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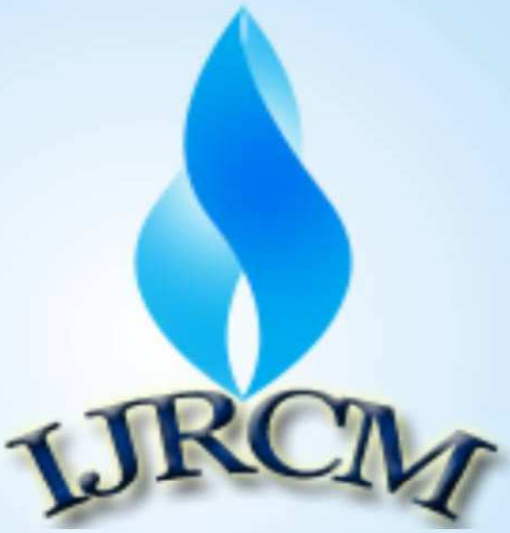


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STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

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# HEALTH INSURANCE STRUCTURE IN INDIA – CURRENT PRACTICES AND CHALLENGES

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**ABSTRACT**

*The paper examines the issues and challenges faced by the health insurance sector in India. One of the critical issues in front of policy makers today is to provide basic health care to the 1.3 billion poor population that lives in low and middle income countries across the world. The burden of a disease is far more critical for these people. They live from hand-to-mouth and their health expenditure relies on out-of-pocket payments. One of the answers to this problem is Health Insurance. Health Insurance, as we know, permits people to prefer the convenience of making small payments for medical care periodically, rather than large contributions at one time during a medical emergency. It is one of the mechanisms to protect against catastrophic healthcare spending. In India the health insurance coverage has been significantly low due to the inability of the poor to pay the premium, cumbersome and time-consuming paperwork required for enrolment and claims. The health insurance can be only successful if issues like adverse selection, renewal rate, administrative cost ratio, exclusion of poor people and equity issues were taken into consideration*

**KEYWORDS**

Health financing, Health insurance, Moral hazard, Third party administrator (TPA), Insurance premium.

## INTRODUCTION

The probable distribution of future state of health is based on its present and past states (Hopkins and Kidd, 1996). The most important and critical issue which we face today is financing and providing health care for the 1.3 billion strong poor population that lives in low and middle income countries across the world (Dreschler & Jutting, 2005). These poor people live from hand-to-mouth and their health financing relies on out-of-pocket payments, which are insufficient. On the poor, the burden of a disease is far more critical (Ahuja, 2004). One of the difficult processes in providing the basic medical care is identifying the groups that need subsidized care. In this context, the Planning Commission (PC) has recently told the Supreme Court that poverty line for urban and rural areas in India could be provisionally placed at Rs.965 per capita per month and Rs.781 per capita per month respectively. This means that those earning over Rs.32 a day in urban areas and over Rs.26 a day in rural areas will no longer be getting Below Poverty Line (BPL) benefits. There was an outrage over this suggestion put forward by Planning Commission on how many people should be included in Below Poverty Line (BPL) and thereby covered under various welfare schemes like the Public Distribution System (PDS). Such a demarcation does not give us a clear picture of the number of people to be covered under various welfare programs (Looking for the poor, EPW, 5 November 2011).

## REVIEW OF LITERATURE

Globally, the financing of health research remains a big concern due to a remarkable difference in buying capacity of healthcare services. According to the estimates of Global Forum for Health Research, only 10% of the world's resources allocated for health research and development are spent on studying 90% of the world's health issues. The Commission on Health Research for Development had recommended in as early as 1990 that the developing countries should spend at least 2% of their national health expenditure in research and research-capacity strengthening and stressed that such investments are one of the most important, cost-effective and sustainable means of advancing health and development. Although information on funding for health-related research and development is available to some extent for high-income countries, there is very little or fragmented information from low- and middle-income countries like India.

While social security for medical emergencies is not a new concept for India, health insurance, as we know it today, was introduced in 1912 when the first Insurance Act was passed (Devadasan et all, 2004). While the current version of the Insurance Act was introduced in 1938, there was no change till 1972, when the insurance industry was nationalized and 107 private insurance companies were brought under the umbrella of the General Insurance Corporation (GIC). In 1999, private and foreign insurance companies were allowed to enter the market with the enactment of the Insurance Regulatory and Development Act (IRDA). The Act allowed the entry of private sector entities in the Indian insurance sector, including health insurance, and created a regulatory authority. The IRDA is supposed to protect the interests of the policyholders, promote efficiency in the conduct of insurance, regulate the rates and terms and conditions of the policies offered by insurers and direct the maintenance of solvency margins. It is also required to provide sufficient protection for capital and solvency margins and has wide powers for accounting and auditing insurers. The IRDA lays down a code of conduct for insurance agents and also allows for a Tariff Advisory Committee to oversee premium rates and insurance plans and to prevent discrimination.

Keeping in mind the country's inequity, inequality and budget deficits, the government has initiated a mix of mandatory social health insurance, voluntary private health insurance, and community-based health insurance. While social security for medical emergencies is not new to India, with villagers taking a *piruvu* (collection) to support a household with a sick patient, the penetration of health insurance in India has been low. It is estimated that only about 12 to 14 percent of all Indian citizens are covered under any form of health financing. The health insurance coverage in India has been significantly low and several reasons for this low health insurance coverage. Chief among them are: the inability of the poor to pay the entire premium at one time for a future benefit; the excessive, cumbersome and time-consuming paperwork required for enrolment and claims; the limited supply of service providers, particularly because government hospitals are not permitted to treat patients insured under these schemes; and lastly, setbacks due to health insurance companies refusing to renew previous year's policies. For the majority of Indian citizens, the public health system is out of reach due to distance, lack of money, or lack of confidence in the system (Ravichandran 2009). Given the poor road connectivity in rural India, the uncertainty of finding the provider at the health centre, and the indirect costs for transport and wages foregone, many of the poor opt for the local quack. Furthermore, even when initial care is accessed, no continuity of care is guaranteed. This has resulted in the dilution of the concept of the integral nature of health, where curative services are a continuum of preventive and promotional health care. Shortage of funds has been primarily responsible for the lack of availability of facilities in accordance with the norms set by the government. Likewise, there is inadequate provision of critical inputs such as drugs, equipment, and facilities like operation rooms. Due to the lack of budgets and the pressure to achieve targets, several states have upgraded the two-room sub-centres to primary health centres with no space for a laboratory, examination room, or pharmacy. One of the most vital components of health care is pharmaceutical drugs, as they account for a substantial part of household health expenditure. The market for drugs, particularly in the allopathic category, has been growing rapidly in India in terms of production, cost, trade, investment and employment (Financing and Delivery of Health Care Services in India, NCMH, 2005). However, the industry is characterized by supplier-induced demand, uncertain demand from patients, oligopoly elements, monopoly profits and other factors. These have far reaching implications for the health care of the masses, whose essential problem lies in low purchasing power, lack of access and lack of sufficient knowledge of health financing mechanism. On the whole, roughly ten percent of the national health budget goes into procuring drugs at the same time three fourths of the total out-of-pocket health expenditure is spent on drugs alone (Sakthivel, 2005). However, the component of drugs and medicines in the overall budget of both the central and state governments is only a minor share.

## CURRENT STATUS OF PRIVATE HEALTH INSURANCE IN INDIA

Currently India has a dual system of health care—a private fee-for-service based sector, where the fee is borne by individual households, and a tax-based public sector. Utilization of insurance under these systems is restricted by the spending capacity of the individual households in the former and the budget availability in the latter. On the other hand, insurance as a means of financing is a far more sophisticated mechanism, requiring a comprehensive understanding of the failures that characterize health insurance markets. For example, a problem such as asymmetry in information puts the patient and the insurer at a disadvantage due to their inability to resist or challenge medical opinion regarding an existing condition or future treatment. Besides, in the absence of knowledge of prices, the provider can shortchange the two by overcharging. Second, cashless insurance creates disincentives to control costs as it appears to be a 'free' good for the patient and the provider, often resulting in excessive treatment by the provider (induced demand) and frivolous use by the patient taking treatment even for a condition which he would normally have ignored or cured with a home remedy (moral hazard). Third, since health insurance is sought after by those in need of health care, this puts the onus on insurance agencies to conduct an extensive selection process, such as medical examination, before enrolling customers, thus increasing the loading fee and consequently the cost of premium. For these reasons, private commercial health insurance is known to select as its customers young, healthy, rich males, leaving the riskier population to the government.

Health insurance in India is usually associated with the 'Mediclaim' policy of the GIC, which was introduced in 1986 as a voluntary health insurance scheme offered by the public sector. The premium is based on the age, risk and the benefit package opted for, ranging from a minimum premium of Rs 201 for those less than 25 years of age, to a maximum benefit of Rs 15,000 with discounts for group memberships. In 2001, there were 7.8 million persons covered under Mediclaim (Gupta & Dasgupta, 2002). The subscribers were usually from the middle and upper class, especially since there was a tax benefit in subscribing to Mediclaim. The standard Mediclaim policy covers only hospital care and domiciliary hospitalization benefits. Most medical conditions are reimbursed; however there are important exclusions, such as pre-existing diseases, pregnancy and child birth and HIV/AIDS. Hospitals with more than 15 beds and registered with a local authority can be identified as providers.

Enacted in 1948, the Employees' State Insurance (ESI) Act was the first major legislation on social security in India. The scheme applies to power-using factories employing ten persons or more, and non-power and other specified establishments employing 20 persons or more, with employees earning up to US$ 150 per month being covered, along with their dependents. The benefit package goes beyond the cost of medical care to include cash benefits (sickness, maternity, permanent disablement of self and dependent) as well as other benefits such as funeral expenses and rehabilitation allowance. The Central Government Health Scheme (CGHS), established in 1954, covers employees and retirees of the central government and of certain autonomous, semi-autonomous and semi-government organizations. It also covers Members of Parliament, Governors, accredited journalists and members of the general public in specified areas.

One of the problems plaguing the industry is the long delays in settling of claims by insurance companies. Being an indemnity scheme, the patient pays the hospital bills and submits the necessary documents to the insurance company or the Third Party Administrators (TPAs) where applicable. The company in turn reimburses the patient; however there is a significant delay between submission of documents and reimbursements. A study of 621 GIC claims for the year 1998–99. Bhat and Reuben (2001) showed that the average time between submission of documents and reimbursement is 121 days! This study also showed that while 33 percent of the claims were due to adverse selection, 38 percent of the claims were also due to doctor's fees and 25 percent charges for diagnostic services. The provider-induced claims thus accounted for 63 percent. Yet another interesting insight was that 22 percent of the total claims were for the treatment of communicable diseases, while 64 percent were for non-communicable diseases.

In addition to the above, there is also uncertainty about the amount that will be reimbursed by insurance companies. There are times when the patient is reimbursed only partially, the usual reason being insufficiency of documentation. The policy is not renewed automatically and is dependent on the timely payment of premium. Ellis Randall et al, (2000) observed that the GIC spent a great deal of time investigating whether the claim pertained to an existing disease or whether the facility was qualified or not, but spent little time on detecting fraud. With claims exceeding 30 percent a year, the problem of moral hazard would clearly need close monitoring more than household spending.

Second, it was observed that the GIC sets a premium on the filing of claims and not on the actual amounts settled, giving it a cushion year on year as settled claim amounts are always lower than those filed, and remain unadjusted. During 1994, 4.4 percent of the insured persons made a claim, of which only 75 percent of claims were settled. The claims ratio was 45 percent. However, of late, the claims ratio is growing at a fast rate, allegedly because of collusion between the patients, insurance agents and hospitals.

## ROLE OF THIRD PARTY ADMINISTRATORS (TPAS)

With the entry of TPAs under the IRDA Regulations Act, 2001, the insurance industry is slowly graduating to the concept of 'Managed Care'. TPAs are registered under the Companies Act, 1956 and licensed by the IRDA, and must be contracted by one or several insurance companies 'for the provision of health services'. The original role of a TPA is to provide the back-office administrative set-up to insurance companies— issuing ID cards to subscribers, processing claims, making payments, etc. Taking advantage of the lack of clarity on the specific role and responsibilities of TPAs, some among them are rapidly developing the capacity to establish provider networks to service the needs of the insured, collecting and analyzing data, fixing and negotiating rates for procedures with providers, contracting providers, processing claims and making direct payment to them and arbitrating any dispute between the subscriber and the provider. This system, often referred to as 'cashless payment', has resulted in relieving the patients of the psychological stress of having to mobilize resources at short notice. By scrutinizing provider claims, TPAs also help in safeguarding the interests of the insuring company against any fraudulent claims by the providers. For all these services, the insurance companies pay 5.5 percent of the total amount of premium collected under the policy to the TPA. In addition, TPAs were also to be given a bonus from insurance companies for reduced claim ratios or for promoting the companies with the insurers. This then would have given them the financial incentives to develop systems for provider control (contracting through predetermined rates for procedures and treatment, undertaking utilization reviews, pre-authorizing expensive surgeries, etc.) and also to ensure that patients do not resort to frivolous use of services. However, with the administrative fee being low and the idea of bonus not operationalized yet, there is really no incentive for the TPAs to reduce the claim ratios.

While the system of TPAs has facilitated cashless payments and expanded access to providers, it is yet to show evidence of having been able to control cost or provide appropriate care. As the system of TPAs expands, there are apprehensions about the success of the TPA: (i) whether patients will get adequate treatment and appropriate care; (ii) whether quality of medical care will be compromised with the gradual loss of control and autonomy of the physician on the kind of treatment to be given to his/her patient; (iii) whether costs will go up due to the substantial administrative cost placed on the providers for record maintenance, filling claim and infrastructure; (iv) whether there are possibilities of collusion between the TPA and some providers in the network, resulting in processing higher claims even if not justified and thus adversely affecting the interests of the insurance agency; (v) whether TPAs, as they get organized over time may acquire monopoly control over the processes and dictate higher administrative fees (in the current system the TPA bears no risk); and finally (vi) whether the ambiguous and unclear framework of the functioning of TPAs will give rise to legal uncertainty in the future.

## UNIVERSAL HEALTH INSURANCE SCHEME (UHIS)

In 2003 the Government of India announced the UHIS for providing financial risk protection to the poor. Under this scheme, health care for an assured sum of Rs. 30,000 was provided for a premium of Rs 365 per year per person, Rs 548 for a family of five and Rs 730 for a family of seven. Families "below the poverty line" (BPL) were given a premium subsidy of Rs 200 per annum. The scheme was redesigned in May 2004 with higher subsidies and restricting eligibility to BPL families only. The subsidy was increased to Rs 200, Rs 300 and Rs 400 to individuals, and families of five and seven, respectively. To make the scheme more saleable, the insurance companies provided for a floater clause that made any member of the family eligible as against the Mediclaim Policy which is for an individual member.

Yet in the last two years of its implementation, the coverage has only been around 10,000 BPL families in the first year and 34,000 in the second year (as of 31 January 2005). The reasons for failing to attract the rural poor are many. First, the public sector companies who were required to implement this scheme find it to be a potentially loss-making exercise and do not invest in promoting it, resulting in very low levels of awareness, which is reflected in the low enrolment and

very poor claim ratios. In fact, it is learnt that several field officers pay up the premium under fictitious names in order to meet their targets. Secondly, a major problem has been the identification of eligible families. Identification becomes cumbersome as the family needs to have some form of certification, which is difficult to obtain from revenue authorities. Second, the really poor also find it difficult to pay the entire premium money at one time for a future benefit, foregoing current consumption needs. Third, the procedures are cumbersome and difficult for the poor - the paperwork required for enrolment as well as for getting claim amounts is very time consuming. Fourth, in most places there is a deficit in the supply or availability of service providers, particularly because government hospitals are not eligible. For example, in Uttaranchal, only 17 hospitals could be accredited under this scheme, which could have gone up to 37 if government hospitals were allowed to be included and also expanded access and choice to the enrollees. Besides, in several areas there are just no doctors available. Fifth, there was a setback when health insurance companies refused to renew the previous year's policies. Finally, the TPAs are also not willing to implement this scheme at 5.5 percent of premium amount as their administrative costs of covering rural populations in dispersed villages are much higher.

During 2004, the Government of India also provided an insurance product, under which, for a premium of Rs 120 the sum assured was Rs 10,000. This was intended to be available only for self-help groups (SHGs). However, the response is reportedly negligible. With the Common Minimum Programme (CMP) committed to having a UHIS, there has been much effort and debate to evolve a suitable and sustainable design. To expand the health insurance business, recommendations are also being made to reduce the minimum pre-qualification of Rs 100 crore equity as it will require 15 years to break even. Another set of recommendations is for permitting TPAs and hospitals to introduce health insurance products. There are, however, doubts regarding this model as it may lead to a conflict of interest. In combining various aspects of provisioning and insuring there could be perverse interests to provide low quality of care, over-diagnose or under-treat— all for making profits.

## COMMUNITY BASED HEALTH FINANCING- APPROACHES AND BENEFICIARIES

The Community Based Health Financing (CBHF) as a method of raising funds at the community level was initiated by UNICEF in 1987 under its Bamako Initiative for Africa. The initiative had the following objectives: (i) to revitalize public health systems; (ii) to decentralize decision-making; (iii) to mobilize resources to cover local operating costs; (iv) to encourage community participation through management of services and locally generated funds; and (v) to define the minimum package of essential health services. (UNICEF 1987).

While the CBHF movement is vibrant in Africa, it is slowly picking up momentum in India. India's voluntary sector demonstrates considerable experimentation and innovation with community and self-financing methods, including user charges, community-based prepayment schemes, fund raising, commercial schemes, and in-kind contributions, (Dave, 1991). A disturbing factor in these programmes (barring one or two) is the very low claim ratio, ranging from 0.25 to 0.66 percent, which indicates that the scheme is not able to overcome the barriers hindering access or that the cover provided is too inadequate or that members are too ignorant about their entitlements. It is also seen that the poorest of the poor get excluded on account of their inability to pay their share within the specified time limit. Again, some of the schemes cover very small numbers and so the potential for scaling-up is restricted. Finally, many of the schemes see health insurance as an end in itself and do not seek to either promote preventive health care or extend adequate provider linkages.

## CONCLUSION

In India the acceptance of health insurance has been a slow process despite the 'huge market', estimated to range between Rs 7,500 and Rs 20,000 crores. Very few studies have tried to analyze reasons for this low penetration (Bhatt, Jain, 2006, Bhat and Mavalankar 2001). Various studies conducted worldwide, Andrew M. Jones, Xander Koolman and Eddy van Doorslaer, 2004 and; Cameron, Trivedi et al (1988) in Australia and Hurd and McGarry (1997) in USA revealed that income has an association with health insurance purchase decisions. According to National Commission on Micro-economics and Health Report, 2005, factors that may explain the slow expansion of health insurance in the country are Insufficient Regulatory Framework, High cost of premiums, Lack of product innovation, Too many exclusions and cumbersome administrative procedures, Inadequate availability of services etc. In India, as in most countries, there is a clear urban-rural, rich-poor divide. Affluent sections, urban populations and those working in the organized sector are covered under some form of health insurance but the rural population and those working in the unorganized sector have only the tax-based public facilities to depend on for free or subsidized care, and private facilities depending on their ability to pay. Population, who are depended on tax based public healthcare facilities, do not prefer to pay in advance as insurance premium for some illness, which they cannot foresee. Therefore, the purchase of health insurance is limited to only for those who are already suffering from some disease or old age population. This makes the entire system more costly due to adverse selection and moral hazard.

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