Chapter I

Introduction

“There are two times in a man’s life when he should not speculate. When he can afford it and when he cannot”

Mark Twain.

Human always sought security. This quest for security was an important motivating force in the earliest formations of families, clans, tribes and other groups. Indeed, groups have been the primary source of both emotional and physical security, since the beginning of human kind. They ensure a less volatile source of life’s necessities than that which isolated humans and families could provide and helped their less fortunate members in the time of crisis. Human today continue their quest to achieve security and reduce uncertainties and for this they rely on groups for financial stability. The group may be our employer, the government or an insurance company, but the concept is same. In some ways, however we today are more vulnerable than ancestors. The physical and economic security formerly provided by the tribes or extended family is diminishing with industrialization. Our income-dependent, wealth acquiring life style renders us and our family more vulnerable to environmental and societal changes over which we have no control. More formalized means are required for mitigating the adverse consequences of unemployment, loss of health, death, old age, lawsuits and destruction of our property. Although, individuals cannot predict or completely prevent such occurrences, yet they can provide for their financial effects. The function of insurance is to safeguard against such misfortune by having contribution of many pay for the losses of the unfortunate few. This is the essence of insurance - the sharing of losses and, in the process, the substitution of certain, small “loss” called the premium for an uncertain, large loss (Black and Skipper, 2003, pp. 1-2).

In other words, insurance is a method which provides security and protection against financial loss upto some limit. It is a mean of shifting risks to insurer in consideration of a nominal cost called premium. Risks may be transferred in two ways: firstly, a person may seek to transfer the activity or avoid such event which creates the risk; for example, a civil engineering contractor may give sub-contract to another person.
Alternatively, contractual agreement may be made to shift responsibility for any losses attributable to the occurrence of specified uncertain event to the other person who is party to the contract. Exclusion and indemnity clause in a contract of sale, building, transport means and similar other contracts are a few examples. In fact, the most important form of risk transfer is insurance

*According to Chief Justice Tindal* “Insurance is a contract in which sum of money paid by the assured in consideration of the insurer’s incurring the risk of paying a large sum upon a given contingency.”

*According to Britannica Encyclopedia* “Insurance may be described as a social device whereby a large group of individuals through a system of equitable contribution may reduce or eliminate certain measurable risks of economic loss common to all member of group.”

*According to Prof. R.S Sharma* “Insurance is a co-operative device to spread loss caused by a particular risk over a number of persons who are exposed to it, who agree to insure themselves against the risk.”

*According to Thomson* “Insurance is a provision which a prudent man makes against fortuitous or inevitable contingencies, loss or misfortunes. It is form of spreading risks.”

*Ghosh and Aggarwal* “Insurance is a co-operative form of distributing a certain risk over a group of person who exposed to it.” *(Singh, Katyal and Arora, 2002, pp.1-4).*

From the above definitions, it is clear that insurance is form of contract or agreement in which one party agrees in return of a consideration called premium to pay an agreed sum of money to another party to make good for a loss, damage, death, injury to something of value in which the insured has insurable interest, as a results of some uncertain event. It is also evident from above that the basic aim of the insurance is to transfer loss of one policyholder to large number of policyholders of same insurance company. So insurance is a contract in which a person whose loss/risk is shifted called “Insured” and the party to whom the loss/risk is shifted called “Insurer” and the consideration paid by the insured to insurer is called “Premium and the contract in which terms and conditions of insurance are mentioned is called “Insurance Policy”.*
1.1 History of Insurance

The roots of insurance might be traced to Babylonia, where traders were encouraged to assume the risks of the caravan trade through loans that were repaid (with interest) only after the goods had arrived safely—a practice resembling bottomry and given legal force in the Code of Hammurabi (c.2100 B.C.). The Phoenicians and the Greeks applied a similar system to their seaborne commerce. The Romans used burial clubs as a form of life insurance, providing funeral expenses for members and later payments to the survivors. Thereafter with the growth of towns and trade in Europe, the medieval guilds undertook to protect their members from loss by fire and shipwreck, to ransom them from captivity by pirates, and to provide decent burial and support in sickness and poverty. By the middle of 14th century, as evidenced by the earliest known insurance contract (Genoa, 1347), marine insurance was practically universal among the maritime nations of Europe. In London, Lloyd's Coffee House (1688) was a place where merchants, ship-owners, and underwriters met to transact business. (Source: http://www.infoplease.com/ce6/bus/A0858849.html assessed on 2nd June 2011).

Alternatively, insurance has a deep-rooted history in India. It finds mention in the writings of Manu (Manusmrithi), Yagnavalkya (Dharmasastra) and Kautilya (Arthasastra). The writings talk in terms of pooling of resources that could be re-distributed in times of calamities such as fire, floods, epidemics and famine. This was probably a pre-cursor to modern day insurance. Ancient Indian history has preserved the earliest traces of insurance in the form of marine trade loans and carriers’ contracts. Insurance in India has evolved over time heavily drawing from other countries, England in particular. 1818 saw the advent of life insurance business in India with the establishment of the Oriental Life Insurance Company in Calcutta. This Company however failed in 1834. Thereafter, in 1829, the Madras Equitable had begun transacting life insurance business in the Madras Presidency. 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency. This era, however, was dominated by foreign insurance offices which did good business in India, namely Albert Life Assurance, Royal Insurance, Liverpool and
London Globe Insurance and the Indian offices were up for hard competition from the foreign companies.

The process of opening up of the insurance sector began in the early 1990s and in the last decade it has been opened up substantially. In 1993, the Government of India set up a committee under the chairmanship of R N Malhotra, former Governor of Reserve Bank of India (RBI), to propose recommendations for reforms in the insurance sector. The objective was to complement with the reforms initiated in the overall financial sector. The committee submitted its report in 1994 wherein, among other things, it was recommended that the private sector be permitted to enter the insurance industry. Beside this, it was stated that foreign companies were allowed to enter by floating Indian companies, preferably a joint venture with Indian partners.

On the line of recommendations of the Malhotra Committee, the Insurance Regulatory and Development Authority (IRDA) was constituted in 1999 as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000 and since then it fastidiously stuck to its schedule of framing regulations and opening up the insurance sector to private players as well as permitting Foreign Direct Investments (FDIs) in insurance sector. Accordingly, foreign companies were allowed ownership upto 26% in insurance market. The FDI was allowed on the same line of as other countries are considering that privatization and liberalization will ensure the efficient and effective services to the insured ones. To what extent Indian liberalized and privatized market has achieved its objectives of increasing and enhancing efficiency of insurers as well as enhancement of consumers’ choice and welfare is a matter of great controversy and discussion.

The IRDA has also power to frame regulations under Section 114A of the Insurance Act, 1938. Accordingly, various regulations ranging from registration of companies for carrying on insurance business to protection of policyholders’ interests were made by IRDA. In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the same time GIC was converted into a national re-insurer. Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002.
Currently in India, 24 general insurance companies including the Export Credit Guarantee (ECGC) Corporation of India and Agriculture Insurance Corporation of India and 23 life insurance companies are operating.  

From the long back history of insurance, it is classified into two fields:

(a) Life insurance.

(b) Non life insurance/property insurance/casualty insurance/general insurance, depending upon the country concerned. For example, Europe classifies the health insurance as non life insurance whereas in India health insurance is covered under the general insurance.

1.2 Concept of Health Insurance

It is generally said that healthy mind resides in a healthy body. Hence, it is very important to stay healthy to get healthy mind. These days life is becoming very fast and stressful. No matter how much we care, but still can fall ill. Alternatively, health treatment is also becoming very costly, as more than a disease, it is the cost of treatment that takes its toll. If we look at the another side then found that a human being can manage to live without good education…without splendid car…without opulent house…But no one can manage to live without good and excellent health that too when he/she is living below the poverty line. The reason behind this is “how the same can approach the good hospitals like Fortis and other to get good quality treatment and how the same can contribute toward the development of a nation”? Moreover, all this lead to a never ending vicious circle of poverty, because an individual without good health could not be able to work, no work means no earnings and the same could not be able to get good quality treatment as well as could not be able to contribute toward the development of the nation. So the question arises, what is the need of hours? Should the person have first access to good education; splendid car; opulent house? Certainly the answer would be “No”. The person should have first access to good health care services and that too at low cost. One of the solutions to this is to take health insurance scheme, which is widely recognized mechanism to finance health care needs of an individual because he/she has to just make gradual contribution as premium and can get rid of all health worries.
Health insurance is a type of insurance that pays for all or part of person’s health care bills. It can be defined as “any form of insurance whose payment is contingent on insured incurring additional expenses or loosing income because of incapacity or loss of good health” (Phillip 2007). In the narrow sense, health insurance can be defined as an individual or group purchasing health care coverage in advance by paying a fee called premium. While in the broader sense, it can be defined as any arrangement that help to defer, delay, reduce or altogether avoid payment of health care incurred by individuals. It is also called disability insurance or medical expense insurance or health care insurance or sickness insurance.

“Health insurance is an insurance against loss by illness or bodily injury. It provides coverage for medicine, visit to doctor or emergency room, hospital stays and other medical expenses. Policies differ in respect what they cover, the size of deductible and/or co-payments, limit of coverage and the option for treatment available to policyholders” (Source: http://www.investorwords.com./2289/health_insurance.html assessed on 2nd January, 2009).

One of the broad and comprehensive definition is given by Insurance Regulatory and Development Authority (IRDA) “health insurance business or health cover means the effecting of contracts which provides sickness benefits or medical, surgical or hospital expense benefits whether in-patient or out-patient, on an indemnity, reimbursement, service, prepaid, hospital or other plans basis, including assured benefits and long term care”.

From the above, it is certain that health insurance contact is a highly broad, comprehensive and flexible contract, as the objective is to serve the needs of insured public. Moreover, it is a financial mechanism that provides protection to individuals and households against the cost of health care incurred as a result of unexpected illness or injury. Under this mechanism, the insurer provides financial coverage and agrees to compensate or agrees to make loss good to the insured person, which was incurred as a result of specified contingent event. In consideration of the same, the insured party pays premium and the insurer provide required services as per the terms and condition agreed at the time of formation of health insurance contract. Beside this, health insurance contracts can be short term or long term; reimbursement type or the fixed benefit type; or both. Some of the basic key terms associated with health insurance contract with their description are given table 1.1.
### Table 1.1
Key Terms Associated with Health Insurance and Their Description

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Key Terms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claim</td>
<td>The process of applying to the insurer for reimbursement of expenses incurred for treatment is called “filing a claim”.</td>
</tr>
<tr>
<td>2</td>
<td>Cashless Services</td>
<td>The insurer or its TPAs have tie-ups with network of hospitals. The insured can get treatment for the disease contracted without any cash payment from this network of hospitals called cashless services.</td>
</tr>
<tr>
<td>3</td>
<td>Coverage Amount</td>
<td>It is the maximum amount payable in the event of a claim. It is also known as “sum insured” and “sum assured”.</td>
</tr>
<tr>
<td>4</td>
<td>Cumulative Bonus</td>
<td>Each claim free year ensures that you get a benefit known as “cumulative” bonus and it is similar to “no claim discount” concept.</td>
</tr>
<tr>
<td>5</td>
<td>Domiciliary Hospitalization</td>
<td>When treatment of a patient is carried out at home, as per the doctor's recommendation called domiciliary hospitalization.</td>
</tr>
<tr>
<td>6</td>
<td>Exclusions</td>
<td>These are conditions for which medical expenses are not covered. It can be of two types – Permanent exclusion or First year exclusion.</td>
</tr>
<tr>
<td>7</td>
<td>Moral Hazard</td>
<td>It is a term used to describe the phenomena where the customer seek an undue advantage, as a result of buying insurance or where customer has not acted in good faith and has provided misleading information.</td>
</tr>
<tr>
<td>8</td>
<td>Network Hospital</td>
<td>These are hospitals and nursing homes which are associated with the TPAs to provide cashless mediclaim facilities to insured.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>S. No.</th>
<th>Key Terms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>No Claim Discount</td>
<td>It is a discount on the basic premium, if there is a claim free year of the policy. In other words, if the insured does not make any claim on his/her policy, then he/she gets a discount (from 5% to 25%) on basic Premium for every claim free year.</td>
</tr>
<tr>
<td>10</td>
<td>Pre-existing Disease</td>
<td>A pre-existing disease is any ailment or disease with which a person is already suffering at the time of purchasing health insurance.</td>
</tr>
<tr>
<td>11</td>
<td>Renewal</td>
<td>Health insurance policies are usually annual contracts. At the end of the policy period, the policy has to be renewed by the insurers.</td>
</tr>
<tr>
<td>12</td>
<td>Reimbursement</td>
<td>Under Health Insurance policy, the cost of various hospital charges (such as bed charges, medicines, lab tests, surgeon's fees etc) are paid back to the insured who logged/makes the claim.</td>
</tr>
<tr>
<td>13</td>
<td>Third Party Administrator (TPA)</td>
<td>TPAs are authorized claim settling agents of the Insurer. They scrutinize the expenses incurred vis-a-vis coverage under the policy and also ensure compliance of the policy terms, conditions and warranties.</td>
</tr>
<tr>
<td>14</td>
<td>Co-payment or Co-pay</td>
<td>It is a payment defined in the health insurance contract and paid by the insured person each time when medical services are availed.</td>
</tr>
<tr>
<td>15</td>
<td>Deductible</td>
<td>It can be defined as the amount of expenses that must be paid out of pocket before an insurer will cover any medical expenses.</td>
</tr>
</tbody>
</table>

(Source:http://www.medindia.net/patients/insurance/healthcare-insurance-terms-and definitions.htm assessed on 13th march 2011).
1.3 Health Insurance - International and National Perspective

The credit for the origination of concept of health insurance goes to Hugh the Elder Chamberlen from the Peter Chamberlen Family, who proposed it for the first time in the year 1694. In the late 19th century, “Accidental Insurance” began which operated much like modern “Disability Insurance”. It was firstly offered by Franklin Health Assurance Company of United State (US), which was founded in 1850. It provides coverage for the accident arising from rail, road and steamboat accident. This payment model continued until the start of 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance. During the middle to late 20th century, traditional health insurance evolved into modern health insurance. Hospital and Medical expenses policies were introduced during the first half of 20th century. During 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of blue cross organizations. The predecessor of today’s Health Maintenance Organization (HMOs) were originated beginning in 1929, through the 1930s and on during World War II.

1.3.1 As far as health insurance in India is concerned, it is stated both with reference to before privatization and after privatization

Phase I- Before Privatization: The enactment of Employee State Insurance (ESI) Act, in 1948 ushered health insurance in India. In 1952, the legislation has introduced a mandatory social insurance scheme for employees in the formal sector known as Employee State Insurance Scheme (ESIS). Since its introduction, it is exclusively managed by Employee State Insurance Corporation (ESIC) of India, a wholly owned enterprise which provides for cash benefits, medical benefits, preventive as well as promotive care, and health education too. It is mainly financed with the contribution of employers, employees and government and is a sort of compulsory social security benefit for workers (including their dependents) having an income less than Rs. 6500 per/month in the formal sector.

In 1954, Central Government Health Scheme (CGHS) was introduced. It is basically a contributory health schemes, which provide for comprehensive medical
care to the central government’s employees (whether serving or retired) including their families; members of parliaments; judges of Supreme Court (SC) and High Court (HC); and certain other categories of beneficiaries (Nagpal, Devadasan and Jain 2008).

Thereafter, government took over the business of all operating companies through General Insurance (Emergency Provision) Act, 1971. This act provided for the appointment of custodians, who were empowered to exercise control over the companies subject to the directions of central government, at the time of nationalization of companies. Accordingly, the General Insurance Business (Nationalization) Act 1972, nationalized the general insurance business in India and with effect from 1 Jan, 1973, 107 general insurance companies were grouped in to 4 public sector companies namely, National Insurance Company Limited, New India Assurance Company Limited, Oriental Insurance Company Limited and United India Insurance Company Limited.

The government company started its first health insurance policy in the year 1986, which is known as Mediclaim. It has been revised from time to time, in order to make it an attractive product. When it was introduced the minimum and maximum age limits were 5 month and 70 years respectively. However this has been changed over a period of time and at present, a person between 3 months to 80 years of age can be granted mediclaim policy up to maximum coverage of Rs. 5 Lac against accidental and sickness hospitalization, during the policy period. The first significant revision in this was made in April 1996, when the Government of India allowed tax benefit upto Rs 10,000 of premium paid as tax deductible expenses. Second significant revision in the policy was made, when all categories of policies was removed and individuals were allowed to get insurance for any sum insured. Now, the premium is calculated on the basis of sum insured as well on the basis of age of person intended to get himself insured.

In 1996, public non life insurance company has started a health insurance policy, called ‘Jan Arogya’ for catering the need of low income people of India. It is a sort reimbursement policy, available to anybody in the age group of 5year to 80years and provides coverage to the family of four members (including husband, wife and two
dependent children). Basically, it provides an assured sum of Rs 5000 per person per annum; the premium varies from Rs 70 to Rs 140 per person depending on the age.

**Phase II- After Privatization:** In India, health insurance found the new track of success and growth in the year 1999, when reforms in the insurance sector was initiated with passage of IRDA Bill in Parliament in Dec 1999. The Insurance Regulatory and Development Authority (IRDA), since its incorporation in April, 2000 has fastidiously stuck to its schedule of framing regulations and opening up the insurance sector to private players as well as permitting Foreign Direct Investments (FDIs) in insurance sector. Accordingly, foreign companies were allowed ownership upto 26% in insurance market.

In the year 2001, IRDA introduced several insurance regulations including provisions for Third Party Administrators (TPAs) system, in order to support the administration and management of health insurance product offered by insurance companies. So, during this period first private health insurance product integrated with TPAs service was introduced.

In the year 2003, one new health insurance scheme was introduced called, Universal Health Insurance Scheme (UHIS), on the line of existing ‘mediclaim’ to carter the need of all section of the society and started by four public sector general insurance companies. The scheme remained far from universal, however played significant role because of the availability of subsidies from the union government, in order to make it an affordable health insurance product.

Thereafter, IRDA moved a step ahead with the formation of a national health insurance working group in 2003, which provided a framework for various stakeholders of health insurance industry to work together and suggest solution to the relevant issues in this sector. One more scheme began in 2003-04 namely, Pandit Deendayal Upadhyaya Senior Citizen Health Insurance Scheme of Indore Municipal Corporation (IMC), which is a group health insurance scheme and is fully funded by the corporation and is made available at free of cost to the senior citizens.

In 2006, the Ministry of Health and Family Welfare (MHFW) published a framework for development of health insurance programs under the umbrella of
National Rural Health Mission (NRHM), which provided that in addition to strengthening public health facilities, health insurance would also be used to remove financing barriers in health care and also to improve access to these, so as to achieve the ultimate objective of financial protection and to improve quality of health care services to the community.

Rajasthan Swasthya Bima Yojana has recently introduced by the government of Rajasthan in the year 2007, which cover all Below Poverty Line (BPL) families in the five pilot district of Rajasthan. The premium amount is Rs 480, out of which (Rs 300) is paid by the government of India and rest by the government of Rajasthan. The insured person can go to either private or public providers to access hospital care. On the basis of implementation experience, the remaining districts were planned to be covered in a phased manner.

One of the recent health insurance schemes which were introduced by the government of India is Rashtriya Swasthya Bima Yojana (RSBY) in the year 2008-09, which cover all the Below Poverty Line (BPL) families in the country. In the beginning, it was just extended to 120 districts in 28 states and later on extended its coverage. The BPL families can enroll under this just with the payment of Rs 30 as registration fee and can get smart card with their photograph, family detail and thumb impression. The patients can avail facility after validating his identification through smart card. No doubt, the owner of scheme is the state government, but it is also financed by the central government because it shares the premium subsidy upto 75%.

From the above it is clear that although, health insurance is of recent origin in India, yet its rapid growth talks about its importance in the country. It is one of the emerging segment for both life and general insurance company as Insurance Act, 1938 has allowed both life and general insurance company to sell health insurance contracts to individuals as well as to groups, and further stated that authority should give preference to those insurer, who plan to focus mainly on health insurance at the time of granting certificate of registration.
Table 1.2
Phases of Development of Health Insurance in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone in Development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Privatization</strong></td>
<td></td>
</tr>
<tr>
<td>1948</td>
<td>Enactment of Employee State Insurance (ESI) Act, ushered health insurance in India</td>
</tr>
<tr>
<td>1952</td>
<td>Introduction of Employee State Insurance Scheme (ESIS), which provide cash and medical benefits; preventive and promotive care to the employees and their families.</td>
</tr>
<tr>
<td>1954</td>
<td>Central Government Health Scheme (CGHS) was introduced, which provide comprehensive medical care to the central government’s employees including their families (whether serving or retired); members of parliaments; judges of Supreme Court and High Court; and certain other categories of beneficiaries.</td>
</tr>
<tr>
<td>1971</td>
<td>Government took over the business of all operating companies through General Insurance (Emergency Provision) Act, 1971. This act provided for the appointment of custodians, who were empowered to exercise control over the companies subject to the directions of central government, at the time of nationalization of insurance companies.</td>
</tr>
<tr>
<td>1972</td>
<td>The General Insurance Business (Nationalization) Act 1972 provided for the nationalization of general insurance business in India.</td>
</tr>
<tr>
<td>1973</td>
<td>Accordingly, with effect from 1 Jan, 1973, 107 general insurance companies were grouped in to 4 public sector companies namely, National Insurance Company Limited, New India Assurance Company Limited, Oriental Insurance Company Limited and United India Insurance Company Limited.</td>
</tr>
<tr>
<td>1986</td>
<td>Introduction of first health insurance policy, which is known as Mediclaim was made.</td>
</tr>
<tr>
<td>1996</td>
<td>Public non-life insurance company has launched a health insurance policy, called ‘Jan Arogya’ for catering the need of low income people of India.</td>
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<tbody>
<tr>
<td><strong>After Privatization</strong></td>
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<tr>
<td>2000</td>
<td>IRDA since its incorporation in April, 2000 has fastidiously stuck to its schedule of framing regulations and opening up the insurance sector to private players as well as permitted 26% Foreign Direct Investments (FDIs) in insurance sector.</td>
</tr>
<tr>
<td>2001</td>
<td>IRDA had introduced several insurance regulations including provisions for TPAs system, in order to support the administration and management. So, during this period first private health insurance product integrated with TPAs service was introduced.</td>
</tr>
<tr>
<td>2003</td>
<td>Universal Health Insurance Scheme (UHIS) was introduced on the line of existing ‘Mediclaim’ to address the need of all section of society and started by four public sector general insurance companies.</td>
</tr>
<tr>
<td>2003-04</td>
<td>Introduction of Pandit Deendayal Upadhyaya Senior Citizen Health Insurance Scheme of Indore Municipal Corporaion (IMC), which is a group health insurance scheme and is fully funded by the corporation and is made available at free of cost.</td>
</tr>
<tr>
<td>2006</td>
<td>The Ministry of Health and Family Welfare (MHWF) has provided for National Rural Health Mission (NRHM), which account for strengthening public health facilities.</td>
</tr>
<tr>
<td>2007</td>
<td>Rajasthan Swasthya Bima Yojana introduced, which cover all Below Poverty Line (BPL) families in the five pilot district of Rajasthan.</td>
</tr>
<tr>
<td>2008-09</td>
<td>Rashtriya Swasthya Bima Yojana (RSBY) was introduced by the government of India, which cover all the Below Poverty Line (BPL) families in the country.</td>
</tr>
</tbody>
</table>
1.4 Need for Health Insurance in India

Health insurance means risk coverage to provide financial shelter in the event of medical treatment incurred due to sickness or injury. There is dire need of health insurance in India, as according to World Bank Report (WBR) some relevant studies reveal that:

- 85% of the working populations in India DO NOT have Rs. 5,00,000 as instant cash.
- 14% have Rs. 5,00,000 instantly BUT will subsequently face a financial crunch.
- Only 1% can afford to spend Rs. 5,00,000 instantly and easily.
- 99% of Indians will face financial crunch in case of any critical illness. Hence the need for health insurance in India cannot be overlooked.


Moreover, if we look at the cost of treatment in a good/reputed hospital, then certainly the earth will skip out; as generally more than a disease, it is the cost of treatment that takes its toll and a common man would not be able to afford the good quality treatment.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Cost of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angioplasty</td>
<td>Rs. 2,00,000 to Rs. 3,00,000</td>
</tr>
<tr>
<td>Open Heart Surgery</td>
<td>Rs. 2,50,000 to Rs. 4,50,000</td>
</tr>
<tr>
<td>Liver Transplant</td>
<td>Rs. 30,00,000</td>
</tr>
<tr>
<td>Kidney Transplant</td>
<td>Rs. 18,00,000 to Rs. 30,00,000</td>
</tr>
<tr>
<td>Hernia Surgery</td>
<td>Rs. 30000 to Rs. 60000</td>
</tr>
<tr>
<td>Cancer-Chemotherapy</td>
<td>Rs. 1,40,000 to Rs. 2,40,000</td>
</tr>
</tbody>
</table>

The table 1.3 depicts the cost of treatment of various diseases in good hospitals. As a common man cannot approach good hospitals to get good quality treatment, then how the same can contribute toward the development of a nation”? Moreover all this lead to a never ending vicious circle of poverty, because an individual without good health could not be able to do work, no work means no earnings and the same could not be able to get good quality treatment as well as could not be able to contribute toward the development of the nation. So the question arises, what is the need of hours? The answer to this is, the person should have first access to good health care services and that too at low cost. One of the solutions to this is to take health insurance scheme, which is widely recognized mechanism to finance health care needs of an individual, because he/she has to just make gradual contribution as premium and can get rid of all health worries. As it is only the health insurance that take care of hospitalization costs of this magnitude. Hence, the need of health insurance cannot be overlooked in a country like India.

1.5 How Health Insurance Work…?

The fundamental concept of working of health insurance is same as that of any other insurance, as the insurance companies balance the health care cost across a large random sample of individuals. The working of health insurance can be explained with the help of following example: an insurance company has a pool of 2000 selected subscribers, each paying monthly contribution towards the premium. One person become ill while other stay healthy, allowing insurance company to use the money paid by healthy people to pay for the treatment cost of sick person. Moreover, a step-by-step procedure is followed in working of health insurance. All these steps are given table 1.4.
Table 1.4

Working of Health Insurance

<table>
<thead>
<tr>
<th>Before health care service</th>
<th>A person will take health insurance policy and will make gradual contribution as <em>premium payment</em>. If a policyholder falls ill, he will select the <em>provider of services i.e. service provider</em> from the list of empanelled hospitals of insurance company. The policyholder will make payment as <em>deductible</em> before companies’ started making payment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the time of health care service</td>
<td>Further, the policyholder requires payment every time for particular visit or service known as <em>co-payment</em>. Policyholder will <em>pay fixed percentage</em> of total cost. For example 20:80, 30:70 etc. as specified in the health insurance contract.</td>
</tr>
<tr>
<td>After health care services</td>
<td>The policyholder will also have to pay any charge in excess of the coverage limit as <em>above coverage limit expenditure</em>. Within coverage all the expenditure will be reimburse by the insurance company i.e. all out-of-pocket maximum will be paid by insurance company. Thereafter, the company will make payment to the networked hospital through TPAs, if services are taken from empanelled hospital or in other case will reimburse to policyholder on the receipt of documents pertaining to treatment in some other hospitals.</td>
</tr>
</tbody>
</table>

1.6 Various Schemes of Health Insurance in India

The health insurance schemes available in India are as under:

1) *Voluntary health insurance schemes or private-for-profit schemes:* In private insurance, premium is set at level, which is based on risk statement of individual or group of persons and the level of benefits provided, rather than as a proportion of consumer’s income. The private insurance companies pools similar risks and insure them for health related expenses and buyers are willing to pay premium to an insurance company. In the public sector, the General Insurance Corporation (GIC) and four subsidiary companies
provide voluntary health insurance scheme. One of the popular health insurance cover offered by public sector company is Mediclaim, which was introduced in the year 1986. Other voluntary health insurance schemes available in the market are: - Asha deep plan II, Jeevan Asha plan II, Jan Arogya policy, Raja Rajeshwari policy, Critical illness policy, Group health insurance policy etc.

2. Mandatory health insurance schemes or government run schemes

(a) Employee State Insurance Scheme (ESIS):- Employee State Insurance Act 1948, ushered the health insurance in India. Accordingly, Employee State Insurance Scheme was introduced in India in the year 1952. The scheme applies to power using factories employing 10 or more persons and in case of non-power using factories employing 20 or more person. The scheme is provided through a network of ESIS facilities, NGOs, public care centre, private care center etc. in order to meet the needs of employees and their dependents against loss of wages due to sickness, disability and death due to employment injury. Funeral expenses and rehabilitation allowance are also cover under this. No doubt, the scheme is formulated and implemented well, but there are certain problem areas in managing these schemes, which are as: high turnover of medical staff, management information is not satisfactory, utilization of hospitals are low, patients are not satisfied with the services and access to services in low especially in rural areas.

(b) Central Government Health Insurance Scheme (CGHS):- Central Government Health Scheme (CGHS) was introduced in 1954. It is basically a contributory health insurance scheme, which provides for comprehensive medical care to the central government’s employees including their families (whether serving or retired); members of parliaments; judges of Supreme Court (SC) and High Court (HC); and certain other categories of beneficiaries (Nagpal, Devadasan and Jain 2008). However, this scheme has been criticized from the point of view of quality, accessibility and slow reimbursement leads to high out-of-pocket expenses by the patients.

(c) Universal Health Insurance Scheme (UHIS):- In the year 2003, one new health insurance scheme was introduced namely, Universal Health Insurance Scheme (UHIS), in order to address the need of all section of the society and implemented by four public sector general insurance companies. The scheme remained far from universal, however
played significant role because of the availability of subsidies from the union government, in order to make it an affordable health insurance product. Beside this, in order to make scheme more successful, many efforts were undertaken, but inspite of those the scheme was not much successful due to following reasons: the public sector companies find it potential loss making and do not invest much in it, recognition and identification of eligible families is a difficult task, difficulty in settlement of claims due to more paper work, difficulty in payment of entire premium at one time by the poor people and moreover, the health insurance companies refusing to renew the previous year’s policies.

3.) **Insurance offered by NGOs/Community based health insurance:** - These schemes are basically targeted at poor population and generally run by the Non Government Organizations (NGOs) or charitable trusts etc. These schemes are mainly financed by collection from patients, grants and donations from state and central government; and provide for preventive, ambulatory and inpatient care to the person covered under this. Now days in India, providers of CBHI schemes are negotiating with profit insurers i.e. insurance companies for the purchase of custom designed group health insurance policy. CBHI also suffer from some of the basic problems as: poor design and management; adverse selection as premium is not based on assessment of risk status of individual; and fails to include poorest of the poor.

4.) **Employer based schemes:** - These schemes are offered by both the public sector and private sector employers. The benefits are provided by way of lump-sum-payments, reimbursement of health care expenditure to the employees, which are incurred for outpatient care, hospitalization. These also provide for fixed medical allowance on monthly or annual basis, irrespective of actual expenses or coverage under group health insurance policies.

In nutshell, we can say that in India, wide variety of health insurance schemes are provided by: private and public sector insurance companies; central and state government as well as provided by employers. The details of such sources of health insurance with respective coverage of lives are given in the table 1.5.
Table 1.5  
Selected Health Insurance Coverage in India

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>Covered Lives (Thousand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Government Health Schemes</td>
<td>4276</td>
</tr>
<tr>
<td>Mediclaim</td>
<td>10000</td>
</tr>
<tr>
<td>Employees States Insurance Schemes</td>
<td>31050</td>
</tr>
<tr>
<td>Government Non-Life Insurance Companies</td>
<td>56</td>
</tr>
<tr>
<td>Non-Government Non-Life Insurance Companies</td>
<td>13</td>
</tr>
<tr>
<td>Employers’ Sponsored Schemes</td>
<td>30000</td>
</tr>
</tbody>
</table>


Table 1.5 depict that maximum numbers of lives (in thousands) are covered under Employee State Insurance Schemes (ESI) i.e. 31050, followed by employers’ sponsored schemes (30000), central government health insurance schemes (4276), and mediclaim (10000), Whereas least followed in case of both government and non-government non-life insurance companies, in which the number of lives covered is only 56 and 13.

1.7  Market Scenario of Health Insurance in India

As far as the market scenario health insurance in India is concerned, this is still at embryonic stage. As the people of India are not much aware about it and very few part of the population is taking advantages of it. Moreover, those who are aware about it, do not actively participating for one reason or another and thereby making it difficult to bring it to the stage of expansion. Beside this, very few insurers are actively venturing in it and thereby making it difficult to construct inroads for health insurance in India. But there is terrible need of health insurance in India as according to World Bank Report (WBR), various studies reveals that 85% of the working populations in India do not have Rs. 5,00,000 as instant cash; 14% have Rs. 5,00,000 instantly but will subsequently will face a financial crunch; Only 1% can afford to spend Rs. 5,00,000 instantly and easily; and 99% of Indians will face financial crunch in case of any critical illness. Hence the need for health insurance in India cannot be overlooked.

Beside above, the following will represent the more transparent picture of market share/status of health insurance in India:

- Number of stand-alone health insurance companies is increasing at a low pace. Star health insurance was the first stand-alone health insurance company, followed by Apollo Munich, which stared operation in August 2007. Thereafter, Max Bupa in April, 2010 started health insurance business as stand-alone company. Religare is planning to start operation in near future.

- In a view of increase in meditation as well as health care costs, the sum assured limit of Rs. 5,00,000 has been steadily increasing and now many companies are issuing policy of Rs. 10,00,000. Max Bupa has introduced a product where even a policy of Rs. 50,00,000 can be issued and that too to a person of 80 years.

- More and more life insurance companies are now selling health plans, which involve the judicial mix of health insurance and mutual fund. It is foreseen that Security Exchange Board of India (SEBI), view on mutual fund will have an impact on health insurance product too.

- Hospital/Pharma Co’s may become promoters/Investors in health insurance companies. It may result in better health care management as resources can be effectively utilized for welfare of the society. But reach can be limited as India is a very large country.

- Projection made by newspaper reports that by 2015, health insurance premium will touch Rs 35000 crores and by 2025, it will be Rs. 4,00,000 crores.

- Concept of Co-pay or Co-payment will get strengthen year by year and we foresee that it will be introduced for all health insurance policies by 2013.

- In between 8 to 10 years most of the general insurance companies in India will withdraw from health insurance as they will not be able to cope up with losses and we will see more and more stand-alone health insurance company entering in insurance market and they will become stronger year by year.

- General insurance companies will consider setting up of 100% owned health insurance companies. Reliance general may make the beginning by setting up Reliance Health Insurance.
Some of the small TPAs may exit the scene as they will find business to be unviable as more and more insurance companies will go in for in-house processing of claim.

During the year 2009-10, private health player are having market share of 40% in health insurance and this market share has increased from 12% in 2003-04 to 40% in 2009-10. Alternatively, the market share of public player has come down to 60%, which was expected by various earlier reports.


1.8 IRDA’s Focus on Health Insurance

Health insurance is a prominent part of the development agenda of IRDA and accordingly, many pro-active steps has been taken in this direction. IRDA had set up a National Health Insurance Working Group in 2003, which provided a platform for various stakeholders of the health insurance industry to work together and suggest solutions for improving the sector. This working group constituted a sub-group to look into the requirements for uniform data on Health Insurance, which led to the introduction of standard data submission formats for collecting data electronically. The data formats were further updated and IRDA has directed all the insurers to implement the same with effect from 2008-09. In 2004, IRDA had also appointed sub-committees to specifically look into the areas of registration of standalone health insurance companies and to suggest innovations in health insurance products. The recommendations of these sub-committees have triggered progress in both these areas. The industry has already seen the entry of two stand-alone health insurance companies, M/s Star Health and Allied Insurance Co Ltd and M/s Apollo DKV Insurance Co Ltd, and the application of a third company, M/s Max Bupa Health Insurance Company Ltd, is under process with IRDA. Newer and innovative health insurance products are being designed and made available to consumers. In addition to hospital daily cash benefit and hospitalization, critical illness benefit products, earmarked products for Senior Citizens, for specific diseases like diabetes, HIV and cancer, for lower socio-economic groups, products providing outpatient coverage, and those covering pre-existing diseases are also available. This
pace of innovations is steadily increasing. During the period under review, products with new features like high deductible hospital indemnity and products offering cover for maternity, dental, outpatient expenses, etc. were also introduced in the market. **New Instructions and Circulars during the period (2008-09):** As a follow up to the recommendations of the Committee on Health Insurance for Senior Citizens in April 2007 IRDA issued circulars on Renewability of Health Insurance (dated 31st March 2009) and on Health Insurance for Senior Citizens (dated 25th May 2009). In May 2008, four working groups on health insurance were constituted by the Confederation of Indian Industry (CII) with a support from IRDA. The recommendations of the groups were disseminated at the CII Health Insurance Summit held in August 2009 and also are hosted on the website of CII. IRDA also supported three working groups set up by the Federation of Indian Chambers of Commerce and Industry (FICCI) and the final reports of these working groups have been disseminated in FICCI Health Insurance Conference in July 2009 and reports are available on the website of FICCI. Between April 2008 and August 2009, both these industry chambers have organized National level workshops exclusively for Health Insurance. The 2\(^{nd}\) CII Health Insurance Summit was held at Mumbai on 9th December 2008, and the third at New Delhi on 31\(^{st}\) August 2009. The FICCI workshop on Health Insurance was held in New Delhi on 10th July 2009. IRDA has also participated in the Health Insurance conference organized by ASSOCHAM in January 2009. IRDA was closely associated with important activities of all these multi stakeholder working groups, especially standardization initiatives undertaken by these groups to enhance awareness of health insurance, thereby increasing penetration. The definition of ‘Pre-Existing Diseases’ was finalized with the help of the General Insurance Council and is effective from 1st June 2008 (Source: IRDA annual report 2008-09, pp. 33-34). http://www.irdaindia.org/annualreport09/annual_rep_eng_09.pdf

### 1.9 Need of the Study

In India, there is dire need to study the state of health insurance both in term of its performance as well as its prospects. The reason is attributable to the facts that firstly; this is one of the recent origins in India and still it is at an embryonic stage, as the people of India are not much aware about it and very few part of the population is taking the
advantages of it. Moreover, very few insurers are actively venturing in it and thereby making it difficult to construct inroads for health insurance. Secondly; this is one of the growing businesses now days as it is expected that by 2015, health insurance premium will touch Rs 35000 crores and by 2025, it will be Rs. 4,00,000 crores. Thirdly; it is the need of hour, as according to world bank report, various studies reveals that 85% of the working populations in India do not have Rs. 5,00,000 as instant cash; 14% have Rs. 5,00,000 instantly but will subsequently face a financial crunch; Only 1% can afford to spend Rs. 5,00,000 instantly and easily; and 99% of Indians will face financial crunch in case of any critical illness. Hence, the need for health insurance in India cannot be overlooked. Moreover, various studies provided that around 94 percent of the total work force is in unorganized sector and one of the major problems among them is the frequent incidence of illness and need for medical care and hospitalization. One of the solutions to this is to take health insurance, which is widely recognized mechanism to finance health care needs of an individual because he/she has to just make gradual contribution as premium and can get rid of all health worries. Keeping into mind such an important role being played by it, the present study is an effort in area of health insurance to evaluate its state in India, both in term of its performance as well as its prospects. For this purpose, on one side selection of general insurance companies providing health insurance was made, so as to come out with conclusive evidence with regard to performance of health insurance business. While on the other hand, customers were also included in the present study, because the real worth of the performance of the company can be evaluated only with the word-of-mouth of ultimate consumer. Thereby, customers’ perception with respect to health insurance was also studied, so as to get insight into their awareness, satisfaction and willingness to join and pay for it. Overall, we would be able to get conclusive evidence with regard to past and current status of public and private sector general insurance companies in relation to health insurance, as well as future of health insurance in India, both in terms of acceptance on the part of community and coverage on the part of providers.

One of the active forces, which are dominating the performance of health insurance business, is Third Party Administrators (TPAs). Basically, a TPA plays a triangular role as assigned by IRDA, of service integrator between the insurers, insured and health service provider. Keeping into mind such an important role being assigned by
the IRDA, there is dire need to study the role actually played by them. Accordingly, one of the components of present study deal with TPAs, which will provide the parameters of parity and deviation between role defined by IRDA and role in practice played by TPAs.

Out of various schemes of health insurance, Community Health Insurance (CHI) is a best serve for the society, as various studies reveals that in India more than 80 percent of health care’s expenditure is borne by individuals themselves and thereby pushing them in to a vicious circle of poverty. In such a situation, Community Health Insurance (CHI) acts as ray in dark clouds to bring them out of the vicious circle of poverty. So there is also dire need to study, how they actually work and perform? Hence in the present study an effort was also made to examine the working and performance of Community Health Insurance (CHI) in India.

1.10 Objectives of the Study

The primary objective of the study is to analyze the performance and prospect of health insurance in India. To fulfill this following are the secondary and sub objectives of the study:

1. **To evaluate the performance of health insurance business of general insurance companies in India.**

   The specific focus to evaluate the performance would be on following issues:

   ✓ To evaluate the efficiencies of health insurance business of general insurance companies.
   
   ✓ To determine the improvement space and improvement direction in order to render an inefficient company to be an efficient.
   
   ✓ To examine the productivity as well as change in productivity of health insurance business of general insurance companies.
   
   ✓ To identify and explore the various derives behind such productivity change.

2. **To make a comparative study of health insurance plans offered by general insurance companies in India.**

   A comparative study of health insurance plans was exclusively made with reference to inclusion/coverage and exclusion/non coverage under these.
Beside this, the following hypothesis were formulated and tested under this:

\( H_0 : \) There is no significant difference in the inclusions/benefits/coverage scores of health insurance plans.

\( H_{01} : \) There is no significant difference in the exclusions/non coverage scores of health insurance plans.

\( H_{02} : \) There is no significant difference in the number of health insurance plans offered as far as the public and private sector general insurance companies are concerned.

\( H_{03} : \) There is no significant difference in the inclusion/coverage scores of public and private insurance companies.

\( H_{04} : \) There is no significant difference in the exclusion/non coverage scores of public and private insurance companies.

3. To examine the working and performance of Community Health Insurance (CHI).

In order to have insight into the working and performance of community health insurance, the following hypothesis were formulated and tested:

\( H_0 : \) There is no significant association between the age of CHI providers and scope/number of services provided by them.

\( H_{01} : \) There is no significant association between the type of CHI providers and scope/number of services provided by them.

\( H_{02} : \) There is no significant association between the linkage of CHI providers with insurance companies and scope/number of service provided by them.

\( H_{03} : \) There is no significant association between the assistance/subsidies received by CHI providers and scope/number of services provided by them.

\( H_{04} : \) There is no significant difference in the scope/number of services provided by the CHI providers with respect to their association/linkage with insurance companies.

\( H_{05} : \) There is no significant difference in the scope/number of services provided by the CHI providers with respect to assistance/subsidies received by them.
4. **To examine the role played by Third Party Administrators (TPAs) with reference to role defined by IRDA.**

The specific focus to examine the role played by TPAs would be on following issues:

- IRDA defined role for TPAs
- Role played by TPAs
- Parity between role defined and role played.
- Deviation between role defined and role played.

5. **To analyze the perception of the customers regarding health insurance.**

While analyzing the perception followings were examined:

- Firstly, it examines the respondents who are aware or not aware about health insurance as well as various sources of awareness;
- Secondly, those who are aware have subscribed it or not;
- Thirdly, those who have subscribed what are the various factors governing and contributing towards the selection of health insurance by them;
- Fourthly, those who have not subscribed what are the reasons behind the same i.e. to examine and explore the various factors which act as barriers and ultimately obstruct the subscription of health insurance;
- Fifthly, to determine are the non health insurance policyholders willing to join and pay for it and also to explore and examine various factors having impact upon their willingness to pay for health insurance. Beside this, following hypothesis were formulated and tested:

\[ H_0: \] There is no significant association between the gender of respondents and their willingness to pay for health insurance.

\[ H_{01}: \] There is no significant association between the age of respondents and their willingness to pay for health insurance.

\[ H_{02}: \] There is no significant association between the marital status of respondents and their willingness to pay for health insurance.

\[ H_{03}: \] There is no significant association between the education level of respondents and their willingness to pay for health insurance.
There is no significant association between the occupation of respondents and their willingness to pay for health insurance.

There is no significant association between the income of respondents and their willingness to pay for health insurance.

1.11 Organization of the Study

The present study consists of IX chapters. The introduction to the concept forms Chapter I.

In Chapter II, the relevant literature (both empirical and conceptual studies) has been reviewed.

Chapter III deals with the detailed discussion on data base and research methodology for the achievement of objectives of the study.

Chapter IV deals with the performance evaluation of health insurance business of general insurance companies. Performance has been evaluated in terms of both efficiency and productivity of general insurance company in relation to health insurance business. Beside this, an attempt was made to determine the improvement space and improvement direction in order to render an inefficient company to be an efficient as well as to identify and explore the various derives behind such productivity change.

Chapter V deals with the comparative study of health insurance plans of general insurance companies in India. While making a comparative study of health insurance plans, it was exclusively done with reference to inclusion/coverage i.e. benefits provided and exclusion/non coverage i.e. benefits excluded under these.

Chapter VI devoted to get insight into working and performance of Community Health Insurance in India (CHI). While examining the working and performance of CHI, an attempt was made to examine the association between the types; age; linkage; and assistance/subsidies with the scope/number of services provided by them. Beside this, an effort was made to determine is significant difference exist in the scope/number of services provided by the CHI with respect to their association/linkage with insurance companies as well as with respect to assistance/subsidies received by them.

Chapter VII deals with the examination of role played by Third Party Administrators (TPAs) with reference to role defined by IRDA. While examining it, the
followings aspects were taken into consideration: IRDA defined role for TPAs; Role played by TPAs; Parity between role defined and role played; Deviation between role defined and role played.

Chapter VIII devoted to the analysis of perception of respondents toward health insurance. This analysis is multidimensional in nature as firstly, it examines the respondents who are aware or not aware about health insurance as well as various sources of awareness; Secondly, those who are aware have subscribed it or not; Thirdly, those who have subscribed what are the various factors governing and contributing towards the selection of health insurance by them; Fourthly, those who have not subscribed what are the reasons behind the same i.e. to examine and explore the various factors which act as barriers and ultimately obstruct the subscription of health insurance; Fifthly to determine are the non health insurance policyholders willing to join and pay for it and also to explore and examine various factors having impact upon their willingness to pay for health insurance.

Chapter IX presents the summary of findings and conclusion of the study.