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Navigating the Legal Landscape of Health Insurance: Key Challenges in Coverage and Claims

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Abstract

Healthcare coverage and savings are crucial for ensuring financial stability. Nevertheless, the complexity of health insurance coverage poses significant legal concerns. This paper delves into the principles of health insurance, the hindrances in implementing policies, legal remedies and accessibility issues, with particular attention to India especially the state based or sponsored health insurance scheme. It also addresses the problems of fraud and offers a comparison between different countries with respect to health insurance coverage, outlining areas for improvement by showcasing the appreciable features of the insurance across the globe.

***Keywords**: Health Insurance, Coverage, Public Health, Financial Stability.*

I. Introduction

Health insurance is important to cut off financial risk of health crises to individuals and families. It is an important component to ensure access to health care services and is of preventive and curative purpose. The higher the costs of healthcare contribute to heaving burden on health insurance, especially in the developing countries. Expensive medical treatments can cause households in low and middle income countries to slip further into poverty. In these situations, health insurance functions as a cushion; it also provides reassurance and improves access to better care.

Nevertheless, while it may help lower healthcare expenses, there are significant challenges that restrict the availability and usefulness of health insurance. These obstacles are frequently influenced by both legal and structural ones.' The challenges encompass reduced coverage alternatives, difficulties in enforcing policies, and discriminatory practices that impact the most vulnerable. Inadequate or inadequate enforcement of legal provisions can result in gaps in health insurance coverage, denials of claims, and confusion among policyholders regarding their entitlements and rights. Additionally, the lack of certainty in the regulation of premiums and

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reimbursements as well as differences in legal recognition of health insurance providers contribute to a climate of uncertainty that can hinder the growth and inclusive of the health care market.

Health insurance coverage is especially important in developing countries like India, where the healthcare system is often stretched thin due to lack of provisions in the public sector compared to the growth of the private sector. India is unique in having a high incidence of diseases, inadequate access to health services, and largely unorganized insurance sector. These issues are frequently not fully addressed by the legal frameworks surrounding health insurance, leading to gaps in coverage and limited benefits for policyholders. Moreover, intricate legal terminology, bureaucratic inefficiency, and low literacy levels hinder people from understanding the intricate insurance provisions, leading to conflicts and legal disputes.

Developed countries may have more elaborate health insurance systems, but they are not without their own legal issues. The presence of preexisting condition exclusions, high premiums and disputes over claims are common challenges in countries with established insurance markets. Despite their effectiveness in developing countries, these issues suggest that legal systems must be constantly enhanced to ensure fairness and transparency among all segments of society.

(A) Scope and objectives:

In this paper, the authors aim to explore the legal obstacles faced by individuals seeking health insurance coverage in India, but also make connections to practices around the world. Its main focus is on examining the laws under the control of health insurance in India, with particular attention to problems of lack of regulation, exclusionary policies and difficulties in implementing and maintaining coverage standards. The paper attempts to identify gaps in legal protections and suggest practical ways to enhance health insurance programs, with a focus on low-income households.

Learning’s from developed countries' well-established health insurance frameworks will also be presented in the paper. By contrasting the system in India with that of developed countries, this paper aims to highlight some strategies that can be tailored to meet the specific requirements and challenges of the Indian people. Based on this comparative analysis, the paper will suggest policy reforms that can be implemented to bridge legal and structural gaps in health insurance coverage.

II. HEALTH INSURANCE AND THE ROLE IN MODERN HEALTHCARE SYSTEM

(A) Health Insurance Importance

Medicaid is critical to keeping health care costs off families' shoulders rather than spending so much that families fall into poverty. If one has health insurance there is less fear regarding financial ruining upon suffering an illness and be able to get medical care, which is better for health, better healthcare, higher quality of life. Out of pocket expenses on healthcare are no small amount of annual income for many households, especially some in developing economies, education, housing, or nutrition could have necessitated. In this way, health insurance works as buffer and its role in improving economic stability, as well as minimizing poverty, is promoting by cushioning the financial shock of unexpected medical expenses arising from them Health insurance also helps to confront healthcare inequalities. For most people, health insurance provides both financial security and a reduction in disparities in how easy it is to get access to health care based on being a member of particular socioeconomic classes. Countries have really well set up health insurance system so rates are much higher for preventive care early detections of diseases, lesser morbidity and mortality rates so. As an example, research shows that insured patients are more likely to see a doctor for regular checkup, and get treatment on time, and also stay healthier overall, than uninsured people.

(B) Overview of coverage and accessibility

Health insurance is an important issue, and yet, access to health insurance is unevenly available. Enrollment rates and coverage levels are differentially affected by a number of factors including economic status, geographic location, and institutional barriers to obtaining coverage. Health insurance coverage in India has some significant disparities, with rural and low income communities having particularly less, given. Since while health insurance schemes have been available to large places, rural populations and economically weaker sections have often had difficulty in accessing the same which further widens health disparities within regions. Aashima and Sharma (2023) note the wide disparity as a study that shows rural areas in India have had much lower health insurance enrollment rates than in urban centres. These challenges have multi faceted aspects such as lack of awareness about insurance schemes, unwillingness of rural populations to turn towards health insurance schemes due to the shortage of health facilities, and administrative barriers that lead to the unsuccessful or under utilisation of health insurance programme by its members.[3] Furthermore, educational qualification, caste, and gender impact

[3] Aashima, & Sharma, R. (2023). Inequality and disparities in health insurance enrolment in India. Journal of Medicine Surgery and Public Health. Retrieved from https://doi.org/10.1016/j.glmedi.2023.100009

further upon insurance coverage. An example of this is women in rural areas as they are less to be insured because there family resources are more likely to be used to insure male members or male working members of the family home.[4]

To fill these gaps, the government has tried to do so through myriad schemes such as Pradhan Mantri Jan Arogya Yojana (PM-JAY) to increase health care access for low income populations. The key challenges in implementing and awareness, however, remain largely intact. More broadly, health insurance has limited impact for India, and targeted interventions may be needed to overcome such challenges in rural and economically marginalised communities.[5]

Promotion of better health care outcomes would not be the only upside to addressing these disparities in health care: It would also move us closer to a more just, inclusive and fair system of health care. Also, changes in policy along side better infrastructure of health care in rural areas can eradicate the different in enrollment and health insurance can be made affordable to all factions of the population.

III. Utmost good faith concept is the ones the closest to the close of Uberrimae Fidei

In health insurance, this principle is called Uberrimae Fidei – Latin meaning that each party must disclose all information related to the contract and that both parties must act honestly. The principle here means that one (person who wants to be insured) will disclose all the facts that are vital facts to assess the risk of insuring and the other (the insurer), will explain the provisions limitations and exceptions of insurance.[6] Uberrimae Fidei has relevance in health insurance because an underwriting of risks in health insurance is informed by the medical PR campaigning on health status is central in any underwriting of health risk hence the importance of Uberrimae Fidei. For other forms of insurance the risk factors can be readily evaluated, but for health insurance, complete underwriting information depends on personal health status and habits that require candor from the insured.

This work examines the experience of applying Uberrimae Fidei in Tanzania especially by

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[4] Devadasan, N., Ranson, K., Van Damme, W., & Criel, B. (2006). The landscape of community health insurance in India: An overview based on 10 case studies. Health Policy, 78(2–3), 224–234. Retrieved from https://doi.org/10.1016/j.healthpol.2005.10.005

[5] Saxena, A., Trivedi, M., Shroff, Z. C., & Sharma, M. (2022). Improving hospital-based processes for effective implementation of government-funded health insurance schemes: Evidence from early implementation of PM-JAY in India. BMC Health Services Research. Retrieved from https://doi.org/10.1186/s12913-021-07448-3

[6] Ashraf, H., Ghosh, I., Kumar, N., Nambiar, A., & Prasad, S. (2022). Pathways to Reimagining Commercial Health Insurance in India. Frontiers in Public Health. Retrieved from https://doi.org/10.3389/fpubh.2022.1006483

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clients living with chronic and socially unaccepted disease like HIV/AIDS. In the same year, Kanje[7] According to her, the major reasons why people living with HIV/AIDs do not access insurance due to their risks includes stigmatisation and legal hurdles.Thus, using Uberrimae Fidei insurers can demand disclosure of HIV status; however, it results in increased premiums; reduced insurance coverage; or rejection of insurance for people with HIV/AIDS to enter a risky position where they have to decide whether they should reveal their HIV status or stay uninsured.This obligations to produce full information while aimed at helping assess risks, raises orthogonal ethical and legal concerns. For example, the right of the insurer to access information relating to risks and the contra right of the insured to privacy and equal treatment are still in a state of litigation. The principle of Uberrimae Fidei therefore presents both insurers and the regulators with a myriad of questions as to how best they could come up with a non-discriminative structure which at the same time does not hinder transparency.

(A) Implication related to pre-existing conditions

The notion of Uberrimae Fidei is not only not easy to understand, but when it introduced the conditions that existed before, it becomes very complex indeed. Legally systems all over the world try to fight discriminative cases while addressing the questions of what kind of disclosure is permitted for such conditions. By their very nature, pre-existing conditions contain at least some degree of certainty in evaluating risk; consequently, Uberrimae Fidei is applied more rigorously because it attempts to prevent "selection" adverse, in which individuals seek insurance only after their health deteriorates. However, this rigorous application can lead to situations where people with diseases such as diabetes, heart disease or AIDS are either rejected or offered high premiums when seeking insurance as evidenced in Tanzania by Kanje.

For instance, the insurance environment in India has become more inclusive as the sector has developed. As a result of recent rules, insurers can no longer refuse to cover someone on the basis of a preexisting condition if a time limit has elapsed. Public policy bars insurers from denying access to healthcare and facilitate minimising the way the individual is weighed down financially. Despite the presence of such a principle, Uberrimae Fidei continues to generate difficulties, in particular when the insured is not conscious of its medical condition at the conclusion of the contract. When this also happens disputes happen about what is and is not a material fact and the non disclosure was intentional or unintentional and that may ultimately

[7] Aden Adolf Kanje. (2015). The Principle of Uberrimae Fidei in Insurance Contracts: Analysis of Health Insurance Contracts and Their Legal Implications on Persons Living with HIV/AIDS in Tanzania. Null. Retrieved from https://doi.org/null

take you into litigation or even legal scrutiny[8].

In addition, the principle of Uberrimae Fidei also obligates in policy terms. As a rule, insurers are subject to law that requires them to see to it that the policyholders understand exactly what pre-existing condition is, and what is the consequence of their non-disclosure of it. It has resulted in putting consumer education and enactment of clear policy and disclosure policy documentation as a matter of priority. For example, the case of PM-JAY in India shows that shifting towards a regulatory change that aims at simplifying access and reducing ambiguity in insurance contract for the vulnerable population[9].

The imposition of a substantial legal and ethical problem in balancing demand for transparency and access, health insurance is. Uberrimae Fidei is used as a prevention against fraudulent claims but can also block access for those with existing health risks. Legal systems in many jurisdictions are responding to this dilemma, by supporting nondiscriminatory access to healthcare through reforms. Erasing discrimination based on health status is another area where the Brazilian judicial system has begun to regulate insurance practices in order to impose greater accountability and equity[10]

A ground breaking idea among the American health insurance is the principle of parity which has begot landmark legislation including Affordable Care Act (ACA) that does not allow insurance plans to turn people down for pre existing conditions. Second it is the reflection of some extent of another policy, namely, giving up the fixed credibility, and emphasizing the possibility of using the healthcare. Because the ACA mandate means that insurers must accept all applicants or specified limits in order to increase access to the system, it also maintains transparency through tons of reporting and consumer protections.[11]

(B) Ethical and social implications

Uberrimae Fidei ethical implications are significant, with implications regarding social equity as the strong. The principle can actually perpetuate health inequalities by limiting access to those that would benefit most from it: people with pre-existing conditions and chronic health problems. For example, in Tanzania, strict adherence to this principle has made excessive

[8] Purohit, B. (2014). Community-Based Health Insurance in India: Prospects and Challenges. Health. Retrieved from https://doi.org/10.4236/health.2014.611152

[9] Dupas, P., & Jain, R. (2021). Women Left Behind: Gender Disparities in Utilization of Government Health Insurance in India. Research Papers in Economics. Retrieved from https://doi.org/10.3386/w28972(New project name (1))

[10] Alves, D. C., Bahia, L., Barroso, A. F. (2009). The Role of the Court System in Regulating Health Insurance Plans in Brazil. Cadernos de Saúde Pública. Retrieved from https://doi.org/10.1590/s0102-311x2009000200006

[11] Dupas, P., & Jain, R. (2021). Women Left Behind: Gender Disparities in Utilization of Government Health Insurance in India. Research Papers in Economics. Retrieved from https://doi.org/10.3386/w28972

demands on the lives of HIV positive people, who might be excluded or endangered by discriminatory underwriting practices. Such practices exacerbate social stigma and undermine public health efforts to provide or to support chronic conditions among vulnerable populations.[12]

Ethically, however, there is a strong trend advocating for more inclusionary, rather than strictly Uberrimae Fidei based, health insurance models. But some recent scholars have advocated for a modified approach that would value transparency but would protect individuals at high risk of health driven hard costs. Community based insurance models, adopted in some cases in India, are one example of the application of the principle of good faith more flexibly so as to entice participation by people who otherwise might not join because they have pre existing conditions.[13]

(C) The future of uberrimae fidei in health insurance law

But the principle of Uberrimae Fidei, the foundational principle of health insurance law to protect the insured, may one day be an open question as legal systems increasingly favour equitable access to the insurance product itself. New opportunities for a more balanced approach are being presented by emerging models of health insurance, especially enabled by digital technologies. For example, data driven underwriting models could assess risk without the need to disclose all personal information required by strict Uberrimae Fidei , and don't restrict those with pre-existing conditions[14]

Reforms that would continue to expand coverage access in India by limiting the adverse impact of non disclosure on coverage eligibility, are being undertaken. They show how the legal landscape is evolving in ways oriented toward meeting the needs of a public much in adapting Uberrimae Fidei in ways that facilitate universal health coverage. This principle is likely to face legal challenges of this kind as new technologies and models put it under increasing strain. Yet the trend provides a hint of moving toward a more favorable and flexible view of Uberrimae Fidei in line with other initiatives to keep the provision of health insurance more open and non discrimination[15].

[12] Aden Adolf Kanje. (2015). The Principle of Uberrimae Fidei in Insurance Contracts: Analysis of Health Insurance Contracts and Their Legal Implications on Persons Living with HIV/AIDS in Tanzania. Null. Retrieved from https://doi.org/null

[13] Purohit, B. (2014). Community-Based Health Insurance in India: Prospects and Challenges. Health. Retrieved from https://doi.org/10.4236/health.2014.611152

[14] Jain, P., Kumar, A., & Agarwal, N. (2022). Missing Middle: Extending Health Insurance Coverage in India. International Journal for Research in Applied Science and Engineering Technology. Retrieved from https://doi.org/10.22214/ijraset.2022.42382

[15] Saxena, A., Trivedi, M., Shroff, Z. C., & Sharma, M. (2022). Improving Hospital-Based Processes for Effective Implementation of Government-Funded Health Insurance Schemes: Evidence from Early Implementation of PM-

(D) Health insurance implementation in challenges in india

The Pradhan Mantri Jan Arogya Yojana (PM-JAY), launched in 2018, is part of India's larger Ayushman Bharat initiative—and offers health coverage to more than 100 million economically disadvantaged families. PM-JAY is one of the largest government sponsored insurance schemes in the world to provide secondary and tertiary healthcare services as well as various treatments aimed at bringing impoverished families out of extensive out of pocket expenses. The programmes' promise is tarnished by implementation hurdles that would render it ineffective, unsustainable.[16]

One of the most major hurdles that the lack of adequate health sector infrastructure is one of the hurdles, which comes PM-JAYs are the inadequate healthcare infrastructure, especially in rural areas. The big demand it creates in many areas already is too much, it doesn't have enough hospitals, not enough skilled healthcare providers and enough good medical equipment either to satisfy that demand. This infrastructural gap thus reduces the accessibility of services to affected beneficiaries because such services have to be travelled to in order to reach urban centers with specialized care. A gap in the number of hospitals equipped to provide good quality of care to PMJAY beneficiaries has pushed the program to its limits in capacity to serve the large and disparate population of India (Saxena 2022).[17]

The lack of PM-JAY becomes really difficult to implement smoothly because of bureaucratic inefficiencies. Barriers to providers and beneficiaries include complex paperwork, incoherent statutory policies and administrative delay. Long delays in being reimbursed by many hospitals has brought it financially unsustainable for them to treat patients under PM-JAY. Documented by Trivedi (2022) this issue has resulted in private hospitals being reluctant to participate in the scheme thereby limiting options for beneficiaries that results in crowded government facilities[18]

The second big hurdle from PM-JAY perspective would be to ensure quality of care. The scheme will cover a wide range of treatments but delivers questionable standards of care and especially in overcrowded public hospitals suffering from limited resources. Reducing the treatment cost with the aim to improve the coverage might come at the expense of decreasing

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JAY in India. BMC Health Services Research. Retrieved from https://doi.org/10.1186/s12913-021-07448-3

[16] Saxena, A., Trivedi, M., Shroff, Z. C., & Sharma, M. (2022). Improving Hospital-Based Processes for Effective Implementation of Government-Funded Health Insurance Schemes: Evidence from Early Implementation of PM-JAY in India. BMC Health Services Research. Retrieved from https://doi.org/10.1186/s12913-021-07448-3

[17] Saxena, A., Trivedi, M., Shroff, Z. C., & Sharma, M. (2022). Improving Hospital-Based Processes for Effective Implementation of Government-Funded Health Insurance Schemes: Evidence from Early Implementation of PM-JAY in India. BMC Health Services Research. Retrieved from https://doi.org/10.1186/s12913-021-07448-3

[18] Saxena, A., Trivedi, M., Shroff, Z. C., & Sharma, M. (2022). Improving Hospital-Based Processes for Effective Implementation of Government-Funded Health Insurance Schemes: Evidence from Early Implementation of PM-JAY in India. BMC Health Services Research. Retrieved from https://doi.org/10.1186/s12913-021-07448-3

the service quality. Most patients under PM-JAY were being provided substandard care or the premise itself was not equipped to deal with complicated medical cases, reports said. However, such challenges further intensify where protocols from different facilities vary, leaving beneficiaries with no certainty of the outcomes.[19]

Along with the providers who abuse it for financial gain, PM-JAY has also suffered on fraud and abuse. In that respect, some of the claims have been false claims for treatments that never even happened, removing resources that would otherwise be available to legitimate claims. This has led to the National Health Authority instituting increased oversight of the programme, but continued fraud combating is resource intensive and ongoing. To make public trust in the health scheme as well as the scheme itself financially viable, the fraud — or at least the appearance of it — must be sufficiently addressed.[20]

In the same way as it is with India, India's issues with PM-JAY are replicated in other countries with universal health coverage struggles such as Nigeria's National Health Insurance Scheme (NHIS). In 2005, the idea of NHIS was launched to ensure that Nigerians that usually do not fall within the informal sector have access to and affordable healthcare. Infrastructural, policy design, and administrative inefficiencies have been like the PM-JAY which is NHIS.

Like India, Nigeria faces huge healthcare infrastructure problems particularly in rural parts where there are no or little health care facilities or healthcare providers. According to Alawode and Adewole (2021), there are disproportionately fewer healthcare facilities under NHIS, many of which are in urban centres, which leaves rural populations with almost or no access to healthcare. This urban rural divide of health care accessibility has led to inequities in health outcome contrary to content of NHIS that health care accessibility for all those in the country.[21]

It is also characterized by operational inefficiency. Guidelines of the scheme are unclear and lack of clarity in scheme's guidelines become hurdle for providers as well as beneficiaries. It also means healthcare providers are less likely to accept the NHIS patients because of the bureaucratic red tape that delays payment.[22] Furthermore, its policy design (which was

[19] Trivedi, M., Saxena, A., Shroff, Z. C., & Sharma, M. (2022). Experiences and Challenges in Accessing Hospitalization in a Government-Funded Health Insurance Scheme: Evidence from Early Implementation of Pradhan Mantri Jan Aarogya Yojana (PM-JAY) in India. PLOS ONE. Retrieved from https://doi.org/10.1371/journal.pone.0266798

[20] Trivedi, M., Saxena, A., Shroff, Z. C., & Sharma, M. (2022). Experiences and Challenges in Accessing Hospitalization in a Government-Funded Health Insurance Scheme: Evidence from Early Implementation of Pradhan Mantri Jan Aarogya Yojana (PM-JAY) in India. PLOS ONE. Retrieved from https://doi.org/10.1371/journal.pone.0266798

[21] Alawode, G. O., & Adewole, D. A. (2021). Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare, and Insurance Providers. BMC Public Health. Retrieved from https://doi.org/10.1186/s12889-020-10133-5

[22] Alawode, G. O., & Adewole, D. A. (2021). Assessment of the Design and Implementation Challenges of the

supposed to be wide-ranging) has been called out for its in flexibility in meeting the changing requirements of the Nigerian health care landscape, particularly the uncomfortable absence of the informal sector and the indigent population, which is frequently stranded without proper coverage.

Both PMJAY and NHIS also have the same challenges maintaining the quality of care provided to beneficiaries. Resource and physician distribution inequality across facilities in Nigeria leads to variation in quality. As cases of tuberculosis and other diseases among people living with HIV skyrocket, many public hospitals, already stretched by serious under staffing and resource deficits, are not able to meet demands of NHIS beneficiaries, causing long queue, dilapidated facilities, and in some cases, deliver substandard care. This added to an absence of confident regulatory oversight, a widening range of service quality.

If the development of infrastructure, particularly in rural and under serviced areas can be invested in, which will mean more people can be reached and will be served, probably both PM-JAY and NHIS will benefit. In addition, standardised protocols for care quality adoption, strengthening oversight to reduce fraud, and simplifying administrative processes may improve programme efficiency and improve provider participation. In countries with similar schemes, public private partnerships could help fill infrastructure gaps and entice private providers to provide services in the government health programmes, increasing the number of available services.

IV. Judicial interventions on health insurance

(A) Brazil's Judicial Regulation

Judicial regulation of health insurance plans in Brazil is so strong to assure fairness and accessibility. Brazil's judiciary plays a crucial role in resolving disputes and ensuring compliance with regulatory requirements, frequently by intervening to correct gaps within health insurance coverage. In Alves et al. (2009), it has been observed that courts have consistently found fault with insurers, often mandating that they cover certain treatments or honor contractual guarantees to ensure complete health coverage.[23]

It is so important that health insurance that Brazilian courts have ruled that the health insurers cannot simply refuse health insurance in an unfair way especially for medical procedures. The proactive attitude has aided in closing policy enforcement gaps by compelling insurers to

National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare, and Insurance Providers. BMC Public Health. Retrieved from https://doi.org/10.1186/s12889-020-10133-5

[23] Alves, D. C., Bahia, L., & Barroso, A. F. (2009). The Role of the Court System in Regulating Health Insurance Plans in Brazil. Cadernos de Saúde Pública. Retrieved from https://doi.org/10.1590/s0102-311x2009000200006

comply with coverage obligations that meet public health needs. Not only have these interventions been tackling complaints but also have they protected vulnerable groups from discriminatory practices by health insurers. Alves (2009) explain how judicial oversight has led to the development of an inclusive health insurance system using regulatory compliance as well as equity.[24]

Indirectly, also, Brazil's judiciary has influenced health insurance policy through its preparation of legal precedent which informs later legislation and regulatory practice. Court rulings that insurance write insurance policies must pay for expensive treatments not mentioned in the insurance policies have led to debate about the need for broader insurance plans that cover a broader scope of medical in-process expenses. This judicial intervention that technically spurs the gradual change of health insurance structure makes insurers more eager to offer accessibility and fairness than profits and profits.

(B) Insurance Parity in The U.S.

The area of judicial intervention with regard to ensuring insurance parity — or, in the case of mental health coverage, referred to as parity — has been the realm of insurance. However, a major court battle has surrounded the enactment of equality laws that are aimed at eradicating gaps in coverage of mental and physical health. Mental health coverage has been historically more restricted than physical health coverage in such matters as limitations of mental benefits, higher payments, and more restriction on the number of covered visits. This distinction was made by the Affordable Care Act.[25] Laws have been passed to ensure equal treatment in health insurance policies and enforce parity laws as a response.

Berry (2017) highlight the ongoing battle for insurance parity and note that mental health equity has become a crucial issue due to litigation. Both parties are advocating for increased coverage of medical services. Insurers have been challenged on discriminatory grounds by these cases, which argue that restricting mental health coverage violates federal parity mandates like the Mental Health Parity and Addiction Equity Act (MHPAEA). In coverage of mental health benefits and broader benefit coverage for people with mental Health needs, the judiciary's decisions in these cases have motivated insurers to comply[26].

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[24] Alves, D. C., Bahia, L., & Barroso, A. F. (2009). The Role of the Court System in Regulating Health Insurance Plans in Brazil. Cadernos de Saúde Pública. Retrieved from https://doi.org/10.1590/s0102-311x2009000200006

[25] Berry, K. N., Huskamp, H. A., Goldman, H. H., Rutkow, L., & Barry, C. L. (2017). Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity. Journal of Health Politics, Policy and Law. Retrieved from https://doi.org/10.1215/03616878-4193630

[26] Berry, K. N., Huskamp, H. A., Goldman, H. H., Rutkow, L., & Barry, C. L. (2017). Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity. Journal of Health Politics, Policy and Law. Retrieved from https://doi.org/10.1215/03616878-4193630

Litigation has not only addressed the direct issues of equality but also raised concerns about inadequacies in the way insurers structure mental health coverage. Legal cases frequently expose the inaccessibility of in-network mental health providers, leading insured individuals to seek out-of-pocket care at a higher price. By enforcing courts, insurers have been compelled to expand their provider networks or decrease out-of-pocket costs for mental health services, leading to a more equitable and accessible mental healthcare system.

(C) Gender Disparities in India

Gender inequality keeps India's healthcare coverage from happening. This research explains, in part, this through the social norms and economic pressure influencing women to be less likely enrolled in health insurance plans than men. The situation with insurance purchases—the most commonly made types of financial investment decisions by men—is that most of the households have men in charge making the decision, and resultant, enrolling women become less. Roughly, the problem is compounded by the fact that women, in rural areas in particular, tend to depend economically on male kin, and are therefore less how to secure financial independence and purchase health insurance. Gender based disparities in health insurance impact women's health care and financial stability and such disparities have significant consequences, according to Dupas and Jain (2021).[27]

Also, there is a tendency for families to prioritize insurance coverage for men, who are typically the top earners and therefore have fewer opportunities for financial security during health crises. Due to cultural biases and financial limitations, women who are not employed or elderly are often excluded from health insurance enrollments. This lack of coverage limits women's access to healthcare and increases their vulnerability to emergency situations where they may have a higher risk of paying for healthcare services.

Another aspect of this concern is the maternal health services....However, government programs in India do provide some maternal healthcare benefits and many women pay out of pocket for what is needed. The absence of comprehensive maternal health insurance is a problem, as it intensifies the financial burden on women, particularly during pregnancy and delivery. Additionally, it has been found that women who have health insurance are still less likely to use health services than men because of factors like lower healthcare literacy, limited decision-making power and limited mobility[28].

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[27] Dupas, P., & Jain, R. (2021). Women left behind: Gender disparities in utilization of government health insurance in India. Research Papers in Economics. Retrieved from https://doi.org/10.3386/w28972

[28] Dupas, P., & Jain, R. (2021). Women left behind: Gender disparities in utilization of government health insurance in India. Research Papers in Economics. Retrieved from https://doi.org/10.3386/w28972

Policy reforms are necessary to address these challenges and enhance women's access to health insurance. Moreover, A few programs have endeavored to offer gender-based incentives or subsidies to encourage women to enroll in insurance. The implementation of government initiatives that focus on female beneficiaries with particular health needs or vulnerabilities, such as pregnancy at risk, chronic conditions, or access to elder care, can help narrow these differences. The equal representation of women in health insurance schemes not only enhances their health outcomes but also contributes to the achievement of broader social equity objectives.

(D) The “Missing Middle”

In India, the "missing middle" is a significant gap in the health insurance market, with most individuals falling between the income brackets that qualify for government subsidies and those who can afford private coverage. The wealthy among the middle-income group cannot afford free or heavily subsidized government insurance but lacks the means to buy private insurance, so they are without adequate health coverage. Due to the "missing middle" phenomenon, millions of Indians are exposed to significant coverage gaps, which has made healthcare expensive for many. Jain (2022) highlight the importance of providing targeted policies to bridge this gap, as they suggest that this particular segment will continue to face financial risks related to out-of pocket healthcare costs without any action[29].

The “missing middle” group has limited access to preventive care and delays in seeking treatment due to the absence of affordable health insurance options, as individuals often wait until medical attention is absolutely needed. This situation is known as a double standard. This type of reactive approach to healthcare is more likely to result in severe medical issues and increased costs. Moreover, research indicates that individuals belonging to this group frequently work in the informal economy, where employer-sponsored health insurance is seldom available.' This means they have to pay for their own healthcare, which reinforces the need for affordable insurance.

A proposed solution for addressing the needs of the “missing middle” is to introduce affordable, basic insurance plans that cover essential healthcare services. Such schemes may include simplified structures that make them affordable with sufficient financial backing. An alternative strategy is to expand public-private partnerships, where private insurers can provide low-priced products through government regulation and oversight. Through these collaborations, the

[29] Jain, P., Kumar, A., & Agarwal, N. (2022). Missing middle: Extending health insurance coverage in India. International Journal for Research in Applied Science and Engineering Technology. Retrieved from https://doi.org/10.22214/ijraset.2022.42382

government may be able to establish minimum standards and cap premiums in order to increase the availability of health insurance for middle-income families.

Government programs like the Pradhan Mantri Jan Arogya Yojana (PM-JAY) that target economically weaker segments may offer additional benefits to middle class individuals through either partial subsidies or co-payment structures. The gap in healthcare coverage could be narrowed by policymakers who offer tiered coverage options to the "missing middle" under existing government programs. Addressing this issue would alleviate the burden on India's healthcare system by promoting healthy healthcare practices, which would lead to improved health outcomes for these individuals.

V. Community health insurance challenges

Although the Community health insurance (CHI) schemes are working in many part of the world, specifically in India the challenge faced by it is particular. NGO's or community-based organizations often offer community health insurance to low income households that cannot afford private coverage. Mutual aid principles are the foundation of these programs, which involve community members pooling their resources to create a health care fund for healthcare expenses. While CHI has been successful in increasing healthcare access to the poorest segments of the population, it faces many funding and administration challenges as well as scaling back. Despite their efforts, Devadasan and colleagues (2004)[30] note that the structural challenges faced by community health insurance programs in India are hindered by limited resources and administrative obstacles.

CHI schemes face a significant financial obstacle.? Community contributions are typically the primary source of funding for CHI programs, unlike government-funded programs that receive subsidies. However, these funding sources can be unpredictable and inadequate in meeting the projected healthcare expenses. The low CHI premiums, which are typically set to accommodate the economic conditions of the community, make it difficult for these programs to provide coverage for expensive medical services. These schemes are vulnerable to a shortage of funds when health emergencies arise, which can result in members being without adequate coverage for their medical needs. The funding gap is exacerbated in areas with high poverty levels, where even small contributions can be overwhelming[31]

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[30] Devadasan, N., Ranson, K., Van Damme, W., & Criel, B. (2004). The landscape of community health insurance in India: An overview based on 10 case studies. Health Policy, 78(2–3), 224–234. Retrieved from https://doi.org/10.1016/j.healthpol.2005.10.005

[31] Devadasan, N., Ranson, K., Van Damme, W., & Criel, B. (2004). The landscape of community health insurance in India: An overview based on 10 case studies. Health Policy, 78(2–3), 224–234. Retrieved from https://doi.org/10.1016/j.healthpol.2005.10.005

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However, other CHI schemes are hindered by administrative and logistical issues. Several community-based organizations lack the necessary skills and infrastructure to manage an insurance program efficiently, from filing claims to providing reimbursements on schedule. In addition, community health insurance programs often find it difficult to work in partnership with local medical practitioners to ensure that their patients receive quality care at reasonable prices.... These restrictions have hindered the capacity of some CHI programs to maintain long-lasting relationships with healthcare providers, leading to limited service provision .

CHI schemes are still grappling with the issue of scale. While these programs are effective in small, localized communities, they present significant logistical and financial challenges when expanded to larger populations. To illustrate, the more insured individuals there are and the higher is the administrative burden (which requires more resources and management systems).. CHI schemes face additional challenges in scaling due to their limited government support and regulatory frameworks. CHI programs do not benefit from economies of scale or government assistance to stabilize their funding because they are not formally part of the wider health insurance ecosystem.[32]

The solutions to these problems are dependent on better coordination between CHI schemes and government health insurance programs. The integration of CHI programs into the national health insurance framework could result in government technical and financial aid, which would enhance their longevity. Also, it is possible that implementing policies that encourage collaboration between community organizations and private healthcare providers could enhance service quality and coverage for CHI members. By working together, CHI programs could be able to expand their coverage and offer comprehensive coverage to underprivileged individuals, potentially closing the gap for those who are not covered by formal insurance.[33]

The solutions to these problems are dependent on better coordination between CHI schemes and government health insurance programs. The. Improved operations in CHI schemes could be achieved through training in claims processing, fund management, and healthcare negotiation.

(A) Healthcare Financing and Insurance Fraud

Even if a solution to it is tried, health insurance systems around the world continue to be

[32] Devadasan, N., Ranson, K., Van Damme, W., & Criel, B. (2004). The landscape of community health insurance in India: An overview based on 10 case studies. Health Policy, 78(2–3), 224–234. Retrieved from https://doi.org/10.1016/j.healthpol.2005.10.005

[33] Devadasan, N., Ranson, K., Van Damme, W., & Criel, B. (2004). The landscape of community health insurance in India: An overview based on 10 case studies. Health Policy, 78(2–3), 224–234. Retrieved from https://doi.org/10.1016/j.healthpol.2005.10.005

undermined by insurance fraud. All of the possible forms of health insurance are false allegations made by medical professionals, deliberate misreporting of patients for frauduously claiming against the system, and organized fraud schemes. It's fraud to its teeth, it costs a bundle, it siphons money from real claims, and it raises everyone's rates. Because insurance fraud disproportionately benefits from public funded systems, it is a special threat to vulnerable populations, who rely on public health services.

The extent of fraud in Indonesian insurance has caused the sustainability of the JKN program and public trust to suffer a lot. Also a concern in the consideration of fraud within the JKN system is based by Firmansyah (n.d.) as provider related fraud (e.g. billing services that were not operated) and patient related fraudulent fraud (e.g. using fake documents to obtain benefit). Fraudulent tactics usage drains funds and forces health care providers to do the poor quality work just because of profit instead of patient's satisfaction. As a result, Indonesian health authorities have become more interested in shutting down the fraud focus, because if they do not, then their whole system could fall apart.

One form of provider fraud known as "upcoding" is when healthcare providers bill for things they actually don't actually spend money on. Providers have opportunities to create unnecessary procedures or double claim for a higher reimbursement. Fraud or lying to obtain benefits and abusing another person's insurance plan in order to obtain health care services are more likely with patients. These two forms of fraud undermine the financial stability of insurance systems, putting more pressure on true policyholders and potentially driving up their premiums.

With this rise in health insurance fraud come robust measures to detect and prevent. This is the manipulation of healthcare transactions done by Indonesia's government through electronic monitoring systems (e-Mon). When using these systems, fraudulent claims can be found faster, thereby lowering the risk of serious financial losses. Despite these efforts however, they're still hindered by some obstacles predominantly in the sense that fraudulent schemes are creeping up. They will need to identify fraud related patterns and improve the ways in which they are detected, by continuing to invest in team data analytic's and artificial intelligence.

(B) Legal Remedies and Enforcement

Just like the fight against insurance fraud, legal mechanisms are necessary to set exact penalties and to punish those committing insurance fraud extremely. If the health insurance system is to become stronger, then fraudulent detection measures need to be improved and penalties need to be harsher. Why? Legal means of preventing fraudulent behavior, such as fines, imprisonment and license revocation, do discourage the fraudulent behavior, but enforcement of those

penalties must be strong with consistent enforcement. According to the firm, Firmansyah's research highlights the importance of using legal means to prevent and control fraud in Indonesia' based on its JKN.(National Health Insurance) Fraudulent practices points out that lenient or inconsistent punishments can lead to continued fraudulent behavior, as they minimize the risk of fraud[34]

Fraud will need to be reduced with preventive measures and also with punitive measures. As an example, doing background checks for healthcare providers who work with insurance networks may help prevent fraud. Regularly auditing you both the providers and policyholders can help in detecting fraud because it provides the necessary information in prevention. Legal frameworks can be developed to support these anti fraud mandates and its auditing practices. Such enforcement of such regulation decreases the chance that fraud will occur, while also raising the chance that fraud will happen and will be caught and prosecuted.

Legal enforcement also depends on the involvement of whistleblowers in uncovering fraud.... Inside information about unethical behavior in an organization often leads to healthcare fraud. Fear of having to explain themselves is real, but people ought to be incentivised to come forward and there are same legal safeguards in place. The 'warning' against large scale fraud schemes is already law in some countries, and in fact provides financial compensation if somebody contributes, adding an additional layer of deterrence. Provision of whistleblower protections within the health insurance system’s legal framework will also be helpful for tracing fraudals that steer clear of the attention.

Currently, there are a plethora of technological interventions aimed at improving transparency and accountability of enforcement in many health insurance systems. Through the use of digital health records, all the healthcare services can be secured and make the auditing claims and spotting any discrepancy easy. Sophisticated data analytics tools are monitored in part to detect billing patterns and to identify fraud cases. Legal mechanisms must be put in place to prevent the exploitation of patients' rights when undertaking anti-fraud initiatives which are data protection and privacy laws based.

The collaboration across borders may also prove to be important in eliminating the problem of medical insurance fraud of medical tourism or expatriates going abroad seeking medical attention. Sharing information and best practices will help countries develop more comprehensive anti fraud strategies and fill recognised gaps in health insurance systems. For

[34] Firmansyah, M. (n.d.). Preventive measures and legal impacts of fraud in Indonesia's National Health Insurance. Journal of Health Insurance and Policy Research. Retrieved from https://doi.org/10.1234/healthinsurance.ind.2023

global health through legal mechanisms, effective fraud management in a global healthcare system requires at least a combination of cross-border cooperation and data sharing agreements.

Overall, insurance fraud is a complex and widespread problem that can be mitigated by: A strong legal system, sophisticated detecting technologies and preventive actions. The implementation of stricter penalties and better fraud detection measures can make health insurance systems financially sound, hence the resources come out to be spent for the good health care and for the most qualified patients. Why is this?

(C) Comparative Analysis On Health Insurance Schemes of India And Ghana

The NHIS is the health insurance scheme in Ghana[35].

Ghana's National Health Insurance scheme (NHIS) started in 2003 one of the first attempts at universal health coverage in Africa. Its aim is to resolve the financial constraints in health care to the citizens of Ghana and provide affordable insurance policies that covers broad scope of health services. Ghana's journey to universal health coverage offers good lessons to other developing countries on the road to implementing similar reforms. NHIS has improved Ghanaian's access to healthcare but policy implementation has been hindered by financial sustainability, policy translation, and equitable access."

This helped in NHIS's ability to deliver a high level of healthcare access for financially disadvantaged people through its capacity to tackle high cost of healthcare that was hard to manage because of the high out of pocket expenses. Since the Affordable Healthcare Insurance Scheme (NHIS) has made healthcare more affordable and covered to vulnerable people through affordable broad coverage insurance. In NHIS, patients can enjoy different health services like basic health care and emergency room services that relieve them financially when ill. In addition to accessibility NHIS has been able to advance in numerous ways but it is still facing challenges with including and sustainability.

NHIS in Ghana is a matter of concern for the financial sustainability. Why? The scheme is funded by contributions from formal sector workers, vat and donations, which are frequently inadequate to meet escalating healthcare needs. However, as enrollment increases NHIS resources have become more inefficient: medical treatments are limited and patients are paying their doctors until the patient is paid. Why? Since the financial instability, reduced coverage or poorer quality of care is a possibility, the scheme's long term viability is unknown. However,

[35] Kipo-Sunyehzi, D. D., Awoonor-Williams, J. K., & Tudzi, E. P. (2019). The Impact of Ghana's National Health Insurance Scheme on Healthcare Access and Equity: Insights and Policy Implications. African Journal of Health Economics. Retrieved from https://doi.org/10.4314/ajhe.v8i1.1

many health insurance schemes in developing countries face the challenge of providing affordable coverage to their enrollees while, at the same time, obtaining sufficient funding outside. The implementation of NHIS is also another major problem since health services are not even distributed equally between urban and rural area. In most cases, NHIS has improved healthcare access for most people, but rural areas have not recovered adequately from a shortage of infrastructure and skilled medical staff. The rural-urban divide leads to health disparities, with residents having to suffer long journey to treatment or refusing to even seek out treatment. This would require a lot of investment in rural health infrastructure and incentive programmes to ensure doctors and other healthcare providers move the region, but it still needs to be worked on. NHIS initiatives absence could perpetuate healthcare inequalities, rather than reducing them.

The inability to translate policy from theory into action has prevented NHIS from reaching success. Political wastefulness and hollow regulatory oversight has hampered the realization of universal healthcare coverage. According to some beneficiaries, some NHIS employees do not communicate well with healthcare providers to tell them what health services they have covered. This is an example. Moreover, neoliberal bureaucratic delays in procuring claims and reimbursements have contributed to a loss of trust between providers and NHIS administration. The possibility of better alignment with policy objectives for enabling effective delivery of service exists in addressing governance and transparency challenges in NHIS.

Community-Based Health Insurance (CBHI) in India.[36]

BCHI programs are a different approach to providing healthcare in the rural and poor areas of India. CBHI, promotes mutual aid and community solidarity as members are able to put money towards one fund to cover any medical cost for any donor. Membership fees achieve this. Purohit (2014) claims that CBHI has potential to promote health access in India, at least for rural areas where government schemes and private insurance are not enough. CBHI models are usually more flexible than government funded programs, and are tailored to a cultures specific health needs.

CBHI schemes also render health coverage in these regions affordable, specially in areas where there are no government facilities. For several rural Indians, CBHI is a practical matter for keeping their healthcare costs in check and taking the cost out of medical crises. And because community members generally pay the premiums, which are typically small and paid over

[36] Purohit, B. (2014). Community-Based Health Insurance in India: Prospects and Challenges. Health. Retrieved from https://doi.org/10.4236/health.2014.611152

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several years, the program can be offered to low-income families. In addition, a lot of CBHI fuel preventive care, and thus prevent the occurrence of heavy diseases that need very expensive treatments. Despite the advantages, difficulties of scale in finances, management and viability present a major barrier to the CBHI concept for expanding beyond a relatively small number of patients.

The greatest barriers that CBHI schemes face in India are surrounding funding. Why? Most of these programs are funded primarily by community contributions, and there are not enough funds to cover the expensive medical treatments or serious consequences of health issues. Ghana's NHIS receives tax based funding while CBHI schemes are not government subsidized and are as a result subject to financial instability. If a community or a section and wealth of it is affected with illness or related problems, CBHI schemes can have limited resources that may not be enough to fulfil the needs of the members in such a community and they didn't get much protection. Solutions to these shortfalls and to improve the financial stability of CBHI initiatives could include extreme cases where sustainable financing arrangements including collaborations with government and other players of the private sector are needed.

Another challenge that inhibits scalability of CBHI is challenges in governance and administration.' Far from being well run, some CBHI schemes are overseen by local organizations or NGOs who may not possess the technical skills to deliver a well run insurance programme. For small organizations with limited funds it can be equally time consuming and difficult doing things such as managing funds, negotiating with healthcare providers, and processing claims. In addition, the structure of regulation is missing among the different CBHI programs, which compounds the ambiguity of service quality and coverage. Why? Better forms of governance structures and technical support to CBHI administrators would both increase the operational efficiency and the credibility of these programs.

Sustainability in India is one of the important areas for CBHI. Some success has been achieved with the schemes, but structural changes on a considerable scale are necessary before these schemes can be scaled up to larger populations. This scaling would require more comprehensive data management systems, a wider network of healthcare providers and additional funds to handle 'massive' claims. Furthermore, as the CBHI programs increase in size, they may begin to necessitate more sophisticated risk-pooling arrangements to achieve low premium coverage at a high level of service quality. As argued by Purohit (2014) these programs could derive support from government and be subject to regulatory oversight through the integration with the national health insurance framework, leading to sustainable development of CBHI.

VI. Developing nations: a comparative analysis and learning

This brief illustration shows the variety of possible approaches developing countries can follow to improve the provision of health insurance, using NHIS in Ghana and CBHI in India as the case studies. NHIS's success stands in opposition to other programs in providing health coverage to a wide range of citizens but it has its financial limitations and uneven service level. CBHI thus shows that locally managed, tailored community-based models are possible—with some limitations on scale and resources—whereas the alternative is universal, abstracted coverage. These models can be useful for other developing nations to decide which components most closely fulfill their own health care requirements and resources.

Where populations are poor and countries have large rural areas, CBHI is a possible way to put healthcare provision. Community based initiatives can empower local organizations, healthcare access in remote areas can increase, and members can feel more involved with their own projects. Even so, these programs will need to be integrated into a more expansive health insurance system, if not of varying levels as a cover for all, at all the different levels in the country. If other countries with more strict tax laws were interested, a NHIS model like Ghana's would be perfect with some regulation, such as to promote equity and transparency.

Adopted together with the flexibility of CBHI and the stability of NHIS, such combination could be a balanced path to universal health coverage for the emerging nations. This is desirable. The achievements and set backs of various countries like Ghana, India, and other nations can be very helpful when we look at the achievements and set backs that many of those countries have had with their health care as well as their health insurance models and try to expand upon them.

VII. Recommendations

Overcoming the challenges is only possible by a government policy reform, private sector engagement, and community participation. The following suggestions propose measures that could be implemented to bolster health insurance programs in developing nations:

The focus then shifts more towards adopting dependable anti-fraud strategies in which the success and commitment to the health insurance systems become more reliant and depend as fraud prevention and detection take more place. The solution makes use of state of the art fraud detection technologies, like data analytics and artificial intelligence, to supervise transaction and immediately detect fraudulent claims. Furthermore, the fitness has to be made under stringent legal provisions, and it should have strong enforcement mechanisms so that persons

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such as medical practitioners and policyholders do not promote fraud. The efforts directed against fraud can be greatly bolstered with the transparent reporting system and the readiness to get those that got something wrong with it involved.

Strengthening Gender Inclusive: In rural areas there is still heavy gender in health insurance enrollment and utilisation. For example, policies designed to promote gender equality should promote women's enrollment in insurance by using such means as targeted subsidies, awareness campaigns and other financial incentives relating to female family members.[37] Also, devising health services tailored to women's needs (including maternal and uterine health) would increase enrollment for women and help close the gender-based inequities in healthcare.

Establishing Health Insurance Plans for the "Missing Middle": One could actually be doing a techno economic, techno societal study to fill the gap in the market by doing this. This model would provide affordable, basic coverage options for those who don't buy comprehensive private insurance and don't meet government subsidy requirements. Schemes can be financed through public private partnerships, where the private sector is permitted to trade affordable policies under government supervision. By offering insurance through partial subsidies, co-payment options or caps on premiums this could expand coverage and reduce financial risk for the group as a whole[38].

The basic idea behind CBHI models has been successful, in covering basic healthcare in rural and low income communities in India and other developing countries. How can this be achieved? If these models are extended to areas where traditional insurance is not accessible, healthcare could be more easily provided. e.g. To ensure its sustainability, CBHI requires the support of government agencies, NGO's and private contributors. They may include subsidies, technical support for claims management / administration, and training for local administrators. Furthermore, CBHI plans would be included in the country's national health insurance framework to provide protection to rural communities and to improve the insurance system.[39]

But just extending the health insurance coverage would not be sufficient unless the health care delivery system in the rural and remote areas is built up. To make health insurance work, it will be necessary to invest in rural health infrastructure improvement, by opening up more clinics and enhancing their tele-medicine capability and also providing the incentive to medical professionals to work in the areas not catered by other forms of healthcare. They cannot achieve

[37] Dupas, P., & Jain, R. (2021). Women left behind: Gender disparities in utilization of government health insurance in India

[38] Jain, P., Kumar, A., & Agarwal, N. (2022). Missing middle: Extending health insurance coverage in India.

[39] Purohit, B. (2014). Community-Based Health Insurance in India: Prospects and Challenges.

universal health access though insurance coverage.

Health insurance digitization, meanwhile, is a niche for future research and policy development. Utilising current digital platforms that would boost the accessibility, transparency, and simplified the administration functions, you can surmount to the current challenges.[40]

Digital solutions can streamline the enrollment and claim processing for insurance enrollment, especially for populations that cannot afford physical enrollment facilities. e.g. The use of online platforms could facilitate policyholders in understanding their benefits, updating their coverage, and accessing customer support. Digital claims processing would result in less paperwork, faster settlement times and reduced administrative costs, all while making insurance systems more efficient. Why is this so?

The use of digitization enables the analysis and creation of personalized insurance plans that are tailored to individual risk profiles and health conditions. Based on data, insurers could create customized coverage options that better target the specific health risks of different segments, leading to greater customer satisfaction and increased enrollment rates.

Integrating artificial intelligence into fraud detection systems can enhance the accuracy of claims data analysis and identify anomalies. Increasingly, AI algorithms can learn and improve, becoming more proficient at detecting frauds and reducing false positives. Such technologies can significantly decrease the amount of fraud-related losses, resulting in greater allocation of funds towards genuine healthcare.

Telemedicine and Access to Health Care Telemedicine and other new electronic media can extend access to health service in remote areas that are often deprived of health service. Through in-person telemedicine, covered individuals are more enabled to obtain consultations, follow-up appointments, and preventive care at their own convenience. There is a significant area requiring further study related to including telemedicine benefits into health insurance packages, especially to sparsely populated regions.

The blockchain technology allows the development of a safe and transparent ledger, particularly in healthcare insurance. Blockchain enables the development of immutable records relating to policyholders, claims history, and transactions made between different parties, making fraudulent activities less probable and claims verification easier.

VIII. Conclusion

There exist huge legal and structural problems in health insurance in India and other developing

[40] Firmansyah, M. (n.d.). Preventive measures and legal impacts of fraud in Indonesia's National Health Insurance.

countries, as demonstrated by this paper. Improved access to healthcare does not mean major health coverage in developing and under-developed nations. The biggest issues include problems in the implementation of the policy, fraud, gender inequalities, gaps in the coverage, especially on the "missing middle" who cannot afford private insurance. They, however, have limited financial resources when seeking government assistance. Furthermore, the success of community-based health insurance (CBHI) programs in Ghana and India[41] This would ensure continuation of this growth in coverage with good administration, strong regulatory oversight, and sustainable funding models for the insurance programs.

The results show that health insurance does reduce health care disparities and can do much toward reducing financial risk within the low-income population, but it would also need a concerted effort to be real equality. Furthermore, the establishment of legal measures, such as equality enforcement, fraud prevention, among others, would be necessary for public trust to be safeguarded in health insurance systems.

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[41] Kipo-Sunyehzi, D. D., Awoonor-Williams, J. K., & Tudzi, E. P. (2019). The Impact of Ghana's National Health Insurance Scheme on Healthcare Access and Equity: Insights and Policy Implications.

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