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The Problems With Health Insurance Sector in India

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KEYWORDS

ABSTRACT

The level of health care spending in India currently is considerably higher and more than three-quarters of this spending includes private 'out-of-pocket expenses'. Despite such a high share of expenditure by individuals, the provision of health care, that is inadequate in terms of quality and access, is becoming more and more problematic. This highlights the need for alternative source of financing health care cost that may be health insurance. This is one of the most growing segment of insurance industry. Despite it there are several bottlenecks prominent such as lack of product innovation, low awareness among people, high claim paid -out ratio of insurers, inefficiency of Third Party Administrator etc. Some other challenges pertain to the demand conditions, competition in the sector, delivery and distribution systems etc. So present study is an effort in the area of health insurance to find out its problems and some solutions also.To accomplish the objective, the paper has been divided into four broad sections. Section I introduce the health insurance in India and deals with review of the work done on health insurance. Section II presents a methodology to work out the problems of health insurance in India. Section III explained the problems associated with health insurance business in India. The Section IV concludes the discussion along with certain policy implications.

Section I:-Introduction

Insurance is a contract (policy) that helps an individual to reduce the potential financial loss or hardship by getting a reimbursement against losses from an insurance company. Insurance is the main way for businesses and individuals to reduce the financial impact of a risk occurring. It is a social device which has become a driving pillar of a nation's risk management system. It is broadly categorized into life, health and non-life insurance. Life Insurance provides financial support to a family in case of death of a family member. General Insurance or non life insurance includes automobiles, homeowners and health insurance policies. Health Insurance is a medical insurance given by an insurance company, wherein it reimburses the medical expenses incurred for a valid hospitalization. The individual has to pay a certain amount (subject to conditions) once each year, known as premium, to keep the health insurance policy active.

Health insurance in India is considered same as "hospitalization", where the policy covers the hospitalization expenses. The expenses for hospital bed, nursing, surgeon's fees, consultant doctor's fees, cost of blood, operation theatre charges are all covered. Certain diseases which are mentioned in the policy's terms and conditions shall be excluded from coverage or may be covered only after one or two years of the policy issue date. Health insurance is the most emerging sector in India nowadays due to increasing rates of illness and diseases and high expenses incurred in hospitalization and treatments for these diseases. Various health insurance schemes are existing in the markets which are providing benefits from an individual to an entire family also called family floater policies. Health Insurance sector also came up with critical illness covers which covers illness like blindness, deafness, alzheimer's disease, kidney transplant, organ transplant, paralysis etc.

INNOVATIONS IN HEALTH INSURANCE:

There are various innovations in Health Insurance sector in India which have taken place in the recent past. Some of them are listed below:

- Health Insurance portability: This will allow all existing health insurance policyholders to freely switch their policy to another insurance company, without losing on benefits like the credit earned on pre-existing diseases and no claim bonus etc.

- Rashtriya Swasthya Bima Yojna: RSBY is a National Health Insurance Programme for the people below poverty line.

- Hybrid Product: This is a combination product which includes health insurance as well as life insurance cover under one policy only.

- Critical Illness cover: Under this cover of critical illness the insurer is liable to pay a lump sum amount to the policyholder if he is diagnosed with the critical illnesses.

An attempt is made to review some of the available literature with the aim of formulating the research problem.

R. P. Ellis et al., (2000) highlighted the need for a competitive environment and an opening up of the insurance sector and recommends improvement in delivery of health care and its financing, efficient functioning of the ESIS and CGHS and amending the mediclaim system and alteration in exclusion clause.

Bhat(2001) state that insurance companies took on an average 121 days to settle the claim. IRDA's proposal to ensure payment settlement within 7 days is highly ambitious.

Mahal(2002) assessed that the entry of private health insurance could have adverse implications for some of goal of health policy, particularly for equity.

Bawa et al (2011) examine all those conditions, code of conduct/role which is defined by IRDA and role in practice played by TPAs. The results of the study provided that deviation exist in case of: lack of knowledge about coverage and exclusion in policies; failure to meet the expectations of parties involved;

delay in settlement of claims; failure to meet the service responsibility; indirect cost to consumer etc.

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

Section-II (Research Methodology)
The study is completely based upon secondary data which is mainly collected from the annual reports of IRDA and other publications related with the health insurance.

Section III-Problems of Health Insurance Sector
Problems associated with various stakeholders and some of their solutions are as follow:-

Third Party Administration
TPA is designed to provide a mechanism to administer large scale in-patient healthcare that provides an efficient, low-cost solution for the poor and eliminates opportunities for misuse by patient and healthcare provider. The TPA provides the network of hospitals around India. Patients need to attend a network hospital with their identity card in order to avail themselves of the cashless facility. The third party administrator handles all the administration of claims providing online real time information to all concerned parties including the policyholder, provider and insurance company. Managing large numbers of clients and a large claims volume necessitates a highly efficient administration system capable of speedy and accurate response to clients' hospitalisation needs. IRDA regulations for TPAs aim at ensuring value added services to the consumers, which take diverse form and include arrangement of ambulance services, medicines and supplies, guide member for specialized consultation, provide information about health facilities, hospitals, bed availability, organization of lifestyle and well-being programmes and 24 hrs help-lines. The most important problems associated with them are lack of value added services and the long Turn-Around Time (TAT) taken by TPA. The TAT for the payment of an insured patient's treatment in an affiliated hospital is 20 days for cashless treatment. Most TPAs fail to meet the deadline even if the insurance company has made the payment to them. This is due to the logistics involved in handling numerous hospitals and claims. Some hospitals become disgruntled with the delay and do not offer cashless treatment facilities. Also, some TPAs do not work on Saturdays, whereas most insurers do. This delays the processing of claims.

Solution: Insurance companies like Bajaj Allianz, Cholamandalam MS and Star Health have opted for direct settlement of claims, eliminating TPAs. Also TPA should work in harmony with all stakeholders. They should strictly follow all the guidelines and rules mandated by IRDA. They should focus on timely payment of all claims due on behalf of insurance company.

Hospitals
If you have a health cover, there is a 90 per cent chance that an empanelled hospital will charge you more. Once they come to know that patients have health insurance cover, their emphasis is more on making high and high treatement charges and rate for them. Higher tariffs for insured patients lead to a higher payout for the insurance company which, in turn, leads to higher premiums. The increase is more than the rise in the cost of medical care. Another issue is the misuse of group insurance by hospitals and patients. Uninsured people are treated because the identity cards of many group insurance schemes do not have photographs.

Solution: Insurers have begun visiting hospitals to meet patients for claims under group insurance schemes. If found at fault, the insurer refuses to renew the policy of the originator policyholders. Also, most insurers now go for pre-agreed rates for surgeries and treatments. This prevents differential tariffs for the insured and uninsured patients. The hospital bills extra charges directly to the patient.

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

Solution: Read the entire policy document before taking a policy. Ask your salesperson for the 'policy wordings'. Do not make a false claim as you may not be able to make a genuine second claim in the same year if the limit has been exhausted. Also, the insurer may load future premiums in case of an abnormal claim. Awareness regarding all aspects of health insurance policies should increased and attractive health insurance policies should come in order to capture and increase market share of health insurance sector.

Companies
To ward off pressure from their superiors and get incentives, salesmen mis-sell products. Sometimes, a wrong product is sold for a higher commission. As company Websites and brochures do not reveal all the terms of the plans, clients fall prey to the salesperson and do not buy the right policy.

Solution: Prospective clients should ask for more information. IRDA intervention in making brochures and other promotional material, more transparent, will help.

Some other challenges
There are also some other problems or hindrances with health insurance sector which create hurdles for its development. Some of hindrances are mentioned as follow:-

- The statistical system is a lifeline for health insurance. India lacks appropriate data and information system for planning and management of health insurance schemes.

- High claim-paid out ratio of insurer specially of public insurer is the main hindrance in the development of health insurance sector as due to high claim paid out ratio , insurer have to face high loss and they lose their interest in this sector.

- Agencies such as State Health System, Indian Medical Association and

Third Parties Administrators (TPAs) are not working for professional regulation of health insurance in India.

- Insurance Regulatory and Development Authority (IRDA) is not more effective and concentrate on accessibility, quality and affordability dimensions of the health insurance sector.

- There are no attractive health insurance policies or scheme for informal sector and the people Below Poverty Line (BPL).

- Adverse selection of health insurance policies by policyholders is another problem.

- Lack of proper awareness about health insurance policies and insurers is one of the main problems in development of health insurance.

- Health insurance as a human right is no basically linked with the distributive social justice for health security.

- Lack of Public and Private Partnership (PPP) is another hindrance in progress path of health insurance sector in India.

- No proper attention is given to rural areas for development of health insurance.

➢ Delay in payment of insurance premium to policyholders by insurance companies.

Section IV-Conclusion

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

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