STATUS OF HEALTH INSURANCE SCHEMES IN INDIA

[1]Shaik Shakeela [2]Chilumuri Srinivasa Rao

[1]Research Scholar, [2] Professors
[1, 2] Dept. of Commerce, Vikrama Simhapuri University P.G Centre, Kavali, Andhra Pradesh, India.

ABSTRACT

Now a day every person is aware of the fact that number of illnesses are increasing day by day. Health care costs are increasing every year. Sedentary lifestyle and stress at work negatively affect the health and can result in a critical illness or medical emergency. Such a scenario is sure to adversely affect one financially, due to the massive outlay of money on medical expenditure. A health insurance policy is the only way to mitigate the financial risks, apart from leading a healthy lifestyle. Health insurance often includes cashless facility at empanelled hospitals, pre and post hospitalisation expenses, ambulance charges, daily cash allowance etc. It is evident that a wide variety of arrangements are described under the umbrella of private insurance and that the boundaries between public insurance and private insurance are becoming increasingly blurred.

The Health Insurance Schemes available in India Classified into Voluntary health insurance schemes or private-for-profit schemes, Mandatory health insurance schemes or government sponsored schemes (namely ESIS, CGHS), Insurance offered by NGOs or Community based health insurance and Employer based schemes. In India have 43,486 private hospitals, 1.8 million beds and 59,262 ICUs, 29,631 ventilators. There are 25,778 public hospitals, 713,989 beds, 35,700ICUs and 17,850 ventilators. Total private infrastructures are nearly 62per cent of India's entire health infrastructure. Availability of sufficient numbers of providers of health insurance schemes in any country is important. In India, on analyzing the classification of health insurance schemes on the basis of ownership and control, it can be drawn that there are sufficient numbers of providers and that to from different classes of the country. The main object of this paper is to assess performance of the health insurance in India. Based on secondary data, from IRDA annual reports, related books and articles analysis, this paper was prepared and concluded with findings and conclusion.

Key words: *ESIS, CGHS, Ayushman Bharat, PMJAY, Micro Health Insurance, NGOs.*

INTRODUCTION

Health care costs are increasing every year. Sedentary lifestyle and stress at work negatively affect the health and can result in a critical illness or medical emergency. Such a scenario is sure to adversely affect one financially, due to the massive outlay of money on medical expenditure. A health insurance policy is the only way to mitigate the financial risks, apart from leading a healthy lifestyle. Health insurance guarantees peace of mind in times of crisis, and helps secure own health and that of one's family. Health insurance covers the medical and surgical expenses of the insured individual due to hospitalisation from an illness. Additional riders enhance the benefits and scope of the cover. Health insurance often includes cashless facility at empanelled hospitals, pre and post hospitalisation expenses, ambulance charges, daily cash allowance etc.,

OBJECTIVE OF THE STUDY

1. The main object of this paper is to assess performance of the health insurance schemes in India.
2. Understand the status of Health insurance companies and their policies in the country.

RESEARCH METHODOLOGY

This study is based on secondary data. The secondary data have been collected from various sources from books, magazines, journals, newspapers, published and unpublished articles websites etc.

STATUS OF HEALTH INSURANCE SCHEMES IN INDIA

The Indian health insurance industry was primarily dormant before the opening up of the market for private players. It is only after the privatization of the health insurance market and introduction of the insurance regulator that one has seen rapid growth in this segment. The growth is also fueled by the complexities and challenges within the health care market. It is evident that a wide variety of arrangements are described under the umbrella of private insurance and that the boundaries between public insurance and private insurance are becoming increasingly blurred. In addition to the three dimensions above, private insurance can be classified by the different roles it plays in the health financing system. When it provides Principal Coverage, private insurance is the primary form of prepayment for some portion of the

population. Principal insurance usually pays for a broad package of health services; often mirroring those financed in a public system.

The Health Insurance Schemes Available In India Can Be Classified Into:

1. Voluntary health insurance schemes or private-for-profit schemes
2. Mandatory health insurance schemes or government sponsored schemes
3. Insurance offered by NGOs or Community based health insurance
4. Employer based schemes.

Availability of sufficient numbers of providers of health insurance schemes in any country is important. But at the same time it is very important that there should be providers of the schemes from different class, targeting to cover special or overall people of the country. In India, on analyzing the classification of health insurance schemes on the basis of ownership and control, it can be drawn that there are sufficient numbers of providers and that to from different classes of the country. Not only the Government and NGOs are being the players or providers but also private players are being aggressively serving the nation.

Voluntary health insurance schemes or private-for-profit schemes

Schemes offered by insurers in the open market comprise of Public Sector as well as Private Sector Companies. The private health insurance (PHI) schemes, frequently called Private Voluntary Health Insurance schemes (PVHI), are the schemes offered by insurance companies in the open market in which enrolment into the scheme is not determined by legislation. In India the public and private sector companies provide the PHI. In India have 43,486 private hospitals, 1.8 million beds and 59,262 ICUs, 29,631 ventilators. There are 25,778 public hospitals, 713,989 beds, 35,700ICUs and 17,850 ventilators.

Total private infrastructures are nearly 62per cent of India's entire health infrastructure (Private healthcare in India: boons and banes, November 2020). There are over 160 health insurance products in the category offered by both life and non-life insurers. In totality there are more than twenty nine of health insurance players in India. Among them there are five public sector companies, six standalone companies and other private players. Above all one general reinsurer is added to the list. While ICICI Lombard, Bajaj Allianz, HDFC and Reliance General are some of the prominent general insurers in the health insurance space Apollo Munich Health

Insurance Company, Star Health and Allied Insurance Company, Max Bupa Health Insurance Company, Religere, Aditya and Cigna TTK Health Insurance Company are the standalone players. An important peculiarity of these corporations is the tie-up with some health care provider having super specialty facilities. In public sector there are overall two main companies, the Life Insurance Corporation of India and the General Insurance Corporation. Subsidiaries of the GIC, namely NIC, NIAC, OIC and UIC are the largest public sector organization of providing the Private Health Insurance in India. Market Based Systems or Private/ Voluntary Health Insurance (PVHI) Schemes offered by Public and Private Sector Companies in open market. Public Sector General Insurance Corporation (GIC), with its four subsidiary companies providing popular schemes like Med claim, personal accidental and Travel insurance etc. The Life Insurance Corporation of India: Health Plus and newly launched policy Jan Arogya. Private Sector Companies: ICICI Lombard, Bajaj Allianz, Star Health and Allied Company are the prominent private company.

Status of Voluntary health insurers

The best insurance companies offered in the time of medical emergencies. In India as discussed Table-1 in the given below health insurance companies that deal in different forms of general insurance products in India 2019-20. It is most important thing to insurance policies that can financial assistance in case a medical emergency where we need a quality treatment but what if we claim to get rejected. An insurance company's claim settlement ratio refers the proportion of claim settled by it against the total claim raised. A higher claim settlement ratio means there is higher chance of getting claim approved in time of need. It will be good news for customers as in the case of bulk claim, the company will have enough to pay the claim to the customers.

The Highest incurred settlement ratio was 111% in United Indian Insurance Company followed by new India and oriental are 108% and lowest ratio was 33% in Raheja QBE insurance company. The Star Health & Allied highest network hospital provides 10200+ cashless hospitals facilities and 2600+ hospitals provide cashless facility least by New India Assurance Company. The highest health annual premium was New India Rs.938.78crores and least was Raheja QBE Rs. 0.62crore in 2019-20.

Table-1 Status of Health Insurance Companies in India

S.No	Name of the Company	Headquarter	Incurred Settlement Ratio year 2019-20 (Percent)	Annual Premium 2019-20 (In Crores)	Cashless Hospitals
1.	National Insurance	Kolkata	108	5,277.67	6000+
2.	New India	Mumbai	104	9,381.78	2600+
3.	Oriental Insurance	New Delhi	108	4,642.63	4300+
4.	United India	Chennai	111	5,329.77	7000+
5.	Raheja QBE	Mumbai	33	0.62	5000+
6.	IFFCO Tokio	Gurugram	102	1,315.81	6400+
7.	Reliance General	Mumbai	94	1,365.92	7300+
8.	Bajaj Allianz	Pune	85	2,138.53	6500+
9.	Royal Sundaram	Chennai	61	394.60	5000+
10.	ICICI Lombard	Mumbai	78	2,695.15	6500+
11.	Kotak Mahindra	Mumbai	75	105.68	4000+
12.	Tata AIG	Mumbai	78	835.42	6200+
13.	Choramandal	Chennai	35	316.99	7240+
14.	HDFC Ergo	Mumbai	62	3,623.29	10000+
15.	Star Health	Chennai	63	6,718.99	10200+
16.	Appolo Munich	Gurugram	62	2151.25	15500+
17.	Universal Sompo	Mumbai	92	160.47	5000+
18.	Futur Generali	Mumbai	73	381.96	5100+
19.	Bharati Axa	Mumbai	89	266.94	4500+
20.	Max Bupa	New Delhi	54	1177.56	5000+
21.	SBI General	Mumbai	52	742.46	6000+
22.	Religare	New Delhi	55	1365.92	7400+
23.	Liberty Videocon	Mumbai	82	243.62	5000+
24.	Magma HDI	New Delhi	34.	47.63	4300+
25.	Manipal cigna	Mumbai	62	567.29	6500+
26.	Aditya Birla	Mumbai	70	755.50	8000+
27.	Digit	Mumbai	63	17.52	5900+
28.	Edelweiss	Mumbai	64	45.06	3280+
29.	Acko	Mumbai	74	23.63	5000+

Source: Network hospital data from various general insurance websites.

Performance Monitoring Systems of the selected Government-sponsored Scheme: Government or State Based Systems in India started health insurance with the oldest continues Employees' State Insurance Scheme (ESIS) that came into existence in February 24, 1952 while

the Central Government Health Scheme (CGHS) was established in 1954, both contributory and mandatory.

The Employees' State Insurance Scheme (ESIS) -1952: Formal systems for Health Insurance in India began with the inception of the Employees' State Insurance Scheme (ESIS), introduced vide the ESI Act, 1948. It was introduced as a social security cover for workers employed in the formal sector, in organizations which meet certain standard for enrolment and these criteria have been revised from time to time. ESIS provides for complete health services through a network of its own dispensaries and hospitals, supplemented by Authorized Medical Attendants and private hospitals to serve needs which cannot be met by its own network. The Employees' State Insurance Corporation (ESIC) raised the monthly wage limit to Rs. 21,000 from the existing Rs.15,000 for coverage with effect from 1 January 2017 The rate of contribution was reduced from 6.5% to 4% (employer's share 3.25% and employee's share 0.75%) effective from 1 July 2019.

ESI Coverage: This scheme has also been made extended to hotels, shops, cinemas and preview theatres, restaurants, newspaper establishments, and road-motor transport undertakings. This scheme has also been extended to the Private Educational and Medical institutions that have employed 10 or more people. This is applicable in certain states and union territories only. The ESI scheme has been implemented are-wise throughout the country. This scheme has been implemented in stages in every state in India except Arunachal Pradesh and Manipur. The scheme has also been enacted in all union territories except for Daman and Diu, Dadra and Nagar, and Lakshadweep Islands. The ESI scheme has been notified in a total of 325 complete districts out of a total of 393 districts. Out of these notified districts, 89 districts implemented the scheme partially. In the year 2017-18 around 83.35 lakhs new subscribers had joined the ESIC; it increased to 1.49 Crores in 2018-19 and gross enrolment o new subscribers were 1.51Crores in 2019-20. Overall last three years newly enrolled were 4.28 Crores in 2017 to 2020.

Central Government Health Scheme (CGHS) -1954: The ESIS was followed by a scheme for central government employees; the Central Government Health Scheme (CGHS) was introduced Ministry of Health and Family Welfare (MHFW) in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families. The list of beneficiaries includes all central government employees, members of parliament and

Supreme Court and High Court Judges. CGHS is financed largely by the Government of India, while the government employees also contribute a nominal amount, ranging from Rs.15 to Rs.150 per month from their salaries based on their scale of pay. Here also, the coverage is comprehensive and includes both outpatient care and hospitalization. Outpatient care is provided through CGHS dispensaries, located in major cities. It also uses the facilities of the government and approved private hospitals to provide inpatient or the hospital, as the case may be. The scheme covers employees, pensioners and dependents of Central Government. CGHS is available in 71 Indian cities. Coverage is wide and includes hospitalization, domiciliary care, consultation facilities, health education, etc. Allopath as well as non-allopathic AYUSH treatments is also covered under the scheme.

Pradhan Mantri Jan Arogya Yojana (PMJAY) / Ayushman Bharat: Pradhan Mantri Jan Arogya Yojana (PMJAY) is a flagship scheme of Government of India under Ayushman Bharat scheme, was launched on September 23, 2018. The scheme provides a health cover of five lakh rupees per family per year for secondary and tertiary care hospitalization to poor and vulnerable households. PMJAY was earlier known as the National Health Protection Scheme (NHPS) which subsumed the Rashtriya Swasthya Bima Yojana (RSBY) which had been launched in 2008. Hospitalization expenses of the covered families are covered up to INR 5 lakhs. Premiums are borne by the Government. Cashless hospitalization facility is provided to the insured members. The coverage is offered on a family floater basis and there is no limit on the number of family members who can be covered under the scheme. A 'Golden Card' is issued by the Government to the beneficiary families and this card should be produced at the hospital for availing cashless claims.

Coverage of Ayushman Bharath major expenditure on India in 2020: In the table-2 shows details regarding the implementation of the AB programs which includes PMJA and HWCs. Total beneficiaries in 1363lakhs families in India, Claim paid by 63%, empanelled hospitals are 19,753 and Health and wellness centers are 29573 in the year 2020 in India.

The scheme is fully funded by the Government and cost of implementation is shared between the Central and State Governments. Popularly called the Ayushman Bharat scheme, this health insurance scheme is the latest offering by the Indian Government for the economically backward sections of the society, 10.74 Crores families which are defined to be 'poor and vulnerable' are covered under the scheme.

Table-2 Coverage of Ayushman Bharath Major Expenditure on India 2020

Items	All India
Beneficiary families covered(in lakhs)	1,363
Percent of claim paid	63%
No.of empanelled hospitals	19,753
Health and Wealth Centers	29,573

Source: MoHFW, HWC portal

NGOs/ Member Organization Based Systems:

Micro Health Insurance (MHI) Schemes in this scheme affordability of health services provided by the private agencies have higher charges with less coverage and the nongovernmental organizations (NGOs) do not provide any insurance schemes rather they work in making health care at affordable costs. CBHI (Central Bureau of Health Intelligence 1961) is a form of micro health insurance, which is an overarching term for health insurance targeted to low-income people. MHI schemes are based on 'not for profit' principle and targeted to the underprivileged sections of the society. In India currently there are more than 20 MHI units and many organizations are coming ahead with various proposals to introduce health insurance from getting inspiration from the successful stories of the existing MHI units.

CBHI schemes are generally characterized by the following institutional design features. Pooling of health risks and of funds occurs within a community or a group of people who share common characteristics, such as geographical location or occupation. Membership premiums are often a flat rate and independent of individual health risks. Entitlements to benefits are linked to contributions in most cases. Affiliation is voluntary. The scheme operates on a non-profit basis.

Employer Based Schemes: These schemes are offered by both the public sector and private sector employers. The benefits are provided by way of lump-sum-payments, reimbursement of health care expenditure to the employees, which are incurred for out- patient care, hospitalization. These also provide for fixed medical allowance on monthly or annual basis, irrespective of actual expenses or coverage under group health insurance policies. Employer-based health insurance (insurance that is purchased by employers for their employees and financed through employer or joint employer-employee contributions) is currently subsidized in

part by the federal government through tax exclusions for employer contributions to employee health insurance plans.

Table- 4.4 Financial performance of Ayushman Bharath 2018-19 to 2020-21

(Rs.in Crores)

S.No	SCHEMES	RE/BE	Actual received from Govt. of India	Grant Utilized
1.	NHA HQs Grant	430.08	310.08	115.70
2.	Grant-in-Aid for administrative Expenses	1721.92	322.20	125.89
3.	Grant-in-Aid for Implementation		1368.89	1723.66
4.	Total (2018-19)	2162.00	2001.17	1965.25
5.	NHA HQs Grant	605.00	321.00	136.38
6.	Grant-in-Aid for administrative Expenses	5795.00	150.00	101.83
7.	Grant-in-Aid for Implementation		2729.00	2891.12
8.	Total (2019-20)	6400.00	3200.00	3129.33
9.	NHA HQs Grant	405.00	80.00	28.38
10	Grant-in-Aid for administrative Expenses	5995.00	120.00	18.77
11	Grant-in-Aid for Implementation		900.00	613.10
	Total (2020-21)	6400.00	1100.00	660.25

Source: Ayushman Bharath Annual Reports.

Note: RE- Revised Estimate; BE- Budget Estimate.

Finding: In the year 2018-19 2162.00cr, actual receive 2001.17cr and utilized fund are 1965.25cr. It is declined to 2020-21 actual received 1100.00cr and utilized 660.25cr. In the year 2018-19 GIA for administrative expenses are actual received Rs.332.20Cr, utilized fund are Rs.125.89Cr it is decline to 120Cr received and untilled fund are 18.77 Cr in the year 2020-20 budget estimated.

Suggestion: The lot of different between revised and budget estimation, it is most popular schemes. So, government concentrate this type schemes to provide health facility BP people. So increased budget fulfilled by the need for all. The scheme is fully funded by the Government and

cost of implementation is shared between the Central and State Governments. Popularly called the Ayushman Bharat scheme, this health insurance scheme is the latest offering by the Indian Government for the economically backward sections of the society. 10.74 Crores families which are defined to be 'poor and vulnerable' are covered under the scheme.

CONCLUSION

Above discussion on the performance of health insurance schemes in India. The government sponsored schemes are benefited to below poverty line peoples and government employees. The middle income people do not benefited by these schemes, they depend upon the public and private health insurance companies provided health in insurance schemes sum premium, It is burden to their life. So, government will be implementing the new schemes to provide health facilities middle income peoples. The most popular Ayushman Bharath schemes are increased to beneficiary and facilitate network hospital to available of rural peoples. So increased budget also fulfilled by the health need for all.

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