A PROJECT REPORT ON

To Study On Awareness, Preference, & Buying Pattern Of Health Insurance In Mumbai

A Project Submitted to

University of Mumbai for Partial Completion of the Degree

of Bachelor in Commerce (Banking and Insurance)

Under the Faculty of Commerce

By

T.Y.B.B.I (SEMESTER – VI)

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Under the Guidance of

'ASST. PROF. DR. KISHOR CHAUHAN'

JNAN VIKAS MANDAL'S

Mohanlal Raichand Mehta College of Commerce

Diwali Maa College of Science

Amritlal Raichand Mehta College of Arts

Dr. R.T. Doshi College of Computer Science

NAAC Re-Accredited Grade 'A+' (CGPA : 3.31) (3rd Cycle)

Sector-19, Airoli, Navi Mumbai, Maharashtra 400708

FEBRUARY, 2024.

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CERTIFICATE

This is to certify that **MR.GAIKWAD PRATYUSH RAMESH** has worked and duly completed his Project work for the degree of Bachelor in Commerce (Banking and Insurance) under the Faculty of Commerce in the subject of **Banking and Insurance** and his project is entitled, **"To study awareness, preference, & buying pattern of health Insurance in Mumbai"**. Under my supervision.

I further certify that the entire work has been done by the learner under my guidance and that no part of it has been submitted previously for any Degree or Diploma of any University.

It is his own work and fact reported by her personal finding and investigations.

Guiding Teacher,

ASST. PROF. DR. KISHOR CHAUHAN.

Date of submission:

DECLARATION

I the undersigned **MR. GAIKWAD PRATYUSH RAMESH** here by, declare that the work embodied in this project work titled **"To study awareness, preference, & buying pattern of health Insurance in Mumbai"**, forms my own contribution to the research work carried out by me under the guidance of **ASST. PROF. DR. KISHOR CHAUHAN** is a result of my own research work and has been previously submitted to any other University for any other Degree/ Diploma to this or any other University.

Wherever reference has been made to previous works of others, it has been clearly indicated as such and included in the bibliography.

I, here by further declare that all information of this document has been obtained and presented in accordance with academic rules and ethical conduct.

GAIKWAD PRATYUSH RAMESH

Certified by:

ASST. PROF. DR. KISHOR CHAUHAN.

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LIST OF ABBREVIATIONS

HI- Health Insurance

PHC - Primary Health Center. BPL - Below Poverty Line.

OOP – Out of Pocket.

PSU – Public Sector Undertakings.

ESIS – Employee State Insurance Scheme. CGHS – Central Government Health Scheme. TPA – Third Party Administrator.

HMO – Health Maintenance Organization. PPO – Preferred Provider Organization.

POS – Point of Service.

HSA – Health Saving Account.

SEWA – Self Employed Women's Association. NGO – Non-Governmental Organization.

NIC – National Insurance Company. VHS – Voluntary Health Services.

GIC – General Insurance Corporation.

IRDA – Insurance Regulatory Development Authority. RTA – Road Traffic Accident.

PPN – Preferred Partner Network.

CHAPTER 1

1. INTRODUCTION

How many accident you need to realise that you need Health Cover? It take just one visit to a hospital to make us realize how vulnerable we are, every passing second. For the rich as well as poor, male as well as female and young as well as old, being diagnosed with an illness and having the need to be hospitalized can be a tough ordeal. Heart problems, diabetes, stroke, renal failure, cancer – the list of lifestyle diseases just seem to get longer and more common these days. Thankfully there are more speciality hospitals and specialist doctors – but all that comes at a cost. The super rich can afford such costs, but what about an average middle class person. For an illness that requires hospitalization/ surgery, costs can easily run into five digit bills. A Health insurance policy can cover such expenses to a large extent. Read why Health Insurance is more important these days compared to Old days Health is a human right, which has also been accepted in the constitution. Its accessibility and affordability has to be insured. While the well-to-do segment of the population both in rural & urban areas have acceptability and affordability towards medical care, at the same time cannot be said about the people who belong to poor segment of the society. It is well known that more than 75% of the population utilizes private sectors for medical care unfortunately medical care becoming costlier day by day and it has become almost out of reach of the poor people. Today there is need for injection of substantial resources in the health sectors to ensure affordability of medical care to all. Health insurance is an important option, which needs to be considered by the policy makers and planners. As mentioned earlier, the cost of Health Insurance depends on the sum assured , age, current health condition and your previous medical history. Higher the sum assured, higher the premium. So what is the ideal health insurance cover requirement? There is no standard answer or thumb rule for this. If we agree that health insurance is important, one has to look at his/ her own lifestyle, health condition, age/ life stage, family history of illnesses and affordability. Keep in mind that most insurance companies limit the sum assured to a maximum of 5 lakhs. Also note that many health insurance policies ―provide additional benefits‖ such as daily allowance, ambulance charges, etc. for hospitalization. Not only are such ―benefits‖ superfluous, they tend to drive the premiums higher. So it is best to avoid such plans and stick to something basic and simple.

1.1 MEANING OF HEALTH INSURANCE

“Health insurance aims that one can access to the best health care without fearing the financial strain, it help people to have peace in mind rather than to have fear”.

Health insurance in a narrow sense would be an individual or group purchasing health care coverage in advance by paying a fee called premium In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. Given the appropriateness of this definition in the Indian context, this is the definition, we would adopt. The health insurance market in India is very limited covering about 10% of the total population Health insurance guarantees payments to a person in the event of sickness or injury. and works as protection scheme. Health insurance is protection, scheme to take care of health of a person and works it works by buying a policy from a company or an insurance agent. Depending on the premium paid the health insurance policy will pay specified amounts for the medical expenses incurred to overcome the health problem. Currently the trend of some of the reputable companies seems to be to build in a health insurance policy as a benefit to an employee. Some countries offers free health insurance to their citizen. In India certain sectors like railways, army and the employees working with the central government are covered in a health scheme provided cover to almost 20million people in different part of country. Health like education should be essential and should be freely available to all the citizens of a country. Some developed countries realizing the importance of the health of the nation spend as much as 6% to 8% of their GDP on it and have advanced facilities in their government run hospitals. Some examples include the United Kingdom where the National Health Services hospitals provide all the health requirements to majority of their citizens. Sweden and Norway follow similar government run health schemes. As per the census of USA in the year 2004, it was noted that 245.3 million people had health insurance coverage; however 45.8 million lived without an insurance cover. In response to some of these stats Senator John Kerry said. "Great physicians and nurses, skilled, caring and unparalleled in their training, intervened in my life and probably saved it. I was lucky but other Americans are not. It is time to speak again and stand again for the ideal that in the richest nation ever on this planet, it is wrong for 41 million Americans, most of them in working families, to worry at night and wake up in the morning without the basic protection of health insurance." Developing countries like India have priority of spending in other sectors like the army and the infrastructure development and barely 2% of the GDP is spent on the health and results in the government hospitals lack in facilities especially for any advanced procedure such as heart surgery or hip placement .Health insurance schemes are particularly

important for individuals from the lower income group to provide them and their family members with adequate cover in event of any mishap or illness. The escalating medical costs are due to the advanced diagnostic and therapeutic procedures that have become the hallmark of modern medical care. An insurance scheme will guarantee that no compromises are made in your treatment for wants of funds. Remember when negotiating a policy you ask for adequate cover as the provided by the health insurance will depend on the type of policy purchased. Before you ask for the best health insurance quote or plan to buy a health insurance plan become an informed consumer. Find definitions of commonly used health insurance terms in this health insurance glossary. It serves as a dictionary to help consumers understand common terms used in health insurance.

1.2 HISTORY AND EVOLUTION

Launched in 1986, the health insurance industry has grown significantly mainly due to liberalization of economy and general awareness. According to the World Bank, by 2010, more than 25% of India's population had access to some form of health insurance. There are standalone health insurers along with government sponsored health insurance providers. Until recently, to improve the awareness and reduce the procrastination for buying health insurance, the General Insurance Corporation of India and the Insurance Regulatory and Development Authority (IRDA) had launched an awareness campaign for all segments of the population.

Launched in 2007, the National Health Insurance Program (Rashtriya Swasthya Bima Yojana-RSBY) is led by the Ministry of Health and was adopted by 29 states in 2014. It is funded 75% by the government and 25% by the states. The worker and 4 of his dependents benefit from health insurance if they are not covered by any system and live below the poverty line. RSBY beneficiaries are required to pay an annual registration fee of INR 30 for hospital coverage up to INR 30,000 per year per family. September 25, 2018, the Indian government announced the launch of a new health insurance for the poorest citizens. Indian Prime Minister, Narendra Modi announced that the new system is expected to reach more than 500 million people and is called "Modicare". The reform is still in progress and aims to install universal social security in the country.

Healthcare in India is in a state of enormous transition: increased income and health consciousness among the majority of the classes, price liberalization, reduction in bureaucracy, and the introduction of private healthcare financing drive the change.

Over the last 50 years, India has achieved a lot in terms of health insurance. Before independence, the health structure was in dismal condition i.e. high morbidity and high mortality and prevalence of infectious diseases. Since independence, emphasis has been put on primary health care and we made considerable progress in improving the health status of the country. But still, India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators.

Health insurance, which remains highly underdeveloped and less significant segment of the product portfolios, is now emerging as a tool to manage financial needs of people to seek health services.

The new economic policy and liberalization process followed by Government of India since 1991 paved the way for privatization of insurance sector in the country. The Insurance Regulatory and Development Authority (IRDA) bill, passed in Indian parliament, is the important beginning of changes having significant implications for the health sector.

Health Insurance is more complex than other segments of insurance business because of serious conflicts arising out of adverse selection, moral hazard, unavailability of data and information gap problems. Health sector policy formulation, assessment and implementation are an extremely complex task, especially, in changing epidemiological, institutional, technological and political scenario. Proper understanding of Indian Health situation and application of principles of insurance, keeping in view the social realities and national objectives, are important

1.3 PERCEPTION OF CUSTOMERS

For an individual, either at a personal level or the family front, of which he or she is a part, health is an extremely important subject, which needs to be given priority. The same concept can be extended to the level of the country, where the health of the citizens, comes at the core for its long-term sustainable development. It is rightly said ‘Health is Wealth’. In short, life is unpredictable. We need to be prepared for such circumstances. Leading a happy life involves good planning and analysis for your personal health. Accidents do happen and you need to be

prepared for such situations. In times of high health cost, you need to get covered for health risks. For the rich as well as poor, male as well as female and young as well as old, being diagnosed with an illness and having the need to be hospitalized can be a tough ordeal. Heart problems, diabetes, stroke, renal failure, cancer the list of lifestyle diseases just seem to get longer and more common these days. Thankfully there are more specialist hospitals and specialist doctors but all that comes at a cost Now a day's health care expenditure is consistently increasing in this situation more money are required to paid hospital bill or expenses, most of the people use out of pocket for the health care expenses or in some cases also sell his or her personal assets. Low-income households are more vulnerable to risks and economic shocks. One way for the poor to protect their health is through insurance. By helping low-income households to manage their health risks, health-insurance can assist them to maintain a sense of financial confidence even in the phase of significant vulnerability. Insurance reduces a person's uncertainty concerning the time and amount of possible future expenses that may incur.

There are various health insurance schemes such as social health insurance, private health insurance and so on. The basic principle is that people contribute a specified amount to an insurance fund which is used to finance health services. Health Insurance policies insure against several illnesses and guarantee to stay financially secure should ever require treatment. They safeguard the peace of mind, eliminate all worries about treatment expenses, and allow focusing energy on more important things, like getting better. Health is a major concern on everybody's mind these days. With skyrocketing medical expenses, the possibility of any illness leading to hospitalization or surgery is a constant source of anxiety unless the family has actively provided for funds to meet such an eventuality

In health insurance, there are pre-payments and pooling. So people pay a small amount when they are healthy. This contribution is shared by many people and is used to meet the health care cost of enrolled members when they need it. Health insurance operates in circumstances where people are risk-averse i.e. they prefer the certainty of insurance to the uncertainty of illness. They are then willing to pay a premium to cover the costs of a medical event. Health insurance is basically a tool to minimize uncertainty.

1.4 STRUCTURE AND ORGANIZATION

The Indian social protection scheme covers insured persons against risks related to old age, invalidity, death, but also sickness and maternity, unemployment and finally accident at work

and occupational diseases. This social protection scheme is not universal and provides only limited coverage, targeting mainly organized sector's workers constituting less than 10% of the population in India. All risks are placed under the supervision of the Ministry of Labour and Employment.

Social security and health insurance is defined by 5 main texts in India:

- The Employees' State Insurance Act, 1948
- Employees' Provident Funds & Miscellaneous Provisions Act, 1952
- The Employees (Workmen's) Compensation Act, 1923
- The Maternity Benefit Act, 1961
- The Payment of Gratuity Act, 1972

1.5 POTENTIABILITY OF THE MARKET

India is about 1.38 million of population and granting that not all may not be insurable for various season , it makes a strong case for potentiality of at least 50 crore plus people to be under some health insurance scheme apart from government schemes for the weaker sections. Unfortunately , even after opening of market the penetration has been poor and roughly only about 3.5 crore people are covered under various insurance scheme as mentioned above making the market quit big ,only being scratched at the surface without being properly tapped. However, since last 2/3 years health insurance has picked up with aggressive selling coupled with awareness making it the second largest portfolio after motor Insurance.

1.6 SELECTION OF HEALTH INSURANCE:

Understanding who chooses to purchase voluntary health insurance is important for understanding both how well targeted the insurance product is and the financial viability of the insurance program. As explained below, the latter will be particularly sensitive to the existence of adverse versus positive selection. The extent of adverse selection or positive selection into insurance has important repercussions for an insurance provider‘s ability to cover its costs. Standard insurance theory predicts that insurance markets will suffer from adverse selection, which occurs when less healthy people or people who are more risky with their health are more willing to purchase health insurance because they know that the amount they spend on healthcare will be larger than the premium they will pay. Voluntary health insurance cannot

be financially sustainable if adverse selection is severe, since only the most costly patients would find it worthwhile to purchase insurance, and premium levels will not be able to cover the high costs of care.

Some studies in wealthier nations find evidence that people with higher expected medical expenditures (measured in a variety of ways across studies) are more likely to buy insurance or pay for health insurance at higher premiums than those with lower expected medical expenditures . However, the extent of adverse selection in health and other insurance is often found to be minimal or non-existent . There is also some recent evidence of positive selection into health insurance (e.g. Fang et al., 2008).

The literature review suggests that income is one of the important determinants of purchase of health insurance . Income has been found to be having a positive association with health insurance purchase decision consistently in different studies conducted in different countries Propper (1989) in UK; Cameron, Trivedi et al. (1988)in Australia and Hurd and McGarry (1997) in USA, Healthcare expenditure is another important variable affecting health insurance purchase. Relation of health insurance purchase decision and health expenditure is based on the premise that families which have higher chances of requiring hospitalization will have higher probability of buying health insurance. Some other socio economic factors like age, education etc. have also been found to be important factors affecting health insurance purchase In India knowledge and awareness about health insurance could be important factor for health insurance purchase decision. Very few studies have tried to analyse reasons for low penetration of health insurance in India. Some studies have tried to analyse community based health insurance in India. (Devadasan, Ranson et al. 2004, Ahuja 2005. Rao (2004) discusses the issues and challenges for health insurance sector in India. These and other studies have tried to analyse health insurance sector in India, but not much systematic empirical work has been done and this area is largely unexplored.

The theory of risk has been applied extensively to the literature related to health insurance decision .Under conditions of consumer rationality and risk averseness, the decision to purchase insurance is made on the basis of expected utility gain.

Health Insurance choice essential decision - whether or not to purchase private health insurance .Binary discrete choice models using either legit or probit has been used to analyze determinants of this type of purchase decision. Cameron and Trivedi (1991) specified a conditional expected utility function that is associated with alternative health care regimes.

The consumer chooses the regime that maximises expected utility The utility gains, expected from the purchase of private insurance are related to the expected medical need of the people in the first instance. Some individuals face greater risk vulnerability than others due to their age, pre-existing health status, job profile and marital status. suggest that the probable probable distribution of future health states is based on present and past Health status, Health care expenditure of the household may be anther proxy of health status of the household this view of the role of education in Health. Health status of the household This view of the role of education in health decision-making has been well documented by Grossman (1972) and Muurinen (1982). The implication is that not only is a better educated person likely to be healthier which would lower the probability of insurance, but also he/she is likely to be better informed about both the services available in the public hospital system and the benefits of joining a private health insurance fund. The indirect effect of education is and the benefits of joining a private health insurance fund its impact on income.

Education and income are generally positively correlated .Higher income generally decreases the opportunity cost associated with the purchase of private health insurance. Overall, increases in both income and education would be expected to lead to an increase in the probability of buying the insurance.

Another set of factors which are found important in the literature of health insurance are demographic and economic variables. These variables are employment, age, marital status and gender. The available evidence suggests that socioeconomic variables act on choice in the expected ways. Those who are employed and those in executive positions are likely to purchase insurance .Married respondents are more likely to take out coverage , though family size apparently has been of little influence on the purchase decision.

CHAPTER 2

RESEARCH OBJECTIVE AND RESEARCH METHODOLOGY\

2.1 PURPOSE OF STUDY

The purpose of this study is to find out the Awareness, Preferences and Buying patter of Health Insurance, in Health Insurance companies. Health Insurance is viable solution to ensure access to basic Health care services to the masses, the number of people with Health Insurance coverage is low in India. There are some structural issues with system. The present study is an attempt to find the cause for low Health Insurance coverage. The study address the awareness and buying pattern of Health Insurance and scope of the private Health Insurance companies schemes. Given the growing interest on the importance of Health Insurance , the outcome of the present study is considered useful in guiding policy making and to help to knowing the complete process of Health Insurance.

2.2 OBJECTIVE OF THE STUDY

- To assess the individual awareness about Health Insurance.
- To know the preference of individual regarding health insurance.
- To evaluate consumption patterns of health insurance.
- To assess the effectiveness of company services.

2.3 SCOPE OF THE STUDY

This report provides a comprehensive analysis of the Health Insurance market in India:

- It covers an exhaustive list of parameters, including premium per capita, incurred loss, loss ratio and paid claims
- It details the competitive landscape in the Indian Health Insurance industry along with the product innovation and customer targeting strategies followed
- It analyses the various distribution channels for Health Insurance products in India.
- It profiles the top health insurance companies in India along with snapshots of their major products and services.

2.4 RESEARCH METHODOLOGY

The information is required for this project study is collected both through the primary as well as secondary source of data.

There are two types of methods of collecting data:-

1. PRIMARY

2. SECONDARY

PRIMARY DATA:-

The main purpose of collection of primary data was to prepared questionnaire. The researcher tried to find out the awareness and Buying pattern of Health Insurance Through :

Personal Approach

- Surveys
- Mails
- Questionnaires
- Articles ,magazines
- Telephone ,discussion meeting with Managers, Agents of all the four Health Insurance companies &customers etc. For this project personal interviews was conducted for collection

SECONDARY DATA consists of published data collected through

- Books
- Websites
- News papers
- Journals
- Magazines
- Research papers

SAMPLE SIZE : 260

COMPANY NAME	SAMPLE SIZE
ICICI LOMBARD	**60**

RELIANCE HEALTH INSURANCE	**30**
BAJAJ ALLIANZ	**50**
BHARTI AXA HEALTH INSURANCE	**40**
NEW INDIA HEALTH ASSURANCE	**50**
OTHER COMPANIES	**30**
TOTAL	**260**

A comparative study of Health Insurance has been done in ICICI Lombard, Reliance health insurance, Bajaj Allianz, New India Health Assurance, Bharti AXA Health Insurance and other companies, the respondents were Senior manager, middle level manager, agent, broker, customers, the sampling technique was Quota sampling, The research tool are questionnaire.

2.5 Hypothesis of the Study

The study proceeds with the following hypothesis, that:

Hypothesis 1: Health insurance in India have been badly lacking of awareness among Indian people.

Hypothesis 2: Government health insurance companies are more beneficial to customers than private health insurance companies.

Hypothesis 3: Government health insurance companies are difficult to access for customers than private health insurance companies.

Hypothesis 4: The Government health insurance companies have transparent procedure and have lesser hidden charges.

THE STATISTICAL TOOL:-

The statistical analysis has been done using Microsoft Excel

CHAPTER 3

LITREATURE REVIEW

When a person experiences a bad shock to health, their medical expenses typically rise and their contribution to household income and home production (e.g. cooking or childcare) declines (e.g. Wagstaff and Doorslaer, 2003; Gertler, Levine & Moretti, 2003; Gertler and Gruber, 2002). According to the WHO,―Each year, approximately 150 million people experience financial catastrophe, meaning they are obliged to spend on health care more than 40% of the income available to them after meeting their basic needs.‖ (WHO Factsheet N°320, 2007)Low income and high medical expenses can also lead to debt, sale of assets, and removal of children from school, especially in poor nations. A short-term health shock can thus contribute to long-term poverty (e.g. Van Damme et al, 2004; Annear et al, 2006). At the same time, because households often cannot borrow easily, they may instead forego high-value care. When they do access care it will often be of low quality (Das, Hammer and Leonard, 2008), which can lead to poor health outcomes.Theory suggests that health insurance can address some of these problems. By covering the cost of care after a health shock, insurance can help to smooth consumption, reduce asset sales and new debt, increase the quantity and quality of care sought, and can improve health outcomes.

Unfortunately, rigorous evidence on the impact of insurance is scarce, and there are even fewer studies on the effects of insurance in developing countries. One reason for the lack of evidence is that it is difficult to find a valid control group for the insured. We cannot simply compare the outcomes of insured and uninsured households, since health insurance status is typically strongly correlated with other household characteristics. For example, rich and well educated households typically have both better health (Asfaw, 2003) and better health insurance coverage (Jütting, 2004; Cameron and Trivedi, 1991), but the positive correlation between health and insurance status tells us nothing about the impact of insurance. On the other hand, those in poor health may be more likely to pay for health insurance (Cutler and Reber, 1998; Ellis, 1989), but finding that the insured tend to be sicker would not imply that insurance causes illness.

Below we review past evidence on the impacts of health insurance, focusing on studies where health insurance status is plausibly exogenous, or where studies have attempted to eliminate bias due to self-selection. A majority of the rigorous studies are based on United States data.

We follow Levy and Meltzer (2004, 2008) in both our choice of U.S. studies and in our main conclusions.

3.1 HEALTH INSURANCE

Health insurance in India is a growing segment of India's economy. The Indian health system is one of the largest in the world, with the number of people it concerns: nearly 1.3 billion potential beneficiaries. The health industry in India has rapidly become one of the most important sectors in the country in terms of income and job creation. In 2018, one hundred million Indian households (500 million people) do not benefit from health coverage. In 2011, 3.9% of India's gross domestic product was spent in the health sector. According to the World Health Organization (WHO), this is among the lowest of the BRICS (Brazil, Russia, India, China, South Africa) economies. Policies are available that offer both individual and family cover. Out of this 3.9%, health insurance accounts for 5-10% of expenditure, employers account for around 9% while personal expenditure amounts to an astounding 82%. In the year 2016, the NSSO released the report "Key Indicators of Social Consumption in India: Health" based on its 71st round of surveys. The survey carried out in the year 2014 found out that, more than 80% of Indians are not covered under any health insurance plan, and only 18% (government funded 12%) of the urban population and 14% (government funded 13%) of the rural population was covered under any form of health insurance.

3.2 ADVANTAGES OF HEALTH INSURANCE

Now a days there are different insurance policies coming in the market like life insurance, vehicle insurance, but the importance of health insurance seems to be growing at a very fast rate. Health insurance is mainly taken to protect a person from any unexpected medical expenses incurred due to any illness. With the present condition, it is observed that with the latest technologies or the advancements taking place, the health care has immensely improved but so has the expenses. The treatments are becoming more and more expensive with each passing day. It is required that every individual gets a financial security related to any unexpected medical expenses coming his way. The main merits observed in health insurance are:-

1 **Medical cash benefits-** this benefit entitles you to get cash benefits, if you are hospitalized. All the financial expenses incurred would be covered in this plan. The amount provided to you will be on per day basis and the amount depends upon the plan you have opted.

2 **Cashless facility-** in this benefit, you can get hospitalized on the basis of this plan without paying a penny. But this benefit can be availed only in some special cases. Sometimes the amount paid by you, is reimbursed within 24 hours.

3 **Before and after expenses**- as per this policy all the expenses related to illness incurred 60 days prior to 90 days after hospitalization would come under the cash benefits that you can avail.

4 **Floater benefits-** this is an add-on benefit for the health insurance policy holders. In this policy, an individual can take a single policy for the whole family which would cover the entire member in a single sum assured.

5 **Other benefits-** the policy holder is entitled to a 5% of bonus amount of the sum assured every year as a bonus. This policy includes, all the expenses including the ambulance charges, health checkups to the maximum limit of Rs 1000 per family. It even provides tax benefits as per income tax act. Considering all the aspects, health insurance has advantages which could be availed very easily. The health insurance is needed now more than ever due to skyrocketing medical expenses, the increasing possibilities of diseases. So, if you still don‘t have a good health care plan, just go for it at the earliest.\

3.3 IMPORTANT FEATURES OF HEALTH INSURANCE:

Though the features may vary from insurer to insurer, some basic features are:

1 Reimbursement for Hospitalization due to illness/disease/ surgery.
2 Reimbursement for Domiciliary Hospitalization expenses in lieu of Hospitalization.
3 Pre-hospitalization Expenses.
4 Post-hospitalization Expenses.
5 Ambulance Charges.
6 Cashless Access.
7 Income Tax Benefit etc.

3.4 Indian Health Insurance is primarily classified into 2 categories:

- Cashless Hospitalization
- Medical Reimbursement

a. Cashless Hospitalization

Cashless hospitalization is a specialized service provided by an insurer wherein an individual is not required to pay the hospitalization expenses at the time of discharge from the concerned hospital. The settlement is done directly by the insurance company (or insurer). However, prior approval is a must from the TPA (Third Party Administrator) before availing the benefits under this option.

CASHLESSLESS HOSPITALIZATION CAN BE OF TWO TYPES

- **Planned hospitalization:** This is a planned hospitalization wherein the insured is aware of the hospitalization in advance. This duration period may vary from case to case. Examples include: FTND (Full Term Normal Delivery), Chemotherapy treatment for carcinoma (cancer), for cataract surgery, tonsillectomy (removal of tonsils).
- **Emergency hospitalization:** It is a sudden hospitalization that may be either an emergency or due to unforeseen circumstances. In short, hospitalization is not anticipated in advance. Examples include RTA (Road Traffic Accident),

b. Medical Reimbursement

Re-imbursement means to repay or to compensate. Thus, Medical Re- imbursement means to repay the products/services availed during hospitalization more importantly after the completion of the treatment. Under this procedure, the insured has to bear the entire expenses incurred during hospitalization. After getting discharged from hospital, the insured/policy holder can claim medical reimbursement. For availing benefits under this option, the insured has to approach the concerned TPA under which he/she is covered, fill the requisite form and satisfy all the requirements as mentioned. This includes submission of TPA card, policy paper, discharge summary, prescriptions, diagnostic laboratory reports, OPD treatment details etc. A sum is granted as reimbursement for treatment expenses.

3.5 FUNCTIONS OF HEALTH INSURANCE

The primary function of Health Insurance is to pay those covered expenses, as outlined in the policy, incurred as a result of an accident or illness. It often has two elements, one being hospitalization expenses and the other being for the medical care rendered by a physician or other health care professional. The vast majority of health insurance is employer-based, meaning that people have access to it through their employment. Not all employers offer it, and

for those whose employers do not, they are free to obtain individual/family policies on their own.

Health insurance comes in a variety of types. These include traditional indemnity plans, which are becoming less common, and an array of managed care plans, including Health Maintenance Organizations and Preferred Provider Organizations. Both of the latter provide medical care on a prepaid basis, but differ in their delivery models, including by the degree of choice of provider that the member retains.

Most health insurance plans have deductibles and co-payments, although different terminology may be used. A deductible is an amount that the insured/member must pay before the insurer's liability for payment is triggered. A co-payment is a form of cost-sharing such that the insurer pays a percentage of a covered expense, and the insured pays the remainder. The size of the deductible and co-payment has an impact on premium. Insurance may be described as a social device to reduce or eliminate risk of life and property.

Under the plan of insurance, a large number of people associate themselves by sharing risk, attached to individual insurance plan that exclusively covers healthcare costs and is called Health Insurance Since the past two decades, there has been a phenomenal surge in acceleration of healthcare costs. This has compelled individuals to have a re-look on their actual monthly expenditures, spending patterns and simultaneously allocate a proportion of their income towards personal healthcare. This has resulted in individuals availing healthcare insurance coverage not only for themselves but also for their family members including their dependants. In short, healthcare insurance provides a cushion against medical emergencies. The concept of Insurance is closely concerned with security. Insurance acts as a shield against risks and unforeseen circumstances. In general, by and large, Indians are traditionally risk averse rather than risk lovers by Nature.

3.6 IMPORTANT TYPES OF COVERAGE OF MEDICLAIM

A. HMO (Health Maintenance Organization).

You go to your family doctor for any health services. If there is urgency in going to a specialist, your family care doctor will help you in referring one. Mediclaim companies will not insure you without the referral from your family doctor and therefore, you will have to pay yourself for such specialist services.

B. PPO (Preferred Provider Organization Plan).

Through this plan you can analysis to any primary, specialist, or medical facility without referral and get totally covered. It is the Mediclaim companies that cover you when your child breaks a bone accidentally and you approach directly to the orthopaedic doctor, without consulting your primary doctor.

C. POS (Point of Service).

This plan essentially includes both an HMO and a PPO plan. Mediclaim companies give you the option from the two plans for every medical case. The plan offers extra covered preventative programs, however, you may have to pay more from your pocket, if you choose a doctor outside your plan.

D. HSA (Health Savings Account).

This plan is much more superior than the above mentioned mediclaim plans. The plan covers eyeglasses, dental, cosmetic procedures, over-the-counter medications, etc. It is a tax-deferred savings account as long as withdrawals are concern for medical expenses. Funds outstanding at the end of the year are carried forward into an IRA account

3.7 MAIN KINDS OF HEALTH INSURANCE

Source – Researcher Analysis

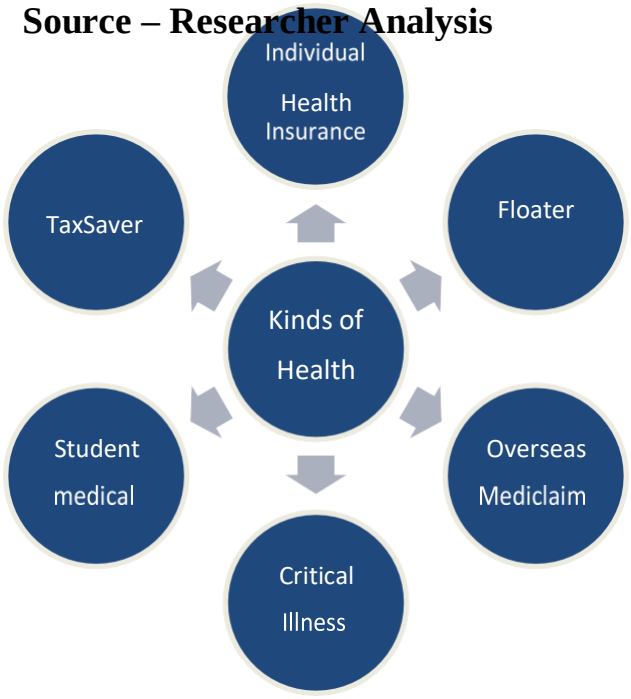


Figure no.3.7.1 Health Insurance Types in India

DIFFERENT KINDS OF HEALTH INSURANCE

1. **Individual Mediclaim Policy.**

This is the plain vanilla mediclaim or health insurance policy for an individual protecting this person from the expenses incurred due to disease or injury.

2. **Floater Policy.**

A floater health insurance policy covers your entire family under one policy with one sum insured and one premium. It covers all the expenses as covered under mediclaim only the cover is now extended to the family instead of one person. This cover can be used by any member of the family any number of times. The advantage of this policy is that saves money by spreading the cover across family members

3. **Critical Illness Policy.**

Insurance companies define certain specified illness or diseases as ―critical‖. If you have a critical illness policy, then the insurance company will pay you a lump sum payment if you are diagnosed with a critical illness as defined by the insurance company. Some of the diseases/conditions which are usually deemed critical are Cancer ,Heart Attack, Kidney Failure, Major Organ Transplant, Stroke, Paralysis and Heart Valve Replacement Surgery. (For a more comprehensive list check with your insurer)

Unlike other general insurance policies, these policies come with multiple options in terms of sum assured and term of the policy. For example ICICI Lombard provides critical cover for 5 years for a Rs. 12, 00,000 coverage. These policies are also available with disability coverage to ensure that you are also covered for loss of income during that critical period.

4. **Overseas Mediclaim Policy**.

An Overseas Mediclaim Insurance policy provides cover for medical expenses incurred abroad for treatment of illness and diseases contracted or injury sustained during the insured period of overseas travel. Anyone who is travelling abroad for business or pleasure or for educational purposes should have this policy.

5. **Student Medical Insurance.**

Student Medical insurance covers the cost of health care while studying abroad. It is an essential requirement of many foreign universities for its overseas students. Students are generally advised to buy it in India as it is substantially cheaper than buying it abroad.

6. **Tax Saver.**

This is a new class of insurance launched to take full advantage of the income tax benefit under section 80 D of the Income Tax Act 1961. The premium is fixed at Rs 15,000 for all plans. For Senior Citizens aged 65 and above, the premium is Rs. 20,000 This plan includes reimbursement of OPD expenses upto Rs. 10,000. This includes diagnostics tests, dental treatment and related expenses. This insurance is suitable for people who are looking to cover all their medical expenses in a tax-free manner

3.8 ESSENTIAL GUIDELINES FOR AVAILING HEALTH INSURANCE POLICY

The following points should be borne in mind while purchasing an individual health policy:

- **Understanding the policy coverage:** The policyholder should be able to clearly comprehend the extent of medical coverage being offered under the particular health insurance policy before opting for it. The individual should check whether pre-existing diseases and its resultant complications are covered or not, as well as the extent of the coverage under that particular policy.

- **Keeping an eye for medical expenses that are not covered/re-imposable under the policy:** Before availing a particular health insurance policy, the prospective policyholder should note the medical expenses not covered under that Insurance policy. It is important to note that deductibles are a part and parcel of any insurance coverage and the expenses incurred as part of the medical treatment need to be borne by the individual. Generally this list includes aprons, sterilization charges, gloves, Dettol, gloves etc.

- **To understand whether it is a co-insurance policy:** Before availing a health policy, the prospective customer should understand whether it is a co- insurance policy or not. It is advisable to get an individual health insurance policy with a co-insurance payment

option. The maximum amount does not exceed 15% of the entire medical coverage for a particular disease.

- **Understanding and updating oneself about expiry period regarding the policy cover:** An individual health insurance cover entails regular premium payments on a monthly, half yearly or annual basis before the expiry of a particular policy. Non-payment of premium within the stipulated time results in the lapsing of the policy with subsequent break in the policy coverage of the concerned individual. Even though the concerned individual holds policy with an Insurance company for many years together, a break in the policy coverage (Which generally does no exceed more than 15 days is treated as fresh policy cover.

3.9 IMPORTANCE OF HEALTH INSURANCE

The importance of Health Insurance can never be undervalued for the following reasons:

- Provides security to human life which is of prime importance to any individual.
- Closely bonds Insurance Companies, Hospitals, Policyholders and TPAs together for the benefit of Indian masses.
- An answer to the solution of uncertainties and risks that are prevalent and ever-pervading in human life.
- Access to quality healthcare.
- Means of savings and a safe investment option.
- Provides financial stability in life.
- A tax-saving instrument that significantly contributes in reduction of tax deductions.
- Reduces tensions and stress caused on account of hospitalization.
- Greatly contributes in leading a stress-free life.

The health insurance schemes marketed by insurance companies face some other challenges worth noting, for example :-Absence of accreditation of providers and a rationalized cost structure.-Adverse claims experience / high loss ratio.-High moral hazard at various levels of service.-Non regulated market and no control through state machinery.-The limited government funding of healthcare programmers.-Lack of propagation of health insurance as a health insurance among masses.-Rising medical costs and imbalance in cost structure among

service providers.-Servicing through third party administrators (TPA) introduced with cashless entry to hospitals meeting with limited success.

3.10 TYPES OF HEALTH INSURANCE PLAN IN INDIA

The escalating cost of medical treatment today is beyond the reach of a common man. In case of a medical emergency, cost of hospital room rent, the doctor's fees, medicines and related health services can work out to be a huge sum. In such times, health insurance provides the much needed financial relief. An investment in health insurance scheme would be a judicious decision. The health insurance scheme could either be a personal scheme or a group scheme sponsored by an employer. Some of the existing health insurance schemes currently available are individual, family, group insurance schemes, senior citizens insurance schemes, long-term health care and insurance cover for specific diseases.

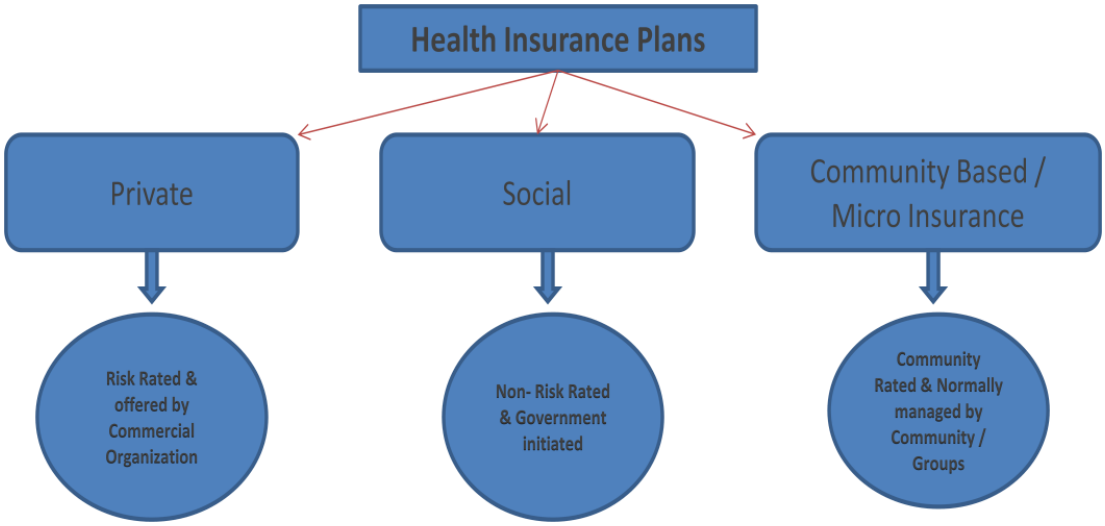


Figure no.3.10.1 Types of Health Insurance plan

HEALTH INSURANCE IS DIVIDED INTO THREE TYPES IN INDIA

1. **COMMUNITY BASED HEALTH INSURANCE**
2. **SOCIAL**
    a. ESIS(Employees state Insurance Scheme)
    b. Central Government Health Scheme (CGHS)
    c. Self-Employed Women‘s Association (SEWA)

3. **PRIVATE**
    a. Individual policy
    b. Group Mediclaim policy (also known as GMC).

1. INSURANCEOFFERED BY NGOS/COMMUNITY-BASED HEALTH INSURANCE

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premium are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits. Community –based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources (International Labour Office Universities Program 2002 as quoted in Ranson K & Acharya A2003).

Such schemes are generally run by trust hospitals or nongovernmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for profit insurers for the purchase of Custom designed group insurance policies. However, the coverage of such schemes is low, covering about 30-50 million. A review by Bennett, Cresses et al. indicates that many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.

2 (a) EMPLOYEE AND STATE INSURANCE SCHEME (ESIS)

The ESIS programmed has attracted considerable criticism. A report based on patient surveys conducted in Gujarat found that over half of those covered did not seek care from ESIS facilities. Unsatisfactory nature of ESIS services, low quality drugs, long waiting periods,

impudent behavior of personnel, lack of interest or low interest on part of employees and low awareness of ESI procedures, were some of the reasons cited.

(b) CENTRAL GOVERNMENT HEALTH SCHEME (CGHS)

Since 1954, all employees of the Central Government (present and retired) some autonomous and semi-government organizations, MPs, judges, freedom fighters and journalists are covered under the Central Government Health Scheme (CGHS). This scheme was designed to replace the cumbersome and expensive system of reimbursements. It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities, and preventive and promotive care in dispensaries. Inpatient facilities in government hospitals and approved private hospitals are also covered. This scheme is mainly funded through Central Government funds, with premiums ranging from Rs 15 to Rs 150 per month based on salary scales.

The coverage of this scheme has grown substantially with provision for the non-allopathic systems of medicine as well as for Allopathy. Beneficiaries at this moment are around 432 000, spread across 22 cities.

The CGHS has been criticized from the point of view of quality and accessibility. Subscribers have complained of high out-of-pocket expenses due to slow reimbursement and incomplete coverage for private health care (as only 80% of cost is reimbursed if referral is made to private facility when such facilities are not available with the CGHS).

(c) SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA), GUJARAT :

This scheme established in 1992, provides health, life and assets insurance to women working in the informal sector and their families. The enrolment in the year 2002 was 93 000. This scheme operates in collaboration with the National Insurance Company (NIC). Under SEWA_s most popular policy, a premium of Rs 85 per individual is paid by the woman for life, health and assets insurance. At an additional payment of Rs 55, her husband too can be covered. Rs 20 per member is then paid to the National Insurance Company (NIC) which provides coverage to a maximum of Rs 2 000 per person per year for hospitalization. After being hospitalized at a hospital of one_s choice (public or private), the insurance claim is the responsibility for enrolment of members, for processing and approving of claims rests with SEWA. NIC in turn receives premiums from SEWA annually and pays them a lump sum on a monthly basis for all claims reimbursed.

- **THE VOLUNTARY HEALTH SERVICES (VHS),**

Chennai, Tamil Nadu was established in 1963. It offers sliding premium with free care to the poorest. The benefits include discounted rates on both outpatient and inpatient care, with the VHS functioning as both insurer and health care provider. In 1995, its membership was 124 715. However, this scheme suffers from low levels of cost recovery due to problems of adverse selection.

- **SOCIAL INSURANCE OR MANDATORY HEALTH INSURANCE SCHEMES OR GOVERNMENT RUN SCHEMES (NAMELY THE ESIS, CGHS)**

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

- **OTHER GOVERNMENT INITIATIVES**

Apart from the government-run schemes, social security benefits for the disadvantaged groups can be availed of, under the provisions of the Maternity Benefit (Amendment) Act 1995, Workmen_s Compensation (Amendment) Act 1984, Plantation Labour Act 1951, Mine Mines Labour Welfare Fund Act 1946, Beedi Workers Welfare Fund Act 1976 and Building and other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996.

The Government of India has also undertaken initiatives to address issues relating to access to public health systems especially for the vulnerable sections of the society. The National Health Policy 2002 acknowledges this and aims to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services. Ensuring more equitable access to health services across the social and geographical expanse of the country is the main objective of the policy.

- **VOLUNTARY HEALTH INSURANCE SCHEMES OR PRIVATE-FOR-PROFIT SCHEMES**

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the

premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumers income.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes.

The Life Insurance Corporation offers Ashadeep Plan IIand Jeevan Asha PlanII. The General Insurance Corporation offers Personal Accident policy, Jan Arogya policy, Raj Rajeshwari policy, Mediclaim policy, Overseas Mediclaim Policy, Cancer Insurance policy, Bhavishya Arogya policy and Dreaded Disease policy. Of the various schemes offered, Mediclaim is the main product of the GIC.

The Medical Insurance Scheme or Mediclaim was introduced in November 1986 and it covers individuals and groups with persons aged 5–80 yrs. Children (3 Months – 5 yrs) are covered with their parents. This scheme provides for reimbursement of medical expenses (now offers cashless scheme) by an individual towards hospitalization and domiciliary hospitalization as per the sum insured. There are exclusions and pre-existing disease clauses. Premiums are calculated based on age and the sum insured, which in turn varies from Rs 15 000 to Rs 5 00 000. In 1995/96 about half a million Mediclaim policies were issued with about
1.8 million beneficiaries. The coverage for the year 2000-01 was around 7.2 million.

Another scheme, namely the Jan Arogya Bima policy specifically targets the poor population groups. It also covers reimbursement of hospitalization costs up to Rs 5 000 annually for an individual premium of Rs 100 a year. The same exclusion mechanisms apply for this scheme as those under the Mediclaim policy. A family discount of 30% is granted, but there is no group discount or agent commission. However, like the Mediclaim, this policy too has had only limited success. The Jan Arogya Bima Scheme had only covered 400000 individuals by 1997.

The year 1999 marked the beginning of a new era for health insurance in the Indian context. With the passing of the Insurance Regulatory Development Authority Bill (IRDA) the insurance sector was opened to private and foreign participation, thereby paving the way for the entry of private health insurance companies. The Bill also facilitated the establishment of an authority to protect the interests of the insurance holders by regulating, promoting and

ensuring orderly growth of the insurance industry. The bill allows foreign promoters to hold paid up capital of up to 26 percent in an Indian company and requires them to have a capital of Rs 100 crore along with a business plan to begin its operations. Currently, a few companies such as Bajaj Alliance, ICICI, Royal Sundaram, and Cholamandalam among others are offering health insurance schemes. The nature of schemes offered by these companies is described briefly.

3. PRIVATE: -

a. Individual policy-

One may obtain a health insurance policy through two different ways: individually or through group insurance. In individual insurance, a person gets to talk with the health insurance providers one-on-one, in order to get themselves a deal that would have most of their requirements fulfilled. Individual health insurance is such that one is able to choose what s/he wants, and is not saddled with any and everything. Many people prefer to go for individualized health insurance because they get to choose what they want to be covered for. In complete honesty they have surrender any knowledge of their family history in terms of illness so that their cases can be assessed thoroughly. In the case of an individual policy, the risks of being rejected before commencement of the policy are higher. This is because of the possibility of the smallest of things affecting any clause in the policy. Sometimes insurance companies do this to save on expenses and payments that may not really be required.

b. Group Health Insurance Policy

In contrast to this is a group insurance policy because there are fewer chances; insurance companies do not usually reject paying up dues to people in a group insurance policy. Group insurance policies tend to be more successful and less prone to obstacles; often in-depth checkups are not conducted as they are with individual health policies. The reason behind this is that insurance companies are suspicious of individuals who approach them; they feel that there must be a particular reason for them approaching them. This is sometimes true, and so, individuals tend to be scrutinized much more than group members.

3.11HEALTH INSURANCE SCENARIO IN INDIA

Health is a human right. It's accessibility and affordability has to be ensured. The escalating cost of medical treatment is beyond the reach of common man. While well to do segment of

the population both in Rural and Urban areas have accessibility and affordability towards medical care, the same cannot be said about the people who belong to the poor segment of the society.

Health care has always been a problem area for India, a nation with a large population and larger percentage of this population living in urban slums and in rural area, below the poverty line. The government and people have started exploring various health financing options to manage problem arising out of increasing cost of care and changing epidemiological pattern of diseases.

The control of government expenditure to manage fiscal deficits in early 1990s has let to severe resource constraints in the health sector. Under this situation, one of the ways for the government to reduce under funding and augment the resources in the health sector was to encourage the development of health insurance.

In the light of escalating health care costs, coupled with demand for health care services, lack of easy access of people from low income group to quality health care, health insurance is emerging as an alternative mechanism for financing health care.

Indian health financing scene raises number of challenges, which are:

- Increase in health care costs
- High financial burden on poor eroding their incomes
- Need for long term and nursing care for senior citizens because of increasing nuclear family system
- Increasing burden of new diseases and health risks
- Due to under funding of government health care, preventive and primary care and public health functions have been neglected

In the above scenario, exploring health financing options became critical. Naturally, health insurance has emerged as one of the financing options to overcome some of the problems of our system.

In simple terms, health insurance can be defined as a contract where an individual or group purchases in advance health coverage by paying a fee called “premium”. Health insurance refers to a wide variety of policies. These range from policies that cover the cost of doctors and hospitals to those that meet a specific need, such as paying for long term care. Even disability

insurance, which replaces lost income if you cannot work because of illness or accident, is considered health insurance, even though it is not specifically for medical expenses.

Health insurance is very well established in many countries, but in India it still remains an untapped market. Less than 15% of India's 1.1 billion people are covered through health insurance. And most of it covers only government employees. At any given point of time, 40 to 50 million people are on medication for major sickness and share of public financing in total health care is just about 1% of GDP. Over 80% of health financing is private financing, much of which is out of pocket payments and not by any pre-payment schemes. Given the health financing and demand scenario, health insurance has a wider scope in present day situation in India. However, it requires careful and significant efforts to tap Indian health insurance market with proper understanding and training.

CHAPTER 4

AWARENESS

4.1 CURRENT STATUS OF PRIVATE/PUBLIC HEALTH INSURANCE IN INDIA

Health care has always been a problem area for a country like India with a large population, majority of the people residing in urban slums and rural areas, below the poverty line. The Indian health care sector has received lowest percentage of the country's national budget and as a result health care expenditure are largely out of pocket (OOP). However, in recent years, Indian health care planners have advocated for the expansion of health insurance schemes in order to improve the health care reforms and reduce poverty. This goal can only be achieved by implementing universal health insurance, which can be a major step in reducing health disparities and OOP health expenditure. Presently, numerous publics, private, and community-based insurance schemes have come to coexist and even merge with each other, a situation that is hardly surprising in a country as diverse as India.

There are various forces which have brought health insurance to the attention of Indian policy makers. These include – high ill health burden, low public spending on health care, high

expenditure with regard to private health care and partial coverage of the already existing health insurance schemes. In the recent years, there has been a substantial private spending on health especially in terms of OOP expenditures on medicines. This is probably due to low national public health spending in India. As a result of this, the private sector has been blooming, providing 80% of outpatient and 60% of inpatient care. Research has revealed that it is not the hospitalization cost but the drug expenditure, which accounts for 60%–80% of the total OOP spending.These findings suggest that insurance schemes which cover only hospital expenses (national insurance schemes in India) will fail to adequately protect the poor against impoverishment due to spending on health. In view of all the above findings, this paper intends to explore private health insurance in India with a spot light on outpatient coverage under this insurance.

4.2 HEALTHCARE INSURANCE AWARENESS IN INDIA

Insurance may be described as a social device to reduce or eliminate risk of life and property. Under the plan of insurance, a large number of people associate themselves by sharing risk, attached to individual insurance plan that exclusively covers healthcare costs and is called Health Insurance. Since the past two decades, there has been a phenomenal surge in acceleration of healthcare costs. This has compelled individuals to have a re- look on their actual monthly expenditures, spending patterns and simultaneously allocate a proportion of their income towards personal healthcare. This has resulted in individuals availing healthcare insurance coverage not only for themselves but also for their family members including their dependents. In short, healthcare insurance provides a cushion against medical emergencies.

Recent reports suggest that public awareness and understanding of health insurance in India is poor. However, general public awareness of health insurance in Kerala and in some other parts in India is increasing as a result of the efforts of private health insurance agents. Lack of necessary education and “culture” are perceived as “barriers” due to which people have difficulties in managing money and health and difficulty in learning this new technology. Poor and less educated people residing in both the rural and urban areas, consult private practitioners more than government practitioners and spend about twice as much on treatment from them than from government practitioners.This thing has led to the deepening of poverty in both rural and urban areas, pushing the millions of people into poverty each year.According to recent surveys and field works carried out in India, understanding of the entitled benefits and

privileges remains confusing not only to the poor and illiterate people but also to the educated middle class citizens. This could be due to promotional languages of the insurance sellers that is difficult to understand for the general public belonging to different educational backgrounds

4.3 THE NEED TO SPREAD HEALTH INSURANCE AWARENESS

India may have ranked in a higher position in 2019 when it comes to rocket science, technology and health care research.

But, getting a health insurance policy for Indians is still not mandatory.

Despite the fact that health insurance should be the first step of all financial plans, a large section of the population is still not aware of health care insurance.

Kicking off such a crucial aspect of health care is apparently what contributes to high death rates and critical medical debt that the nation is grappling with.

In fact, the lack of health insurance awareness among people is one of the hurdles in the penetration of the country's health sector industry.

Although the healthcare industry ranks among the fastest-growing industries in the country, health insurance keeps pace at a slow speed.

Various types of health insurance products are available online in the country, such as:

- Individual health insurance plans
- Family floater health insurance plans
- Senior citizens health insurance policies
- Critical illness insurance plans
- Health insurances, especially for women, newborn, etc.
- Some specific health insurance for vector born diseases
- Single disease health insurance products, etc.

The sad part is that insurance companies are unable to tap a major chunk of the population. This is what putting the lives of millions at risk.

Do you think development in medical science is helping people avail of specialized treatment in rural areas?

The answer sadly is ‘NO.’

This is what prompts us to raise public awareness of health insurance policies in India.

Read below to know the factors that promote public awareness program related to health insurance in India.

Only 27% of the People are Covered

If we go by the joint report of KPMG and FICCI, we find that only 27% of the people have health insurance in India. The number is undoubtedly very low in comparison to our mammoth population.

The gap is alarming and astonishing. Astonishing because on the one hand, we are claiming to pace up with other countries when it comes to the private and public healthcare sector. On the other hand, medical costs are escalating rapidly and are on a continuous rise.

Dependency on Corporate Plans

The dependency on the corporate health insurance plan that does not provide coverage for major or critical illnesses is another reason. The result is that the majority of people are reluctant to personal health cover.

Illiteracy & Lack of Awareness

Illiteracy & Lack of Awareness are other causes. We can understand this by understanding insurance penetration and insurance density.

With the IRDAI annual report, we have tried to figure out where we stand as a country in terms of Insurance Penetration and Insurance Density. In general, Insurance Penetration and Insurance Density are the two benchmarks that signify consumption and awareness of insurance in a particular geographical area.

Insurance Penetration: It is calculated as a first-year new business premium to GDP, i.e. the percentage of the insurance premium to GDP. Currently, Insurance Penetration is one of the lowest at 3.69% in India.

Insurance Density: It is the ratio of premium in a given year to the total population. The insurance density in India was $59.7 in 2016 (life 46.5 and general 13.2), as per the government and industry data.

There is a huge difference in insurance penetration and density in India compared to countries like the US and the UK.

Insurance Penetration and Insurance Density - A Proportional to the Literacy Rate

A very closer study has found that insurance penetration and insurance density are somewhat proportional to the literacy rate.

Let me prove,India ranks among countries with the lowest general insurance penetration and density. And we have a comparatively lower literacy rate - just 73%.

US and UK have a 99.0% literacy rate, so they have higher insurance penetration rates.Similarly, Delhi with one of the highest literacy rates boasts of the highest penetration. In contrast, Bihar with the lowest literacy rate of 63.82% has the lowest insurance density. This means the higher the literacy rate, the higher the penetration rates.

It’s not wrong to say that educated people are well aware of health insurance - its needs and benefits.

So, the need for health insurance awareness programs and proper education should be the priority in villages and remote areas where literacy rate is low. Several initiatives should be taken with objectives to tell people the importance of health insurance and build the trust and credibility of insurance companies among them.

Listed below are highlights of such public awareness programs:

Optimal coverage: Let people know about the optimal coverage offered by health insurance.Cashless treatment: Let people know about cashless treatment. Make them understand that they will be treated without spending even a single rupee in world-class hospitals.

Financial cushion: People should be taught that health insurance policies act as much needed financial support in case of medical emergencies. It saves them from getting stuck in financial stress.

Helpful during medical inflation: The medical costs are increasing, and it will keep increasing. Let customers know that it is only health insurance plans that enable them to get better treatment without spending from their own pocket.

Increased life risks: In today's world, we're at a higher risk of breaking our health and being hospitalized. Getting a health cover can solve this problem.

Lump-sum payment: Make people aware that a lump sum amount is paid to the insured or nominee in case the insured person is diagnosed with a critical illness, like cancer, heart attack, stroke, etc.

Worldwide cover: It's also necessary to explain people about the worldwide coverage benefits under some policies.

Types of Health Policies: Spreading knowledge about the coverage provided in different types of health insurance plans is another area of concern to lure people to buy health insurance. Enlighten them about the monetary and maternity benefits offered in a health insurance cover.

Clarifying doubts: Health insurance is a subject matter of discretion. Let people know that they should not buy any plan blindly. Instead, they ask questions and clarify all their doubts from the insurance agent before choosing a plan.

Terminologies & parameters: It is essential to equip potential policy buyers with terminologies and parameters such as claim settlement ratio (CSR), incurred claims ratio (ICR), Solvency Ratio and so forth. These factors will help them distinguish between various players.

Optional benefits: In the awareness program, focusing on optional benefits such as add-on cover, riders along with general inclusions is necessary. Also, exclusions should not be ignored.

Healthy lifestyle: Letting buyers know that if they live a healthy lifestyle or buy a policy at a young age, it can lead them to lower premium rates.

Use of technology: We should increase customer awareness and engagement through mailers, videos, radio YouTube, etc.

Insurer's Responsibility

Besides including the above topics in public awareness programs, there are also great roles of insurance companies. Every insurer should be committed to building trust among people by

paying quality services and approving claims without delay. They should be focused on real-time engagement with customers through their website. They must give a prompt reply to queries to motivate people to buy health insurance.

Bottom Line

No doubt, we are witnessing an unbelievable economic and development growth. But, it is a long way to go to achieve health goals. Making people aware of health insurance and allowing customized policies available to them will be a turning point.

After all, effort never goes waste. We must be committed to promoting public awareness of health insurance in India. We can do this by organizing campaigns in suburban locations, villages and cities, explaining why health insurance is important to cope up with the increasing health care challenges in our country.

4.4 AWARENESS HELP TO BOOMING HEALTH INSURANCE IN INDIA

In the Indian non-life insurance industry, health insurance is the second largest segment. It has picked up pace in previous fiscals, and is set to reach new heights in the coming few years as public and private insurers are coming up with various schemes to cover the untapped insurance market. As per our latest findings, the Indian health insurance industry is one of the most prolific ones in the world. As the healthcare costs and awareness are rising in the country, we expect the segment to grow with gross premiums scaling up at a CAGR of around 32.5% during 2010-11 to 2013-14. India‘s health insurance landscape has undergone tremendous changes in the last few years with the launch of several health insurance schemes, largely initiated by central and state governments. We observed that a significant share of coverage has been achieved through central and state government-sponsored health insurance schemes. Besides, private and public health insurers have introduced a large number of plans and schemes to cover an individual and his family against critical ailments like heart failure, stroke and kidney failure.

As a chunk of population in India is living with HIV/AIDS, the private health insurance companies are cashing in on the big opportunity by designing special policies for such people. India could soon see a national medical insurance policy for people living with HIV (PLHIV). The National Aids Control Organization is planning to make insurance 'inclusive and universal for PLHIV', we observed while studying and analyzing trends in the Indian health insurance industry.

During the health insurance market analysis, researcher found that there are around 28 active third party administrators (TPAs) in India, and the TPA infrastructure in the country has witnessed a strong growth with the rising penetration of health insurance. The TPAs are recognized as valuable service providers in the health insurance services delivery chain. Our comprehensive report also identified that emergence and growth of health insurance have given rise to a need for maintaining and optimizing claims processing and management. It aims at enhancing services, offered by health insurance companies, for the maximum benefit of the insured.

According to the study, health insurance portability is also gaining popularity in India as it allows health insurance policyholders to switch companies while retaining their no-claims benefit. The report also provides an overview of the rural health insurance segment, and expects that the number of uninsured rural households will decrease with time. Various Insurance Regulatory and Development Authority (IRDA) acts and amendments have also been studied to understand the regulatory framework for the industry. The research also looks into profiles of various players in public and private sectors to present the competitive landscape and a balanced outlook of the Indian health insurance industry to clients.

4.5 HOW TO CHOOSE BEST HEALTH INSURANCE PLAN

Ever since the new ideas and new techniques have been witnessed in the market, health insurance has gained real importance. It is very important to choose the right kind of plan not only for your benefit but for family‘s as well. The basic idea of the insurance companies is to bring more and more plans which would suit your needs the best way. And hence, there are innumerable unique plans made available in the market by the insurance companies. The only thing you need to know is the right kind of criteria while choosing any plan. There are certain tips which would surely help you choose the right kind of plans;

- While choosing a plan, the first priority for is to acknowledge your needs and then act accordingly while choosing the kind of plan you need.
- Check out the prices of the various policies available in the market.
- Compare them and buy the plan as per your paying capacity.
- Search for the individual or family policies available, as are much more economical and provides higher coverage for all the members of your family.

- Normally a broker is the best option when buying a policy cover as he can review all the terms of the policy properly and doesn‘t push an individual towards buying any policy.
- Preferably, avoid insurance policies which have tie-ups with any particular hospitals or have specific conditions for buying the plans.
- The most important thing is to be truthful with the broker or the insurance company and give them all the proper details required for their procedures.

Rest will depend upon the insurance policy taken by you and the way it would be helpful in the near future. The better way is to maintain utmost care in your wellbeing and you’re eating habits. This would keep you away from the germs as well as harmful diseases.

CHAPTER 5

REGULATORY FRAMEWORK

5.1 ROLE OF REGULATOR

As Health Insurance is in its very early phase, the role of IRDA will be very crucial. It has to ensure that this sector develops rapidly and benefit of insurance goes to the consumers. It has to guard against the ill effects of privatization. Unless privatization and development of health insurance is managed well it may have negative impact of health care, especially to a large segment of rural population in the country. If it is well managed then it can improve access to care and health status in the country rapidly. Experience from other countries suggest that the entry of private firms into the health insurance sectors, if not properly regulated , does have adverse consequences for the cost of care, equity, consumer satisfaction, fraud and ethical standards. Some of the areas of concern which the regulator has to look into are:

Many times the insurance claims are rejected due to small technical reasons. This leads to disputes

- Various conditions included in the insurance policy contract is not negotiable and these are binding on consumer
- There no analysis on what is fair practice and what is unfair practice
- The most important area of dispute and unfair treatment is the knowledge and implications of pre-existing conditions.
- The main danger in the health insurance business is that the private companies will cover the risk of middle class who can afford to pay high premiums. Unregulated reimbursement of medical costs by the insurance companies will push up the prices of private care. So large section of India's population who are not insured will be at a relatively disadvantage as they will, in future, have to pay more for the private care.

IRDA has stipulated regulations for both life and non-life insurance companies in many aspects of business but the same is lacking in respect of health insurance business. Given the health insurance is assuming greater significance, it is time for the regulator to etch a frame work for operating the health schemes.

IRDA will have to evolve mechanism so that the private insurance companies do not skim the market by focusing on rich and upper class clients and in the process neglect a major section of India's population.

In a view to ensure that the rural and less-developed areas do not fall prey to a step-motherly treatment in penetration of health business, the Regulator may ensure, in line with its rules jotted down for private life and non-life insurers, that minimum annual targets are given to the benefit providers so that at any given point in time, a decent portfolio of health coverage's represent the rural sector IRDA should ensure and encourage different organizations and private insurers to develop products for the poorer segment of the community and if possible build an element of cross subsidy for them.

The IRDA will have a significant role in regulating the health insurance sector and safe guarding the interests of the policy holders by minimizing the unintended consequences.

5.2 RULES BY IRDA

- All Health Insurance products henceforth would be renewable for lifetime, without any renewal ceasing age.
- Grace period for renewal of Health Insurance would be 30 days, before which delay of renewal could be condoned by the Insurance Company.
- Health Insurance policies from Life Companies would have a minimum term of 4 years, whereas Non-Life companies could have a maximum term of 3 years.
- Clear procedures specified for smooth migration of children from Floater plans proposed by their Parents, into their own independent plans.
- Insurers would be required to have policy wordings of all their products mandatorily put up on their website. (Yes, there are some good companies which don't have Policy Wordings on their portal)
- Communication of Denial of Coverage, and Loading on fresh Health Insurance proposals should be in writing.
- Separate Claims and Grievance Cell for Senior Citizens.
- Loading on Claims only when individual claims for 3 consecutive years exceed 500% of the renewal premium.
- Health Insurance Customers with multiple insurance policies, would have a choice to choose which product he wants to use. Contribution would be effected between Insurance companies, without involving the customer.

- Standard Definitions, Exclusions, and Forms (like Claim Forms) are expected to be released by IRDA.
- Renewal Procedure (regarding maximum age, changes in coverage at later ages, upgrading cover, loading charges) would have to be clearly detailed in the policy wordings
- Any change in Terms of the policy at the time of renewal need to be communicated with the policy holder 3 months before the renewal date.
- Insurers are required to mandatorily settle claims within 30 days of submission of complete documents.
- Insurance Companies cannot reject claims on technical grounds of delayed submission, if the customer can provide valid reasons for the delay caused.
- Cashless Cards should be issued within 15 days of issue of the Health Insurance Policy. No Fresh cards would be issued every year on renewal. The same cashless card would be continued every year.
- Hospital Network would be the responsibility of the Insurance Company, and not the TPA (which is the case currently) Insurance Companies would be required to make direct agreements with Hospitals. These agreements could be tripartite with the TPA. In short, Insurance Companies would administer the network and would be held responsible for issues that arise in the network. (Since TPAs were originally brought in to primarily administer the network of hospitals, their role after these regulations take effect, would be diluted significantly.)
- Any Change of TPA in a policy should be informed to customer with 30days of such change. All data should be seamlessly transferred to the new TPA, ensuring there is no hassle caused to the customers.

5.3 THIRD PARTY ADMINISTRATION

A Third Party Administrator (TPA) is an organization which processes claims or provides cashless facilities as a separate entity. Seen as an outsourcing of claim processing, TPA processes claims for both retail and corporate policies. The risk of loss incurred remains with the insurance company. The insurance company usually contracts a reinsurance company to share its risk. An insurance company hires TPA to manage its claims processing, provider

network and utilization review. While some TPA operates as units of insurance companies, most are often independent.

TPA is also involved in handling employee benefit plans such as processing retirement plans. Handling healthcare or employee benefit claims requires using a specialized set of manpower and technology, therefore hiring a TPA for the same is a more cost effective method. The Insurance Regulatory and Development Authority of India (IRDA) defines TPA as a Third Party Administrator who, for the time being, is licensed by the Authority, and is engaged, for a fee or remuneration, in the agreement with an insurance company, for the provision of health services. TPA was introduced by the IRDA in 2001.

Being one of the prominent players in the managed care industry, it has the expertise and capability to administer all or a portion of the claims process. The services include claims processing, premium collection, enrollment and cashless processing. Insurance companies setting up its own health plan often outsource certain responsibilities

The TPA acts like a claims adjuster for the insurance company. In some cases the insurance company sets up an entire department within their own company to act as TPA as opposed to hiring a commercial TPA company.

5.4 ROLE OF TPA IN HEALTH INSURANCE

Large number of the health insurance companies in India suffer losses and have been doing so for years together. The group health insurance profile is what may cause optimum leakage to the health insurance companies in India. TPA was introduced through the notification on TAP Health Insurance regulation 2001 by the IRDA-their basic role is to function as intermediary between the insurer and the insured and facilitate the cashless services of insurance .For this service they are paid a fixed percent of insurance premium as commission . The commission is currently fixed at 5.6 percent of premium. The introduction of TPAs is of great help and relief to the insurance companies, which have been searching for ways and means to get their management expenses in line with the specifications laid down by the IRDA. TPA is maintaining a database of policy holders and issue identity cards with unique identification numbers to them. They also handle all the policy- related issues, including claim settlements for the policy holders Insurance companies (insurers) can now outsource their administrative activities, including settlement of claims, to third party administrators, who offer such services for a cost.

The insurers remunerate the TPAs; hence, policyholders receive enhanced facilities at no extra cost. Once the policy has been issued, all the records will be passed on to the TPAs and all further correspondence of the insured will be with the TPAs and not with the insurance companies. The TPA's are expected to provide value-added services to the consumers, like arranging ambulance services, medicines and supplies, guiding policy holders for specialized consultation, and providing information about 24- hour help lines, health facilities, bed availability, organization of lifestyle management and well- being programs.

In the middle of 2010, the public sector health insurance companies, namely United India, New India, Oriental Insurance and moreover National Insurance took a tough stand and penalized major hospitals where such procedure were taking place. They eliminated these hospitals from the list from which cashless medical services can be availed by the customers. This caused a lot of pain to the insured, however the industry woke up to the fact that insurance companies were being taken for a ride. The 4 public sector health insurance companies then decided to float a TPA of their own and even do away with the middlemen who were not falling in line. This action is likely to cut down the frequency of false claims creeping their business. The move has acquired big support even from the private health insurance companies. The issuer was not of the public sector health insurance companies alone as well as certain private sector

companies have done away with the practice of TPAs as well as used to process claims through in-house representatives. The TPA undoubtedly aims to give the health insurance industry the required boost in India.

5.5 HEATH INSURANCE PORTABILITY

Portability allows customers to carry forward continuity benefits accrued on their previous policy. These benefits are gained by being under continuous coverage for a certain period. This is essential for getting coverage for pre- existing diseases. Earlier, policyholders had to stick to a policy only to retain the waiting period benefit.

Those covered under employer group health insurance policies or family floater policies can also port to an individual health cover .However, they will first have to switch to a plan offered by their existing insurer and will be allowed to switch to the insurer of their choice only after a year.

- **IRDA Has issued two circulars on the subject of portability of Health Insurance**

1. Circular dated 10th February , 2011:

- Insurance companies have been advised by IRDA to permit the policyholder to carry forward the credit gained for pre-existing conditions in terms of waiting period when he or she switches from one insurer to another , or one plan to another , provided the previous policy has maintain without break.
- The entire data base of the companies , including the claim details , in respect of polices where the policyholder have opted for portability will have to be shared with there counterparts, if requested by the counterpart within seven working days of such request. A time period of three days has been granted by the regulator to acknowledge portability applications.
- This reform is expected to bring about a positive change in the insurance industry as a whole. The industry players have welcomed this development. Health insurance portability will bring about a higher level of competition within seven working insurers in order to retain existing customers. This will insure that there is constant innovation and improvement in the efficiency , standard and services.

2. Circular dated 9th September, 2011:

- It was felt necessary to put in place a system to enable collection of data on the history of Health Insurance and monitoring the transfer of record of the porting policyholder.

In that context, it was decided that the implementation of portability of health insurance polices would be mandate to commence no later than 1st October 2011.

- Detailed procedures of Health insurance portability have been set out.
- Definition of portability and break in policy.

5.6 PORTABILITY IN HEALTH INSURANCE: HELP TO INCREASE BUYING PATTERN OF CUSTOMERS

The IRDA, vide circular dated February 10, 2011, had issued guidelines on portability of health insurance policies which was to be introduced from 1st July 2011. Subsequently, on 24th June 2011, it was felt necessary to put in place a system to enable collection of data on the history of health insurance and monitoring the transfer of records of the porting policy holder. In that context, it was decided that the implementation of portability of health insurance policies would be mandated to commence no later than 1st October 2011. In continuation of the above guidelines, the detailed procedure on health insurance portability shall be as set out in these guidelines.

1) In these guidelines, the following terms shall carry the meanings as assigned to them.

a. Portability: Portability means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

b. Break in policy: A break in policy occurs when the premium due on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

2) All policyholders are hereby vested with the right of portability, i.e., policyholders have the right to purchase a Health Insurance Policy from another insurer from amongst the products such insurer is marketing and the right will be limited to transfer of the period gained in the existing policy (ies) which would account towards PEDs and the time-bound exclusions of the new policy.

3) A policyholder desirous of porting his policy to another insurance company shall apply to such insurance company at least 45 days before the premium renewal date of his/her existing policy.

a. The Insurer may not be liable to offer portability if policyholder fails to approach the new insurer at least 45 days before the premium renewal date.

b. The insurer may consider a proposal for portability even if the policyholder fails to approach the insurer at least 45 days before the renewal date, it may be free to do so.
c. Where the outcome of acceptance of portability is still waiting from the new insurer on the date of renewal:
d. The existing policy shall be allowed to extend, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and
e. Shall not cancel existing policy until such time a confirmed policy from new insurer is received or at the specific written request of the insured
f. The new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.
g. If for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.

4) On receipt of an application for porting, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure _A' to these guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.
5) The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.
6) On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA within 7 working days of the receipt of the Portability form.
7) The insurance company receiving from another insurance company a request for relevant data shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.
8) On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal in accordance with its underwriting policy as filed by the company with the Authority in accordance with clause 6 of IRDA Form R2 of IRDA (Registration of Indian Insurance Companies) Regulations, 2000 and clause 14-15 of F&U Guidelines (circular no. 021/IRDA/F&U/Sep. 06 dated 28th September 2006),

and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders‘ interest) Regulations, 2002.

9) If on receipt of complete information and data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.

10) Portability shall be allowed in the following cases:

a. All individual health insurance policies issued by non-life insurance companies including family floater policies

b. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, he/she shall be accorded the right mentioned in 10.1 above.

SAMPLE PORABILITY FORM

Portability Form

	Name of the Policyholder / insured (s)	
	Date of Birth/Age	
	Address of the policyholder/insured	
	Details of existing insurer	
	Name of the product	
	Sum Insured	
	Cumulative Bonus	
	Add-ons/riders taken	
	Policy number	
	Details of the proposed insurance	
	Name of the product proposed/intend to take	
	Sum Insured Proposed	
	Whether Cumulative Bonus to be converted to an enhanced sum insured	
	Reason(s) for Portability	
	No. of family members to be included in the policy to be ported:	
Enclosure: Photocopy of the existing policy documents		
Date: Signature of the policyholder		

CHAPTER 6

HEALTH INSURANCE ISSUES

6.1 Reasons for Poor Penetration of Health Insurance in India.

Penetration of health insurance has been slow and halting, despite the huge market estimated to range between Rs 7.5–20 crores. Some reasons that explain for the slow expansion of health insurance in the country are as follows:

1. **Lack of regulations and control on provider behavior**

The unregulated environment and a near total absence of any form of control over providers regarding quality, cost or 282 Financing and Delivery of Health Care Services in India ata-sharing, makes it difficult for proper underwriting and actuarial premium setting. This puts the entire risk on the insurer as there could be the problems of moral hazard and induced demand. Most insurance companies are therefore wary about selling health insurance as they do not have the data, the expertise and the power to regulate the providers. Weak monitoring systems for checking fraud or manipulation by clients and providers, add to the problem.

2. **Unaffordable premiums and high claim ratios**

Increased use of services and high claim ratios only result in higher premiums. The insurance agencies in the face of poor information also tend to overestimate the risk and fix high premiums. Besides, the administrative costs are also high—over 30%, i.e. 15% commission to agent; 5.5% administrative fee to TPA; own administrative cost 20%, etc. Patients also experience problems in getting their reimbursements. Including long delays to partial reimbursements

3. **Reluctance of the health insurance companies to promote their products and lack of innovation**

Apart from high claim ratios, the non-exclusivity of health insurance as a product is another reason. In India, an insurance company cannot sell non-life as well as life insurance products. Since insurance against fire or natural disaster or theft is far more profitable, insurance companies tend to compete by adding low incentive such as premium health insurance products to important clients, cross-subsidizing the resultant losses. With a view to get the

non-life accounts, insurance companies tend to provide health insurance cover at unviable premiums. Thus, there is total lack of any effort to promote health insurance through campaigns regarding the benefits of health insurance and lack of innovation to make the policies suitable to the needs of the people.

4. **Too many exclusions and administrative procedures**

Apart from delays in settlement of claims, non-transparent procedures make it difficult for the insured to know about their entitlements, because of which the insurer is able to, on one stratagem or the other; reduce the claim amount, thus demotivating the insured and deepening mistrust. The benefit package also needs to be modified to suit the needs of the insured. Exclusions go against the logic of covering health risks, though, there can be a system where the existing conditions can be excluded for a time period—one or two years but not forever. Besides, the system entails equity implications.

5. **Inadequate supply of services**

There is an acute shortage of supply of services in rural areas. Not only is there non-availability of hospitals for simple surgeries, but several parts of the country have barely one or two hospitals with specialist services. Many centres have no cardiologists for several non communicable diseases that are expensive to treat and can be catastrophic. If we take the number of beds as a proxy for availability of institutional care, the variance is high with Kerala having 26 beds per 1000 population compared with 2.5 in Madhya Pradesh.

6. **Co-variety risks**

High prevalence levels of risks that could affect a majority of the people at the same time could make the enterprise unviable as there would be no gains in forming large pools. The result could be higher premiums. In India this is an important factor due to the large load of communicable diseases. A study of claims (Bhat 2002) found that 22% of total claims were for communicable diseases.

6.2 Major issues in health insurance

Rising population and medical inflation are often cited as major healthcare challenges in India. Looking ahead, these challenges are going to become even more challenging. As per a UN report, India is poised to overtake its neighbor, China, to become the most populous country in the world in the next decade. Willis Survey suggests India may record 10.50%

medical inflation in 2019. Thus, these two major issues are going to be troublesome in the short-run as well as the long run as far as healthcare is concerned. But that's not it. Apart from these constant impediments, there are other issues plaguing Indian healthcare as well. Read ahead to know top 5 healthcare challenges in India.

a. Medical Expenditure

Unpredictable medical expenditure pushes people into poverty's sinking sand. Once in, it is difficult to come out of it. With exhausted savings and towering loans, there is very little that such families can do to emerge out of this emergency-induced catastrophe. The World Health Organization (WHO) recognizes this problem and thus, its theme for World Health Day 2019 is Universal Health Coverage. This includes creating awareness about equal access to health services for everyone. Such out-of-pocket medical expenses are a major healthcare challenge in India.

b. Preventive Care

Home remedies are often the first response for health issues. While they might be productive for minor issues, home remedies can be further damaging in cases where prompt medical attention is required. Also, blind-faith on the videos and articles easily available online can be detrimental.

c. Rural Infrastructure

There is a massive gulf when it comes to urban and rural infrastructure with regard to healthcare. Physicians, dispensaries, hospitals, etc. are clustered in cities whereas rural areas are left unserved to a great extent. The rural infrastructure is so worrisome that there is only one government hospital bed for around 2000 people in India.

d. Public Welfare

Subsidies and increase in welfare budgets are some of the activities undertaken by the authorities for citizens' benefit. The government keeps churning out public welfare schemes from time to time but are they enough for the rising population? Are there enough skilled medical professionals across the country to cater to the health requirements of the citizens? Is technology leveraged optimally to ensure rural penetration for better awareness regarding precautionary measures?

e. Low Medical Insurance Coverage

When it comes to low per capita healthcare expenditure across the globe, India features among the lowest. A Forbes article states, more than 75% of Indians do not have medical insurance. Absence of the financial cushioning provided by medical insurance results in exhaustion of savings in order to tackle medical issues.

f. Interlinked Issues

As it is evident from the above-mentioned points, major healthcare challenges in India are interlinked. Solving one or two issues won't be enough. A strategic level change needs to be implemented that can tackle all these challenges. Perhaps, the emergence of digital infrastructure can play a huge role in intensifying the drive to find a solution to overcome these mammoth challenges. Digitization can be perceived as an enabler that can play a critical part in overcoming major healthcare hurdles in India.

6.3 MAJOR ISSUES IN HANDLING HEALTH INSURANCE

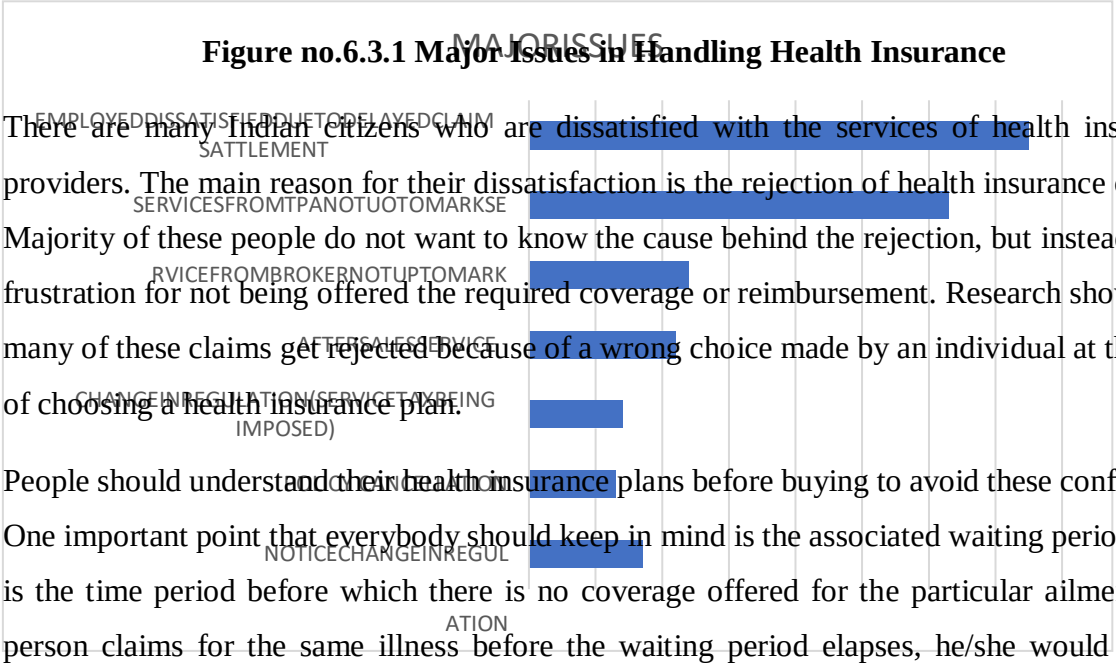


Figure no.6.3.1 Major Issues in Handling Health Insurance

There are many Indian citizens who are dissatisfied with the services of health insurance providers. The main reason for their dissatisfaction is the rejection of health insurance claims. Majority of these people do not want to know the cause behind the rejection, but instead show frustration for not being offered the required coverage or reimbursement. Research shows that many of these claims get rejected because of a wrong choice made by an individual at the time of choosing a health insurance plan.

People should understand their health insurance plans before buying to avoid these confusions. One important point that everybody should keep in mind is the associated waiting period. This is the time period before which there is no coverage offered for the particular ailment. If a person claims for the same illness before the waiting period elapses, he/she would not be offered the coverage. The other important point that a person should ponder over is to go through the exclusions section. It will help in informing him/her about the uncovered perils.

The single grievance that any dissatisfied health insurance consumer would have is that of slow settlement of claims, or that of disputed claims. In order to overcome the concept of Third-Party Administrators was introduced which was essentially for outsourcing claim settlement. The cashless model of hospitalization also depends on the TPAs, where policy holders are allowed to avail medical treatment at any of the networked hospitals without having to pay

cash up front. However, TPAs are also a source of discontentment among consumers. The survey shows that their quality of service and infrastructure needed to improve, and that the service form hospitals was really not up to the mark.

Most of the brokers are not provided the services up to mark, after selling the policy they are not taking care about the after-sale service procedure The study revealed that the satisfaction levels in health insurance plans was the least. Indicating that the health insurance segment needs to consolidate its services and bring down the dissatisfaction levels of consumers who use the service. because of the half knowledge of the customer, the policy can get not approve and customer get the cancellation notice from company, There is much confusion with regard to cashless hospitalization facility. People should remember that this facility can be availed only in network hospitals and thus, going to non-network hospitals to seek treatment on cashless basis does not make any sense. The common cause behind all these problems is that people do not read the terms and conditions of their health insurance policy carefully and thus, face problems at the time of claim settlement. Many of these people do not look into their healthcare needs while buying insurance, which is the other important point to be pondered over.

6.4 FRAUDS IN HEALTH INSURANCE

Health insurance fraud is considered a major crime that could result in serious implications. Since the health insurance industry is facing a lot of issues with regard to fraud, the punishment is severe for those who indulge in fraudulent activities.

The Health Insurance industry is expanding today and many insurance companies in India are offering various health insurance policies to the customers. Earlier, health insurance policies covered medical expenses incurred only in India, but now some policies offer coverage for treatments abroad as well. Companies have also started offering health insurance for AYUSH treatments or alternate medication now.

Today, the health insurance industry is facing a major loss in India because of the increase in fraudulent activities. Insurance fraud is a crime and it affects both the consumers and the policy makers. According to a news report, one in every ten insurance claims are fraud cases.

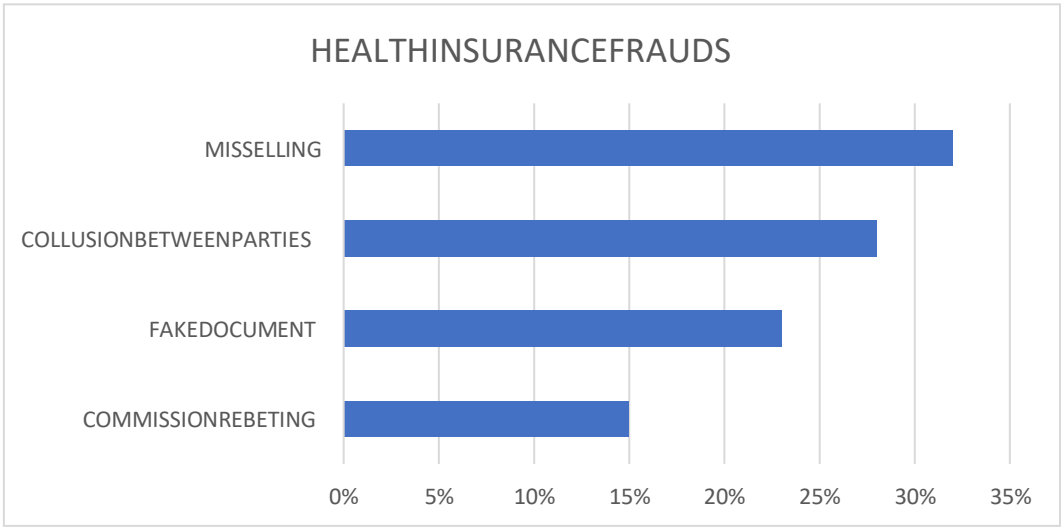


Figure no. 6.4.1

Different Types of Health Insurance Frauds:

Opportunity Fraud – Any information which is inaccurate or misleading is called opportunity fraud. It is typically done by a policyholder to ensure that they get the underwriting in their favour.

Deliberate Fraud – Here, an accident or loss that is covered by the policy is presented purposely to get the benefit.

External Fraud – This type of fraud is committed by policyholders, beneficiaries, vendors or against a company.

Internal Fraud – This type of fraud is committed by against a company or a policyholder by the employees such as agents, managers or executives.

Fraud by Policyholders – As customer now understand and know the features and terms and conditions of the insurance policies, they try to reap benefits from the policies through fraudulent activities. Some of the frauds committed by policyholders are claim fraud, eligibility fraud and application fraud.

Claim Fraud – This is one of the biggest problem faced by the insurance industry at present. When policyholders make an illegal claim to get the benefitted from the policy, then it is considered as a claim fraud. There are many cases where illegal claims have been made. For example – invisible injury, unwitnessed accidents that are not reported on the spot, etc. In some cases, the insured and the physicians together commit this type of fraud. Health care providers also commit this fraud by billing insurers for treatment that is covered by the policy of the

insured, even if the same treatment has not been given to the patients. Some policyholders purchase various health insurance policies without informing the insurance providers to enjoy claim settlement from all of them.

Eligibility Fraud – Policyholders commit this fraud by providing false details about them to be eligible for the policy. They provide wrong information about their pre-existing diseases, employment status, dependent, etc.

Application Fraud – Policyholders commit this fraud by entering wrong details in the application form about the diseases they suffer from, claims, etc., to get extra benefits. For example – Some policyholders write wrong information about the diseases to avail extensive coverage.

CHAPTER 7 KEY PLAYERS

7.1 ICICI lambord insurance

ICICI Lombard GIC Ltd. is a joint venture between ICICI Bank Limited, India's second largest bank with consolidated total assets of over USD 91 billion at March 31, 2012 and Fairfax Financial Holdings Limited, a Canada based USD 30 billion diversified financial services company engaged in general insurance, reinsurance, insurance claims management and investment management.

ICICI Lombard GIC Ltd. is the largest private sector general insurance company in India with a Gross Written Premium (GWP) of Rs. 5,358 crore for the year ended March 31, 2012. The company issued over 76 lakh policies and settled over 44 lakh claims and has a claim disposal ratio of 99% (percentage of claims settled against claims reported) as on March 31, 2012. The company has been conferred the "Golden Peacock Award 2012" for Corporate Social Responsibility, "Golden Peacock Innovation Award-2010" for Rashtriya Swasthya Bima Yojana. It also received the "Skoch Financial Inclusion Award-2011" in the micro finance category. The company has been conferred with 'NASSCOM - CNBC TV18 IT User Award 2010' for Best Technology Implementation in the Insurance Sector. It has been awarded CNBC Awaaz Consumer Award 2010 for being the 'most preferred brand' in the General Insurance category. ICICI Lombard Auto Insurance has been rated highest in customer satisfaction by J.D. Power Asia Pacific in India among 11 auto insurance providers. It was awarded Customer and Brand Loyalty award in the 'Insurance Sector - Non-Life' at the 3rd Loyalty awards, 2010 and the 'General Insurance Company of the Year' at the 11th Asia Insurance Industry Awards. The company also won the NDTV Profit Business Leadership Award 2007 and was adjudged as the most Customer Responsive Company in the Insurance category at the Economic Times Avaya Global Connect Customer Responsiveness Award

2006. It has the Gold Shield for 'Excellence in Financial Reporting' by the ICAI (Institute of Chartered Accountants of India) for the year ended March 31, 2006.

PRODUCT OFFERED

- Family Protect Premier
- **Health Advantage Plus**
- Critical Care
- Personal protect
- Health Care Plus

Popular Product

Health Advantage Plus-

Health Advantage which covers not only hospitalization expenses but also outpatient expenses like dental, up to a limit. Maternity cover is also available under this product. The company has also added Health insurance Guide, an interactive tool to help the customer Selecta plan to suit his requirements.

Health Advantage Plan has two fixed Premium brackets of Rs. 15,000 and Rs. 20,000 for senior citizens. This ensures that you get the entire Tax benefit.

IMPORTANT HEALTH FEATURES:

1. A Choice of cover of Rs. 2 lakh and Rs.3 lakh at the same premium rate
2. You can avail Outpatient treatments under this policy
3. You can cover 2 individuals in the same policy at the same rate.
4. Pre existing illness covered after 2 years
5. No pre-screening or medical test till age limit 55
6. The premium does not change as per age.

7.2 RELIANCE HEALTH INSURANCE

Reliance Health Insurance Reliance General Insurance Company Ltd is a leading health insurance company in India. The company has a huge customer base consisting of Individuals, subject matter experts, and corporate people. They look forward to satisfying the insurance needs of an individual at the crucial hour, offer the best customer service, fine-tune their products at different times, and provide them the better reach countrywide. They also look forward to making insurance as much affordable and easily accessible as they can while focusing on their operation in a consumer-centric way. In the meantime, the major aim at protecting the interest of the policyholder. They have around 139 offices and more than 12,000 intermediaries across the country, hence making them very reachable and accessible. Their mission is to satisfy the insurance need at the crucial hour, offer the best customer service, innovate their products from time to time, and provide better reach across the country. Reliance Health Insurance plans more affordable & accessible, keeping the customers at focal point in their operations, and most important protect the interest of the policy holder.

RELIANCE HEALTH INSURANCE AT A GLANCE :-

KEY FEATURES	HIGHLIGHTS
NETWORK HOSPITALS	4000+
INCURED CLAIM RATIOS	106.54
RENEWABILITY	LIFE LONG
WAITING PERIOD	4 YEARS

PRODUCT OFFERED

- Reliance HealthGain Policy.
- Reliance Critical Illness Policy.
- Reliance Personal Accident Policy.

While the former is a conventional health insurance policy, the latter two are benefit policies offering specific coverage against the risk of an accident and critical illnesses respectively.

RELIANCE HEALTH GAIN INSURANCE PLAN

Mahatma Gandhi once said, “It is health that is real wealth and not pieces of gold and silver.” We, at Reliance General Insurance, take these words quite seriously and believe that everyone should have a health insurance policy!

Take care of yourself and be prepared for any emergencies - Get yourself and your family insured with Reliance HealthGain!

- Discount of 5% for a single woman or girl child on health insurance
- Re-instatement of base sum insured, if you’ve exhausted the total sum insured
- Buy a policy with a sum insured of Rs. 3 lakh, at any age
- Automated one-year extension of policy in case of a 'named critical illness'
- Immediate & extended family members can be covered under individual health insurance plan
- Lifelong renewal for health insurance
- Cashless hospitalisation in 4000+ preferred network hospitals.
- Quick and hassle-free claim settlements

7.3 BAJAJ ALLIANZ

Bajaj Allianz General Insurance Company Limited is a joint venture between Bajaj Finserv Limited (recently demerged from Bajaj Auto Limited) and Allianz SE. Both enjoy a reputation of expertise, stability and strength.

Bajaj Allianz General Insurance received the Insurance Regulatory and Development Authority (IRDA) certificate of Registration on 2nd May, 2001 to conduct General Insurance business (including Health Insurance business) in India. The Company has an authorized and paid up capital of Rs 110 crores. Bajaj Finserv Limited holds 74% and the remaining 26% is held by Allianz, SE.As on 31st March 2010, Bajaj Allianz General Insurance maintained its premier position in the industry by achieving growth as well as profitability. Bajaj Allianz has made a profit before tax of Rs. 180 crores and has become the only private insurer to cross the Rs.100 crore mark in profit before tax in the last four years. The profit after tax was Rs. 121 crores, 27% higher than the previous year.

Bajaj Allianz General Insurance has received the prestigious "Business Leader in Bajaj Allianz today has a countrywide network connected through the latest technology for quick communication and response in over 200 towns spread across the length and breadth of the country. From Surat to Siliguri and Jammu to Thiruvananthapuram, all the offices are interconnected with the Head Office at Pune.

Bajaj Allianz has received iAAA rating, from ICRA Limited, an associate of Moody's Investors Service, for Claims Paying ability. This rating indicates highest claims paying ability and a fundamentally strong position. Bajaj Allianz General Insurance has received the prestigious "Business Leader in General Insurance", award by NDTV Profit Business Leadership Awards 2008. The company was one of the top three finalists for the year 2007 and 2008 in the General Insurance Company of the Year award by Asia Insurance Review.

PRODUCT OFFERED

1. Individual Health Guard
2. Family floater Health Guard
3. Extra Care
4. Health Ensure
5. Critical illness care

POPULAR PRODUCT

Health Guard

Health Guard (Mediclaim), Silver health (Senior Citizen) and Star package (Family Floater), there are also other plans like Hospital Cash which gives an amount on every day of hospitalization and Critical Illness which gives a lump sum in the event that the insured contracts one of the critical illnesses listed like cancer during the policy period. Bajaj was the first company to come up with a captive TPA with ensuing efficiencies.

MAIN IMPORTANT FEATURES OF HEALTH GUARD:-

- The member has cashless facility at over 2900 hospitals across India.
- With Health Guard, the member has access to cashless facility at various empanelled hospitals across India.
- Pre and post - hospitalization expenses covers relevant medical expenses incurred 60 days prior to and 90 days after hospitalization
- Covers ambulance charges in an emergency subject to limit of Rs. 1000 /-
- No tests required up to 45 years up to SI 10 lacs*
- 10% co- payment applicable if treatment taken in non-network hospitals
- 20% co-payment applicable for members of age group 56 -65 years, opting this policy for first time
- Waiver on 10% co-payment is available on payment of additional premium.

7.4 BHARTI AXA HEALTH INSURANCE

Bharti AXA health insurance company offers comprehensive health insurance plans to meet the varied insurance needs of its customers. The insurer has a wide range of network hospitals where the insured members can avail cashless treatment. Bharti AXA health insurance coverage can be enhanced with various add-on benefits like coverage for critical illness, maternity expenses, genetic disorders, as per the needs and requirements of the policyholder.

Bharti AXA General Insurance Company Limited is a joint venture between Bharti Enterprises, which is a reputed Indian business group and AXA, which is a world leader in financial protection and wealth management. The company started its operations in August 2008 and within the first year itself, it received dual certifications of ISO 9001:2008 and ISO 27001: 2005. It is the first organization dealing in general insurance that has received these two certifications in the very first year of operations. These certifications were subsequently renewed in the year 2012 for three more years. In case of Health Insurance, the company offers a range of products designed to meet all the requirements of the individual.

BHARTI AXA HEALTH INSURANCE AT A GLANCE

FEATURES	**SPECIFICATIONS**
NETWORK HOSPITALS	4500+
INCURRED IN RATIO (AS PER THE IRDAI 2018-19 REPORT)	89%
NO OF CLAIM SETTELED	18 LAKH +
NUMBER IF POLICIES ISSUES	1.3 MILLION
RENEWABILITY	LIFELONG

PRODUCT OFFERED

- Bharti AXA smart health assure plan.
- Bharti AXA smart super health insurance plan.
- Bharti AXA smart health insurance classic plan.
- Bharti AXA smart health insurance uber plan.
- Bharti AXA smart health critical illness plan.
- Bharti AXA smart individual personal accident insurance plan.

Bharti AXA general insurance company offers health insurance plan for individuals, families, and even senior citizens. While the two major plans are Bharti AXA smart super health insurance and smart health assure.

POPULAR PRODUCT

BHARTI AXA SMART SUPER HEALTH INSURANCE PLAN

The Smart Super Health Insurance Plan from Bharti AXA Health Insurance comes in three variants – the Value Plan, the Classic Plan, and the Uber Plan. Thus, you can choose an optimum sum insured amount as per your choice of the plan variant. The Smart Super Health Insurance Plan from Bharti AXA covers the policyholder's hospitalisation expenses and also offers a range of other added benefits.

BENEFITS

- No claim bonus up to 100% of the sum insured can be availed.
- Annual health checks can be availed by the policyholder.
- There is no capping on expenses incurred as a result of room rent.
- Policy buyers can opt for a sum insured between Rs.5 lakh and Rs.1 crore, as per their needs.

COVERAGE

- Policy covers hospitalization, in-patient treatment, pre-hospitalization expenses (60 days), post-hospitalization expenses (90 days), organ donor charges, day care treatments, AYUSH treatments, and domiciliary hospitalization.

- Up to 100% of the sum insured amount can be restored upon exhaustion of the coverage.
- Up to Rs.3,000 per event will be reimbursed for ambulance charges
- Convalescence benefit, outpatient emergency treatment, outpatient dental emergency, etc. will be covered on the basis of the plan variant opted for
- Optional add-ons (Hospital Cash Allowance, Maternity Benefit, etc.) can be purchased.
- Lump sum benefit will be offered upon detection of critical illnesses.

BHARTI AXA SMART HEALTH ASSURE

Bharti AXA Smart Health Assure is a health insurance policy that covers all the medical expenses and emergency hospitalization. It is suitable for people who are looking for insurance cover up to Rs. 4 lakh. This plan offers some special benefits including renewal discounts, no-claim bonus, tax saving, and free health check -ups.

BENEFITS

- There is a 30-day waiting period for coverage of most diseases except for pre-existing diseases and critical illnesses that have 48 months and 60 days waiting periods respectively.
- Pre and post hospitalization of 60 days and 90 days is covered
- There are flexible sum insured options to be availed with this policy.
- Lump sum critical illness benefit is provided over and above the sum assured.
- There is no claim bonus up to a certain percentage of sum insured offered with the policy for every claim-free year.
- Lifelong renewability is available with this policy.
- There is free cashless reimbursement from over 4500 hospitals.
- This premium paid under this policy is eligible for tax rebate under section 80D of the Income Tax Act 1961.
- The insured can be offered with annual health check-up up to a certain SI limit.

COVERAGE

- All hospitalization expenses, including charges for room rent, boarding, nursing, ICU, diagnostic tests, physician charges, drugs, blood, oxygen and equipment charges are covered up to sum insured.

- 130 Day care treatment expenses are covered.
- Medical expenses incurred for treatment under Ayurveda, Homeopathy, Naturopathy, Unani and Siddha systems are covered up to sum insured.
- Domiciliary hospitalization expenses are covered.
- Medical expenses incurred for treatment of an illness taken while at home that may normally require hospitalization are covered up to sum assured.
- If the sum insured amount is exhausted due to claims made during the year, the sum insured will be restored up to 100% for all policy members.
- Expenses incurred for the medical treatment of the organ donor are covered up to sum insured.

7.5 NEW INDIA ASSURANCE

New India is a leading global insurance group, with offices and branches throughout India and various countries abroad. The company services the Indian. It is one of the first Indian owned companies when it was formed in 1919. It offers different health insurance products like Mediclaim policy, senior citizen and universal health insurance policy. New India is a leading global insurance group, with offices and branches throughout India and various countries abroad. The company services the Indian subcontinent with a network of 1068 offices, comprising 28 Regional offices, 393 Divisional offices and 648 branches. With approximately 21000 employees, New India has the largest number of specialist and technically qualified personnel at all levels of management, who are empowered to underwrite and settle claims of high magnitude. New India has been rated "A-" (Excellent) by A.M.Best Co., making it the only Indian insurance company to have been rated by an international rating agency. Rating based on following factors:

- Superior Capital Position.
- Strong Operating Performance.
- Only Company to develop significant International operations, long record of successful trading outside India .

PRODUCT OFFERED

- Mediclaim Policy.
- Senior citizen policy.
- Universal health Insurance.

Popular Product:

Mediclaim Policy

We have designed a new Policy called as Family Floater Mediclaim Policy for covering the family members with one sum insured. All the terms and conditions of Individual Mediclaim Policy 2007 will be applicable for Family Floater Mediclaim Policy.

This insurance is available to persons between the age of 18 years to 60 years. The persons beyond 60 years can continue their insurance provided they are insured under Mediclaim policy with our Company without any break.

MAIN FEATURES MEDICLAIM POLICY:

- Existing policy holders can continue to renew their Mediclaim policy till lifelong.
- The policy offers an attractive discount in premium for family cover.
- Loyalty Discount is offered on continuous policy renewal.
- Good Health Discount is provided for claim free years.
- Cost of Health Check up is also provided after a certain period of time.

7.6 OTHER COMPANIES

- **HDFC ERGO GENERAL INSURANCE COMPANY**

- **ADITYA BIRLA HEALTH INSURANCE**

- **MAX BUPA HEALTH INSURANCE**

- **IFFCO TOKIO GENERAL INSURANCE**

- **STAR HEALTH AND ALLIED INSURANCE**

CHAPTER 8

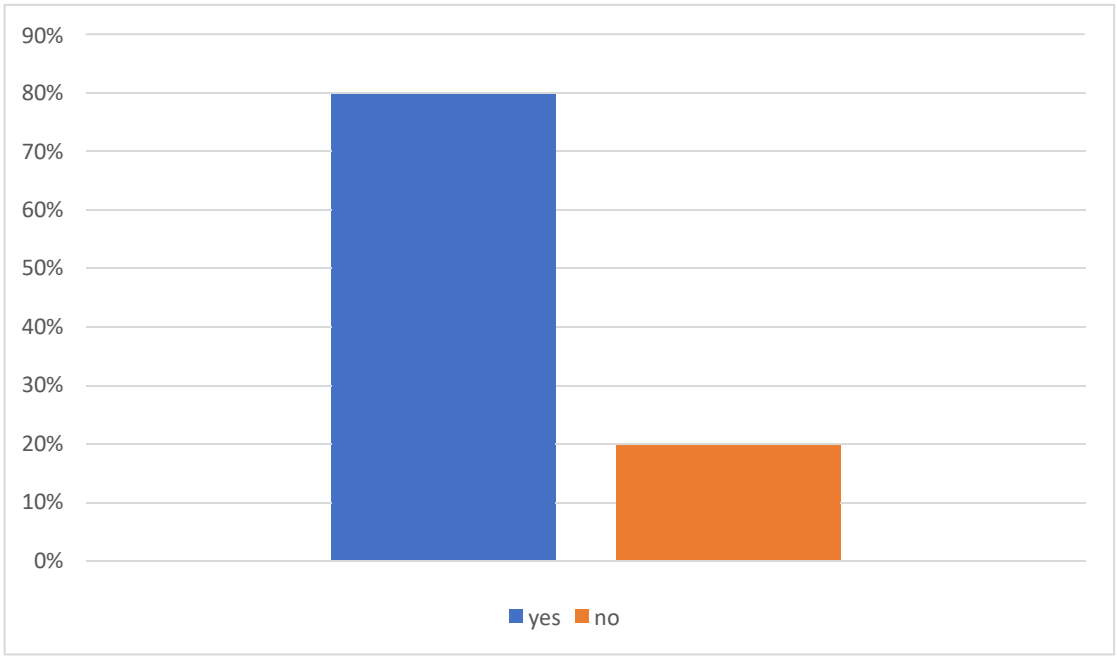
DATA ANALYSIS AND INTERPRETATION

Survey has been done to know the awareness, preference and consumption pattern of health insurance by using questionnaire method.

SAMPLE SIZE-300

Q.1 Are you aware of Health insurance ?

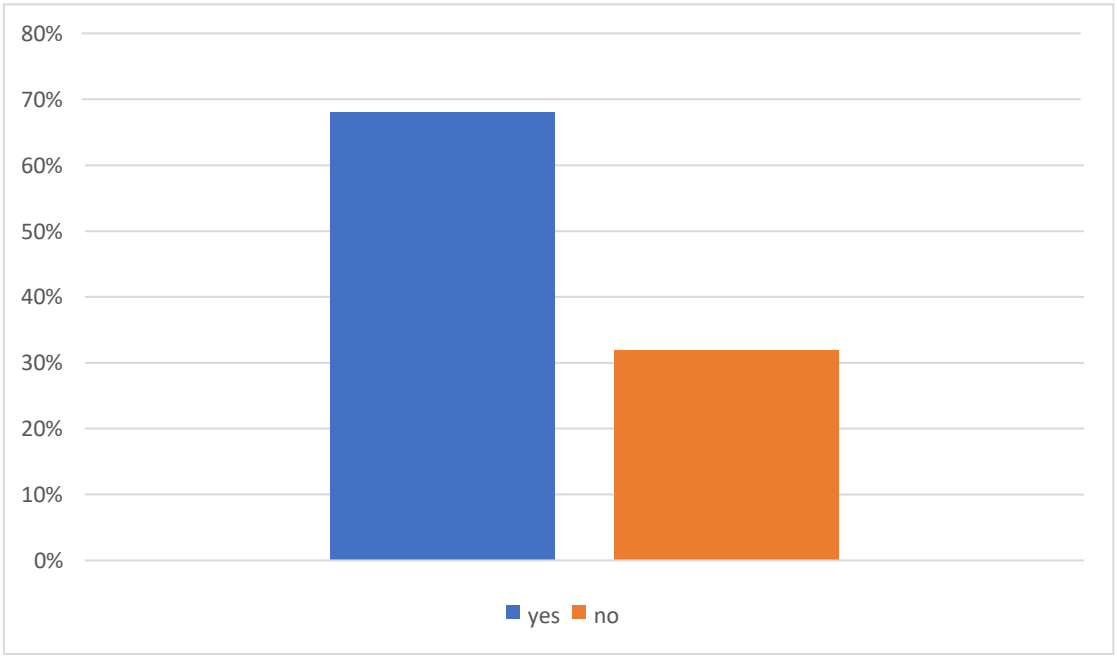
(a) Yes (b) No



Analysis: - The analysis shows that 80% of people are aware of health insurance while 20 % of people are still not aware of health insurance policy. Most of the respondent does not use health insurance to finance their medical expenditure these people pay for there medical expenditure from their pocket.

Q.2 Do you have any health insurance policy

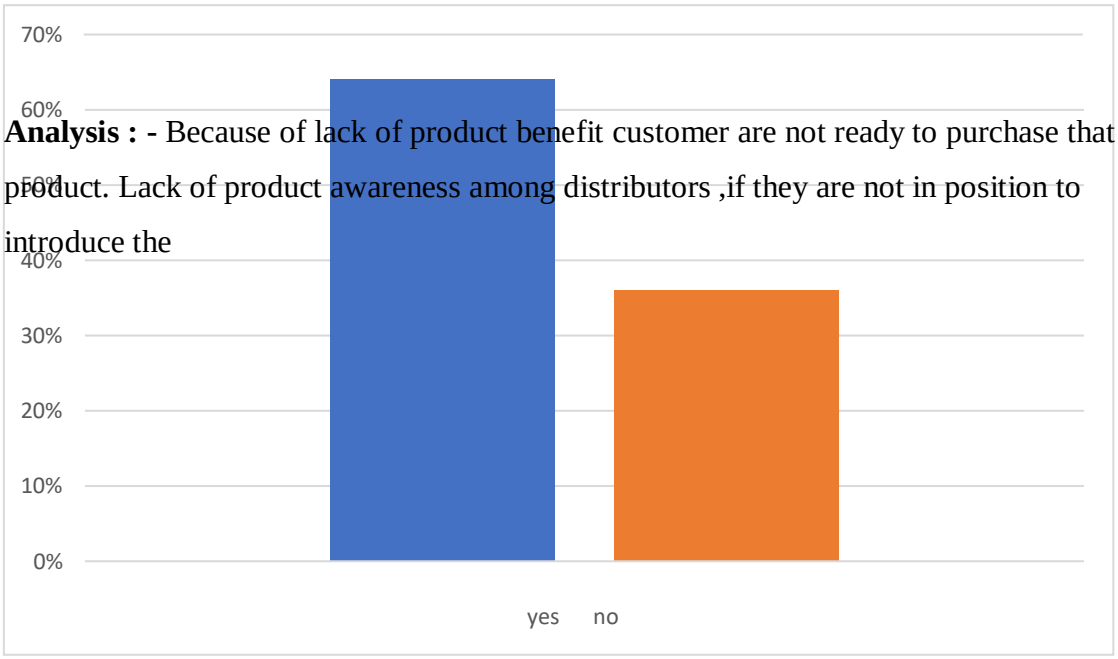
(a) Yes (b) No



Analysis: - The analysis shows that 68% of respondent have health insurance policy and 32% of respondent does not have any kind of health insurance policy.

Q.3 If yes do you know benefits of health insurance

(a) Yes **(b) No**



Analysis : - Because of lack of product benefit customer are not ready to purchase that product. Lack of product awareness among distributors ,if they are not in position to introduce the

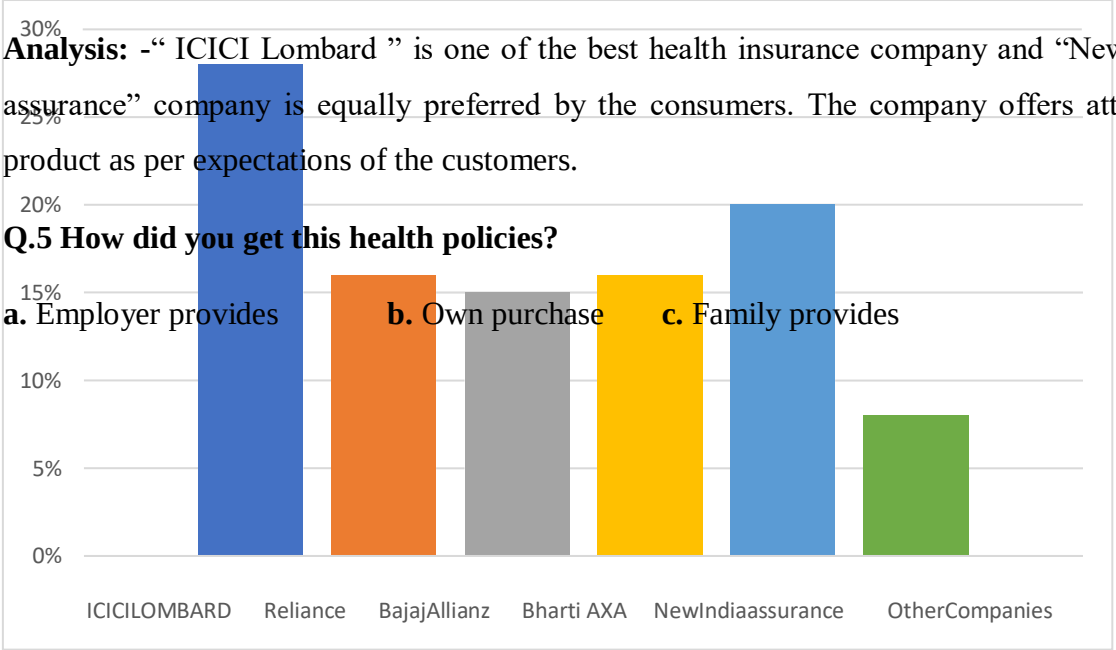
product to customer it will not be in a position to understand the importance and uses of health insurance. it is rightly said that awareness develop brand equity , due to awareness a customer recognized the product and purchase the same , a customer is in position to identify the product because of such awareness.

Q.4 If yes which company plan do you avail ?

a. ICICI Lombard **b. Reliance health insurance**

c. Bajaj Allianz **d. Bharti AXA**

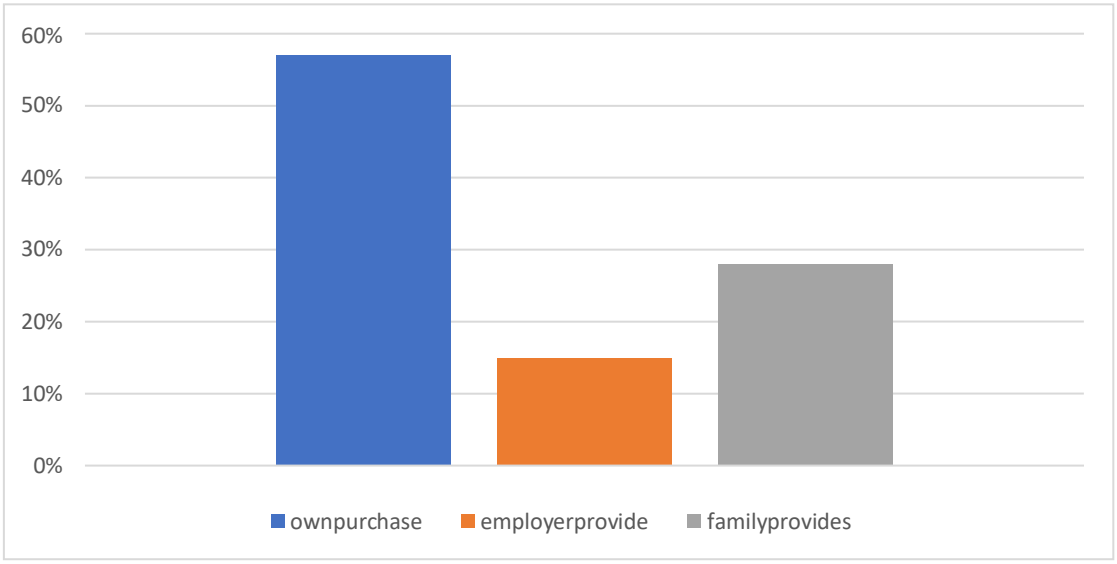
e. New India assurance **f. Other companies**



Analysis: -" ICICI Lombard " is one of the best health insurance company and "New India assurance" company is equally preferred by the consumers. The company offers attractive product as per expectations of the customers.

Q.5 How did you get this health policies?

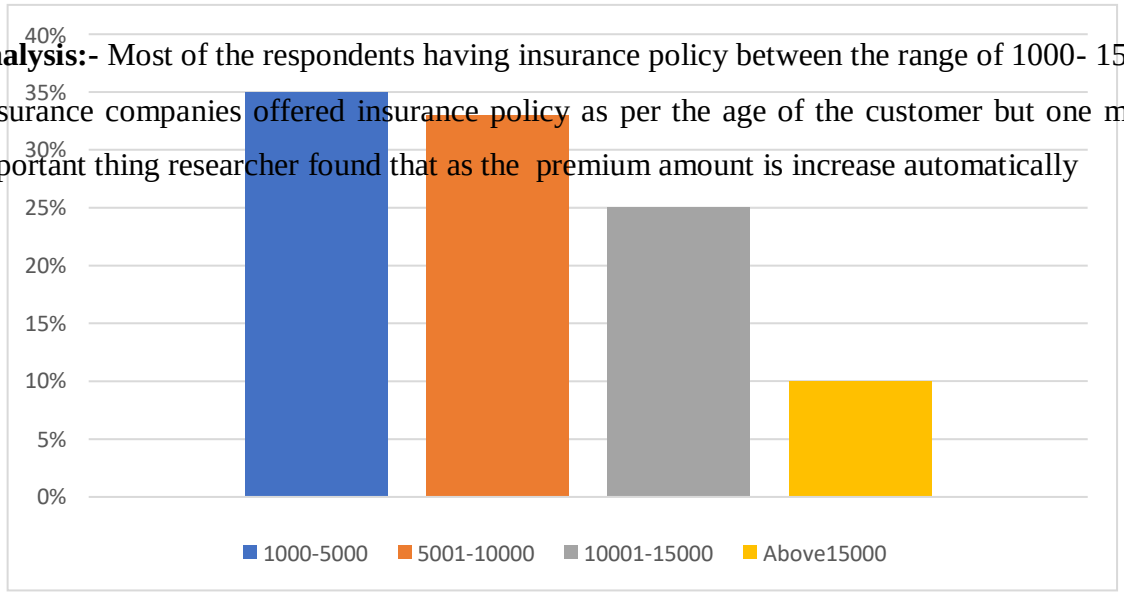
a. Employer provides **b.** Own purchase **c.** Family provides



Analysis:- The Analysis shows that 57% respondents purchased own Health Insurance .Single premium provide lots of extra lifetime facility, as compare to family floater plan customer will get maximum sum assured. very few companies are provide health insurance for their employee and in case of family floater company charge more premium as per the age of the family member.

Q.6 How much premium do you pay annually?

(a) 1000- 5000 (b) 5001- 10000 (c) 10001 – 15000 (e) Above 15000



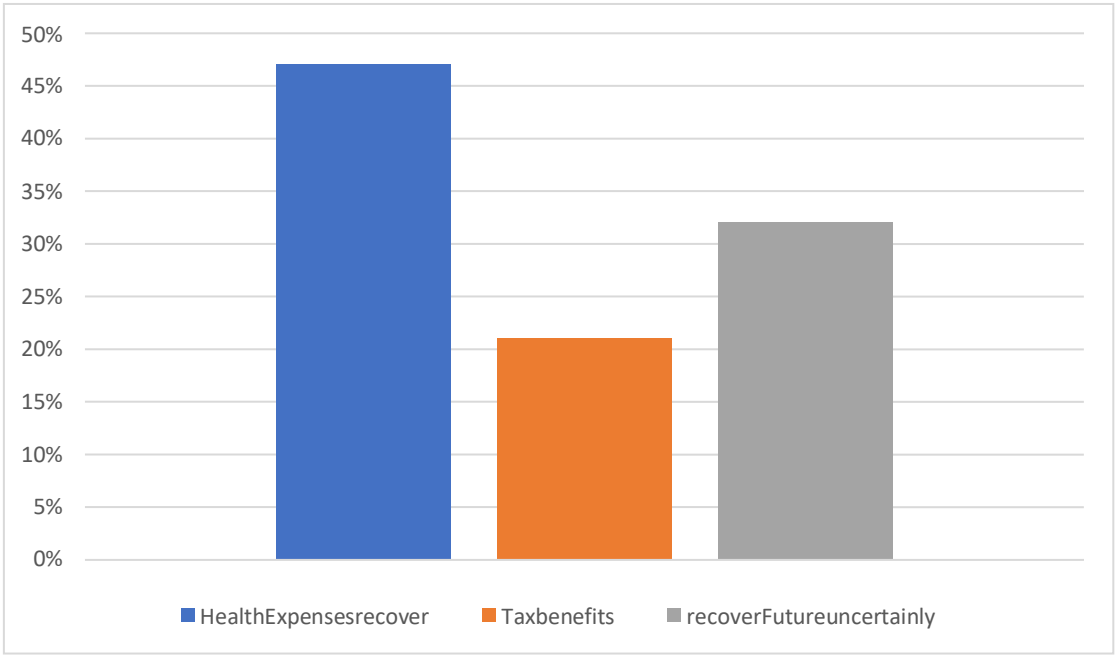
Analysis:- Most of the respondents having insurance policy between the range of 1000- 15000 ,Insurance companies offered insurance policy as per the age of the customer but one most important thing researcher found that as the premium amount is increase automatically

customer will get better coverage and benefit but some middleclass and lower-class customers not able to pay more amount for premium.

Q.7 Why did you purchase this health insurance plan?

(a)Health Expenses recover **(b)Tax benefits**

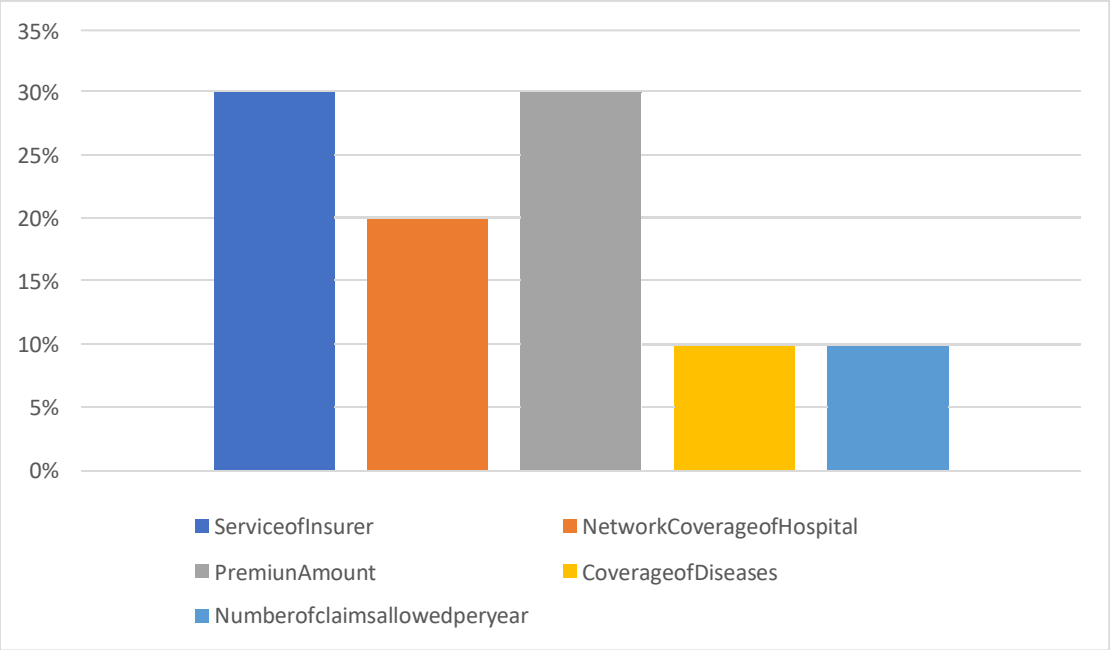
(c)Recover Future uncertainty



Analysis : - The main concern of any insurer by purchasing any Health Insurance is to cover their Health expenses ,the number of diseases increases day by day and peoples are paying high amount for that so to recover that expense people preferred Health Insurance. and most of the customers purchase health plan for the tax benefit and recover the future uncertainty.

Q.8 Kindly Rate The Following Factors Important To You In Opting Health Insurance (More than one)

a. **Service of Insurer**
b. **Network Coverage of Hospital**
c. **Premium Amount**
d. **Coverage of Diseases**
e. **Number of claims allowed per year**



Analysis :- For the continued development of the health insurance market, and also to protect the long-term interests of the insured persons, the prices of health insurance products should continue to be affordable to ensure wider acceptance and increased reach, while on the other, the insurance industry requires that this line of business remains commercially viable and better after sale service.

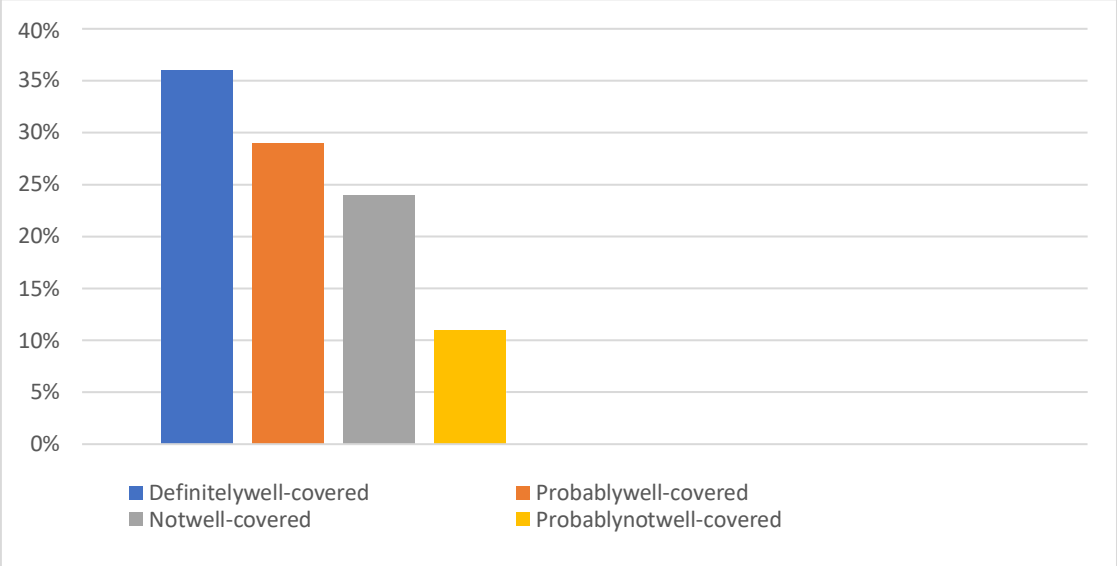
Q.9 How Well Do You Think, You Are Covered By Your Current Health Insurance Policy?

a) **Definitely well-covered**

b) **Probably well-covered**

c) **Not well-covered**

d) **Probably not well-covered**



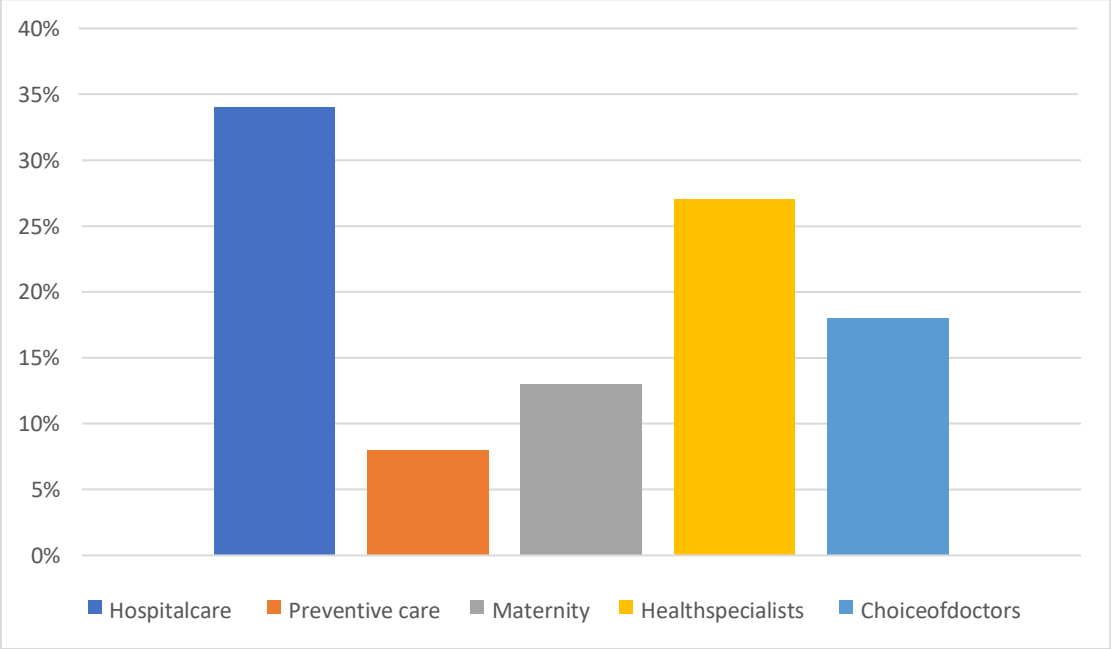
Analysis:- 35% respondents says that their health insurance plan not well covered and probably not well covered the percentage is quite high. people should understand their health insurance plans before buying to avoid these confusions. One important point that everybody should keep in mind is the associated waiting period. This is the time period before which there is no coverage offered for the particular ailment. If a person claims for the same illness before the waiting period elapses, he/she would not be offered the coverage.

Q.10 Which according to you is the most important aspect that every health insurance plan should cover?

a) Hospital care **b) Preventive care**

c) Maternity **d) Health specialists**

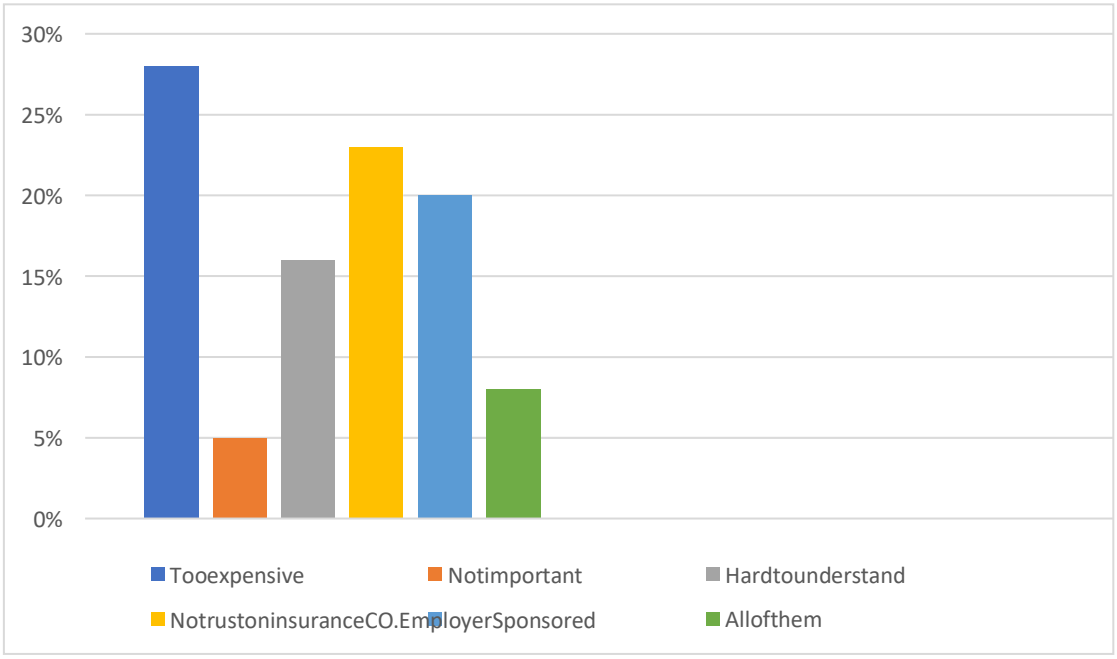
e) Choice of doctor



Analysis :- Most of the respondents says that they want better coverage of hospitals and coverage of maternity also because many of the reasons doctors are taking decision for suzerain so its not affordable for common men and they want their own family doctors for treatment so this are the main things that researcher found.

Q.11 What Are The Reasons, You Do Not Have Any Health Insurance

a. **It's Too Expensive**
b. **Insurance Is Not Important, No Reason To Get It**
c. **It Is Too Hard To Understand/Confusing**
d. **I Do Not Have Trust On Insurance Companies**
e. **Employer Sponsored Cover Is Sufficient For Me**
f. **All of Them**



Analysis:- Respondents think health insurance is too expensive high premium and other problems have resulted in a very complicated and perhaps unsustainable health insurance system. Respondents says that the concept of insurance is very hard and confusing to understand because of that insurance agents mislead people and not provide them actual hidden charges information and because of other customers experience other peoples are also not having trust on Insurance company.

CHAPTER 9

CONCLUSION

This paper makes an attempt to understand the awareness, preference and consumption pattern of Health insurance plan.

The result of this study shows that the annual premium is the most important factor that influences the decision or choice of health Insurance plan. This means that households having higher income have higher probability of buying healthcare plan. Thus, less income groups may not opt for health insurance plan. Thus there is a need to develop more products that cater to need of larger and all levels of income groups. Apart from annual premium, hospital network and disease coverage or coverage of services hold importance in making choice of healthcare plan. Thus, insurance company should provide larger network of hospitals and services in their plans in order to satisfy their customer fully. Accessibility of service provider and company reputation also moderately influence the decisions. The decision made for choosing the plan is mainly influenced by self perceptions. Family and relatives and past experience hold second position for assisting in the choice of plan. Most people would prefer to buy healthcare plan from private insurance companies for they provide better services and innovative products. Thus, there is large scope for private insurance companies to grow.

The legal and regulatory framework of private health insurance, particularly because it operates in the voluntary market, should continually balance competing goals of access, affordability and quality of healthcare and provide health coverage to a larger fraction of the population with varying risk characteristics and ability to pay.

To create the awareness of health insurance is very important, the Government and all the associated bodies should all offer their support in spreading health insurance awareness so that Indian citizens are aware of the right to seek quality healthcare without any financial thought. and it will help to increase the awareness of health Insurance among the people.

RECOMMENDATION

Only 11% of the rural population in Maharashtra was aware of health insurance and only 6% actually had any health insurance policy.

- Incentivizing life insurance agents to sell and promote health insurance policies: The profit margin earned from selling health insurances is not lucrative enough at present which deters agents in health insurance categories. Therefore households which are solely dependent on agents for information pertaining to different insurance policies are devoid of information on health insurance schemes. Since life insurance products are a major hit in most of the urban and rural households in India, linking promotion of health insurance products to life insurance agents can help improve its awareness especially amongst semi-urban and rural households not so well- versed with internet and sites like policy bazaar.
- A Higher number of the cashless network: Currently, even the biggest health insurance providers have only around 4000 hospitals in its network which are mostly out of reach of the common man in India. This becomes worrisome for lower middle-class people. The insurance providers with the help of State health care bodies should try to expand their network to smaller hospitals, clinics, and dispensary so that insurance claim becomes hassle free for the major population.
- Coverage plans mandatory for all employees: As discussed above, we strongly recommend making health insurance as part of employment contract compulsory for any firm or institution operational in India, both for employees and contracted vendors. The government of India and State Ministries shall take the initiative by making health insurance cover mandatory for all central and state employees respectively.

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