SOC 204 (CBCS) Sociology of Health

Unit V: The State and Health

Topic c: What Is Health Insurance?

Health insurance is a type of insurance coverage that pays for medical, surgical, and sometimes dental expenses incurred by the insured. Health insurance can reimburse the insured for expenses incurred from illness or injury, or pay the care provider directly. It is often included in employer benefit packages as a means of enticing quality employees, with premiums partially covered by the employer but often also deducted from employee paychecks. The cost of health insurance premiums is deductible to the payer, and the benefits received are tax-free.

Health spending is one of the important causes of poverty in India. The country's public financing for health care is less than 1 percent of the world's total health expenditure, although it is home to over 16 percent of the world's population. Families meet almost 70 percent of their health expenses out of their own pockets, placing considerable financial burden on poor households, often pushing them deeper into poverty.

As India contemplates a significant increase in public spending on health care, the World Bank has carried out the first comprehensive review of India's major government sponsored health insurance schemes.

The report, "Government-Sponsored Health Insurance in India: Are You Covered?", authored by Gerard La Forgia and Somil Nagpal, finds that over the last five years, government-sponsored schemes have contributed to a significant increase in the population covered by health insurance in the country, scaling up at a pace possibly unseen elsewhere in the world.

Over 300 million people, or more than 25 percent of India's population, gained access to some form of health insurance by 2010, up from 55 million in 2003-04. More than 180 million of these were people below the poverty line.

Given these trends, the report projects that more than 630 million persons, or **about half of the country's population, can be covered with health insurance by 2015**. By this time, spending through health insurance is also likely to reach 8.4 percent of total health spending, up from 6.4 percent in 2009–10, the study says.

KEY TAKEAWAYS

- Health insurance is a type of insurance coverage that pays for medical and surgical expenses incurred by the insured.
- Choosing a health insurance plan can be tricky because of plan rules regarding in- and out-of-network services, deductibles, co-pays, and more.

- Since 2010, the Affordable Care Act has prohibited insurance companies from denying coverage to patients with pre-existing conditions and has allowed children to remain on their parents' insurance plan until they reached the age of 26.
- Medicare and the Children's Health Insurance Program (CHIP) are two public health insurance plans that target older individuals and children, respectively. Medicare also serves people with certain disabilities.

How Health Insurance Works

Managed care insurance plans require policyholders to receive care from a network of designated healthcare providers for the highest level of coverage. If patients seek care outside the network, they must pay a higher percentage of the cost. In some cases, the insurance company may even refuse payment outright for services obtained out of network.

Many managed care plans—for example, health maintenance organizations (HMOs) and point-of-service plans (POS)— require patients to choose a primary care physician who oversees the patient's care, makes recommendations about treatment, and provides referrals for medical specialists. Preferred-provider organizations (PPOs), by contrast, don't require referrals, but do have lower rates for using in-network practitioners and services.

Insurance companies may also deny coverage for certain services that were obtained without preauthorization. In addition, insurers may refuse payment for name-brand drugs if a generic version or comparable medication is available at a lower cost. All these rules should be stated in the material provided by the insurance company and should be carefully reviewed. It's worth checking with employers or the company directly before incurring a major expense.

Increasingly, health insurance plans also have co-pays, which are set fees that plan subscribers must pay for services such as doctor visits and prescription drugs; deductibles that must be met before health insurance will cover or pay for a claim; and coinsurance, a percentage of healthcare costs that the insured must pay even after they've met their deductible (and before they reach their out-of-pocket maximum for a given period).

Insurance plans with higher out-of-pocket costs generally have smaller monthly premiums than plans with low deductibles. When shopping for plans, individuals must weigh the benefits of lower monthly costs against the potential risk of large out-of-pocket expenses in the case of a major illness or accident.

The health insurance industry has witnessed consistent growth since its launch in 1986, more so after the liberalisation of the insurance sector in 2000. The growth has been especially magnificent in the last five years, following the advent of standalone health insurers and various government-sponsored health insurance schemes. In 2013, the health insurance industry got a great fillip, with several noteworthy events making the news headlines.

More awareness & relevance

Most people are yet to accept insurance as a tool for financing healthcare expenses. They usually procrastinate when it comes to buying health insurance unless faced with a challenging situation. To counter this, GIC and the Insurance Regulatory and Development Authority (IRDA) launched a comprehensive marketing media campaign aimed at boosting awareness across different segments of the population. This effort, we believe, will aid the growth of awareness in the long run, and help health insurance evolve as an important financial tool.

A step to boost penetration

Thanks to high medical inflation, paying for healthcare expenses out of personal funds is no longer viable for the common Indian. Unfortunately, only about 30% of Indian population has some kind of financial tool to cover its medical expenses either partially or wholly. The industry has been unable to expand its reach, especially in Tier 2 and Tier 3 cities, with lack of effective distribution channels a cause of concern.

To improve health insurance penetration, I believe, the regulator has taken a step in the right direction by allowing standalone health insurers to distribute their products to bank customers. This will ensure wider reach for health insurance products, and it can happen at a very brisk pace.

For mono-line companies like us, it is not feasible to set up branches in locations with limited potential as it takes at least 5-7 years to break even. By partnering banks for distribution, we will get a shot in the arm as far as widening reach is concerned.

Boosting uniformity

Although the need for adoption of health insurance is obvious , people are hesitant to purchase medical covers due to the confusion they harbour. There are many products available in the market nowadays that vary in terms of the benefits offered, exclusions, waiting periods and inclusions.

In order to bring in better clarity among customers and create a level-playing field, Irda has created Health Insurance Standardisation Guidelines, which all health insurance providers must follow.

The guidelines have standardised the 46 most commonly used definitions/terms/conditions in health insurance policies. They also include definitions of 11 common critical illnesses covered under various health insurance policies in India. All this is done to ensure there is no ambiguity among products and so that customers can make informed decisions while choosing a policy. The creation of the standardised guidelines is a step in the right direction and it will bring in a number of spinoff benefits.

Product innovation

One size no more fits all, and to keep pace with changing consumer behavior and demographics, the industry has started moving from the basic indemnity format to coverage of specific ailments, laden with benefits and features. This year, disease-management products have made an appearance in the market, and these policies are aimed at specific diseases. With preventive care being used worldwide as a means to reduce the effect of lifestyle-related ailments, its time India moved towards disease-specific health insurance programmes.

A lot of effort has been made this year and the stakeholders in the segment insurance companies, healthcare providers, TPAs and the regulatory body must work as a cohesive unit to ensure long-term growth. Insurance companies must be able to bring all these parties together to ensure that the customer benefits the most and is able to handle medical emergencies without any hassle.

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