The Problems and Challenges of Health Insurance in India

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ABSTRACT
In India the Health care expenditure is increasing now days. At present its level is considerably highland more than three-fourth of this expenditure includes private ‘out-of-pocket expenses’. Even after such a high share of expenditure by individuals, the provision of health care are not adequate in terms of quality and access. Health care insurance has become more and more problematic. This is one of the most rising segment of insurance industries. There are a lot of challenges for health care insurance sector prominent such as lack of product innovation, high claim paid - out ratio of insurers less awareness among people, inefficiency of Third Party Administrator etc. along with these some other challenges as to forecast demand conditions, delivery and distribution systems, competition in the sector etc. In the present study an efforts are made to analysis the health insurance sector, to find out its problems and to suggest some solutions also.

KEYWORDS: Health Care, Health care insurance, Expenditure, TPA

INTRODUCTION
In the present Scenario, the need for health insurance is increasing in India. Insurance is regarded as a contract that helps a person to reduce or minimize the potential financial loss by getting a re-imbursement against financial losses, from an insurance company. Insurance is instrument through which for businesses and individuals are able to lower their financial impact of a risk occurring. It is a social instrument which is playing an important role in nation’s risk management system. It is broadly divided in to various category as into life, health and non-life insurance. The objective of Life Insurance is to provide financial support to a family in case of demise of a family member. General Insurance or non life insurance includes cars and bikes, house owners and health insurance policies. Health Insurance is a medical insurance provided by an insurance company, wherein it re-imburse the medical expenses occurred for a valid hospitalization. The individual has to pay some amount each year, known as premium, to keep the health insurance policy valid. Health insurance in India is considered same as “hospitalization”, where the policy and company covers the hospitalization expenses. The health insurance covers all the expenses for hospital bed, surgeon’s fees, lab tests, nursing, doctor’s fees, O. T; charges etc. Some conditions which are mentioned in the policy’s terms and conditions shall be in exclusions from coverage or may be covered only after 1or 2 years of the date of issue of the policy. Health insurance is a rising sector in India currently due to increasing rates of illness and diseases and high expenses incurred in hospitalization and treatments for these diseases. A lot of health insurance schemes are present in the markets that are providing benefits from an individual to an entire family also called family floater policies. Health Insurance schemes also coming up with critical illness covers which covers illness like blindness, deafness, kidney transplant Alzheimer’s disease, , organ transplant, paralysis etc.

INNOVATIONS IN HEALTH INSURANCE:
A number of innovations in Health Insurance sector has introduced in India which have taken place in the recent past. Some of them are as follows:

- **Health Insurance portability**: It provides the facility of switchover from one insurance company to another insurance company at any time. A health insurance policyholder may freely switch their policy to other insurance company, without losing on benefits like the credit earned on pre-existing diseases and no claim bonus etc.
- **Rashtriya Swasthya BimaYojna**: Rashtriya swasthya Bima Yojna (RSBY) is a National Health Insurance Programme for the poor people who are from below poverty line.
- **Hybrid Product**: It is a combo product which includes health insurance as well as life insurance cover under one policy only.
- **Critical Illness cover**: Under the coverage of critical illness the insurer is liable to pay a lump sum amount to the policyholder if he is diagnosed with the critical illnesses.

REVIEW OF LITERATURE
A Study is made to review the available literature with an object of formulating the research problem. R. P. Ellis et al., (2000) emphasized in his study the requirement for a competitive environment and an opening up of the insurance sector and recommends improvement in delivery of health care and its financing, efficient functioning of the ESIS and CGHS and correcting the mediclaim system and alteration in exclusion clause.
Bhat (2001) discuss that insurance companies took on an average 121 days to settle the claim. IRDA’s proposal to ensure settlement of payments within 7 days is highly ambitious.

Mahal(2002) found in his study that the entry of private health insurance could have adverse implications for some of the health policy goals particularly for equity.

Bawa et al (2011) discussed all those conditions, code of conduct/role which is allowed by IRDA and role in practice played by TPAs. His study shown that deviation exist in case of: lack of knowledge about coverage and exclusion in policies; failure to meet the expectations of parties involved;delay in settlement of claims; failure to meet the service responsibility; indirect cost to consumer etc.

Amsaveni and Gomathi (2013) analyzed that major problems faced by the respondents are lack of timely communication and limited list of hospitals covered by the insurance companies.

**RESEARCH METHODOLOGY**

The Present study is totally based on secondary data. The secondary data is collected from the annual reports of IRDA and other publications related with the health insurance.

**HEALTH INSURANCE SECTOR PROBLEMS**

In present study various Problems associated with various stakeholders are discussed. Some of their Possible solutions are also suggested:-

**Third Party Administration (TPA)**

TPA provides a mechanism to administer large scale in-patient healthcare sector. It provides an efficient, low-cost solution for the poor and removes the opportunities for misuse by patient and doctor. It provides a sound network of hospitals around India. In this system Patients need to attend a network hospital with their i - card in order to avail themselves of the cashless facility. The TPA mechanism handles all the administration of claims of patients. It also provides online real time information to all concerned parties including the policyholder, provider and insurance company. A highly efficient administration system, managing a number of clients and a large claims volume , may capable for speedy and accurate response to hospitalization needs of the client. The objectives of IRPA Regulations for TPAs is to ensure the value added services (VAS) to the consumers, which take diverse form and include arrangement of ambulance services, medicines and supplies, guide member for specialized consultation, providing information about health facilities, hospitals, bed availability, organization of lifestyle and well-being programmes and 24 hrs help-lines. There are the common problems associated with them are lack of value added services (VAS) and the long Turn-Around Time taken by TPA. The TPA for the payment of an insured patient’s treatment in a network hospital is 20 days for treatment without cash. Most TPAs fall short to meet the last date even if the insurance company has paid to them. This is due to the transport involved in handling so many hospitals and claims. Some hospitals become sad with the delay and do not offer cashless treatment facilities. Also, some TPAs do not work on Saturdays, while most insurers do. This delays the claims processing.

**Solution:** Insurance companies like Bajaj Allianz, Cholamandalam MS and Star Health have choosed for direct claims settlement, eliminating TPAs. Also TPA should work in accordance with all stakeholders. They should religiously follow all the guidelines and rules mandated by IRDA. They should concentrate on timely payment of all claims due on behalf of insurance company. If you have a health insurance; there is a 90 per cent chance that an empanelled hospital will charge you more than needed. Once the hospital come to know that patients have health insurance cover, their emphasis is more on making high and high treatment charges and rates for them. Higher rates for insured patients lead to a higher payout for the insurance company which, in turn, leads to higher premiums. The increase is higher than the rise in the cost of medical care.

**Wrong use of group insurance**

Another issue is the wrong use of group insurance by hospitals and patients. Uninsured people are treated because the identity cards of many group insurance schemes do not have photo.

**Solution:** Insurance companies have begun visiting hospitals to meet patients for claims under group insurance schemes. If found anything wrong, the insurer refuses to renew the policy of the originator policyholders. Also, most insurance companies now go for pre-agreed rates for surgeries and treatments. This prevents different tariffs for the insured and uninsured patients. The hospital bills extra charges directly to the patient and his attendant.

**Customers**

Many people come to hospital for an illness that does not require hospital. Other issue is that they take a policy after a disease has been diagnosed and confirmed. Health insurance does not cover pre-existing diseases (PED). Also, most patients do not read the policy document and expect all expenses within the limit of cover to be reimbursed. Customers are not well informed and aware about many aspects of health insurance. Customers are also not or less interested in taking any health insurance policy instead of that they want to buy life insurance cover and other investment instruments.

**Solution:** Read the entire health insurance policy document before taking a policy. Ask your insurance agent for the ‘policy wordings’. Do not make a false claim as you may not be able to make a genuine second claim in the same year if the coverage limit has been exhausted. Also, the insurance companies may load future premiums in case of an abnormal claim. Awareness regarding all aspects of health insurance policies should be increased and attractive and good health insurance policies should come in order to capture and increase market share of health insurance sector.
Companies
To reduce the pressure from their bosses and get commission, insurance agent’s mis sell products. Sometimes, a wrong product or insurance scheme is sold for a higher commission. As the company’s Websites and brochures do not disclose all the terms of the schemes, customers fall prey to the insurance agent and do not buy the right policy.

Solution: Prospective customers should ask for more information about the scheme. IRDA’s intervention in making brochures and other promotional material, more clear and transparent, will help a lot.

Some other Problems
There are also some other problems with health insurance sector which create hurdles for its development. Some of the problems are mentioned as follow:

- The statistical system is a lifeline for health insurance sector. India lacks right data and information system for planning and management of health insurance schemes.
- High claim-paid out ratio of insurance companies specially of public insurance companies is the main problem in the development of health insurance sector as due to high claim paid-out ratio, insurance companies have to face high loss and they lose their interest in this sector.
- Agencies such as State Health System, Indian Medical Association (IMA) and (TPAs) are reluctant to work for professional regulation of health insurance in India.
- Insurance Regulatory and Development Authority (IRDA) is ineffective and focus more on accessibility, quality and affordability dimensions of the health insurance sector.
- There are not very good health insurance policies or schemes for informal sector and the people Below Poverty Line (BPL).
- Wrong selection of health insurance policies by customers is another problem.
- Lack of awareness about health insurance policies and insurance companies is one of the main problems in development of health insurance.
- Health insurance as a human right is not linked with the distributive social justice for health security.
- Lack of Public and Private Partnership (PPP) is another roadblock in progress path of health insurance sector in India.
- No proper attention is given to village and rural areas for development of health insurance sector.
- Time taking in payment of insurance premium to policyholders by insurance companies.

CONCLUSION
There is no doubt health insurance sector is one of the growing segment of insurance industry but there exists various problems on behalf of all stakeholders such as insurance companies, clients (policyholders), TPA and hospitals also. Insurance companies have high claim paid-out ratio, customers are less aware about health insurance basic terms, hospitals charges more expenses from insured patients and TPA make delay in payment of claims which are made on behalf of insurance companies to customers. For healthy growth of health insurance sector all stakeholders should work with great honesty, transparency and faith and not involve themselves in fraud activities which harm health insurance business.

REFERENCES