Health insurance Challenges and Opportunities in India

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0. Introduction

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 underfunding 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.

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 liberalisation 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.

This paper attempts to discuss the following areas:

- ✓ State of health insurance penetration in India
- ✓ Awareness about Health Insurance among masses in India
- ✓ Various Health Insurance products available in India
- ✓ Challenges for the Health Insurance Sector in India
- ✓ Challenges of frauds by policyholders in connivance with hospitals
- ✓ IRDA's New Regulatory Provisions and Challenges for the Health Insurance Sector
- ✓ Increasing cost of Health care for the masses
- ✓ Opportunities for Health Insurance Industry in India

1. State of Health Insurance penetration in India

In a country where less than 15 per cent of population has some form of health insurance coverage, the potential for the health insurance segment remains high. It seems that there is an urgent need to ramp up the health insurance coverage in the country as out-of-pocket payments on account of health care expenses are still among the highest in the world. [SOURCE:http://www.dnaindia.com/health/report-health-insurance-in-india-still-remains-an-untapped-market-1891509]

Furthermore, according to the statistics of the World Health Organization (WHO), in 2011, India has spent only 3.9 per cent of gross domestic product (GDP) on the health

sector which is the lowest amongst the BRICS (Brazil, Russia, India, China, South Africa) member countries pack.

Moreover amongst the BRICS nations, in 2011, Russia's out-of-pocket expenses stood highest at 87.9 per cent closely followed by India (86 per cent), China (78.8 per cent), Brazil (57.8 per cent), and South Africa (13.8 per cent). On the other hand, these expenses in developed economies of US and UK were comfortably poised at 20.9 per cent and 53.1 per cent respectively. [Out of pocket expenses here mean the portion of healthcare expenses incurred by an individual from his own pocket rather than getting claim reimbursement from an insurance company.]

Exhibit 2: Out-of-pocket expenses and total expenditure on health as a percentage of GDP across nations

Country	Out-of-pocket expenditure as a percentage of private expenditure on health (2011)	Total expenditure on health as a percentage of GDP (2011)
Russia	87.9	6.2
India	86	3.9
China	78.8	5.2
Brazil	57.8	8.9
United Kingdom	53.1	9.3
USA	20.9	17.9
South Africa	13.8	8.5

Source: WHO

The condition of health insurance in India is pathetic. 85% of Indian population does not use health insurance to finance their medical expenditure. These people pay for their medical expenditure from their pocket. As a result, many of these uninsured individuals either end up with poor quality healthcare or have to bear financial hardships. The financial stress that is engendered due to rising medical expenses is believed to affect the lifestyle of all family members for years. [SOURCE:http://www.dnaindia.com/health/report-health-insurance-in-india-still-remains-an-untapped-market-1891509]

If the same continues, how will the people of India pay their medical expenses in the future? How will the efforts of medical care providers be fruitful, when there will be no one to avail medical treatment? Thus, there is a need to increase the number of insured individuals in India. Working in this direction, every individual, every medical care provider and every health insurance company should play an active role. It is only then possible that people would be able to avail quality healthcare in times of medical emergency. Insurers have designed plans, but people should be encouraged to buy them so that the overall condition of medical care insurance in the country can be improved.

The products and offerings brought by different medical insurance providers vary from each other. The only point that should be brought to light is that people should buy these products to remove inconveniences from quality medical treatment. These products offer much relief to them and their family members at the time of medical emergency. There is no need for an insured individual to scramble for the arrangement of funds at the last hour. Hence, 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.

The Government should educate people about the rise of medical costs and the importance of these products. Regulators should bring change in the guidelines, allowing only the right players to enter the health insurance market. Health insurance providers should design products, according to health needs of target customers and encourage people to buy them. The combined efforts of all these bodies will surely bring some improvement.

2. Awareness about Health Insurance among masses 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 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.

Categories of Health Insurance

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. Cashless 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 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), Myocardial infarction (heart attack), Acute Appendicitis.

b) Medical Reimbursement

Re-imbursement means to repay or to compensate. Thus, Medical Re-imbursement means to repay the products/services availed during hospitalization and 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 reimbursement of medical expenses. 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.

A recent survey conducted in 2008 showed that only 3% of the entire Indian population has availed some sort of insurance policy and enjoys benefits included under its coverage. This miniscule percentage constitutes both – **PSU** (Public Sector Undertaking) and **Private insurance companies**. Since, the general public are by and large ignorant about the benefits of availing healthcare insurance policies, there lies an urgent need to educate the masses regarding the *importance* of Healthcare Insurance and the *benefits* derived on account of it.

There are numerous reasons for not availing health insurance. There is a lack of knowledge regarding the existing insurance products/services in the markets. On top of it, there are numerous misconceptions about Insurance prevalent in the Indian Markets. Also there are numerous fly-by-night agents out to fleece the gullible Indian public.

In India, public funded healthcare is available only to a miniscule section of BPL (Below Poverty Line) groups, low-income groups and to government employees. BPL families are covered under central government sponsored scheme called Rashtriya Swasthya Bima Yojana (RSBY). The Indian Government has formulated Employee State Insurance Scheme (ESIS) that focuses on the public healthcare policy for low-income groups. The government employees can avail Central Government Health Scheme (CGHS) that offers medical treatment at a subsidized cost.

With the opening up of insurance sector for private participation, numerous players have entered the healthcare segment, but in spite of the entry of private sector, penetration of insurance coverage in India is abysmally low. A bill to allow 49% FDI in insurance industry is pending in parliament.

Essential Guidelines for availing individual Health Insurance Policy:

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

• **Understanding the policy coverage and policy conditions:** 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-insurable under the policy (policy exclusions):** 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 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 not exceed more than 15 days) is treated as a ***fresh policy cover***.

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 is prevalent and ever-pervading in human life.
- Prevention and minimization of unforeseen losses. Access to quality healthcare.
- A health insurance policy in a person's portfolio will make his other savings and investment safe.
- 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.

3. Various Health Insurance Products Available in India

The existing health insurance schemes available in India can be broadly categorized as:

3.1. Voluntary health insurance schemes or private-for-profit schemes

3.2. Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

3.3. Insurance offered by NGOs/Community based health insurance

3.4. Employer based schemes

3.1. **Voluntary health insurance schemes or private-for-profit schemes**:

In private insurance, buyers are willing to pay premium to an insurance company that pools similar risks and insures them for health related expenses. The main distinction is that the premiums are set at a level, which are based on assessment of risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of consumer's income.

In the public sector, the General Insurance companies (National Insurance Company, New India Assurance Company, Oriental Insurance Company and United Insurance Company) provide voluntary insurance schemes. The most popular health insurance cover offered by them is medi-claim policy.

• **Medi-claim policy**: - It was introduced in 1986. It reimburses the hospitalization expenses owing to illness or injury suffered by the insured, whether the hospitalization is domiciliary or otherwise. It does not cover outpatient treatments. Government has provided deductions for the premium paid (up to a certain limit) under medi-claim policy by individuals from their taxable income. Because of high premiums it has remained limited to middle class, urban tax payer segment of population.

• Some of the various other voluntary health insurance schemes available in the market are :- Asha deep plan II , Jeevan Asha plan II, Jan Arogya policy, Raja Rajeswari policy, Overseas Mediclaim policy, Cancer Insurance policy, Bhavishya Arogya policy, Dreaded disease policy, Health Guard, Critical illness policy, Group Health insurance policy, Shakti Shield etc.

• At present Health insurance is provided mainly in the form of riders. There are very few pure health insurance policies under voluntary health insurance schemes.

3.2. Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

Employer State Insurance Scheme (ESIS):- Enacted in 1948, the employers' state insurance (ESI) Act was the first major legislation on social security in India. The scheme applies to power using factories employing 10 persons or more and non-power & other specified establishments employing 20 persons or more. It covers employees and the dependents against loss of wages due to sickness, maternity, disability and death due to employment injury. It also covers funeral expenses and rehabilitation allowance. Medical care comprises outpatient care, hospitalization, medicines and specialist care. These services are provided through network of ESIS facilities, public care centres, non-governmental organizations (NGOs) and empanelled private sector practitioners. The ESIS is financed by three way contributions from employers, employees and the state government.

Even though the scheme is formulated well there are problem areas in managing this scheme. Some of the problems are :-

- Large numbers of posts of medical staff remain vacant due to high turnover and low remuneration compared to corporate hospitals.
- Rising costs and technological advancement in super specialty treatment.
- Management information is not satisfactory.
- The patients are not satisfied with the services they get
- Low utilization of the hospitals
- In rural areas, the access to services is also a problem

All these problems indicate an urgent need for reforms in the ESIS Scheme.

Central Government Health Scheme (CGHS):- Established in 1954, the CGHS covers employees and retirees of the central government and certain autonomous and semi autonomous and semi-government organizations. It also covers Members of Parliament, Governors, accredited journalists and members of general public in some specified areas.

Benefits under the scheme include medical care, home visits/care, free medicines and diagnostic services. These services are provided through public facilities with some specialized treatment (with reimbursement ceilings) being permissible at private facilities. Most of the expenditure is met by the central government as only 12% is the share of contribution.

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 the cost is reimbursed if referral is made to private facility, when such facilities are not available with the CGHS).

• **Universal Health Insurance Scheme (UHIS):-** For providing financial risk protection to the poor, the government announced UHIS in 2003. Under this scheme, for a premium of Rs. 165 per year per person, Rs.248 for a family of five and Rs.330 for a family of seven , health care for sum assured of Rs. 30,000/- was provided. This scheme has been made applicable to below poverty line (BPL) families only. To make the scheme more saleable, the insurance companies provided for a floater clause that made any member of family eligible as against mediclaim policy which is for an individual member. In spite of all these, the scheme was not successful.

The reasons for failing to attract rural poor are many:-

- The public sector companies who were required to implement this scheme find it to be potentially loss making and do not invest in propagating it.
- To meet the target, it is learnt that several field officers pay the premium under fictitious names.
- Identification of eligible families is a difficult task
- Poor find it difficult to pay the entire premium at one time for future benefit, foregoing current consumption needs.
- Paper work required to settle the claims is cumbersome
- Deficit in availability of service providers
- Set back due to health insurance companies refusing to renew the previous year's policies.

In 2004, the government also provided an insurance product to the Self Help Groups (SHGs) for a premium of Rs.120 and sum assured of Rs.10000/-. However, the intake is negligible. The reasons for poor intake are similar to those cited above.

3.3 Insurance offered by NGOs/Community based health insurance (CBHI)

Community based schemes are typically targeted at poorer population living in communities. Such schemes are generally run by charitable trusts or non-governmental organizations (NGOs). In these schemes the members prepay a set amount each year for specified services. The premia are usually flat rate (not income related) and therefore not progressive. The benefits offered are mainly in terms of preventive care, though ambulatory and inpatient 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-for-profit insurers for the purchase of custom designed group insurance policies.

CBHI schemes suffer from poor design and management. Often there is a problem of adverse selection as premiums are not based on assessment of individual risk status. These schemes fail to include the poorest of the poor. They have low membership and require extensive financial support. There are also other issues relate to sustainability and replication of such schemes.

Some of the popular Community Based Health Insurance schemes are: - Self-Employed Women's Association (SEWA), Tribuvandas Foundation (TF), The Mullur Milk Co-operative, Sewagram, Action for Community Organization, Rehabilitation and Development (ACCORD), Voluntary Health Services (VHS) etc.

3.4. Employer based schemes

Employers in both public and private sector offers employer based insurance schemes through their own employer. These facilities are by way of lump sum payments,

reimbursement of employees' health expenditure for patient care and hospitalization, fixed medical allowance or covering them under the group health insurance schemes.

The Railways, Defense and Security forces, Plantation sector and Mining sector run their own health services for employees and their families.

4. Increasing cost of health care for the masses

There is no respite in India's woes when it comes to healthcare. While the common man faces acute shortage of hospital beds and doctors, the rising medical expenses haven't helped their cause. According to a report by the National Sample Survey Office (NSSO), consumer expenditure on healthcare is ever increasing both in urban and rural India post 2004-05.

While the consumer expenditure on healthcare in rural India increased from 6.6% in 2004-05 to 6.9 per cent in 2011-2012, urban Indians' expenditure on medical care increased from 5.2% in 2004-05 to 5.5% in 2011-2012. Medical expenses fall under the miscellaneous goods and services category in the NSSO report.

NSSO report also reveals that expenditure on healthcare is highest in rural India and fifth highest in urban India during 2011-2012 in miscellaneous goods and services category.

Experts suggest that access to affordable and quality health care is still a dream for most rural Indians. Government hospitals can hardly fill the gap and therefore, most rural Indians are left with no choice but to rely on costly private hospitals.

Out of all other miscellaneous expenses the expenditure share on medical care is higher in rural India because rural India lacks affordable medical options and in that case the only available options are costly private hospitals. Not just NSSO but, the issue of inflating consumer expenditure on health care has also been raised by the World Health Organisation (WHO).

According to WHO , "70% Indians are spending their out-of-pocket income on medicines and healthcare services in comparison to 30-40% in other Asian countries like Sri Lanka, and are still suffering from infected diseases due to lack of best quality drugs and healthcare facilities."

Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

Voicing concern over the impoverishing impact of health and medical expenses on the vulnerable sections of the society, President Pranab Mukherjee while addressing 40th convocation function of All India Institute of Medical Sciences (AIIMS) in New Delhi said, "It was unacceptable that almost 80% of the expenditure on healthcare by people was met by personal, out of pocket, payment. I am shocked to note that as many as 4 crore people of our country plunge into poverty each year due to expenses on medical treatment."

An increasing proportion of people are using private health care facilities, rather than public, though the costs in the latter are much more affordable, a countrywide survey on health care access has revealed.

The primary reason, the study goes on to prove, is the absence of doctors and a dissatisfaction with quality standards at state-run, or public hospitals. However, it did

add that between 85 per cent and 90 per cent of the patients are willing to shift from the private sector if the situation improved in the public health care facilities.

5. Challenges for the Health Insurance Sector in India

The challenges for the health insurance sector are as follows:

1. Health insurance sector must achieve high efficiency, penetration of services, and standardisation of charges, adoption and compliance to STGs and ICD-10 coding, IT-enabled speedy and cashless settlement of claims by strengthening TPAs, whose actual role and responsibilities need to be fully understood and exploited.

2. Health insurance sector must continuously develop and introduce innovative products and pricing, distribution channels which are the key drivers of growth for this sector. The industry must build up robust data repositories, data analytic capabilities and information exchange mechanisms. The insurers must endeavour to achieve true portability and provide cover for wellness services, OPD treatment, pre-existing diseases and senior citizens who need health insurance most.

3. Health insurance industry looses Rs 700 crore (15 per cent of total claims) every year to fraudulent claims, which the society cannot afford to overlook. Health insurance fraud and abuse is defined as an act of omission or commission intended to gain dishonest or unlawful advantage by unfair means such as, concealing pre-existing disease or claiming inflated bills. This malpractice is hurting the industry as well as insured people since it increases the premium. Fraud can be mitigated by adopting a 3600 process improvement, medical audit, whistle blower policy, effective industry and regulatory intervention and strong legislation.

4. **Moral hazard** is a matter of concern that poses a serious challenge to the growth of health insurance. This is a tendency by the insured persons to overuse healthcare services, for example, demanding tests not required on medical grounds **(demand-side moral hazard)**, and providers' propensity to provide more services than they would if the individual did not have health insurance **(provider-induced moral hazards)**. This practice can be curbed by **co-insurance a**nd **co-payments.**

5. **Adverse selection** is another challenge wherein people with higher risk and possibility of excessive consumption of healthcare services buy insurance, thus increasing the premium rates for other pool members. This is a problem of **asymmetric information** for insurers that disturbs the operation of the insurance market, resulting in an inequitable transaction. Members with the low risk are likely to drop out. Insures counter adverse selection through **medical underwriting** and **rate-making process**.

6. In view of the high OOP (out of pocket) expenses and 3 per cent of population falling into below the poverty line each year due to health-related expenses, there is a need to reach out to **bottom of the pyramid** through **micro-insurance**. This is possible to achieve by distributing low ticket health insurance products at a low administrative cost in rural areas. The NGOs/SHGs and insurance companies need to reach out to this segment of society to achieve penetration of health insurance.

7. The Insurance Amendment Bill, which seeks to raise FDI cap in the sector from 26 to 49 per cent, has been pending in parliament for enactment since long. Its enactment would result in surge of global players and even more customised products targeting all sections of society. In the event of the minimum capital requirement of $ 22 million being reduced to $ 11 million, a number of standalone players would enter the market, as is the trend across the world for health insurance.

6. Challenges of frauds by policyholders in connivance with hospitals

In simple parlance, insurance fraud can be defined as: The act of making a statement known to be false and used to induce another party to issue a contract or pay a claim. This act must be wilful and deliberate, involve financial gain, done under false pretences and is illegal.

Healthcare fraud as defined by the National Health Care Anti-Fraud Association (USA): "The deliberate submittal of false claims to private health insurance plans and/or tax-funded public health insurance programs." "Intentional deception or misrepresentation that the individual or entity makes, knowing that the misrepresentation could result in some unauthorised benefit to the individual, or the entity, or to another party."

Abuse can be defined as practices that are inconsistent with business ethics or medical practices and result in an unnecessary cost to claims. The billing of services that may not be fraudulent, but may be of marginal utility, are inconsistent with acceptable business and/or medical practices, and are intended for the financial gain of a particular individual or corporate can be classified as abuse. Few examples of common health insurance abuse would be - excessive diagnostic tests, extended LoS (length of stay), conversion of day procedure to overnight admission, admission limited to diagnostic investigations etc.

Commonly committed fraud by a customer of health insurance relate to:

- concealing pre-existing disease (PED) / chronic ailment, manipulating pre-policy health
- check-up findings
- fake / fabricated documents to meet policy terms conditions,
- duplicate and inflated bills, impersonation,
- participating in fraud rings, purchasing multiple policies,
- staged accidents and fake disability claims,

It would be quite difficult for a customer to file a fraudulent claim or fake medical documents without connivance of treating doctor or hospital. Provider related fraud usually pertain to:

- Overcharging, inflated billing, billing for services not provided
- Unwarranted procedures, excessive investigations, expensive medicines,
- Unbundling and up coding
- Over utilisation, extended length of stay
- Fudging records, patient history

7. IRDA's New Regulatory Provisions and Challenges for the Health Insurance Sector

The new regulatory provisions and norms of IRDA will bring about a lot of challenges for the health insurance providers. Some of these important new provisions/norms of IRDA are described here below.

Speedy claim settlement

From now on, your insurance company will have to process the claims within 30 days of receiving all required documents. It means the company won't be able to sit on a claim for more than a month. If there is a delay beyond this period, the company will have to pay a penal interest to the policyholder.

"If the claim is rejected, the company will have to specify the medical grounds on which the decision was taken," says activist Gaurang Damani, who had filed a petition seeking

regulations for the health insurance space, which triggered the drafting of these new rules.

Bonus for claim-free years

Before the new regulations were implemented, a policyholder stood to lose the entire no claim bonus earned over the years due to a single claim made. For instance, say, you have earned an annual bonus of 5% pa for three years.

If you were to make a claim in the fourth year, you would stand to lose the entire bonus (15%) you had earned during the previous three years. That means with the new regulation your cumulative bonus will not go down to zero after the claim in the fourth year — it will shrink to 10%.

Insurer is solely responsible

Insurers will also have to play a greater role in claims handling. Earlier, third-party administrators (TPAs) were given the authority to deny or accept a claim. Now, such decision-making powers can't be delegated and the insurer will need to be involved directly with the hospitals in settling claims. Now, insurers will not be allowed to offer any incentives to TPAs to reduce claims. In other words, insurance companies will be directly responsible for claim settlement now. Third-party administrators' role will be limited to processing of claims only.

Standardisation of definitions

Standard definition for 46 commonly-used terms in health insurance policies will provide clarity in interpretation on these terms and reduce disputes or complaints and would enable just and speedier settlement of claims. The new formula prescribed for calculating co-pay amount will also benefit policyholders.

The Insurance Regulatory Development Authority has also prescribed uniform definitions for 11 critical illnesses. It also reduces the ambiguity in respect of various terms. For example, co-payment has been defined by the regulation to be linked to the claim amount (earlier it could have been defined as linked to claim amount or sum insured). And therefore, the room for different interpretations is removed.

Similarly, quantifying and defining the 199 exclusions — expenses not payable by the insurer — will also help reduce the ambiguity.

Uniform claim forms

The impact of this measure may not be felt immediately, but will surely help policyholders in the long term. It is expected to reduce the procedural hurdles faced by policyholders, besides streamlining the processes across the industry.

The standardisation of claim forms and cashless pre-authorisation forms will help develop a robust information system. In the long run, the interface between insurers, TPAs and hospitals would be well regulated.

For the policyholder, more efficient process could mean smoother claim settlement. Besides these newly-introduced measures, the regulations also cover some of the major changes announced earlier, including minimum entry age of 65 years and mandatory life-long renewal for all policies.

Therefore, 60-65 year-old senior citizens, whose proposals were rejected earlier due to their age, can now hope to buy a policy. Similarly, insurers can no longer refuse to renew your policy beyond a particular age, as the rules stipulate renewability for life except in cases of fraud or misrepresentation.

8. Opportunities for Health Insurance Industry in India

Healthcare is one of the fastest growing sectors in India. According to the rating agency Fitch, the sector is currently estimated to be worth US$ 65 billion and is expected to reach US$ 100 billion by 2015. Some of the major factors driving the sector growth are an increasing population, growing lifestyle-related health issues, cheaper costs for treatment, improving health insurance penetration, increasing disposable incomes, government initiatives and a focus on Public Private Partnership (PPP) models.

In another effort to improve the insurance prospects for India, the IRDA is focused on standardizing medical definitions to ensure consistent pricing and products, and is providing incentives for stand-alone insurance companies. In addition, government subsidies and tax incentives for health insurance are expected to attract key players to the industry.

In response to liberalization, a large number of international private insurance companies are moving into India and forming joint ventures.

Some companies are experimenting with more targeted forms of insurance coverage. For example, they are offering plans designed specifically for diabetics. We can expect to see more innovations as the health insurance market evolves in the coming years.

While the liberalisation of the healthcare sector will increase the penetration of insurance policies, the widespread use of health insurance in India could take many years. One reason is that insurance companies lack the data they need to assess health risks accurately.

Over the period the private health care expenditure has grown at the rate of 12.84% per annum and for each one percent increase in per capital income the private health care expenditure has increased by 1.47%. Number of private doctors and private clinical facilities are also expanding exponentially. Indian health financing scene raises number of challenges, which are:

- increasing health care costs,
- high financial burden on poor eroding their incomes,
- increasing burden of new diseases and health risks and
- Neglect of preventive and primary care and public health functions due to under funding of the government health care.

Given the above scenario exploring health-financing options becomes critical. Health Insurance is considered one of the financing mechanisms to overcome some of the problems of our system.