Forum for Linguistic Studies 2025, 7(1),
https://doi.org/10.24294/fls.v6i2.2135
ISSN:2705-0610 E-ISSN:2705-0602

A STUDY ON THE CLASSIFICATION OF HEALTH INSURANCE SCHEMES IN INDIA

Dr Kamidi Srinivasa Rao[1],
Dept. of Economics, Research Investigator, Population Research Centre, Andhra University, Visakhapatnam (AP), drshreeprc@gmail.com

Dr B. Muniswamy[2],
Professor, HOD, Dept. of Statistics, Andhra University, Visakhapatnam (AP), munistats@gmail.com

ABSTRACT:

Health Insurance has become inevitable these days. Basic amenities of human life, to have food, shelter and clothing need to be extended by adding health care and insurance. To maintain himself for living human being need to make himself fit but some inevitable health crisis disturbs his life for a while or forever. It's better to cope up with the odd instead of waiting for the mis-happening to go on. But for tackling with illness, medical cost becomes inevitable. These medical costs either to be borne by way of availing some social/governmental aid or most of the time from personal pocket. But the facts are very bitter. Facts have been covered in following two points highlighting failure of a person to take initiative and even of the country sometimes.If to write something about number data in respect of Indian health insurance market, then there are about more than two and a half dozens of companies catering health insurance schemes in India. Near about 140 varieties of health insurance schemes are presently catered by two dozens of private health insurance players, whereas LIC of India and four subsidiaries of GIC (as public health insurance providers) are having this number approximately upto 35. This paper aims to examine the classification of health insurance schemes in India.

INTRODUCTION:

About their businesses, with special reference to health insurance, reveals some more interesting facts. In brief among private players the sampled company, ICICI Lombard is on the top because of its huge volume of business. Highest Net Earned Premium and Net Claim Incurred, which are the very basic highlighting factors makes the company to be on the top. Among Standalone Companies, Star Health and Allied Insurance Company Limited is on the top because of its numerous health insurance schemes, each of the scheme carrying a special feature that brings acceptability and ultimately results in increase in business.Policies of public and private players as well cover more or less same kind of risks but with different names. Most of their policies belong to the classification as follows: Mediclaim is Pure Health Insurance Policy, Critical Illness Policy, Accidental Policy, Overseas Travel Insurance Policy and Group Medical Insurance.On the basis of illness, policy providing a simple health insurance is there and on the other hand some critical illnesses are specially covered.Private sector health insurance policies are loaded with some additional features making it comparatively better than the public sectors companies.

The existing health insurance schemes can be broadly be classified into two categories, first one is the basis of Ownership and Control of the Schemes and basis of medical coverage of the 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 NGO's are being the players or providers but also private players are being aggressively serving the nation. Also Employer's provided scheme makes an effort to cover service class people of India. Following is the classification, done on the basis of different class players/providers of health insurance schemes in India:

GOVERNMENT OR STATE BASED SYSTEMS:

India started its tryst with health insurance with the oldest running Employees' State Insurance Scheme (ESIS) that came into existence in 1952 while the Central Government Health Scheme (CGHS) was established in 1954, both contributory and mandatory. In recent past couple of new schemes got added to the list.

THE EMPLOYEES' STATE INSURANCE SCHEME – 1952: Employees' State Insurance Scheme of India is a multidimensional social security system tailored to provide socio-economic protection to worker population and their dependants covered under the scheme. Besides full medical care for self and dependants, that is admissible from day one of insurable employment, the insured persons are also entitled to a variety of cash benefits in times of physical distress due to sickness, temporary or permanent disablement etc. resulting in loss of earning capacity, the confinement in respect of insured women, dependants of insured persons who die in industrial accidents or because of employment injury or occupational hazard are entitled to a monthly pension called the dependants benefit.

The Employee State Insurance Scheme (ESIS) is a health insurance program for non-seasonal power-using factories employing 10 or more persons and non-power using factories employing 20 or more persons. Employees must make under Rs 10,000 per month to participate in the scheme. Employers pay a contribution of 4.75% of the wages payable to the employee; employees contribute 1.75% of their wages. Beneficiaries can use the services in ESIS facilities, which are financed by the State Governments (USAID Report, Gupta et al., 2008). In 2006, there were nearly 355 lakh beneficiaries (see Exhibit 1 – page 23), 4% of which are women based on the Employee State Insurance Corporation's (ESIC) Report 2010.

THE CENTRAL GOVERNMENT HEALTH SCHEME (CGHS) - 1954: Senior citizens and retired personnel who have worked in Central Government bodies are assured of their health care needs through the Central Government Health Scheme or CGHS. This scheme for pensioners provides medical assistance to retired central government officials along with their dependents, freedom fighters and widows of government officials. The CGHS Scheme also covers Delhi Police, retired judges of the Supreme Court, Accredited Journalists, Parliament Secretaries and their families. The Central Government Health Scheme initially started functioning in Delhi. After a few years, CGHS today covers 24 cities such as Allahabad, Ahmedabad, Bangalore, Mumbai, Chennai, Kolkata, Hyderabad, Jaipur and Patna. The CGHS offers health services through Allopathic and Homeopathic systems as well as through traditional Indian forms of medicine such as Ayurveda, Unani, Yoga and Siddha. These medical facilities are provided through dispensaries and polyclinics operated by CMOs.

The main components of the scheme are dispensary services including domiciliary care, specialist consultation facilities, X-ray, Electro Cardiogram (ECG), laboratory testing, hospitalization, purchase and distribution of medicines and provision of health education. There are private hospitals and diagnostic centres recognized under the Central Government Health Scheme. As per CGHS Annual Report 2009-10 there were about 0.87 million families enrolled under the schemes covering 3.0 millions of beneficiaries. (Source: official webpage CGHS, Ministry of Health and Family Welfare. Accessed - May 01, 2011) In the recent past the government has announced two new initiatives in the social sector - Universal Health Insurance Schemes (UHIS) and Unrecognized Sector Workers' Social Security Schemes (SSS) – (Mahendran, 2008).

UNIVERSAL HEALTH INSURANCE SCHEMES (UHIS): The budget of 2003-04 launched the UHIS in the country. This scheme is the first broad-based health security scheme, having element of financial contribution from the state. This could therefore be said to be within the ambit of 'social health insurance'. Universal Health Insurance Scheme got launched for improving the access of health care to poor families. The scheme, principally offers a package of insurance cover for a limited reimbursement of expenses for hospital services. The scheme envisages reimbursement of hospitalization expenses to an individual or a family, subject to specific sub-limits relating bed expenses, nursing expenses and maximum reimbursement for a single illness etc. The Universal Health Insurance Scheme (UHIS) has been redesigned targeting only the BPL families.

The scheme provides for reimbursement of medical expenses upto Rs.30,000/- towards hospitalization floated amongst the entire family, death cover due to an accident @ Rs.25,000/- to the earning head of the family and compensation due to loss of earning of the earning member @ Rs.50/- per day upto maximum of 15 days. The premium subsidy has been enhanced from Rs.100 to Rs.200 for an individual, Rs.300 for a family of five and Rs.400 for a family of seven, without any reduction in benefits. The scheme does not seem to be based on rigorous actuarial analysis it has been unsuccessful at attracting the poor for several reasons (USAID Report, Gupta et al., 08).

UNRECOGNIZED SECTOR WORKERS' SOCIAL SECURITY SCHEMES (SSS) The scheme was announced as one of the pilot projects for workers of unrecognized sector engaged in scheduled employments. The plan was to cover 25 lakhs workers in 50 districts. The ultimate objective was to enact an overarching law – the Unorganized Sector Worker's Act – to regulate the employment and conditions of service of all the workers of unrecognized sector and to provide for safety, social security, health and welfare. The proposed scheme is a long overdue initiative to take some substantive measures for the welfare of the workers in the unrecognized sector. it, therefore, deserves a serious scrutiny to access its chances of success, and to highlight the modification s that may be required.

EMPLOYER PROVIDED HEALTH INSURANCE SCHEMES: Employer based health insurance schemes are generally offered both by public and private sector companies through their own employer managed facilities. Workers buy health insurance through their employers taking insurance in lieu of part of the wage given to them. Mode of payment is generally in lump sum, reimbursements or covering them under the group health insurance policy with one of the subsidiaries of GIC. (Gupta & Kumar, 2006)

NGO/ MEMBER ORGANIZATION BASED SYSTEMS: MICRO HEALTH INSURANCE (MHI) SCHEMES 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 (Devadasan et al. 2008).

MARKET BASED SYSTEMS OR PRIVATE/ VOLUNTARY HEALTH INSURANCE (PVHI): Schemes offered by insurance companies in the open market comprise of Public Sector Companies as well as Private Sector Companies. The private health insurance (PHI) schemes, often 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. With a reach of just about 2% of India's 1.26 billion populations, it offers a huge potential in health insurance market. There are over 140 health insurance products in the category offered by both life and non-life insurers. In totality there are more than two dozens of health insurance players in India. Among them there are twenty one private players, five public sector companies and four stand alone companies. Above all one general reinsurer is added to the list.

While ICICI Lombard, Bajaj Allianz and Reliance General are some of the prominent general insurers in the health insurance space, Apollo Munic Health Insurance Company, Star Health and Allied Insurance Company, Max Bupa Health Insurance Company and Religare 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 LIC of India and the GIC. Subsidiaries of the GIC, namely NIC, NIAC, OIC and UIC, is the largest public sector organization of providing the PHI in India. New India Assurance Company Limited is the best among all out of the four subsidiaries, of the GIC and whereas LIC of India is having only two health insurance policies which makes it out of the race though being giant in other sub-sectors of insurance.

ON THE BASIS OF MEDICAL COVERAGE OF THE SCHEMES:

When we look at the products range in this portfolio, we find that in 1986, only Mediclaim and Cancer Policy existed. Today we have myriad products in the market. There are many products, based on disease management platforms. These products are primarily targeted a person whom may be already suffering from chronic disease. Kumar J. (2009) broadly classified health insurance products on the basis medical coverage.

Following are the available health insurance products in Indian market:

1. Basic Medical Expenses Insurance: Mediclaim Policy

2. Major Medical Insurance Policy

3. Disability Income Insurance Policy

4. Medicare Supplement Insurance Policy

5. Long-Term Care Insurance Policy

BASIC MEDICAL EXPENSES INSURANCE: MEDICLAIM POLICY:

Medical Expenses Insurance, often itself called simply health insurance. It encompasses a broad range of benefit arrangements that can cover virtually any expenses connected with hospital and medical care and related services for the insured and covered family members. Plans may be limited to basic benefits for specific kinds of medical services or may provide comprehensive benefits for all major medical expenses associated with severe injury or long term illness. Benefits may be paid directly to the health care provider or institution or as reimbursement of actual expenses incurred. Some benefits are paid as fixed amounts without regard to the actual costs. Basic medical insurance policies often have no deductible provision and salespeople often call this insurance first-rupee coverage because the insurer pays covered losses from the first rupee onward.

MAJOR MEDICAL INSURANCE POLICY:

Major Medical Insurance policies provide coverage for potentially large medical expenses rather than paying for the first rupees of loss. This coverage provides valuable family protection but can be expensive, costing families a higher premium. The characteristics which distinguish major medical coverage from basic medical plans are:

1. Major medical insurance plans have high limits of liability.
2. Major medical policies have participation provision.

With a major medical policy, the insurer agrees to pay only a percentage of the insured's bill; the insured must pay the difference. This sharing of costs is called the participation provision. Typically the insurer pays 75 to 80 % of the bills after the deductible requirement is met. The insured pays the remaining.

Major medical policies have a substantial deductible provision. These policies cause insured to pay an amount of medical bills equal to a substantial deductible. This deductible lowers the insurer's costs because the first rupees of all losses are not covered, and these are the most likely to be incurred. Some polices apply the deductible to each illness or accident but limit the total amount deducted to some annual maximum. Initially these policies were less popular but in gradual course of time they are taking their existence back.

DISABILITY INCOME INSURANCE:

Disability resulting from illness or accident may be an even greater peril to a family than premature death because disability not only cuts off income but also may create large medical expenses. Moreover, a six month or longer period of disability is a more likely of cause of loss to people in their working years than is premature death. Disability income insurance replaces income not earned because of illness or accident.

Payment is made because of physical or mental disability hinders the insured from working. However such coverage is also called as loss of time or loss of income insurance, providing periodic payments when an insured looses income because of injury or sickness. Coverage customarily is directly related, at least in part to the insured’s occupational duties and earnings.

MEDICARE SUPPLEMENT INSURANCE: CRITICAL ILLNESS PLAN:

Medicare supplement insurance, also known as Critical illness insurance, is designed specially to supplement benefits provided under the Health insurance policies. This coverage typically pays for such illnesses the various health policies exclude. Insurers base the premiums for critical illness cover on the insured's age when the policy is issued and the amount of coverage provided. Policies do not cover ordinary illness and normal hospitalization. These health insurance plans provide coverage against critical illnesses such as heart attack, organ transplants, stroke, and kidney failure among others. These plans aim to cover infrequent and higher ticket size medical expenses.

LONG TERM CARE INSURANCE POLICY:

It provides financial protection against insured's incurring exceptional expenses because of their need for assistance in connection with the essential activities of daily living. Coverage is triggered by an insured's inability to perform such activities and usually is paid as fixed amounts.

ON THE BASIS OF NUMBERS OF INSURED PERSONS COVERED:

Following is the classification based on the numbers of insured persons covered in a policy. Even if an individual based policy is purchased initially, latter it can be converted in a group insurance policy by paying additional premium.

INDIVIDUAL HEALTH INSURANCE COVERAGE:

Individual Health Insurance is an arrangement in which coverage is provided to a specific individual under a policy issued to the individual and sometimes covering multiple family members. Except in mass marketing approaches and in certain state sponsored or mandated plans, insured typically must furnish evidence of insurability for a policy to be issued. Companies maintain separate records for each policy and conduct all transactions, including premium collection, on a direct basis with each insured. With individual health insurance contracts, the ownership of the contract is vested in the insured. It is important to be noted that a policy serving coverage of a person and his or her family members is considered to be under this category only.

GROUP HEALTH INSURANCE COVERAGE:

Group Health Insurance refers to arrangements in which coverage is provided for groups of individuals under a single master contract issued to a group policy owner. The policy owner may be an employer, an association, a labour union, a trust, or any other legitimate entity not organized solely for the purpose of obtaining insurance. Members of larger groups generally obtain coverage without having to furnish evidence of insurability. Because of reduced marketing and administrative costs, group health insurance generally costs less than individual plans with comparable coverage. Benefits of Group Insurance: Low amount of premium in comparison to individual's policy, discount offered depends of the size of the group, products can be customized to the size of the group and group insurance is more flexible and provides more benefits.

FLOATER PLANS (FAMILY FLOATER):

A floater is a unique plan wherein the value of sum insured opted can be used by all the members of the family or by a single-family member. In simple words, Family Floater Plans refer to those which cover the entire family under one plan. Basically, the sum insured amount floats over all the

members covered. The main benefit under such a plan is that since a large group of people share the same insurance cover the premium to be paid is far lesser in case they all would have bought an individual plans for themselves. For example: if the policy is bought for 3 Lacs, then either all three members of the family can use Rs 1 Lac each or one member can use the entire cover of 3 Lacs.

HEALTH INSURANCE RELATED TAX BENEFITS:

Every family has regular medical expenses. This may be towards a health insurance premium, or expenditure related to a family member's disability/critical illness. The Income Tax Act of 1961 has made provisions to reduce this burden through tax deductions under section 80D on having a medical insurance coverage. According to the provision, investments made towards payment of health insurance premiums, qualify for a tax deduction under section 80D.

Scope of Deduction: Individual assesses can claim deduction for premiums paid towards health insurance of self, spouse, parents and children. Remarkably, children of the premium payer should be dependent on him and for rest of the members dependency is not required. The deduction is allowed even to a Hindu Undivided Family (HUF) assessee on premium paid for insuring the health of Karta of the family any coparceners of the family, can be used for deduction.

Available Deduction: For individuals less than 65 years of age, amount of health insurance premium paid or 15,000, whichever is lesser. For senior citizens above 65 years, amount of health insurance premium paid or 20,000, whichever is lesser.

Interpretation of the Section and Tax Planning: Generally, a notion regarding this provision which prevails into the mind of an assessee is that this section allows separate deductions of 15,000 and 20,000 on medical insurance premiums. In other words only either of the limits prevails and if the insured party is having age of 65 years or an above then the second limit of 20,000 will be allowed. But with the correct interpretation of this section of the statute reveals that an individual can avail total deduction of 35,000 in an assessment year. For an instance, if an individual of age below 65 years takes a medical policy for himself and for his father being a senior citizen and pays mediclaim premium for the both upto the limits specified then he can avail the deduction upto 35,000.

Some important aspects relating with this section are:

1. The premium may be paid by any mode of payment, other than cash.
2. The deduction extents to premium paid under Central Government Health Scheme and payment for Preventive Health Check-up.
3. Deduction for Preventive Health Check up shall be maximum ` 5,000 in aggregate for self, spouse, dependent children and parents.
4. Individual paying the premium from the taxable income will avail the deduction. Premiums should not be from gifts received by an assessee.
5. Premia paid for self, spouse, children and even for parents (only father and mother) is eligible. For this children need to be dependent rest spouse and even for the parents condition of dependency doesn't matter.
6. Medical insurance shall be in accordance with a scheme framed and approved by the Insurance Regulatory and Development Authority (IRDA).

CONCLUSION:

After exploring and comparing various dimensions of health insurance products of public and private sector companies it was found that later is better than the former.Today for getting into treatment of any chronic disease involving surgery need to have high price and population of India cannot afford to spend instantly and easily.So, maximum Indians are depending on the health insurance schemes for their medical urgency. Many of ailments were untreated for financial reasons shockingly, 47% of hospital admissions in rural India and 31% in urban India were financed by loans and the sale of assets.Government's initiative to provide aid and even to improvise health structure in India becomes important. As status of health care facilities for its people is one of the major aspects of Human Development Index of a country therefore India is also bound to take initiatives in this direction. For improvising, government can either build more hospitals or to start more community health insurance schemes.

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