market for insurers is thus from the emerging middle class buying privately-funded and individual health insurance products. Product and channel innovation and appropriate pricing must be the hallmark of these products. Network tiering for customers could be one option. Apart from the hospitalization benefits health policies could also cover a number of preventive care techniques to improve medical outcomes and provide cost-effective health insurance in India.

3.4.4 Modification of the Contribution Clause in Health Policies

The contribution clause is present in both individual and group health policies. Health insurance concepts are still undergoing a process of evolution, this is an area which needs a re-look by the regulator and insurers alike. It would be worthwhile to modify this clause and health policies and encourage individuals insuring themselves under more than one policy to declare the same and obtain an discount from insurer as the insurer would benefit from this disclosure of the insured. The insurer will be in a position to make recoveries from the insurer of the other policy. Incentivizing disclosure will facilitate the disclosure of facts as this information about other existing insurances of Health can best be obtained with the corporation of the insured and also utilized, with the knowledge of the insured.

3.4.5 Insurance and Loss Minimization of Corporate Groups

With fierce competition for securing the business of corporate accounts, rates are often reduced to unsustainable levels by insurers. It is therefore necessary for the regulator to also set some basic parameters until this aspect is rectified. Corporate groups are resisting cost cutting measures and curtailment of benefits and negotiate for customized policies with all possible add-on benefits and removal of the checks and balances, which are in built in standard covers, to restrict the loss ratio.
3.4.6 Regulation of Brokers and Agents Engaged in Health Business

The role of agents and brokers assumes significance in health insurance business. The quantum of agencies commission or brokerage is an attractive incentive for procurement of business and intermediaries are keen to procure such business since there is a growing market for the same. Insurance agents are usually the first point of contact for individuals deciding to insurance themselves and they play a pivotal role in conveying information and helps for the assessment of risk by insurers.

3.4.7 Third Party Administrator (TPA) Review

TPA plays an important role in the health sector. Though some private health insurers have dispensed with their services, their services are utilized by most insurers at present. They support the work of insurers by providing insured persons with identity cards and engage in empaneling hospitals for providing cashless facilities. They also process and settle claims on behalf of insurers. It would be realistic to acknowledge the fact that it is impossible to engage in loss minimization and make this portfolio viable without the active participation of TPAs who are utilized for servicing claims.

3.4.8 Restricting Leakages Through Frauds

As in all financial sectors, fraud is also prevalent in the area of health insurance. Health insurance fraud is described as an intentional act of deceiving, concealing, or misrepresentation information that results in healthcare benefits being paid illegitimately to an individual or group. Health insurance is a bleeding sector with a very high claims ratio. Hence, for health insurance to be viable the loopholes exploited by fraudsters must plugged and a system of checks and balances set in place to eliminate fraud claims.10

3.5 Factors Affecting Health Insurance Consumption

Health insurance is one of the fastest growing segments in India but the insurance amount is not sufficient as there is lack of awareness about the amount of

10 ibid 8
sum insured, over dependence on corporate health insurance coverage, willingness to pay a premium that is only up to the highest limit of rebate under Section 80D of the Income Tax Act etc.\textsuperscript{11} Price and innumerable economic, demographic, socio-cultural, political and other factors determine economy’s consumption of health insurance.

**Price**

It is a critically important determinant of insurance demand and supply. The price is that insurers charge is influenced by their cost structure, by the competitiveness of the particular line of insurance and by government tax and other policy.

**Economic Environment**

Many economic factors influence health insurance consumption. Among those found to be the most consistently important is a level of a country’s economic development. Level of country’s income has been found to be the most important factor in explaining the level of national life and health insurance consumption. The higher a country’s income, other things being equal, the more it’s spends on all type of insurance.

**Demographic Environment**

Aging populations, education level of the population, the structure of household, industrialization and urbanization, etc., are the demographic factors influence life and health insurance consumption.

**Social Environment**

Country’s political and economic stability influences the insurance demand. An unstable political environment depresses insurance demand because citizens cannot fully rely on insurance marketing their premium, as loss maybe unenforceable.\textsuperscript{12}

\textsuperscript{11} Jagendra Kumar, “Health Insurance is the Fastest Growing Segment in India”, Bimabazaar, June 27, 2017.

3.6 Issues and Challenges

The Indian insurance industry currently is in a state of instability. After a decade of strong growth, the Indian insurance industry is currently facing severe problems. For the non-life sector the problem areas include micro-insurance in non-life widening reach, improved fraud control mechanisms, standardization to reduce claims loss, reducing inefficiencies by revisiting Third Party Administrator (TPA) agreements. On another front, policyholders have very little knowledge about the empanelled hospitals for cashless hospitalization services. Hospital administrators perceive significant burden in terms of effort and expenditure after the introduction of TPA. Another challenge for the industry is a tendency of insurance companies to under price their products to gain an edge over the competition, which is also allowing the industry to bleed. Artificial pricing leads to artificially excessive competition. The inadequate development of health related infrastructure in the country is one of the major challenges today in the health insurance sector. The industry is also required to work on the education and awareness levels of the market to resolve the situation partly. Going forward, Indian health insurance sector may evolve into a scenario of an independent regulator for health insurance but that will be a function of the growth of the market and the dynamics it entails.13

3.6.1 Issues and Challenges in the Health Insurance Industry in India

The significant economic growth in India at the turn of the millennium has left its medical care and health insurance systems struggling to keep up with the growing healthcare demands of its people. India is characterized by a growing middle class and a large near subsistence population. Given the population, the geographical size of the country, different levels of evolution within the rural and urban strata of the society, it is not surprising that players are faced with various challenges in increasing health insurance coverage.

• Limited healthcare delivery network in top few cities still accounting for the majority of investment in secondary and tertiary health care, leading to limited penetration of health insurance.
• Lack of standardization and accreditation is in most healthcare facilities leading to complexity in judging the authenticity of procedures and costs.
• Low level of awareness among consumers about health insurance products and their benefits.
• Health insurance being governed by the regulations similar to non-life insurance business impacting the development of long term health insurance policies.
• Limited funding support from the insurance company impacting the claims disbursement time.
• Insufficient data on Indian consumers and disease patterns resulting in difficulty in product development and pricing.
• Lack of standardization and accreditation norms for healthcare providers resulting in unreasonable pricing demands by insurance companies.
• The limited incentive for selling health insurance compared to other financial services products like life insurance due to the comparatively lower commission structure.

Thus, there are significant challenges being faced by the existing participants of the health insurance industry in India. While these challenges need to be addressed to increase the health insurance coverage in India, there is also a need to understand the challenges faced by the Indian consumer in the existing market environment.

3.6.2 Issues and Challenges faced by the Indian Health Insurance Consumers

The endeavor of health insurance the consumers with the options or the products that can address issues of prevention and treatment of illness, lead to wellness and thereby help them to healthier life. Thus, there are significant challenges being faced by the health insurance policyholders.
Problems with Claims Processing

Problems with claims processing, experienced either firsthand or by peer groups, deters consumers across segments from buying health insurance.

i. Consumers believe that reimbursement of claims from insurance companies for cash paid in hospitals require numerous follow-ups.

ii. In case of cashless transactions, the perception is that there is a need to submit several documents.

iii. Another predominant perception is that insurance companies reject claims on dubious grounds, rendering the insurance policy futile.

Such instances discourage consumers from investing in health insurance policies. Negative experiences with claims processing could also lead to negative publicity, making insurance policies less popular.

Limited Product Coverage

Health insurance plans do not cover outpatient care and certain ailments such as diabetes, blood sugar, eye and dental surgeries. The view is that the policy covers health problems that have a low probability of occurring, rendering the premium paid futile if hospitalization does not occur in a particular year.

Less Importance is given to Health Insurance

For most consumers, the need to save and invest for a home, education, vehicle, children’s marriage and other lifecycle needs to take precedence over the need for a health insurance policy. A misconception prevalent among many consumers is that the return on investment in health insurance is low, with little reward if they make no claims. In addition, several consumers, particularly younger age group, tend to believe that people over 45 years of age who are more prone to ailments need a health insurance policy. There is therefore a tendency to invest in a health insurance policy only when extra funds are available, or if consumers have faced hardships in the past during a medical emergency. One of the reasons for this
could be the confusion created by multiple participants about insurance being an investment or risk transfer mechanism in the consumer’s mind.

**Limited Options of Doctors and Hospitals**

Insurance companies have their own network of hospitals and seldom reimburse procedures performed in hospitals outside of the network.

i. In the event that a consumer uses a non-network hospital during an emergency, the policy becomes ineffectual.

ii. Further, Indian consumers tend to establish a comfort level with doctors. They are reluctant to switch to other providers if their doctors are not part of the network.

**Agent and Payment Related Issues**

Insurance advisors do not suggest suitable options to consumers hide information, are unaware of the products they sell or coerce them into buying policies that are not suited to their needs. This has created discontent among consumers that agents do not act in their interest and instead of treating advisors as trusted partners, several consumers are wary of them. Another common grievance of consumers is that there are few outlets to deposit premiums. Moreover, while companies have been encouraging the use of the internet to pay insurance premiums, consumers in non-metros make limited use of the internet. There are other challenges which are cited below:

**Complicated policy document:** Consumers find it difficult to understand the various jargons and paperwork involved in the health insurance policy.

**Limited awareness:** Limited awareness about health insurance has led to non consideration this option to a significant number of people.

**Expensive:** Consumers perceive that health insurance policies are expensive and are meant for the rich and the educated only. It has been found that consumers with a health insurance cover share similar views as those without, in terms of their skepticism towards claims processing, limited coverage in terms of products, and
doctors and network hospitals. While this skepticism has been based on experience, many of the other negative perceptions stem from the fundamental lack of awareness about health insurance.\textsuperscript{14}

3.7 Coverage of Health Insurance

The insurance coverage depends on various factors like the type of the policy, the age of the insured, type of treatment availed, and the insurer. Generally, the below benefits are covered:

3.7.1 Cashless Treatment

All health insurance providers partner with a number of hospitals across the country to make the process of insurance settlements smoother. If a policyholder chooses to avail treatment at any of these hospitals that fall under the insurance company’s network, then they can avail cashless treatment. With this facility, the insurance company will pay for the expenses through a direct channel between the insurer and the hospital. The customer will not be required to pay for anything except for any expenses not covered by the insurance plan. If expenses exceed the limits mentioned in the policy, the insurer will pay up to the amount that is covered. The remainder will have to be borne by the policyholder. This facility lightens the out-of-pocket expenses that the life insured needs to bear.

3.7.2 Pre - Hospitalization and Post - Hospitalization

When a person first sees signs or symptoms of an illness, it is imperative to get tested and checked up. But undergoing these medical tests can cost quite a bit. If the tests reveal a diagnosis that requires hospitalisation, they can claim for a reimbursement for these expenses. After hospitalisation, there are further check-ups that might be required, along with medication and follow-up treatments. These expenses will also be taken care of by the health insurance policy. The period for this facility ranges between 30 days and 180 days before and after hospitalisation.

\textsuperscript{14} Health Insurance Summit 2008, Health Insurance Inc., The Road Ahead, December 2008, pp. 11-16.
3.7.3 Ambulance

When emergencies arise, an ambulance is usually the given method of transportation. In many cases, ambulances are have the equipment to keep the person stable. Ambulances are also needed while shifting the person from one hospital to another whenever necessary. The insurance plan will cover these costs in most cases.

3.7.4 No-claim Bonus

An attractive feature of health insurance policies is the no-claim bonus. If a policyholder does not make a claim for the entire year, then the insurance company rewards them with a no-claim bonus (NCB). The NCB is given in the form of a discount on the renewal premium. For every no-claim year, the NCB increases. NCB in the first year is usually 10 percent and goes up to a maximum of 50 percent over the years.

3.7.5 Preventive Check-ups

Many of us do not feel the need for health check-ups when do not show symptoms or have any pain. A visit to the doctor usually arises when there is a problem. But regular check-ups can help detect illnesses early on and this can help doctor’s nip it in the bud and prevent it from become worse. Preventive health check-ups help minimize costs associated with health issues and also reduce chances of diseases progressing to later stages. Insurance plans cover the cost of such check-ups because it contributes to minimizing larger claims.

3.7.6 Tax Benefits

Under the Income Tax Act, 1961, premiums paid towards health insurance are eligible for tax deductions under Section 80D. Therefore health insurance is a good investment to make for those who want to save tax as well.

3.7.7 Co-payment

Co-payment reduces the premium of the plan but will not affect the sum assured. The co-pay clause is applied in different ways by insurers. Some may apply it when a policyholder gets treatment in a Non-Preferred Provider Network (PPN)
hospital. In some cases, co-pay maybe applied only to certain ailments specified in the policy or medical expenses related to pre-existing conditions. Others may insist on co-pay if the policyholder undergoes treatment in certain metropolitan cities. The main advantage of co-pay to the policyholder is a low premium. Higher co-pay may lower the premium. Unfortunately, the co-pay clause is rife in senior citizens’ mediclaim where premiums are not low. It means that the age at which insured need medical facilities the most is when the insurer will also have to bear the burden of hospital bills partially.

3.7.8 Portability

The life insured is allowed to switch between health insurance providers without losing certain benefits such as the waiting period for pre-existing illnesses, no-claim bonuses and other advantages earned in the previous policy. If a policyholder is not satisfied with the current insurer or finds a more suitable plan, switching is an easy option available from almost all insurance companies.

3.7.9 Restoration Benefits

Many health insurance providers offer this benefit under which if the total sum assured amount is exhausted, it will be replenished. Usually, the restored amount can be used on a completely different ailment from the one that the insurance was used for before. Some companies offer restoration options of up to three times in one policy period. This means the life insured can claim the sum assured thrice for three different ailments without having to pay extra premiums.

3.7.10 Healthy Lifestyle Benefits

Insurance companies reward those who opt to live healthier lifestyles. For non-smokers and teetotalers, the insurance premium may be discounted. Furthermore, for those who quit smoking during the policy, there are rewards in the form of discounts on premiums awarded for making the healthier choice.
3.7.11 International Cover

Having global coverage in case of emergencies is a great benefit for those who travel out of the country. If anything were to happen while the insured are abroad, cost of medical expenses can be very high. An insurance plan that covers anywhere in the world can really be helpful financially in case anything untoward were to happen while the insured are abroad.\(^\text{15}\)

Exclusions

While coverage is at the discretion of individual insurers, there are certain exclusions or conditions that form an important part of the contract. The more common ones are elucidated below -

- The policy comes into effect after a waiting period, usually 30 days from inception.
- Pre-existing diseases and other specified ailments may be covered subject to a waiting period. This usually ranges between 2 to 4 years.
- Some policies specifically exclude maternity/new-born expenses.
- Injuries/ailments arising from:
  - War, civil unrest, terrorism and related acts.
  - Nuclear risks.
  - Suicide attempts, hazardous activities, acts of negligence.
- Ailments such as HIV, STDs and other related illnesses/illnesses of similar nature.
- Alternative/unrecognized treatments that are non-allopathic in nature (some policies cover ayurvedic, unani and similar treatments).
- Procedures like cosmetic/plastic/sex change surgeries, hormonal replacements etc.
- Dental, optical procedures etc.
- Genetic disorders and Psychiatric disorders.
- Expenses for rest and rehabilitation, common illnesses of mild severity.
- Unnecessary diagnostic tests, treatment, post-care procedures.
- Treatment/diagnosis undertaken outside India or by an unqualified medical professional.

\(^{15}\) http://www.Bankbazaar insurance.com/
3.8 Health Insurance Claim Process

Health insurance acts as a safety net for an individual’s finances in case he/she meets with an unforeseen accident. The insurance policy ensures that the insured gets the best treatment available without worrying about clearing the costs at the time of discharge. Knowing about the claim process is an important piece of information that the insured should be armed with at all times. There are certain procedures that the insured will have to follow at the time of making a claim.

There are two main types of claim process which an individual can choose when making a claim on their health insurance. These are:

- Cashless Claim Process
- Reimbursement Claim Process

3.8.1 Cashless Claim Process

When the insured provides their health insurance details along with their e-card or any other type of physical proof of the purchased health insurance policy, the insured can receive treatment at a hospital. This holds good if the injury or illness is covered under the health insurance policy. Once the insured is discharged from the hospital, the hospital will forward the medical bills to the health insurance company. The company will then analyze and evaluate the expenses and settle the payment. This process is known as cashless hospitalization. Over here, the hospital settles the bills with the insurance company. This provides a stress free recovery period for the insured.

The process of making a claim on a health insurance at a cashless hospital depends on the type of treatment that the insured has to undergo.

- **Claim Process for Planned Treatment**: To avail this plan, the insured will have to inform the health insurance company prior to being admitted into the hospital. The insurer should be informed at least 4 days before the policyholder is admitted or before the treatment date. This time frame varies with each insurance company. The insured should inform the insurance
company by submitting a cashless claim form to the insurer via email, post or fax. Once the insurance agency receives the form, they will contact the hospital as well as notify the insured regarding about the claim request. The policyholder will have to provide their health insurance card at the time of admission into the hospital. Any medical expenses incurred thereafter are paid for by the insurance company.

- **Claim Process for Emergency Treatment:** At the time of an unforeseen event that lands the insured in a hospital, either the insured or the next of kin should contact the customer care team of the health insurance company to locate the nearest cashless hospital. Once admitted, the hospital will have to duly fill up a cashless claim request form. Once done, they will have to submit the same to the health insurance company by either email, post or fax. The insurance company will then send an authorization letter to the hospital indicating the converge of the policy. The medical bills incurred by the policyholder will be covered by the health insurance company. If the claim gets rejected, the insurance company will notify the insured and the hospital stating their reasons for rejection.

3.8.2 **Reimbursement Claim Process**

In the event that the policyholder or insured has been admitted into a hospital or clinic and pays for their treatment, the policyholder will have to reclaim the money spent from the insurer. The hospital that the insured has been admitted into does not have to be empanelled with the insurance company. In such cases, the cashless claim facility thats provided by the insurance policy cannot be claimed. Once the insurer has paid for their treatment and hospitalization costs, they will have to make a reimbursement claim. The insurer will have to provide the original bills to the health insurance company to make a reimbursement claim. The insurance company will evaluate the claim that will then decide to either approve or reject it. Once the insurance company approves the claim, they will make the payment to the policyholder. The insurance company will notify the insured in case they reject the reimbursement claim.
3.9 Key Participants in the Health Insurance Industry

The health insurance industry comprises several key players across its value chain.

3.9.1 Insurance Companies

The robust growth of health insurance premium income in recent years has helped ensure that health insurance is considered a focus segment by most Insurance companies. Health insurance is currently being offered by non-life Insurance companies, specialized health insurance companies and life insurance companies in India. Star Health and Allied Insurance and Apollo DKV Insurance are the only two specialized health insurance companies in India. Bupa Group, A leading international health and care company and Max India Ltd formed a new Partnership to enter the health insurance market in India. Major health insurers from overseas, such as Aetna Insurance Company, CIGNA Insurance Company as well as other multi-national life and nonlife companies, have also evinced interest in entering the Indian health insurance Market.

3.9.2 Third Party Administrators (TPAs)

TPAs were established as a result of regulations introduced in the financial year 2001. Their key responsibilities include providing administrative support for insurers, such as admission and settlement of claims, and establishing provider networks of hospitals that policyholders can utilize. Many TPAs provide a wider variety of value added services such as ambulance service, medicines and supplies, information about health facilities, hospitals, bed availability, and have moved beyond the boundaries that they were originally intended to fulfill.

3.9.3 Reinsurers

Reinsurers play a critical role in the health insurance value chain. They take on part of the risk that insurers assume from their customers so that the insurer can assume greater individual risks. In the past, most of the top 50 global reinsurers operated indirectly from their overseas offices by sharing the reinsurance risks assumed by the General Insurance Corporation of India. One reason for this was that
global reinsurers felt that rates for reinsurance products were inadequate and not at all reflective of global market conditions. However, with the entry of large players into the Indian market, this seems to be changing. Apart from providing reinsurance support, reinsurers can also support insurance companies in defining their product and customer segments based on their global experience.

3.9.4 Healthcare Providers

Increased favorable regulatory drivers, changes in demographics and changes in disease profile have led to the rapid demand for quality healthcare provision. Private players have invested significantly in this market, leading to ‘corporatization’ or emergence of hospital chains. However, the focus of these players has been largely urban as this is where the infrastructure and the patient pool is available for these players. The selective concentration of health care providers is a major concern to be addressed, especially since studies have shown that those living in rural areas spend about as much on healthcare as those in towns. Currently healthcare providers are not being regulated in India with regard to standardization and accreditation norms. This has resulted in each healthcare provider being significantly different from the other in terms of the healthcare costs, processes and quality amongst others.

3.9.5 Distribution Channel Partners

Agents and brokers are the key distribution channels for selling retail and group health insurance respectively. Bank assurance is also evolving as an important distribution channel for retail health insurance. The usage of direct distribution channels like the internet, telemarketing etc is limited in India currently, but will gain importance as the industry matures. This form of distribution is popular in the developed countries and is catching on in India as well.

3.9.6 Regulators

The Insurance Regulatory and Development Authority (IRDA) regulates, promotes, ensures orderly growth of the insurance and the reinsurance business in India and protects the interests of the policyholders. Currently, health insurance forms a part of the non-life insurance business and is being governed by the non-life
insurance regulations in India. The IRDA is considering announcing separate guidelines for health insurance to promote sustainable growth of the health insurance in India. Despite a well established industry structure in the health insurance industry in India, the industry has not been able to achieve its true potential.\textsuperscript{16}

3.10 Emerging Trends

Technology can uncomplicated and enhance customers’ experience multifold. Health insurance is aiming to take customer experience to the next level by making it more interconnected and seamless at the same time. A smart app containing one’s medical history, treatments, as well as, medicines taken right from the day he/she bought health insurance, irrespective of the fact that a policyholder may have changed or continued with his/her initial insurer and can reveal the required information, with one touch could be the next in our mobile wallet. Such a smart app would also show policy benefits, exclusions, inclusions, sum insured and eligibility for related claims would then be instantaneous.\textsuperscript{17}

3.10.1 Multi-Distribution

To increase market penetration, insurance companies need to expand their distribution network. In the recent past, the industry has witnessed the emergence of alternate distribution channels. The typical distribution channels used by insurance companies now include bancassurance, direct selling agents, brokers, online distribution, corporate agents such as Non-Banking Financial Companies (NBFCs) and tie-ups of para-banking companies with local corporate agencies (for example NGOs) in remote areas. Agencies have been the most important and effective channel of distribution hitherto. According to the industry, the role of agents has started evolving from merely a prospecting and selling role to an advisory and service related one. Bancassurance in India has taken a different and perhaps an increased involvement in distributing insurance products with banks becoming joint venture partners of insurers. This makes them more committed to using their customer base.


\textsuperscript{17} Antony Jacob, “Technology to be a game changer in health insurance” IRDAI Journal Quarterly, January-March 2017, Volume 15, Number 1, p.31.
and infrastructure. A few alternative distribution channels have evolved in the recent years such as:

**Online/Internet**: The internet penetration in India has been on the rise, whereby an increased number of people have access to the internet both through computers as well as through mobile phones, including the population in tier-2 and tier-3 cities.

**Direct Marketing and Telemarketing**: With increasing telecom penetration in India, the use of direct marketing via database marketing is growing. Direct access to the customer and savings in intermediary cost make it an attractive option for the companies and is the key in the development of the channel.

**NGOs and Affinity Groups**: With IRDA allowing NGOs/SHGs to distribute micro insurance, insurers can access the “untapped” areas at relatively lower costs using the existing relationships of such entities.

Globally, various insurance markets are at different stages of development, which is also reflected in their insurance distribution networks. Where insurance penetration is low, face-to-face interaction in the form of agents is required to educate customers. As the insurance penetration develops, other distribution channels such as Independent Financial Advisors (IFAs), brokers, bancassurance and electronic channels come to the fore to supplement agency model.

### 3.10.2 Product Innovation

With customers asking for increased levels of customization, product innovation is one of the best strategies for companies to increase their market share. This also creates increased efficiency as companies can maintain reduced unit costs, offer improved services, can increase flexibility to pay increased commissions and generate higher sales. Regulatory changes, especially those with respect to health insurance portability and micro insurance, offer considerable potential for insurance companies to be more innovative, while others such as product design guidelines are likely to stifle innovation if not conceived and implemented in an appropriate manner. Micro insurance is important not only from the social and economic perspective
(prosperity and financial inclusion) but also from insurers’ perspective for new avenues of sustainable profitable growth in future.

### 3.10.3 Claims Management

Timely and efficient management of claims is crucial for performance in the industry. Delay in claim settlement generally results in higher claims cost. There can be a huge variation in costs among different hospitals for the same procedure. The insured may not worry, as making a claim is looked at as ‘payback time’ for getting the benefit of premium payment over a period of time. The insurer pays the claim but, ultimately, the insured pays with a possible increase in the premium.

### 3.10.4 Profitable Growth

In the period following the liberalization of the insurance sector, most insurers were heavily inclined to achieve growth at the cost of profitability. In the recent years, most players have shifted from the philosophy of “growth versus profitability to profitable growth by focusing on expanding product range, developing innovative products and building robust distribution channels. Profitability continues to be a big concern and insurers have now shifted their focus to their bottom line to avoid exerting pressure on solvency and share capital. In the last two years, most private insurers have been reducing their operating expenses in a move toward profitability.

### 3.10.5 Regulatory Trends

The IRDA has mandated regulatory changes in order to promote a competitive environment in both the life and non-life insurance sectors. With health insurance portability being introduced, insured persons are likely to get credits for the covered term across the industry and will be limited to a specific insurance company. The regulator envisaged that this initiative will compel the insurance industry to act toward standardization of costs incurred on treatments, fix accountability and transparency about costs and push insurers to think about product innovations to survive the competition.\(^\text{18}\)

\(^{18}\) *Insurance Industry Challenges, Reforms and Realignment, Confederation of Indian Industry, pp.4-36.*
3.11 Health Insurance Data Report

The Insurance Information Bureau has been collecting transaction level data on Health Insurance policies, members and claims from all non life insurance and standalone health insurance companies in India. The Health data is collected in three formats.

Members Data
Health Insurance Premium and
Claims Data

The data received from Insurers for the year 2012-2017 has been analyzed and the following analyses are generated for the information/use of all the stakeholders.

3.11.1 Number of Persons Covered under Health Insurance

Table: 3.1. Number of Persons Covered under Health Insurance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Government Sponsored Schemes</td>
<td>1494</td>
<td>72</td>
<td>1553</td>
<td>72</td>
<td>2143</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2733</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3350</td>
</tr>
<tr>
<td>Group Business (other than Government)</td>
<td>343</td>
<td>17</td>
<td>337</td>
<td>15</td>
<td>483</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>570</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>705</td>
</tr>
<tr>
<td>Individual Business</td>
<td>236</td>
<td>11</td>
<td>272</td>
<td>13</td>
<td>254</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>287</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>320</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2073</td>
<td>100</td>
<td>2162</td>
<td>100</td>
<td>2880</td>
</tr>
<tr>
<td></td>
<td>3590</td>
<td>100</td>
<td>4375</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: IRDA Annual report 2016-17

Health insurance business can be classified into Government Sponsored Health Insurance, Group Health Insurance (other than government sponsored) and Individual Health Insurance. In terms of a number of persons covered under health insurance, three fourth of the persons were covered under government sponsored health insurance schemes and the balance one fourth were covered by group and individual policies issued by general and health insurers.
### 3.11.2 Trends in Health Insurance Premium

#### Table: 3.2. Trends in Health Insurance Premium (Sectorwise) (in Crore)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Public Sector Insurers</td>
<td>9580</td>
<td>62</td>
<td>10841</td>
<td>62</td>
<td>12882</td>
<td>64</td>
<td>15591</td>
<td>64</td>
<td>19227</td>
<td>63</td>
</tr>
<tr>
<td>Private Sector Insurers</td>
<td>4205</td>
<td>27</td>
<td>4482</td>
<td>26</td>
<td>4386</td>
<td>22</td>
<td>4911</td>
<td>20</td>
<td>5632</td>
<td>19</td>
</tr>
<tr>
<td>Stand-alone Health Insurers</td>
<td>1668</td>
<td>11</td>
<td>2172</td>
<td>12</td>
<td>2828</td>
<td>14</td>
<td>3946</td>
<td>16</td>
<td>5532</td>
<td>18</td>
</tr>
<tr>
<td>Grand Total</td>
<td>15453</td>
<td>100</td>
<td>17495</td>
<td>100</td>
<td>20096</td>
<td>100</td>
<td>24448</td>
<td>100</td>
<td>30392</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: IRDA Annual report 2016-17

During 2016-17, general and health insurance companies collected Rs.30392 crores as health insurance premium, registering a growth of 24.3 percent over the previous year. In terms of market share of health insurance premium, the four public sector general insurers continue to hold larger market share at 63 percent during the financial year 2016-17. The market share of public sector insurers remained stagnant at this level over the past 5 years. On the other hand, the share of private sector general insurers in health insurance premium is deciding from 27 percent in the financial year 2012-13 to 19 percent during the financial year 2016-17. And the share of standalone health insurance in health insurance premium had grown up from 11 percent to 18 percent over the last 5 year period.
3.11.3 The Trend in Net Incurred Claims Ratio (NICR) under Health Insurance

Table: 3.3. Sector Wise Net Incurred Claim Ratio of Health Insurers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Sector General Insurers</td>
<td>103</td>
<td>106</td>
<td>112</td>
<td>117</td>
<td>122</td>
</tr>
<tr>
<td>Private Sector General Insurers</td>
<td>78</td>
<td>87</td>
<td>84</td>
<td>81</td>
<td>84</td>
</tr>
<tr>
<td>Stand-alone Health Insurers</td>
<td>61</td>
<td>67</td>
<td>63</td>
<td>58</td>
<td>58</td>
</tr>
<tr>
<td>Industry Average</td>
<td>94</td>
<td>97</td>
<td>101</td>
<td>102</td>
<td>106</td>
</tr>
</tbody>
</table>

Source: IRDA Annual report 2016-17

The trend of increase in net incurred claim ratio continued in 2016-17. The Net ICR has consistently grown up from 94 percent in 2012-13 to 106 percent in 2016-17. From the table 3.3, it may be observed that the Net ICR of public sector general insurers was more than 100 percentages for all the proceeding 5 years. On the other hand, during the same period the Net ICR of private sector general insurers and standalone health insurers was gradually improving.
### 3.11.4 The State Wise Distribution of Health Insurance Business

#### Table: 3.4. Share of Top 5 States in Health Insurance Premium 2016-17

<table>
<thead>
<tr>
<th>State/ UT</th>
<th>Group Business (other than government)</th>
<th>Government Business</th>
<th>Individual Business</th>
<th>Total Health Insurance Business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount (in lakhs)</td>
<td>%</td>
<td>Amount (in lakhs)</td>
<td>%</td>
</tr>
<tr>
<td>Maharasthra</td>
<td>559104</td>
<td>38</td>
<td>77311</td>
<td>25</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>221973</td>
<td>15</td>
<td>65273</td>
<td>21</td>
</tr>
<tr>
<td>Karnataka</td>
<td>249490</td>
<td>17</td>
<td>8091</td>
<td>3</td>
</tr>
<tr>
<td>Delhi</td>
<td>110356</td>
<td>7</td>
<td>-4</td>
<td>0</td>
</tr>
<tr>
<td>Gujarat</td>
<td>20524</td>
<td>1</td>
<td>5152</td>
<td>2</td>
</tr>
<tr>
<td>Rest of India</td>
<td>310319</td>
<td>21</td>
<td>152774</td>
<td>49</td>
</tr>
<tr>
<td>All India Total</td>
<td>1471766</td>
<td>100</td>
<td>309048</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: IRDA Annual Report 2016-17

Statewise distribution of the health insurance business has indicated a skewed distribution of health insurance business across various States and Union Territories of India. While five states namely, Maharasthra, Tamil Nadu, Karnataka, Delhi and Gujarat contributed 69 percent of total health insurance business, the rest of 31 States/Union Territories have contributed 30 percentage of total health insurance premium. The state of Tamil Nadu contributed Rs. 386165 lakhs (13 %) of the total health insurance premium.
3.11.5 Metro City-wise Number of Claims and Amount of Claims Paid

Table 3.5 Metro City-wise Number of Claims and Amount of Claims Paid - 2013-14

<table>
<thead>
<tr>
<th>Metro City</th>
<th>Number of Claims#</th>
<th>Total Claims Paid# (Rs in crs.)</th>
<th>Average Claim Paid# (in Rs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumbai</td>
<td>2,23,160</td>
<td>967</td>
<td>43,324</td>
</tr>
<tr>
<td>Delhi</td>
<td>1,60,400</td>
<td>677</td>
<td>42,225</td>
</tr>
<tr>
<td>Kolkata</td>
<td>1,16,253</td>
<td>419</td>
<td>36,034</td>
</tr>
<tr>
<td>Bangalore</td>
<td>1,00,374</td>
<td>428</td>
<td>42,598</td>
</tr>
<tr>
<td>Chennai</td>
<td>88,912</td>
<td>299</td>
<td>33,587</td>
</tr>
<tr>
<td>Hyderabad</td>
<td>82,934</td>
<td>288</td>
<td>34,684</td>
</tr>
<tr>
<td>Total</td>
<td>7,72,033</td>
<td>3,077</td>
<td>39,854</td>
</tr>
</tbody>
</table>

# Excluding Claim Records where Claim Paid Amount is less than `1,000 and greater than `20 lakh

Source: Health Insurance Data Report - Insurance Information Bureau

Among six metro cities Mumbai, Delhi, Kolkata, Bangalore, Chennai and Hyderabad, Mumbai leads them in a number of claims and amount of claims paid and also has the highest average claim paid amount. Hyderabad has least average claim paid amount, during the year 2013 – 14.

3.12 Summary

This chapter provides a brief outline of the role of health insurance market in India and its implications. It deals with forms of health insurance, health insurance market in India and profitable portfolio, key players of health insurance, issues and challenges, benefits of health insurance, emerging trends and macro indicators of health insurance.

The forthcoming chapter four is health insurance companies and its services for the promotion of health insurance awareness among the policyholders of various health insurance companies.

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