A Legislative Study and Globalisation of Health insurance in India

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Introduction

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programs funded by the government.

By estimating the overall risk of healthcare expenses, a routine finance structure (such as a monthly premium or annual tax) can be developed, ensuring that money is available to pay for the healthcare benefits specified in the insurance agreement. The benefit is administered by a central organization, most often either a government agency or a private or not-for-profit entity operating a health plan.

A health insurance policy is a contract between an insurance company and an individual or his sponsor (e.g. an employer). The contract can be renewable annually or monthly. The type and amount of health care costs that will be covered by the health insurance company are specified in advance, in the member contract or "Evidence of Coverage" booklet. The individual insured person's obligations may take several forms.

- **Premium:** The amount the policy-holder or his sponsor (e.g. an employer) pays to the health plan each month to purchase health coverage.
- **Deductible:** The amount that the insured must pay out-of-pocket before the health insurer pays its share. For example, a policy-holder might have to pay a $500

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deductible per year, before any of their health care is covered by the health insurer. It may take several doctor's visits or prescription refills before the insured person reaches the deductible and the insurance company starts to pay for care.

- **Co-payment:** The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service. For example, an insured person might pay a $45 co-payment for a doctor's visit, or to obtain a prescription. A co-payment must be paid each time a particular service is obtained.

- **Co-insurance:** Instead of, or in addition to, paying a fixed amount up front (a co-payment), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%. If there is an upper limit on coinsurance, the policy-holder could end up owing very little, or a great deal, depending on the actual costs of the services they obtain.

- **Exclusions:** Not all services are covered. The insured person is generally expected to pay the full cost of non-covered services out of their own pocket.

- **Coverage limits:** Some health insurance policies only pay for health care up to a certain dollar amount. The insured person may be expected to pay any charges in excess of the health plan's maximum payment for a specific service. In addition, some insurance company schemes have annual or lifetime coverage maximums. In these cases, the health plan will stop payment when they reach the benefit maximum and the policy-holder must pay all remaining costs.

- **Out-of-pocket maximums:** Similar to coverage limits, except that in this case, the insured person's payment obligation ends when they reach the out-of-pocket maximum, and the health company pays all further covered costs. Out-of-pocket maximums can be limited to a specific benefit category (such as prescription drugs) or can apply to all coverage provided during a specific benefit year.

- **Capitation:** An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.

- **In-Network Provider:** (U.S. term) A health care provider on a list of providers preselected by the insurer. The insurer will offer discounted coinsurance or co-payments, or additional benefits, to a plan member to see an in-network provider. Generally, providers in network are providers who have a contract with the insurer.
to accept rates further discounted from the "usual and customary" charges the insurer pays to out-of-network providers.

- **Prior Authorization:** A certification or authorization that an insurer provides prior to medical service occurring. Obtaining an authorization means that the insurer is obligated to pay for the service, assume it matches what was authorized. Many smaller, routine services do not require authorization.

- **Explanation of Benefits:** A document sent by an insurer to a patient explaining what was covered for a medical service, and how they arrived at the payment amount and patient responsibility amount.²

**Non-life insurance**

The other important part of the classification of insurance is the non-life insurance category. Insurance other than 'Life Insurance' falls under the category of General Insurance. General Insurance comprises of insurance of property against fire, burglary etc, personal insurance such as Accident and Health Insurance, and liability insurance which covers legal liabilities. There are also other covers such as Errors and Omissions insurance for professionals, credit insurance etc.³

Non-life insurance companies have products that cover property against Fire and allied perils, flood storm and inundation, earthquake and so on. There are products that cover property against burglary, theft etc. The non-life companies also offer policies covering machinery against breakdown, there are policies that cover the hull of ships and so on. A Marine Cargo policy covers goods in transit including by sea, air and road. Further, insurance of motor vehicles against damages and theft forms a major chunk of non-life insurance business.

In respect of insurance of property, it is important that the cover is taken for the actual value of the property to avoid being imposed a penalty should there be a claim. Where a property is undervalued for the purposes of insurance, the insured will have to bear

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a rateable proportion of the loss. For instance if the value of a property is Rs.100 and it is insured for Rs.50/-, in the event of a loss to the extent of say Rs.50/-, the maximum claim amount payable would be Rs.25/- (50% of the loss being borne by the insured for underinsuring the property by 50%). This concept is quite often not understood by most insured.

Personal insurance covers include policies for Accident, Health etc. Products offering Personal Accident cover are benefit policies. Health insurance covers offered by non-life insurers are mainly hospitalization covers either on reimbursement or cashless basis. The cashless service is offered through Third Party Administrators who have arrangements with various service providers, i.e., hospitals. The Third Party Administrators also provide service for reimbursement claims. Sometimes the insurers themselves process reimbursement claims.

Accident and health insurance policies are available for individuals as well as groups. A group could be a group of employees of an organization or holders of credit cards or deposit holders in a bank etc. Normally when a group is covered, insurers offer group discounts.

Liability insurance covers such as Motor Third Party Liability Insurance, Workmen’s Compensation Policy etc offer cover against legal liabilities that may arise under the respective statutes Motor Vehicles Act, The Workmen’s Compensation Act etc. Some of the covers such as the foregoing (Motor Third Party and Workmen’s Compensation policy) are compulsory by statute. Liability Insurance not compulsory by statute is also gaining popularity these days. Many industries insure against Public liability. There are liability covers available for Products as well.

There are general insurance products that are in the nature of package policies offering a combination of the covers mentioned above. For instance, there are package policies available for householders, shop keepers and also for professionals such as doctors, chartered accountants etc. Apart from offering standard covers, insurers also offer customized or tailor-made ones.

Suitable general Insurance covers are necessary for every family. It is important to protect one’s property, which one might have acquired from one’s hard earned income.

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4 Ibid.
5 Id.
A loss or damage to one’s property can leave one shattered. Losses created by catastrophes such as the tsunami, earthquakes, cyclones etc have left many homeless and penniless. Such losses can be devastating but insurance could help mitigate them. Property can be covered, so also the people against Personal Accident. A Health Insurance policy can provide financial relief to a person undergoing medical treatment whether due to a disease or an injury.

Industries also need to protect themselves by obtaining insurance covers to protect their building, machinery, stocks etc. They need to cover their liabilities as well. Financiers insist on insurance. So, most industries or businesses that are financed by banks and other institutions do obtain covers. But are they obtaining the right covers? And are they insuring adequately are questions that need to be given some thought. Also organizations or industries that are self-financed should ensure that they are protected by insurance. Most general insurance covers are annual contracts. However, there are few products that are long-term.

It is important for proposers to read and understand the terms and conditions of a policy before they enter into an insurance contract. The proposal form needs to be filled in completely and correctly by a proposer to ensure that the cover is adequate and the right one.

Certain important and traditional categories of general insurance are marine insurance, fire insurance, aviation insurance and accident risk insurance. I shall now explain each of these important categories.

**Importance of Health Insurance**

For every individual in India, health insurance has become a necessity. It provides risk coverage against expenditure which is caused by unforeseen medical emergencies. Today, when the medical inflation rates are so high, failing to hold an adequate health cover can prove costly financially.

**Low Penetration of Insurance in India**

Medical emergencies come unannounced. To get the best medical facilities without a financial burden you will need a health insurance. Buying a health cover is no longer an option but has become a compulsion. [Health insurance policy](http://www.skirec.com) is well established in most countries but in India is remains an untapped
market. Only 1.1 billion of the Indian population which is less than 15% of the Indian population is covered through health insurance.

According to WHO statistics 31% and 47% of the hospital admissions in urban and rural India are either financed by loans or through sale of assets. Additionally as per the statistics, 70% of Indians spend their entire income on healthcare and 3.2% of Indians fall under the poverty line owing to high medical bills.

**Health insurance is one way to get an insurance which covers all expenses related to:**

- Medical tests, doctor fees
- Costs of the ambulance
- Hospitalization charges
- Post hospitalization charges which includes doctor visits, diagnostic tests and medicines.

The Hon'ble Supreme Court of India\(^6\) held that the National Commission did not commit any error in accepting the surveyor’s report dated May 15, 2000 as the assessment made there under is proper and is accordance with the provisions of the policy. The Supreme Court relied upon the decision in New India Assurance Company Limited v. Pardeep Kumar as to interpretation of Section 64- UM (2) of the Insurance Act, 1938. Further, the Court observed that a claim of Rs. 1,000, 000 made by the appellant for mental harassment is wholly misconceived and untenable. The appellant was a company and therefore, claim for mental harassment was not legally permissible. It is only a natural person who can claim damages for mental harassment and not a corporate entity.

**Conclusion**

In present scenario health insurance is very important for every individual because the medical treatments of the diseases are very costly and every person is not in capacity to bear the expenses of medical treatment. So this is the duty of the Government to provide health insurance to their citizens for all diseases free of cost.

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