

A Study of Health Insurance Market in India in The 21st Century

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Abstract:

Health insurance is now emerging as a massive tool used by insurance companies in India for their growth. It has been growing consistently on a different path unlike other lines of business of non-life insurance. The paper makes an attempt to study the health insurance market in India. The Indian health insurance market has emerged as a new and lucrative growth avenue for both the existing players as well as the new entrants. It has witnessed a number of initiatives in recent years to garner the views of various stakeholders to expand the reach of health insurance.

Keywords: Health Insurance, Taxonomy, History, Growth and Development.

Introduction:

Health is of prime concern not only for a person but also for the society. It is said that a healthy mind resides in a healthy body. Hence it is very important

to stay healthy. These days life is very fast and stressful. No matter how much you care one can always fall ill. Health treatment nowadays is very costly. Health-related expenses in India are increasing year on year. The financial burden from health-related expenses is a bigger threat to the well being of the Indian population. More than the disease it is the cost of treatment that takes its toll. To get rid of health worries, health or medical insurance is the answer. A comparative study by a leading media group has found that the treatment cost for patients without any insurance is 25 per cent to 60 per cent higher than for those with health insurance cover. Moreover health care has always been a problem area for India, a nation with a large population and a larger percentage

of this population living below the poverty line. In such a situation insurance becomes an important issue in the country.

Health Insurance in a very narrow sense means, individual or group purchases in advance the health coverage by paying a fee called 'premium'. But it can be also defined in a broad sense by including all financing arrangements where consumers can avoid or reduce their expenditure at time of use of the services. The health insurance existing in India covers a very wide spectrum of arrangements and hence the latter-broader interpretation of health insurance will be more appropriate. The Indian health insurance scenario is a mix of mandatory health insurance schemes or government run schemes (namely Employee State Insurance Scheme, Central Government Health Scheme, etc), voluntary health insurance schemes or private-for-profit schemes, employer based schemes and insurance offered by NGOs or community-based health insurance (CBHI). Though health insurance is a very well developed concept in many countries, it is a new

concept in India and its awareness is growing fast.

Objectives:

- To study various health insurance products available in India.
- To study the growth and development of health insurance market in India.

Methodology:

The paper is only based on secondary data, which was sourced from various research publications, periodicals, online journals, printed journals, magazines, books, web sites etc.

Taxonomy of Health Insurance in India:

The Indian health insurance scenario is a mix of Social Health Insurance or Mandatory Health Insurance Schemes or Government-run Schemes, Voluntary Health Insurance Schemes or Private Health Insurance, Employer Based Schemes and health insurance offered by NGOs or Community Based Health Insurance (CBHI) or Micro Health Insurance. Each has its own specificities. Each category of health insurance has been described elaborately below:

(i) **Social Health Insurance (SHI) or Mandatory Health Insurance Schemes or Government run Schemes:**

Social Health Insurance Schemes are statutory programmes financed mainly through wage-based contributions and related to level of income. These schemes are mandatory for defined categories of workers and their employers. 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. It is based on a combination of insurance and solidarity. The government also provides significant funding to cover those who are not able to contribute. In India there are three well known SHI schemes and they are Employer State Insurance

Scheme (ESIS), Central Government Health Insurance Scheme (CGHS) and Universal Health Insurance Scheme (UHS).

(ii) **Voluntary Health Insurance Schemes or Private Health Insurance:**

Private Health Insurance (PHI), often called Private Voluntary Health Insurance Schemes, refers to insurance schemes that are financed through individual private health premiums, which are often voluntary, and risk rated. These schemes are offered by insurance companies in the open market in which enrolment into the scheme is not determined by legislation. For profit insurance companies manage the funds. In India, the public as well as the private sector companies provide PHI. In public sector there is Life Insurance Corporation of India (LIC) and four general insurance companies namely

National Insurance Company Limited, The New India Assurance Company Limited, The Oriental Insurance Company Limited and United India Insurance Company Limited providing PHI in India. On the other hand, in private sector there are total 31 insurance companies (life as well as non-life) providing PHI. Out of the 31 private insurance companies three are standalone health insurers namely Star Health and Allied Insurance Company Limited, Max Bupa Health Insurance Company Limited and Apollo Munich Health Insurance Company Limited. The government insurance companies started first health insurance in 1986, under the name Mediclaim; thereafter Mediclaim has been revised to make it an attractive product.

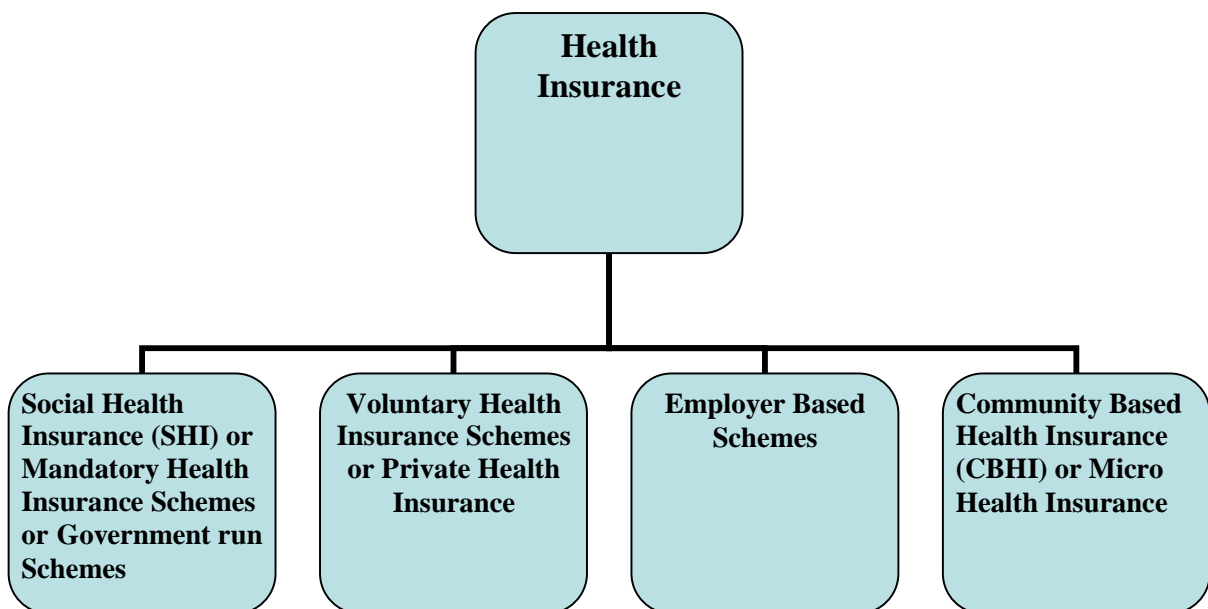
(iii) **Employer Based Schemes:** Employers in both the public and private sector offer

employer-based insurance schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or covering them under the group health insurance policy. The railways, defence and security forces, plantations sector and mining sector provide medical services and / or benefits to its own employees.

(iv) **Community Based Health Insurance (CBHI) or Micro Health Insurance:** It is a form of micro-insurance in which resources are pooled to mitigate health risks and cover health care services in full or in part. Micro health insurance schemes are more complex in nature compared

to life insurance schemes, as they provide services towards specific risks or illnesses and involve the role a health care provider, whether independent of or in partnership with the scheme. The scheme can be provided by government, a private

insurance company, an NGO or a CBO. Micro health insurance is important for the poor because health risks are often identified by the poor as the greatest and costliest risks among all other natural, social, economic etc risks faced by them.



History of Health Insurance:

The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the mid-1800s, a new type of insurance called casualty insurance appeared. The companies that wrote them were called

casualty insurers. The earliest form of casualty insurance was accident insurance.

The history of health insurance in India traces back to 1923 when the ‘Workmen’s Compensation Act’ was passed. According to this act, an employer was required to pay

compensation to his workers who received injuries or contracted occupational diseases during the course of their work. The year 1948 saw the introduction of Employees' State Insurance (ESI) Act. The ESI Act replaced the Workmen's Compensation Act, 1923. The act was enacted with the object of introducing a scheme of health insurance for industrial workers. The scheme i.e. Employees State Insurance Scheme (ESIS) envisaged by it was one of compulsory state insurances providing for certain benefits in the event of sickness, maternity and employment injury to workmen employed in or in connection with the work in factories other than seasonal factories. Since then, the health insurance market has been a wild frontier with rules constantly evolving.

The Central Government Health Scheme (CGHS) was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. It was basically designed to replace the cumbersome and expensive system of reimbursements. Over the years the coverage has grown

substantially with provision for the non-allopathic systems of medicine as well as for allopathy.

The General Insurance Corporation (GIC), which was set up by the government in 1973 as a public sector organization, marketed a range of insurance services including hospitalization cover. It introduced the standard 'Mediclam' health insurance scheme in 1986, and became operational in 1987. This policy was modified in 1996 to allow for differentials in premium for six age groups: 5-45, 46-55, 56-65, 66-70, 71-75 and 76 plus. This policy was framed by the GIC for both groups and individuals. Before the GIC came into existence, a number of private insurance companies were engaged in offering health insurance cover to most corporate bodies. With the formation of the GIC, these companies were merged into four of its subsidiaries based in Bombay (National Insurance), New Delhi (New India Assurance), Calcutta (Oriental Insurance) and Madras (United India Insurance). In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the

same time GIC was converted into a national re-insurer. Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002.

The Life Insurance Corporation of India introduced a specialty insurance programme in 1993 which covered medical expenses for only four dreaded diseases. This programme was withdrawn subsequently, but reintroduced in 1995. The latest introduction of LIC's health insurance product is 'Jeevan Arogya'.

Community Health Insurance (CHI) or Micro Health Insurance emerged as a possible means of: (i) improving access to health care among the poor; and (ii) protecting the poor from indebtedness and impoverishment resulting from medical expenditures. In India, community health insurance has a long history. The earliest such scheme was started in Kolkata in 1952 as part of a student's movement. With 70 per cent of population in India living in rural areas and 95 per cent of work-force working in unorganized sectors, and disproportionately large percentage of these populations living below poverty line, there is a strong need to develop

social security mechanisms for this segment of population. This need for security is further increased because the poor are the most vulnerable for ill health, accidents, death, desertion, social disruptions such as riots, loss of housing, job and other means of livelihood. There are some efforts in this direction of providing social security to the poor by a few NGOs. The most prominent among them is that of Self-Employed Women's Association (SEWA). The SEWA health insurance scheme was introduced by the SEWA Bank in March 1992 with initial enrolment of 7000 women from Ahmedabad city. Later on it was extended to cover rural woman members from nine districts of Gujarat. The main motivation behind the initiation of a health insurance scheme for women was that maintenance of an active health seeking behaviour which is a vital component of ensuring a good quality life. The coverage of the SEWA health insurance programme includes maternity coverage, hospitalisation coverage for a wide range of diseases, and occupational health related illness and other diseases specific to women. The other scheme by government insurance companies

developed to focus on poor is called Jan Arogya Bima Policy which was introduced in 1995 and covers expenditure up to Rs.5,000 for a premium of Rs.70 per annum.

Thus, before January 2000, in fact, the insurance business in India was a government monopoly. After independence, the life insurance business was nationalized in 1956 and the general insurance sector followed the same path in 1972. Since then, the market was dominated by two state-owned entities, the Life Insurance Corporation (LIC) and the General Insurance Corporation (GIC) and its subsidiaries.

The process of re-opening of the sector had begun in the early 1990s and the last decade and more has seen it been opened up substantially. In 1993, the Government set up a committee under the chairmanship of R.N. Malhotra, former Governor of RBI, to propose recommendations for reforms in the insurance sector. The objective was to complement the reforms initiated in the financial sector. The committee submitted its report in 1994 wherein, among other things, it recommended that

the private sector be permitted to enter the insurance industry. They stated that foreign companies should be allowed to enter by floating Indian companies, preferably a joint venture with Indian partners.

Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000. The key objectives of the IRDA include promotion of competition so as to enhance customer satisfaction through increased consumer choice and lower premiums, while ensuring the financial security of the insurance market.

The IRDA opened up the market in August 2000 with the invitation for application for registrations. Foreign companies were allowed ownership of up to 26%. The Authority has the power to frame regulations under Section 114A of the Insurance Act, 1938 and has from 2000 onwards framed various regulations ranging from registration of companies for carrying on insurance

business to protection of policyholders' interests. During the liberalization period a large number of private insurance companies started their business in India, which are regulated by the IRDA.

Growth and Development of Health Insurance in India:

Health insurance has been growing consistently on a different path unlike other lines of business of non-life insurance. This segment has grown with a Compound Annual Growth Rate (CAGR) of 30.05 per cent during the past seven years (2005-2012), which is substantially higher than the CAGR (17.50 per cent) of the Gross Domestic Premium growth for the same period. Accordingly, the insurance penetration of health insurance (health insurance premium divided by total GDP of India) has witnessed a sharp growth. At present, health insurance penetration in the country stands at 14 per cent. Penetration of health insurance is expected to be more than double by 2020. Increasing penetration of health insurance is likely to be driven by government-sponsored initiatives such as Rashtriya Swasthya Bima Yojna (RSBY) and Employee's State Insurance

Corporation (ESIC) and also with government increasing Foreign Direct Investment (FDI) permit from 26 per cent to 49 per cent, Indian economy will see more flow of foreign investment. The high CAGR of health segment has led to a noticeable rise in its share in the non-life premium. The country ranked 19th among 156 countries in the non-life premium income, with a share of 0.62 per cent in the financial year 2012-13. The total health insurance premium collected by non-life insurers during the year 2012-13 was Rs. 15,701 crore. The premium collected during the year was 16.57 per cent more than the health insurance premium collected during the previous year. The health segment of the non-life insurance business has continued to grow at double digit figure for the past five years, although the growth rate has receded considerably from the high level witnessed during the period from 2006-07 to 2010-11. The share of the four public sector insurers in the total health insurance premium was 61 per cent in 2012-13. While private insurers contributed 28 per cent of the total health insurance premium, the rest 11 per cent was contributed by the four

standalone health private insurers. The four public sector insurers continue to be the dominant players in the health insurance domain in India. It is also emerging as an increasingly significant line of business for life insurance companies, and all the large life insurance companies now have products in the health insurance space.

The premium collection in Health segment continues to surge ahead. The non-life insurance industry underwrote total premium of Rs. 15,700.88 crore in 2012-13 as against Rs. 3,341.80 crore in 2006-07 registering

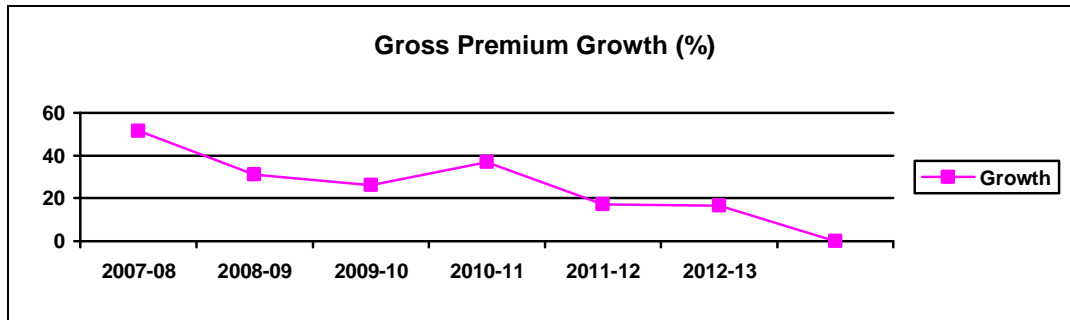
an impressive growth of 369.83 per cent. The year 2007-08 shows the most impressive growth of 51.58 per cent in comparison to all other years. The public sector insurers as well as the private sector insurers exhibited impressive growth in the period of last seven years (2006-2013), whereas the standalone health insurers could not show an impressive growth as compared to public and private sectors (Table-1). The growth in the Health Segment far out-paced the growth rate achieved by the non-life industry as a whole.

Table-1 GROSS DIRECT PREMIUM INCOME OF NON-LIFE INSURERS IN INDIA (Health Segment)

Year	Insurer			Total (Rs. in crore)	Growth Rate (in per cent)
	Public	Private	Standalone		
2006-07	2,158.65	1,160.64	22.51	3,341.80	-
2007-08	3,127.37	1,767.05	171.16	5,065.58	51.58
2008-09	3,863.47	2,224.54	558.01	6,646.02	31.20
2009-10	4,981.16	2,330.21	1,076.44	8,387.81	26.21
2010-11	6,912.56	3,031.47	1,536.00	11,480.03	36.86
2011-12	8,148.23	3,660.79	1,659.78	13,468.8	17.32
2012-13	9,592.15	4,382.52	1,726.21	15,700.88	16.57

(Source: IRDA Annual Reports 2006-2013)

Figure 1



The net premium income (earned) of non-life insurance industry has been increasing at a tremendous growth rate. The net premium earned in health segment for 2012-13 was Rs. 12,179.5 crore (Rs. 7,980.91 crore from public sector, Rs. 3,117.59 crore from

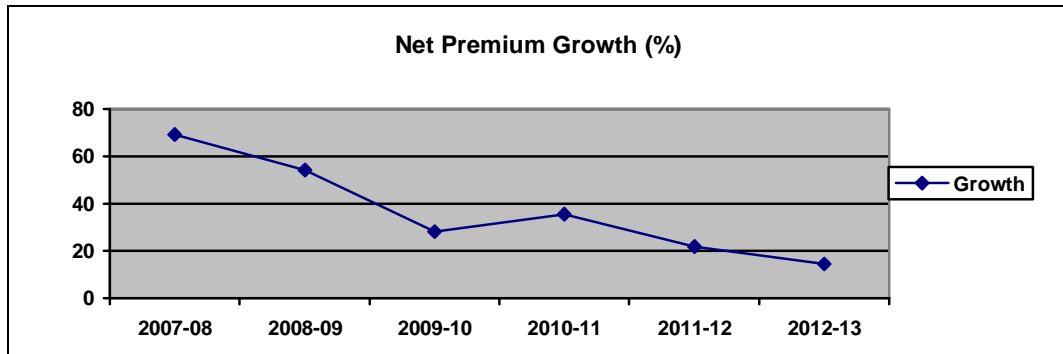
private sector and Rs. 1,081 crore from standalone health insurers) in comparison to Rs. 1,920.54 crore in 2006-07 registering an impressive growth of 534.17 per cent (Table-2). The year 2007-08 shows the highest growth of 69.33 per cent.

Table-2 NET PREMIUM INCOME (EARNED) OF NON-LIFE INSURERS IN INDIA (Health Segment)

Year	Insurer			Total (Rs. in crore)	Growth Rate (in per cent)
	Public	Private	Standalone		
2006-07	1,317.20	598.45	4.89	1,920.54	-
2007-08	2,175.69	960.07	116.37	3,252.13	69.33
2008-09	3,094.87	1,599.51	323.09	5,017.47	54.28
2009-10	3,937.98	1,815.42	680.39	6,433.79	28.23
2010-11	5,457.25	2,281.05	988.21	8,726.51	35.63
2011-12	6,805.84	2,666.52	1,161	10,633.36	21.85
2012-13	7,980.91	3,117.59	1,081	12,179.5	14.54

(Source: IRDA Annual Reports 2006-2013)

Figure 2



The Indian health insurance market has emerged as a new and lucrative growth avenue for both the existing players as well as the new entrants. According to a latest research report "Booming Health Insurance in India" by research firm RNCOS released in April 2010, 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.

There are certain factors driving growth of health insurance in India such as increasing awareness of Health Insurance, especially in the formal sector/ employed groups, rising healthcare costs have increased need for health insurance, Government schemes like RSBY and Aarogyasree, in terms of premium and even more so in lives covered, de-tariffing of the general

insurance industry (which has increased emphasis and efforts by insurance companies towards health insurance and other personal lines of business), rationalization of premium rates (e.g. trend of upward revision in respect of Group Health policies), etc.

The development of health insurance in India is a reflection of broader policy changes that are being felt in the Indian economy. As a part of its financial sector reform agenda, the Indian Government liberalized the Indian insurance industry by the enactment of the Insurance Regulatory and Development Authority (IRDA) Act by the Indian Parliament in 1999. This led to the opening up of the sector for participation of private insurance companies. Due to liberalization and a growing middle class with increased spending power, there has been an increase in the number of insurance

policies issued in the country. In 2001 with the entry of various private insurance companies now the customers had the choice of buying health insurance from various insurance companies. The IRDA eliminated tariffs on general insurance as of January 1, 2007, and this move is expected to drive additional growth of private insurance products.

As of 2010, leading insurance companies are coming out with plans that target individual customer needs. For example, insurance plans advertise and accommodate older age groups and the elderly. Plans cover medical expenses such as medicines, nurses, disabilities and hospice care. According to the International Observatory on End of Life Care, a study in India in 2006 found that successful models are in development in India for affordable, sustainable community-based hospice and palliative care services.

The evolution of a new body for cash less claim processing in the form of Third Party Administrators (TPAs) marked a new chapter towards addressing some of the problems of health insurance industry. Third Party

Administrator (TPA) was introduced through the notification on TPA- Health Services Regulations, 2001 by the IRDA. Their basic role is to function as an intermediary between the insurer and the insured and facilitate the cash less service of insurance. For this service they are paid a fixed per cent of insurance premium as commission. The core product/ service of a TPA is ensuring cashless hospitalization to policyholders. Intermediation by TPAs ensures that policyholders get hassle free services, insurance companies pay for efficient and cost efficient services, and health care providers get their reimbursement on time. By doing this it is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs, developing protocols to minimize unnecessary treatments/investigations, improve quality of services and ultimately lead to lower insurance premiums.

According to the Government of India Insurance Regulatory and Development Authority (IRDA), India installed an insurance "ombudsman" in 1998 to handle customer complaints

over faulty and overpriced insurance policies. Because the institution gives health insurance policyholders a platform to express and resolve insurance issues, customers are better protected and insurance companies are accountable for their transactions. According to an Indian Express article published in March 2010, maternity is the most widespread reason people are hospitalized in India. While health insurance policies do not usually cover consultation or medical fees, new insurance companies are trying to clarify and simplify the process to accommodate women seeking hospital care during pregnancy. Some current plans cover maternity care, dental costs and pharmaceuticals. Policies are also centering on senior citizen health care plans for maximum coverage at a lower cost.

With a view to bringing together all stakeholders in the health insurance space, the IRDA has created the Health Insurance Forum in Feb, 2012 taking in representatives from all related fields including non-life insurers, life insurers, standalone health insurance companies, concerned ministries, National

Accreditation Board for Hospitals and Health care providers (NABH), hospitals, service providers, TPAs, Confederation of Indian Industry, Federation of Indian Chambers of Commerce & Industry, etc. The objective of the forum is to aid, advice and assist the Authority in further improvements in health insurance, health provider services and all health insurance related issues. The forum meets periodically to discuss topics of common interest and works on areas of relevance in the health insurance area.

The Authority examined at length various issues involved in the portability of health insurance plan and issued the circular for effecting portability of Health insurance policies in 2010-11. Health Insurance Portability is a regulation set by IRDA where an individual is allowed to switch between insurers at their own choice without having to worry about their no claim bonus and pre-existing diseases cover. All non-life insurers issuing Health insurance policies shall allow for credit gained by the insured for pre-existing condition(s) in terms of waiting period when he/she switches from one insurer

to another or from one plan to another, provided the previous policy has been maintained without break. Introduction of health insurance portability is expected to boost the orderly growth of the insurance sector.

Conclusion:

Health insurance, which remained under “miscellaneous portfolio” and was generally not considered a very important area for business growth (or a significant segment of the product portfolios of these insurance companies), is now emerging as a massive tool used by insurance companies in India for their growth. The growth of health insurance industry lies mainly in better customer orientation in terms of servicing the customers, standardization of procedures and definitions across the industry. Health insurance market has witnessed a number of initiatives in recent years to garner the views of various stakeholders to expand the reach of health insurance. Increased awareness about the benefits of health insurance, particularly in urban areas has occurred due to rise in medical costs and also as a result of popular government schemes.

Needless to say, health insurance presents an emerging opportunity for insurers in India. The potential market is large, as is evident from the high out-of-pocket expenditure borne by Indian households. Thus, the insurers must focus on new categories of products combining five pillars of successful innovation- risk mitigation, health costs, financing mechanisms, elements of managed care and advice.

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