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INSURANCE AGENTS
SECTION-HEALTH

ACKNOWLEDGEMENT

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The contents are based on prevailing best practices and not intended to give interpretations or solutions in case of disputes, legal or otherwise.

This is only an indicative study material. Please note that the questions in the examination shall not be confined to this study material only.

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PREFACE

Insurance Institute of India, (the Institute) has developed this course material for Insurance Agents based on the syllabus prescribed by Insurance Regulatory and Development Authority of India (IRDAI). Industry experts were involved in preparing the course material.

The course provides basic knowledge of Life, General and Health insurance to enable agents in the respective line of business to understand and appreciate their professional career in the right perspective.

The course is structured as four sections. (1) Overview - a Common section that covers Insurance Principles, Legal Principles and Regulatory matters that Insurance agents need to know. Separate sections are provided for those aspiring to become (2) Life Insurance Agents, (3) General Insurance Agents and (4) Health Insurance Agents.

A set of model questions are included in the course to give students an idea of the examination format and the types of objective questions that may be asked. The model questions will also help them in revising what they have learnt.

Insurance operates in a dynamic environment. Agents need to be up to date about changes in the market. They should actively pursue knowledge through personal study and participation in the in-house training programmes arranged by the respective insurers.

The Institute thanks IRDAI for entrusting this work to the Institute. The Institute wishes all interested in studying the material a successful career in insurance marketing.

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HEALTH SECTION

CHAPTER H-01

INTRODUCTION TO HEALTH INSURANCE

Chapter Introduction

This chapter will tell you about how insurance evolved over time. It will also explain what healthcare is, levels of healthcare and types of healthcare. You will also learn about the healthcare system in India and factors affecting it. Finally, it will explain how health insurance evolved in India and also the various players in the health insurance market in India.

Learning Outcomes

A. Understanding Healthcare

B. Levels of Healthcare

C. Types of Healthcare

D. Evolution of Health Insurance in India

E. Health Insurance Market

After studying this chapter, you should be able to:

a) Understand how insurance evolved.
b) Explain the concept of healthcare and the types and levels of healthcare.
c) Appreciate the factors affecting healthcare in India and the progress made since independence.
d) Discuss the evolution of health insurance in India.
e) Know the health insurance market in India.

A. Understanding Healthcare

The word 'Health' was derived from the word 'hoelth', which means 'soundness of the body'.

In olden days, health was considered to be a 'Divine Gift' and illness was believed to have been caused due to the sins committed by the concerned person. It was Hippocrates (460 to 370 BC) who came up with the reasons behind illness. According to him, illness is caused due to various factors relating to environment, sanitation, personal hygiene and diets. Vedic texts of ancient India speak about *'Arogyame Mahabhagyam'* meaning 'Health is great luck' or in other words, 'Health is Wealth'. Many treatises of ancient India like *Atharva Veda, Charaka Samhita, Sushruta Samhita, Ashtangahrdayam, Ashtangasamgraha, Bhela Samhita*, and *Kashyapa Samhita* discuss healing traditions practiced in India in olden times.

Definition

A widely accepted definition of health was given by World Health Organization (WHO) –*'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'*

Determinants of health

It is generally believed that the following factors determine the health of any individual:

a) Lifestyle factors

Lifestyle factors are those which are mostly in the control of the individual concerned e.g. exercising and eating within limits, avoiding worry and the like leading to good health; leading to diseases such as cancer, aids, hypertension and diabetes, to name a few.

b) Environmental factors

Communicable diseases like Influenza and Chickenpox etc. are spread due to bad hygiene, diseases like Malaria and Dengue are spread due to bad environmental sanitation, while certain diseases are also caused due to environmental factors.

c) Genetic factors

Diseases may be passed on from parents to children through genes. Such genetic factors result in differing health trends amongst the population spread across the globe based on race, geographical location and even communities.

It is quite obvious that a country's social and economic progress depends on the health of its people. This poses a question as to whether different types of healthcare are required for different situations.

Test Yourself 1

Which of the following diseases is not attributed to Lifestyle factors (i.e. not in the control of the individual)?

I. Cancer
II. Aids
III. Malaria
IV. Hypertension

B. Levels of Healthcare

Healthcare is nothing but a set of services provided by various agencies and providers including the government, to promote, maintain, monitor or restore health of people. Health care to be effective must be:

- Appropriate to the needs of the people
- Comprehensive
- Adequate
- Easily available
- Affordable

The health care facilities should be based upon the probability of the incidence of disease for the population. For example, a person may get fever, cold, cough, skin allergies etc. many times a year, but the probability of him/ her suffering from Hepatitis B is less as compared to cold and cough.

Hence, the need to set up the healthcare facilities in any area whether a village or a district or a state will be based upon the various healthcare factors called indicators of that area such as:

- ✓ Size of population
- ✓ Death rate
- ✓ Sickness rate
- ✓ Disability rate
- ✓ Social and mental health of the people
- ✓ General nutritional status of the people
- ✓ Environmental factors such as if it is a mining area or an industrial area
- ✓ The possible health care provider system e.g. heart doctors may not be readily available in a village but may be in a district town
- ✓ How much of the health care system is likely to be used
- ✓ Socio-economic factors such as affordability

Based on the above factors, the government decides upon setting up of centres for primary, secondary and tertiary health care and takes other measures to make appropriate healthcare affordable and accessible to the population.

C. Types of Healthcare

Healthcare is broadly categorized as follows:

1. Primary healthcare

Primary health care refers to the services offered by the doctors, nurses and other small clinics which are contacted first by the patient for any sickness, that is to say that primary healthcare provider is the first point of contact for all patients within a health system.

For example, if a person visits a doctor for fever and the first diagnosis is indicative of Dengue fever, the primary health care provider will prescribe some medicines but also direct the patient to get admitted in a hospital for specialized treatment.

At a country level, Primary Health care centres are set up both by Government and private players. Government primary health care centres are established depending upon the population size and are present right up to the village level in some form or the other.

2. Secondary healthcare

Secondary health care refers to the healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patient. It includes acute care requiring treatment for a short period for a serious illness, often (but not necessarily) as an in-patient, including Intensive Care services, ambulance facilities, pathology, diagnostic and other relevant medical services.

3. Tertiary healthcare

Tertiary Health care is specialized consultative healthcare, usually for inpatients and on referral from primary/ secondary care providers.

Examples of Tertiary Health care providers are those who have advanced medical facilities and medical professionals, beyond the scope of secondary health care providers e.g. Oncology (cancer treatment), Organ Transplant facilities, High risk pregnancy specialists etc.

It is to be noted that as the level of care increases, the expenses associated with the care also increase. The infrastructure for different levels of care also varies from country to country, rural-urban areas, while socio-economic factors also influence the same.

Test Yourself 2

Which of the following are part of primary healthcare?

I. Fever
II. Cancer
III. Organ Transplant
IV. High risk pregnancy

D. Evolution of Health Insurance in India

While the government had been busy with its policy decisions on healthcare, it also put in place health insurance schemes. Insurance companies came with their health insurance policies only later. Here is how health insurance developed in India:

1. Employees' State Insurance Scheme

Health Insurance in India formally began with the beginning of the Employees' State Insurance Scheme, introduced vide the ESI Act, 1948, shortly after the country's independence in 1947. This scheme was introduced for blue-collar workers employed in the formal private sector and provides comprehensive health services through a network of its own dispensaries and hospitals.

ESIC (Employees State Insurance Corporation) is the implementing agency which runs its own hospitals and dispensaries and also contracts public/ private providers wherever its own facilities are inadequate.

2. Central Government Health Scheme

The ESIS was soon followed by the Central Government Health Scheme (CGHS), which was introduced in 1954 for the central government employees including pensioners and their family members working in civilian jobs. It aims to provide comprehensive medical care to employees and their families and is partly funded by the employees and largely by the employer (central government).

3. Commercial Health insurance

Commercial health insurance was offered by some of the non-life insurers before as well as after nationalisation of insurance industry.
In 1986, the first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies (these were then the subsidiaries of the General Insurance Corporation of India). This product, **Mediclaim** was introduced to provide coverage for the hospitalisation expenses up to a certain annual limit of indemnity with certain exclusions such as maternity, pre-existing diseases etc.
The hospitalization indemnity-based annual contract continues to be the most popular form of private health insurance in India today. With private players coming into the insurance sector in 2001, health insurance has grown tremendously. However, there is a large untapped market even today.

The Government has encouraged individuals to purchase Health Insurance policies. Premiums paid by the individuals towards Health Insurance of self, spouse and family members are allowed to be deducted from taxable income under Section 80 D of the Income Tax Act. The Section allows higher limits for paying premiums of parents/ parents in law above 60 years of age.

Considerable variations in covers, exclusions and newer add-on covers have been introduced which will be discussed in later chapters.

Test Yourself 3

The first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies in the year _____.

I. 1948
II. 1954
III. 1986
IV. 2001

E. Health Insurance Market

The health insurance market today consists of a number of players some providing the health care facilities called providers, others the insurance services and also various intermediaries. Some form the basic infrastructure while others provide support facilities. Some are in the government sector while others are in the private sector.

1. Private sector Health Care providers

India has a very large private health sector providing all three types of healthcare services - primary, secondary as well as tertiary. These range from voluntary, not-for-profit organisations and individuals to for-profit corporate, trusts, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks).

India also has the largest number of qualified practitioners in other systems of Medicine (Ayurveda/ Siddha/ Unani/ Homeopathy) which is over 7 lakh practitioners. These are located in the public as well as the private sector. Apart from the for-profit private providers of health care, the NGOs and the voluntary sector have also been engaged in providing health care services to the community.

Insurance Companies in the general insurance sector provide the bulk of the health insurance services. Stand Alone Health Insurance (SAHI) Companies are allowed to transact all types of Health Insurances, while Life Insurance Companies are also permitted to transact certain types of Health Insurances.

2. Intermediaries:

A number of people and organizations providing services as part of the insurance industry also form part of the health insurance market. Insurance Intermediaries are defined under Section 2 of the IRDA Act, 1999. These include insurance brokers, reinsurance brokers, insurance consultants, surveyors and loss assessors as well as Third Party Administrators.

A Third Party Administrator (TPA) is a company registered with IRDAI and engaged by an insurer, for a fee, for providing health services. A TPA may render the following services to an insurer under an agreement in connection with health insurance business:

a. Servicing of claims under health insurance policies by way of pre authorization of cashless treatment or settlement of claims other than cashless claims or both, as per the underlying terms and conditions of the respective policy and within the framework of the guidelines issued by the insurers for settlement of claims.
b. Servicing of claims for Hospitalization cover, if any, under Personal Accident Policy and domestic travel policy.
c. Facilitating carrying out of pre-insurance medical examinations in connection with underwriting of the health insurance policies.

Summary

a) Insurance in some form or other existed many centuries ago but its modern form is only a few centuries old. Insurance in India has passed through many stages with government regulation.

b) Health of its citizens being very important, governments play a major role in creating a suitable healthcare system.

c) Level of healthcare provided depends on many factors relating to a country's population.

d) The three type of healthcare are primary, secondary and tertiary depending on the level of medical attention required. Cost of healthcare rises with each level with tertiary care being the costliest.
e) India has its own peculiar challenges such as population growth and urbanization which require proper healthcare.

f) The public sector insurance companies were the first to come up with schemes for health insurance followed later by commercial insurance by private insurance companies.

g) The health insurance market is made up of many players some providing the infrastructure, with others providing insurance services, intermediaries such as brokers, agents and third party administrators servicing health insurance business and also other regulatory, educational as well as legal entities playing their role.

Answers to Test Yourself

Answer 1 The correct option is III.
Answer 2 The correct option is I.
Answer 3 The correct option is III.

Key terms

a) Healthcare
b) Commercial insurance
c) Nationalization
d) Primary, Secondary and Tertiary Healthcare
e) Third Party Administrator

CHAPTER H-02

HEALTH INSURANCE DOCUMENTATION

Chapter Introduction

In the insurance industry, we deal with a large number of forms, documents etc. This chapter takes us through the documents and their importance in a health insurance contract.

Learning Outcomes

A. Proposal forms

B. Acceptance of the proposal (underwriting)

C. Prospectus

D. Policy Document

E. Conditions and Warranties

After studying this chapter, you should be able to:

a) Explain the contents of proposal form.
b) Describe the importance of Prospectus
c) Explain terms and wordings in insurance policy document.
d) Discuss policy conditions and warranties.
e) Appreciate why endorsements are issued.
f) Understand the premium receipt.
g) Appreciate why renewal notices are issued.

A. Proposal forms

1. Health Insurance Proposal forms

As discussed in the common chapters, the Proposal Form contains information which is useful for the insurance company to accept the risk offered for insurance. Given below are some of the details of the proposal form for a health insurance policy:

1. The proposal form incorporates a prospectus which gives details of the cover, such as coverage, exclusions, provisions etc. The prospectus forms part of the proposal form and the proposer has to sign it as having noted its contents.
2. The proposal form collects information relating to the name, address, occupation, date of birth, sex, and relationship of each insured person with the proposer, average monthly income and income tax PAN No., name and address of the Medical Practitioner, his qualifications and registration number. Bank details of the insured are also now a days collected to make payment of claim money directly through bank transfer.
3. In addition, there are questions relating to the medical condition of the insured person. These detailed questions in the form are based on past claims experience and are to achieve proper underwriting of the risk.
4. The insured person is required to state full details if he has suffered from any of the specified diseases in the form.
5. Further, the details of any other illness or disease suffered or accident sustained are called for as follows:
   a. Nature of illness/ injury and treatment
   b. Date of first treatment
   c. Name and address of attending Doctor
   d. Whether fully recovered
6. The proposer as to state any additional facts which should be disclosed to insurers and if he has any knowledge of any positive existence or presence of any illness or injury which may require medical attention.
7. The form also includes questions relating to past insurance and claims history and additional present insurance with any other insurer.
8. The special features of the declaration to be signed by the proposer must be noted.
9. The insured person agrees and authorises the insurer to seek medical information from any hospital/ medical practitioner who has at any time attended or may attend concerning any illness which affects his physical or mental health.
10. The insured person confirms that he has read the prospectus forming part of the form and is willing to accept the terms and conditions.
11. The declaration includes the usual warranty regarding the truth of the statements and the proposal form as the basis of the contract.

2. Medical Questionnaire

In case of adverse medical history in the proposal form, the insured person has to complete a detailed questionnaire relating to diseases such as Diabetes, Hypertension, Chest pain or Coronary Insufficiency or Myocardial Infarction.

These have to be supported by a form completed by a consulting physician. This form is scrutinised by company's panel doctor, based on whose opinion, acceptance, exclusion, etc. are decided.

Standard form of Declaration

The IRDAI has specified the format of the standard declaration in the health insurance proposal as under:

1. I/ We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/ or particulars given by me are true and complete in all respects to the best of my knowledge and that I/ We am/ are authorized to propose on behalf of these other persons.
2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. I/ We further declare that I/ we will notify in writing any change occurring in the occupation or general health of the life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/ We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/ proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/ or claim settlement.
5. I/ We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/ or claims settlement and with any Governmental and/ or Regulatory Authority.

3. Nature of questions in a proposal form

The number and nature of questions in a proposal form vary according to the type of insurance concerned. Sum insured indicates the limit of liability of the insurer under the policy and has to be indicated in all proposal forms.

In **personal lines** like health, personal accident and travel insurance, proposal forms are designed to get information about the proposer's health, way of life and habits, pre-existing health conditions, medical history, hereditary traits, past health-insurance experience etc. along with the proposer's profession, occupation or business which important as they could have a material bearing on the risk.

Example 1

- ✓ A delivery man of a fast-food restaurant, who has to frequently travel on motor bikes at a high speed to deliver food to his customers, may be more exposed to accidents than the accountant of the same restaurant.
- ✓ A person working in a coal mine or a cement plant may be exposed to dust particles leading to lung ailments.

Example 2

- ✓ For the purpose of overseas travel insurance, the proposer is required to state (who is travelling, when, to which country, for what purpose) or

  For the purpose of health insurance, the proposer is asked about his/ her health (with person's name, address and identification) etc. depending on the case.

Example 3

- ✓ In case of health insurance, it could be the cost of hospital treatment, while for personal accident insurance this could be a fixed amount for loss of life, loss of a limb, or loss of sight due to an accident.

a) Previous and Present insurance

The proposer is required to inform the details about his previous insurances to the insurer. This is to understand his insurance history. In some markets there are systems by which insurers confidentially share data about the insured.

The proposer is also required to state whether any insurer had declined his proposal, imposed special conditions, required an increased premium at renewal or refused to renew or cancelled the policy. Details of current insurance with any other insurer including the names of the insurers are also required to be disclosed. Further, in personal accident insurance an insurer would like to restrict the amount of coverage (sum insured) depending on the sum insured under other PA policies taken by the same insured.

b) Claim Experience

The proposer is asked to declare full details of all losses suffered by him/ her, whether or not they were insured. This will give the insurer information about the subject matter of insurance and how the insured has managed the risk in the past. It means the insurance company has a duty to record all the information received even orally, which the agent has to keep in mind by way of follow up.

B. Acceptance of the proposal (underwriting)

A completed proposal form broadly gives the following information:

- ✓ Details of the insured
- ✓ Details of the subject matter
- ✓ Type of cover required
- ✓ Details of the physical features both positive and negative
- ✓ Previous history of insurance and claim experience

In the case of a health insurance proposal, the insurer may also refer the prospective customer e.g. above 45 years of age to a doctor and/ or for medical check-up. Based on the information available in the proposal and, where medical check-up has been advised, based on the medical report and the recommendation of the doctor, the insurer takes the decision. Sometimes, where the medical history is not satisfactory, an additional questionnaire to get more information is also required to be obtained from the prospective client. The insurer then decides about the rate to be applied to the risk factor and calculates the premium based on various factors, which is then conveyed to the insured.

C. Prospectus

A Prospectus is a document issued by the insurer or on its behalf to the prospective buyers of insurance. It is usually in the form of a brochure or leaflet or it can be in electronic form also and serves the purpose of introducing a product to such prospective buyers. Issue of prospectus is governed by the Insurance Act, 1938 as well as by Protection of Policyholders' Interest Regulations 2017 and the Health Insurance Regulations 2016 of the IRDAI. Insurers of Health policies usually publish Prospectuses about their Health insurance products. The proposal form in such cases would contain a declaration that the customer has read the Prospectus and agrees to it.

As discussed in Chapter 4, Section 64 VB of the Insurance Act 1938 stipulates that Premiums have to be collected in advance. However, considering the need for easing the payment of health insurance premiums in view of conditions owing to COVID-19 outbreak, IRDAI allowed insurers to collect premiums of individual health insurance products in instalments. It was also mandated that Insurance companies would announce the availability of the facility of payment of premiums in instalments, and the conditions thereof, on their websites. This facility would be offered to all policyholders without any discrimination.

D. Policy Document

IRDAI Regulations for protecting policy holder's interest act 2017 specified that a Health Insurance Policy document should contain:

a) The name(s) and address(es) of the insured and any other person having insurable interest in the subject matter
b) Full description of the persons or interest insured
c) The sum insured under the policy person and/ or peril wise
d) UIN of the product, name, code number, contact details of the person involved in sales process;
e) Date of birth of the insured and corresponding age in completed years;
f) The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break
g) The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross reference to the concerned policy section;
h) Co-pay limits if any;
i) The pre-existing disease (PED) waiting period, if applicable;
j) Specific waiting periods as applicable;
k) Deductible as applicable – general and specific, if any Perils covered and exclusions
l) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium along with periodicity of instalments if any
m) Policy terms, conditions and warranties
n) Action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy

o) The obligations of the insured in relation to the subject-matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances
p) Any special conditions
q) Provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured
r) The details of the Add-on covers, if any
s) Details of Grievance Redressal mechanism and address of Ombudsman
t) Details of Grievance Redressal mechanism of Insurer;
u) Free-look period facility and portability conditions;
v) Policy migration facility and conditions where applicable.

E. Conditions and Warranties

Here, it is important to explain two important terms used in policy wordings. These are called Conditions and Warranties.

1. **Conditions:** A condition is a provision in an insurance contract which forms the basis of the agreement.

EXAMPLES:

a. One of the standard conditions in most insurance policies states:

If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof or if any fraudulent means or devices are used by the Insured or any one acting on his behalf to obtain any benefit under the policy or if the loss or damage be occasioned by the wilful act, or with the connivance of the Insured, all benefits under this policy shall be forfeited.

b. The Claim Intimation condition in a Health policy may state:

Claim must be filed within certain days from date of discharge from the Hospital. However, waiver of this Condition may be considered in extreme cases of hardship.

A breach of condition makes the policy voidable at the option of the insurer.

2. **Warranties:** A warranty is an agreement between insurer and insured that must be carried out fully. It forms a part of the policy document. For example, the Insurer may be covering the risk of a particular disease on the condition that the insured shall do a quarterly consultations with a specialist. In the above example, failure of the insured to fulfil his part of the agreement shall either negate or reduce the liability in respect of that particular section/ warranty.

Warranties must be observed and complied with strictly and literally, whether it is material to the risk or not.

Test Yourself 1

Which of the below statement is correct with regards to a warranty?

I. A warranty is a condition which is implied without being stated in the policy
II. A warranty forms part of a policy document

III. A warranty is always communicated to the insured separately and cannot be part of the policy document
IV. Claims will be payable even if a warranty is breached.

Endorsements in Health Insurance

It is the practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others.

Definition

If certain terms and conditions of the policy need to be changed at the time of issuance, it is done by setting out the amendments/ changes through a document called endorsement.

It is attached to the policy and forms part of it. The policy and the endorsement together make up the contract. Endorsements may also be issued during the currency of the policy to record changes/ amendments.

Whenever material information changes, the insured has to advice the insurance company who will take note of this and incorporate the same as part of the insurance contract through the endorsement.

Endorsements normally required under a policy relate to:

a) Variations/ changes in sum insured
b) Addition and deletion of insured family members
c) Change of insurable interest by way of taking of a loan and mortgaging the policy to a bank.
d) Extension of insurance to cover additional perils/ extension of policy period
e) Change in risk, e.g. change of destinations in the case of an overseas travel policy
f) Cancellation of insurance
g) Change in name or address etc.

Test Yourself 2

If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments through _____.

I. Warranty
II. Endorsement
III. Alteration
IV. Modifications are not possible

Answers to Test Yourself

Answer 1 -The correct option is II.

Answer 2 - The correct option is II.

CHAPTER H-03

HEALTH INSURANCE PRODUCTS

Chapter Introduction

This chapter will give you an overall insight into the various health insurance products offered by insurance companies in India. From just one product – Mediclaim to hundreds of products of different kinds, the customer has a wide range to choose appropriate cover. The chapter explains the features of various health products that can cover individuals, family and group.

Learning Outcomes

A. Classification of health insurance products
B. IRDA Guidelines on Standardization in health insurance
C. Hospitalization indemnity product
D. Top-up covers or high deductible insurance plans
E. Senior citizen policy
F. Fixed benefit covers – Hospital cash, critical illness
G. Combo-products
H. Micro insurance and health insurance for poorer sections
I. Rashtriya Swasthya Bima Yojana
J. Pradhan Mantri Jan Arogya Yojna
K. Pradhan Mantri Suraksha Bima Yojana
L. Personal accident and disability cover
M. Overseas travel insurance
N. Group health cover
O. Special products
P. Key terms in health policies

After studying this chapter, you should be able to:

a) Explain the various classes of health insurance
b) Describe the IRDAI guidelines on standardization in health insurance
c) Discuss the various types of health products available in the Indian market today
d) Explain Personal Accident insurance
e) Discuss overseas travel insurance
f) Understand key terms and clauses in health policies

A. Classification of health insurance products

1. Introduction to health insurance products

Definition

"Health insurance business" is defined under Section 2(6C) of the Insurance Act, 1938 as *"the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover."* IRDAI follows this definition of Health insurance business.

Health insurance products available in the Indian market are mostly in the nature of **hospitalization products.** These products cover the expenses incurred by an individual during hospitalization.

Therefore, health insurance is important mainly for two reasons:

- ✓ **Providing financial assistance to pay for medical facilities** in case of any illness.
- ✓ **Preserving the savings of an individual** which may otherwise be wiped out due to illness.

Today, the health insurance segment has developed to a large extent, with hundreds of products offered by almost all general Insurance companies, standalone health insurers and life insurers. However, the basic benefit structure of the Mediclaim policy i.e. cover against hospitalization expenses still remains the most popular form of insurance.

2. Broad classification of health insurance products

Whatever be the product design, health insurance products can be broadly classified into two categories:

a) Indemnity covers

These products constitute the bulk of the health insurance market and pay for actual medical expenses incurred due to hospitalization.

b) Fixed benefit covers

Also called as 'hospital cash', these products pay for a fixed sum per day for the period of hospitalization. Some products also provide for a pre-decided amount for different surgeries.

3. Classification based on customer segment

Products can also be classified on the basis of the target customer segment. Products classified based on customer segments are:

a) **Individual cover** offered to retail customers and their family members

b) **Group cover** offered to corporate clients, covering employees and groups, covering their members

c) **Mass policies** for government schemes like/ Pradhan Mantri Jan Arogya Yojana/ various State health insurance schemes covering very poor sections of the population.

The benefit structures, pricing, underwriting and marketing for each segment are quite distinct.

Regulations for Health Insurance: Some important changes have been brought in Health Regulations, 2016 regarding Health Products, some of which have been given below:

1. Life Insurance Companies can offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.
2. Non-Life and Standalone Health insurance companies can offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium will remain unchanged for the tenure.
3. Insurance companies may offer innovative 'Pilot-Products'. General-Insurers and Health-Insurers, can offer these products for policy tenure of 1 Year, but not exceeding 5 Years. Group Health Policies can be offered by any insurer for a term of one year except credit linked products where the term can be extended up to the loan period not exceeding five years.
4. No Group Health Insurance Policy shall be issued where a Group is formed with the main purpose of availing itself of insurance. The Group shall have a size as determined by the Insurer which shall be applicable for all its group policies, subject to a minimum of 7.
5. General Insurers and Health Insurers may also offer Credit Linked Group Personal Accident policies for a term extended up to the loan period not exceeding five years.
6. Multiple policies –In case insured has taken health policies from more than one insurance company which provide fixed benefits, each insurer shall make the claim payment, on occurrence of an insured event, independent of payments received from other similar policies in accordance with the terms and conditions of the policies.

   If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to ask for a settlement of his/ her claim in terms of any of his/ her policies. The insurer on whom the claim is made shall make the claim payment and balance claim or claims disallowed under the earlier chosen policy/ policies may be made from the other policy/ policies even if the sum insured is not exhausted in the earlier chosen policy/ policies.

B. IRDA Guidelines on Standardization in health insurance

With so many insurers providing numerous varied products and with different definitions of various terms and exclusions, confusion arose in the market. It became difficult for the customer to compare products and take a considered decision. Moreover, in critical illness policies, there is no clear understanding as to what is meant by critical illness and what is not.

To remove the confusion among insurers, service providers, TPAs and hospitals and the grievances of the insuring public, the regulator tried to provide some kind of standardization in health insurance. Based on a common understanding, IRDA issued Guidelines on standardization in health insurance in 2016 which was further amended in 2020. These are applicable to all General and Health Insurers offering indemnity based Health insurance (excluding PA and Domestic/ Overseas Travel) products (both Individual and Group)

The guidelines now provide for standardization of:

1. definitions of commonly used insurance terms
2. definitions of critical illnesses
3. list of optional items of expenses in hospitalization indemnity policies
4. claim forms and pre-authorization forms
5. billing formats
6. discharge summary of hospitals
7. standard contracts between TPAs, insurers and hospitals
8. standard File and Use format for getting IRDAI for new policies
9. Standardisation of exclusions
10. Exclusions not allowed

C. Hospitalization indemnity product

Hospitalization indemnity products protect individuals from the expenditure they may need to incur in the event of hospitalisation. In most of the cases, they also cover a specific number of days before and after hospitalisation, but exclude any expenses not involving hospitalisation.

Hospitalization indemnity policy popularly called Mediclaim operates on an **'indemnity' basis. It indemnifies the policyholder by covering the expenses** during hospitalisation. **Some expenses that are not covered are specified in the policy document.**

Example

Raghu has a small family consisting of his wife and a 14 year old son. He has taken a Mediclaim policy, covering each member of his family, from a health insurance company, for an individual cover of Rs. 1 lakh each. Each of them could get recovery of medical expenses up to Rs. 1 lakh in case of hospitalization.

Raghu was hospitalized due to heart attack and required surgery. The medical bill raised was Rs. 1.25 lakhs. The insurance company paid Rs 1 lakh according to the plan coverage and Raghu had to pay the remaining amount of Rs. 25,000 from his own pocket

The main features of the indemnity based Mediclaim policy are detailed below, **though variations in limits of cover, additional exclusions or benefits or some add-ons may apply to products marketed by each insurer**.

1. Inpatient hospitalization expenses

The policy pays the insured the cost of hospitalization expenses incurred on account of illness/ accident. The policy has a minimum prescribed period of hospitalization (generally 24 hours) after which the policy provisions come into force. However once this period is reached then the expenses for the entire period become payable.

Most of the expenses related with the treatment are paid, yet certain expenses that includes items of personal comfort, cosmetic surgeries are not. It is therefore important for the customer to be made aware of the excluded items of expenses that are not covered under the policy.

i. Room, boarding and nursing expenses as provided by the hospital/ nursing home. This includes nursing care, RMO charges, IV fluids/ blood transfusion/ injection administration charges and similar expenses

ii. Intensive Care Unit (ICU) expenses

iii. Surgeon, anaesthetist, medical practitioner, consultants, specialists fees

iv. Anaesthetic, blood, oxygen, operation theatre charges, surgical appliances,

v. Medicines and drugs,

vi. Dialysis, chemotherapy, radiotherapy

vii. Cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents

viii. Relevant laboratory/ diagnostic tests and other medical expenses related to the treatment

ix. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

2. Day Care Procedures

There are many surgeries that do not require can be conducted at specialized hospitals. Treatments such as eye surgeries, chemotherapy; dialysis etc. can be classified under day-care surgeries and the list is ever growing. These are also covered under the policy.

3. OPD cover

Coverage of outpatient expenses is still very limited in India, with few such products offering OPD covers. However there are some plans that provide cover treatment as outpatient and also related health care expenses associated with doctor visits, regular medical tests, dental and pharmacy costs.

4. Pre and post hospitalization expenses

i. Pre hospitalization expenses

Hospitalization could be either emergency hospitalization or planned. If a patient goes in for a planned surgery, there would be expenses incurred by him prior to the hospitalization. Such expenses are known as Pre hospitalisation expenses

Definition

It means medical expenses incurred during a predefined number of days preceding the hospitalization of the Insured Person, provided that these expenses are incurred immediately before the insured person is hospitalized and

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
Pre hospitalization expenses could be in the form of tests, medicines, doctors' fees etc. Such expenses relevant and pertaining to the hospitalization are covered under the health policies.

ii. Post hospitalization expenses

After stay in the hospital, in most cases there would be expenses related to recovery and follow-up immediately after the insured is discharged from hospital.

Both these two types of expenses are admissible if
a) They are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days after hospitalization and will be considered as part of claim.
Post hospitalization expenses could be in the form of medicines, drugs, review by doctors etc. after discharge from hospital. Such expenses have to be related to the treatment taken in hospital and are covered under the health policies.

Though the duration of cover for pre and post hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for **thirty days pre and sixty days post hospitalization**.

Pre and post-hospitalization expenses form part of the overall sum insured for which cover is granted under the policy.

iii. Domiciliary Hospitalization

iv. There is also a benefit available for patients whose illness otherwise needs hospitalisation but avail treatment at home either for accommodation in hospitals or in a position that they cannot be moved to a hospital.

To prevent misuse of the provision, this cover usually carries an **excess clause of three to five days** meaning that treatment costs for the first three to five days have to be borne by the insured. The cover excludes domiciliary treatments for certain chronic or common ailments such as Asthma, Bronchitis, Diabetes Mellitus, Hypertension, Influenza Cough, Cold, and fevers etc.

Example

Mira had taken a health insurance policy for coverage of expenses in the event of hospitalisation. The policy had a clause for initial waiting period of 30 days. Unfortunately, 20 days after she took the policy, Mira contracted malaria and was hospitalised for 5 days. She had to pay heavy hospital bills.

When she asked for reimbursement from the insurance company, they denied payment of the claim because the event of hospitalization occurred within the waiting period of 30 days from taking the policy.

a) COVERAGE OPTIONS AVAILABLE

i. **Individual coverage:** An individual insured can cover himself along with family members such as spouse, dependent children, dependent parents, dependent parents in law, dependent siblings etc. Some insurers do not have a restriction on the dependents who can be covered. It is possible to cover each of such dependent insured's under a single policy with a separate sum insured chosen for each insured person. In such covers, each person insured under the policy can claim up to the maximum amount of his sum insured during the currency of the policy. Premium will be charged for each individual insured according to his age and sum insured chosen and any other rating factor.

ii. **Family floater:** In the variant known as a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

Example

If a floater policy of Rs. 5 lacs is taken for a family of four, it means that during the policy period, it will pay for claims related to more than one family member or multiple claims of a single member of the family. All these together cannot exceed the total coverage of Rs. 5 lacs. Premium will normally be charged based on the age of the oldest member of the family proposed for insurance

The covers and exclusions under both these policies would be the same. Family floater policies are getting popular in the market as the entire family gets coverage for an overall sum insured which can be chosen at a higher level at a reasonable premium.

Pre-Existing diseases

Insurance is designed to cover accidents/ diseases etc. that happen unexpectedly. Covering the costs of treating existing medical conditions is not part of insurance, as it is unfair to healthy people who would have to pay for the existing illnesses of

some others. It goes against the principle of creating risk pools covering similarly placed risks. So, it is very important to collect details of the existing ailments/ injuries of each insured person before issuing a health policy. This will enable the insurer to decide on accepting the proposal for insurance, charging proper premiums and/ or providing additional conditions for those who are more likely to make claims.

What is a pre-existing disease?
Diseases suffered by an insured person within 48 months prior to commencement of the policy are regarded as pre-existing diseases. Based on the same logic, insurers are not allowed to exclude pre-existing diseases after a person is covered for insurance continuously for 48 months.

Renewability: Although Healthcare policies have a contract life of one year, and a fresh policy is to be issued every year, Lifelong renewability has been made compulsory by IRDAI for all policies.

SPECIAL FEATURES

In order to provide new features in the product as also to maintain the pricing, insurance companies have come out innovative modifications in the products. For example, the Mediclaim Policy, which was the most popular policy before 2000, has undergone many changes and new special features have been added to the coverage. Some features have been added to the basic indemnity cover. These features may vary from insurer to insurer and product to product and may not be available uniformly for all products.

i. Sub limits and Disease specific capping

Some of the products have disease specific capping e.g. cataract. A few also have sub limits on room rent linked to sum insured e.g. per day room rent restricted to 1% of sum insured and ICU charges to 2% of sum insured. As expenses under other heads such as ICU charges, OT charges and even surgeon's fees are linked to the type of room opted for, room rent capping helps in restricting expenses under other heads also and hence the overall hospitalization expenses.

ii. Co-payment (popularly called Co-pay)

Co-payment is defined by IRDAI as a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
Co-payment is the concept of the insured bearing a portion of each and every claim under a health policy. These could be compulsory or voluntary depending on the product. Co-payment brings in a certain discipline among the insured to avoid unnecessary hospitalizations. This ensures that the insured exercises caution in selecting his healthcare options and avoids luxurious ones.

When an insured event occurs, many health policies require the insured to share a part of the insured loss. E.g. If the insured loss is INR 20000 and the co-pay amount is 10% in the policy, then insured pays INR 2000.

iii. Deductible/ Excess

As explained in Chapter 5, 'Deductible', also called 'Excess' is a cost-sharing provision. Under a health insurance policy, it provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/ hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. In Health policies, it is the fixed amount of money the insured is required to pay initially before the claim is paid by insurer, for e.g. if the deductible in a policy is Rs. 10,000, the insured pays first Rs. 10,000 in each insured loss claimed for. To illustrate, if the claim is for Rs. 80,000, the insured bears the first Rs. 10,000 and the insurer pays Rs. 70,000. A deductible does not reduce the Sum Insured.

Deductible may also be a specified number of days/ hours in case of hospital cash policies which will apply before any benefits are payable by the insurer.

An agent must examine and inform the insured whether the deductible is applicable per year, per life or per event and the specific deductible to be applied.

iv. Waiting Period

A waiting period of 30 days from inception of policy is normally applicable in most policies for making any claim. This however will not be applied for hospitalization due to an accident.

v. Waiting periods for specific diseases

This is applicable for diseases for which treatment can be delayed and planned. Depending on the product waiting periods of one/ two/ four years are imposed by the insurance companies and claims are paid for these ailments only after expiry of this period. Some of the diseases are Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders etc.

vi. Coverage for Day care procedure

Advancement of medical science has seen inclusion of large number of procedures under day care category as already discussed earlier

vii. Cost of pre policy check up

Cost of medical examination was earlier borne by prospective clients. Now insurer reimburses the cost, provided the proposal is accepted for underwriting, the reimbursement varying from 50% to 100%.Now this has also been mandated by IRDAI that insurer would bear at least 50% of health check-up expenses.

viii. Add on covers

Various new additional covers called Add-on covers have been introduced by some of the insurers. Some of them are:

- ✓ **Maternity cover:** Maternity was not offered earlier under retail policies but is now offered by most insurers, with varying waiting periods.
- ✓ **Critical illness cover:** Available as an option under the high end version products for certain ailments which are life threatening and entail expensive treatment.
- ✓ **Reinstatement of sum insured:** After payment of claim, the sum insured (which gets reduced on payment of a claim) can be restored to the original limit by paying extra premium.
- ✓ **Coverage for AYUSH – Ayurveda - Yoga - Unani - Siddha – Homeopath: A f**ew policies cover expenses towards AYUSH treatment up to a certain percentage of the hospitalization expenses.

ix. Value added covers

Few indemnity products include value added covers as listed below. The benefits are payable up to the limit of sum insured specified against each cover in the schedule of the policy, not exceeding the overall sum insured.

- ✓ **Outpatient cover:** Health insurance products in India mostly cover only in-patient hospitalization expenses. Few companies now offer limited cover for out-patient expenses under some of the high-end plans.

- ✓ **Hospital cash:** This provides for fixed lump sum payment for each day of hospitalization for a specified period. Normally the period is granted for 7 days excluding the policies deductible of 2/ 3 days. Thus, the benefit would trigger only if hospitalization period is beyond the deductible period. This is in addition to the hospitalization claim but within the overall sum insured of the policy or may be with a separate sub-limit.

- ✓ **Recovery benefit:** Lump sum benefit is paid if the total period of stay in hospital due to sickness and/ or accident is not less than 10 days.

- ✓ **Donor's expenses:** The policy provides for reimbursement of expenses towards donor in case of major organ transplant as per the terms and condition defined in the policy.

- ✓ **Reimbursement of ambulance:** Expenses incurred towards ambulance by Insured/ insured person are reimbursed up to a certain limit specified in the schedule of the policy.

- ✓ **Expenses for accompanying person:** This is intended to cover the expenses incurred by accompanying person towards food, transportation whilst attending to insured patient during the period of hospitalization. Lump sum payment or reimbursement payment as per the policy terms is paid, up to the limit specified in the schedule of the policy.

- ✓ **Family definition:** Definition of family has undergone changes in few health products. Earlier, primary insured, spouse, dependent children were granted

cover. Now there are policies where parents and in-laws can also be granted cover under the same policy.

x. Failure to seek or follow medical advice or failure to follow treatment

Initially the health insurance cover was denied to persons suffering from pre-existing diseases. Such cases are now being offered cover by excluding such diseases.

Standard Health Product – Arogya Sanjeevani: In the background of the Covid-19 pandemic, IRDAI asked all Insurance Companies to come out with a standard health product called Arogya Sanjeevani with no variations in terms and conditions to make it easy to understand. The premium may however vary according to the pricing policy of each company. This is to ensure better penetration of Health Insurance in market. All Insurers are required to offer this product called Arogya Sanjeevani. [The context for this move was that there were different Health Insurances available in the market and customers were not able to compare them, causing confusion.]

The following two types of plans are available under Arogya Sanjeevani Insurance Policy:

- **Individual Plan**: A single policyholder will be the beneficiary of Arogya Sanjeevani policy.
- **Family Floater Plan**: Multiple family members of the policyholder can become the beneficiaries of Arogya Sanjeevani plan.

This product comes with a capping on room rent and ICU charges but it also covers modern day treatment and stem cell therapy with 50% capping.

D. Top-up covers or high deductible insurance plans

A top-up cover is also known as a high deductible policy. Top-Up policies by insurers, provide cover for high sums insured over and above a specified amount (called threshold).This policy works along with a basic health cover having a low sum insured and comes at a comparatively reasonable premium. For example, Individuals covered by their employers can also opt for a top-up cover for additional protection (keeping the sum insured of the first policy as the threshold).

To be eligible to receive a claim under the top-up policy, the medical costs must be greater than the deductible (or threshold) level chosen under the plan and the reimbursement under the high deductible plan would be the amount of expense incurred i.e. greater than the deductible.

Example

An individual is covered for a sum insured of Rs. 3 lacs by his employer. He could opt for a top-up policy of Rs. 10 lacs in excess of Rs. Three lacs. If the cost of a single hospitalization is Rs. 5 lacs, the basic policy would cover up to Rs. Three lacs only. With the top-up cover, the balance sum of Rs. Two lacs would be paid out by the top-up policy.

Top-up policies come cheap and the cost of a single Rs. 10 lacs policy would be far higher than the top-up policy of Rs. 10 lacs in excess of Rs. Three lacs.

These covers are available on individual basis and family basis the top-up plan requires the deductible amount to be crossed at every single event of hospitalization. However some top-up plans that allow the deductible to be crossed post a series of hospitalizations during the policy period are known as Aggregate based high deductible plans or Super top-up cover as known in the Indian market. A super top-up plan covers the total of all hospitalisation bills (up to the super top-up plan limit) above the deductible amount, that is, the deductible is applied to the total claims in one year. Hence, once the deductible is paid, the plan becomes active for subsequent claims.

E. Senior Citizen Policy

These plans are designed to offer cover to elderly people who often were denied coverage after certain age (e.g. people over 60 years of age). The structure of the coverage and exclusions are much like a hospitalization policy.

Special attention is paid to diseases of the elderly in setting coverage and waiting period. Entry age is mostly after 60 years and renewable lifelong. Sum insured range from Rs. 50,000 to Rs. 5,00,000. There is variation of waiting period applicable to certain ailments.

Example: Cataract may have 1 year waiting for one insurer and 2 year waiting period for some other insurer.

Example: Sinusitis does not fall in waiting period clause of some insurers but few others include it in their waiting period clause.

Some policies have waiting periods or capping in respect of Pre-existing diseases. Pre-post hospital expenses are either paid as a percentage of hospital claims or a sub limit whichever is higher. In some policies they follow the typical indemnity plans such as expenses falling within specified period of 30/ 60 days or 60/ 90 days.

IRDAI has mandated that all health insurers and TPAs shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

F. Fixed benefit covers – Hospital Cash, Critical Illness

Under this cover, the insured gets a fixed sum as claim amount irrespective of the amount spent by him for the named treatment. In this product, commonly occurring treatments are listed under segments such as ENT, Ophthalmology, Obstetrics and Gynaecology, etc. and the maximum pay out for each of these is spelt out in the policy.

These policies are simple as only proof of hospitalization and coverage of ailment under the policy are sufficient to process the claim. Some products package a daily cash benefit along with the fixed benefit cover.

A provision is made to pay a fixed sum for surgeries/ treatment which do not find a place in the list named in the policy. Multiple claims for different treatments are possible during the policy period. However the claims are finally limited by the sum insured chosen under the policy.

Some of the fixed benefit insurance plans are:

- ✓ Hospital daily cash insurance plans
- ✓ Critical illness insurance plans

1. HOSPITAL DAILY CASH POLICY

a) Per day amount limit

Hospital cash coverage provides a fixed sum to the insured person for each day of hospitalization. Per day cash coverage could vary from (for example) Rs. 1,500 per day to Rs. 5,000 or even more per day. An upper limit is provided on the daily cash pay-out per illness as well as for the duration of the policy, which is usually an annual policy.

b) Number of payment days

In some of the variants of this policy, the number of days of daily cash allowed is linked to the disease for which treatment is being taken. A detailed list of treatments and duration of stay for each is stipulated which limits the daily cash benefit allowed for each type of procedure/ illness.

c) Standalone cover or add-on cover

The hospital daily cash policy is available as a standalone policy as offered by some insurers while, in other cases, it is an add-on cover to a regular indemnity policy. These policies help the insured to cover incidental expenses as the pay-out is a fixed sum and not related to the actual cost of treatment. This also allows the pay out under the policy to be provided in addition to any cover received under an indemnity based health insurance plan.

d) Supplementary cover

These policies could supplement a regular hospital expenses policy as it is cost effective and provides compensation for incidental expenses and also expenses not payable under the indemnity policy such as exclusions, co-pay etc.

e) Other advantages of the cover

From the insurer's point of view, this plan has several advantages as it is easy to explain to a customer and hence can be sold more easily. It beats medical inflation as a fixed sum per day is paid for the duration of hospitalization whatever may be the actual expense. Also, acceptance of such insurance covers and claims settlements are really simplified.

2. CRITICAL ILLNESS POLICY

With advancement in medical science, people are surviving some of the major diseases like cancer, strokes and heart attack etc., which in earlier times would have resulted in death. However surviving a major illness entails huge expense for treatment as well as for living expenses post treatment. Onset of critical illness threatens the financial security of a person. A basic health insurance policy may not be sufficient to cover all medical costs in such cases.

Critical illness policy has a provision to pay a lump sum amount on diagnosis of certain named critical illness. The sum insured is high to take care of large expenses.

In India, Critical Illness (CI) benefits are most commonly sold by life insurers as riders to life policies and two forms of cover are offered by them – accelerated CI benefit plan and standalone CI benefit plan. To avoid confusion, the definitions of 22 most common critical illnesses have been standardized under IRDA Health Insurance Standardization guidelines.

The critical illnesses covered vary across insurers and products. Generally 100% of the sum insured is paid on diagnosis of a critical illness. In some cases compensation could vary from 25% to 100% of sum insured depending on the policy terms and conditions and severity of illness.

There is a waiting period of 90 days from inception of policy for any benefit to become payable under the policy and the survival clause of 30 days after diagnosis of the illness. Rigorous medical examinations are to be undergone for persons especially over 45 years of age.

The policy terminates, once compensation is paid under the policy in respect of any of the insured person. This policy is also offered to groups especially corporates who take policies for their employees.

Disease Specific Products- Corona Kavach

In June 2020, when the country was facing many cases of Corona Virus infection (Covid-19), the market saw the introduction of many benefit based products providing lump sum payment on the diagnosis of Covid-19 positive. Later some companies introduced indemnity based products too. However, there were many consumables like PPE kits, Oximeter etc. and quarantine expenses that were not taken care of in these products.

IRDAI came up with two standard Health Insurance Policies called *Corona Kavach* and *Corona Rakshak (discussed separately under Life insurance section)*. While it is mandatory for general and health insurers to provide *Corona Kavach* as an indemnity-based standard COVID-19 product, *Corona Rakshak,* offering the benefit-based product, is optional for all insurers. Both products have a waiting period of 15 days.

Corona Rakshak is a standard benefit based health insurance designed for providing lump sum benefit to insured individuals affected by COVID-19 and require hospitalisation for a minimum continuous period of 72 hours. The plan offers coverage on individual basis for people between the age of 18 years and 65 years, with different policy terms of 3.5months, 6.5 months and 9.5 months as a one-time benefit policy and terminates upon the payment of benefit. *Corona Rakshak* offers sum insured options ranging from Rs. 50,000 to Rs. 2.5 lakh, in multiples of 50,000.The policy provides (i) complete sum insured benefit, (ii) economical premium, (iii) lump-sum amount of claim, (iv) a short waiting period of 15 days and (v) tax benefits.

Corona Kavach offers the following coverage vide Guidelines issued by IRDAI in June 2020:

1. Hospitalization Expenses incurred for the treatment of Covid-19 on Positive diagnosis of Covid-19 in a government authorized diagnostic centre covering the following: (Expenses on Hospitalization for a minimum period of 24 hours are admissible.)

    a. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
    b. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees
    c. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, ventilator charges, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, PPE Kit, gloves, mask and such other similar expenses
    d. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
    e. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

2. Home Care Treatment Expenses for availing treatment at home up to maximum 14 days per incident subject to the conditions (not exhaustive) mentioned below:
    a. The Medical practitioner advices the Insured person to undergo treatment at home.
    b. There is a continuous monitoring of the health status by a medical practitioner for each day, including records of treatment administered.

3. Other Expenses covered if prescribed by the treating medical practitioner and related to treatment of COVID,
    a. Diagnostic tests undergone at home or at diagnostics centre
    b. Medicines prescribed in writing
    c. Consultation charges of the medical practitioner
    d. Nursing charges related to medical staff
    e. Medical procedures limited to parenteral administration of medicines
    f. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer

Additional Cover - Hospital Daily Cash: The Insurer will pay 0.5% of sum insured per day for each 24 hours of continuous hospitalization for treatment of Covid following an admissible hospitalization claim under this policy.

Standard Vector Borne Disease Health Policy:

IRDAI vide its Guidelines dated 3 February 2021 decided that Standard Products for vector borne diseases shall offer the following coverage:

1. **Hospitalization Benefit:** Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of any of the following vector borne disease (s) requiring hospitalization for a minimum continuous period of 72 hours.
   a) Dengue fever
   b) Malaria
   c) Filaria (Lymphatic Filariasis)
   d) Kala-azar
   e) Chikungunya
   f) Japanese Encephalitis
   g) Zika Virus

2. **Diagnosis Cover:** 2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under "diagnosis cover" payment for each disease only once in the policy year.

G. Combo-products

Health plus Life Combo Products offer the combination of a life insurance cover of a Life Insurance Company and a health insurance cover offered by Non-Life and/ or Standalone Health Insurance Company.

The product may be offered both as individual insurance policy and on group insurance basis. However in respect of health insurance floater policies, the pure term life insurance coverage is allowed on the life of one of the earning members of the family who is also the proposer on health insurance policy subject to insurable interest and other applicable underwriting norms of respective insurers.

Package policies

Package or umbrella covers give, under a single document, a combination of covers.

Examples of package policy in health insurance include combining Critical illness cover benefits with indemnity policies and even life insurance policies and hospital daily cash benefits with indemnity policies.

Travel Insurance:

Travel insurance policy is also offered as a package policy covering not only health insurance but also accidental death/ disability benefits along with Medical expenses due to illness/ accident and the coverages like Loss of or delay in arrival of checked in baggage, Loss of passport and documents, Third party liability for property/ personal damages, Cancellation of trips and even Hijack cover traditionally provided under travel policies. (Details of Travel Insurance are provided later.)

H. Micro insurance and health insurance for poorer sections

Micro-insurance products are specifically designed to aim for the protection of low income people from rural and informal sectors. It is a low value product, with an affordable premium and benefit package. Micro insurance is governed by the IRDA Micro Insurance Regulations, 2005.

Such covers are mostly taken on a group basis by various community organizations or non-governmental organizations (NGOs) for their members.

Two policies particularly created by PSUs to cater to the poorer sections of society are Jan Arogya Bima Policy and Universal Health Scheme. The private sector insurance companies have also come out with many innovative micro insurance health products to cater to this target segment like Bima Kavach Yojana, Grameena Jeevan Raksha Plan, Bhaghya Laxmi - the entire list can be found on IRDAI website.

I. Rashtriya Swasthya Bima Yojana

The government has also launched various health schemes, some of them applicable to particular states. It had implemented the Rashtriya Swasthya Bima Yojana (RSBY) in association with insurance companies to provide health insurance coverage for the below poverty line (BPL) families. However RSBY provided a Sum Insured of only Rs 30,000 which was not considered enough to cover major surgeries/ hospitalisation expenses.

J. Pradhan Mantri Jan Arogya Yojana

To address the shortcomings of RSBY, as recommended by the National Health Policy 2017, the Government of India launched 'Ayushman Bharat Scheme' in 2017, a flagship scheme of to achieve the vision of Universal Health Coverage (UHC). Also known as Pradhan Mantri Jan Arogya Yojana (PMJAY) Ayushman Bharat came with a Sum Insured of Rs. 5,00,000.

It subsumed the then existing Rashtriya Swasthya Bima Yojana (RSBY). PM-JAY is fully funded by the Government and cost of implementation is shared between the Central and State Governments.

K. Pradhan Mantri Suraksha Bima Yojana

Features of the recently announced PMSBY covering personal accident death and disability cover are as follows:

Scope of coverage: All savings bank account holders in the age 18 to 70 years in participating banks are entitled to join through one savings bank account only and if he enrols in more than one bank, he gets no extra benefit and the extra premium paid will stand forfeited. Aadhaar would be the primary KYC for the bank account.

Enrolment Modality/ Period: The cover shall be for the one year period from 1st June to 31st May for which option to join/ pay by auto-debit from the designated savings bank account on the prescribed forms will be required to be given by 31st May of every year,

Joining subsequently on payment of full annual premium may be possible on specified terms. Individuals who exit the scheme at any point may re-join the scheme in future years through the above modality.

Benefits under the insurance are as follows:

Table of Benefits	Sum Insured
Death	Rs. 2 Lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of hand or foot	Rs. 2 Lakh
Total and irrecoverable loss of sight of one eye or loss of use of one hand or foot	Rs. 1 Lakh

Joining and Nomination facility is available by SMS, email or personal visit.

Premium: Rs.12/- per annum per member. The premium will be deducted from the account holder's savings bank account through 'auto debit' facility

Termination of cover: The accident cover for the member shall terminate:

1. On member attaining the age of 70 years (age nearest birth day) or
2. Closure of account with the Bank or insufficiency of balance to keep the insurance in force or

If the insurance cover is ceased due to any technical reasons such as insufficient balance on due date or due to any administrative issues, the same can be reinstated on receipt of full annual premium, subject to conditions that may be laid down.

L. Personal Accident and Disability cover

A **Personal Accident (PA) Cover** provides compensation due to death and disability in the event of unforeseen accident.

In a PA policy,

a) The death benefit is payment of 100% of the sum insured,

b) In the event of disability, compensation varies from a fixed percentage of the sum insured in the case of permanent disability

c) Weekly compensation for temporary disablement.

Weekly compensation means payment of a fixed sum per week of disablement subject to a maximum limit in terms of number of weeks for which the compensation would be payable.

1. Types of disability covered

Types of disability which are normally covered under the policy are:

i. **Permanent total disability (PTD):** means becoming totally disabled for lifetime viz. paralysis of all four limbs, comatose condition, loss of both eyes/ both hands/ both limbs or one hand and one eye or one eye and one leg or one hand and one leg,

ii. **Permanent partial disability (PPD):** means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.

iii. **Temporary total disability (TTD):** means becoming totally disabled for a temporary period of time. This section of cover is intended to cover the loss of income during the disability period.

The client has choice to select only death cover or death plus permanent disablement of Or Death plus permanent disablement and also temporary total disablement.

2. Sum insured

Sums insured for PA policies are usually decided on the basis of gross monthly income. Typically, it is 60 times of the gross monthly income. However, some insurers also offer on fixed plan basis without considering the income level. In such policies sum insured for each section of cover varies as per the plan opted.

3. Personal Accident Insurance – a Benefit plan

Being a benefit plan, PA policies are not subject to the principle of 'contribution' at the time of claim. Thus, if a person has more than one policy with different insurers, claims would be paid under all the policies.

4. Scope of cover

These policies are often extended to cover medical expenses, i.e. reimbursement of hospitalization/ medical costs incurred following the accident.

5. Value added benefits

Along with personal accident, many insurers also offer value added benefits like hospital cash on account of hospitalization due to accident, cost of transportation of mortal remains, education benefit for a fixed sum and ambulance charges on the basis of actual or fixed limit whichever is lower.

6. Exclusions:

Common exclusions under Personal Accident insurance are accidents arising out of disability existing prior to the inception of policy, death or disability due to mental disorders or any sickness, injury due to war, invasion, culpable homicide or murder, intentional self-injury, suicide, intake of drugs/ alcohol, injury while engaging in defined extra hazardous activity like aviation or ballooning . This is an indicative list and can vary from company to company.

PA policies are offered to individuals, family and also to groups.

Group Personal Accident Policies

Group Personal Accident Policies are usually annual policies with renewals being allowed on the anniversary. However, non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to specific events.

Broken bone policy and compensation for loss of daily activities

This is a specialised PA policy. This policy is designed to provide cover against listed fractures. Fixed benefit or percentage of sum insured mentioned against each fracture is paid at the time of claim. Quantum of benefit depends on the type of bone covered and nature of fracture sustained.

M. Overseas Travel insurance

Need for the policy: To cover expenses of accidental injury or hospitalisation whilst travelling outside India for business, holidays or studies. , The cost of medical care, especially in countries such as USA and Canada, is very high and could cause major financial problems.

Scope of coverage

Such policies are primarily meant for accident and sickness benefits, but most products available in the market package a range of covers within one product.

The usual covers offered are:

a) Medical and sickness section:
   i. Accidental death/ disability
   ii. Medical expenses due to illness/ accident

b) Repatriation and evacuation

c) Personal accident cover

d) Personal liability

e) Other non-medical covers:
   i. Trip Cancellation
   ii. Trip Delay
   iii. Trip interruption
   iv. Missed Connection
   v. Delay of Checked Baggage
   vi. Loss of Checked Baggage
   vii. Loss of Passport
   viii. Emergency Cash Advance
   ix. Hijack Allowance
   x. Bail Bond insurance
   xi. Hijack cover
   xii. Sponsor Protection
   xiii. Compassionate Visit
   xiv. Study Interruption
   xv. Home burglary

1. Types of plans

The popular policies are the Business and Holiday Plans, the Study Plans and the Employment Plans.

2. Who can take the policy

An Indian citizen travelling abroad on business, holiday or for studies can avail this policy. Employees of Indian employers sent on contracts abroad can also be covered.

3. Sum insured and premiums

The cover is granted in US Dollars and generally varies from USD 100,000 to USD 500,000 for the section covering medical expenses, evacuation and repatriation. For other sections the Sum Insured is lower, except for the liability cover. Premiums can be paid in Indian rupees except in the case of the employment plan where premium has to be paid in dollars. The plans are usually of two types:

- ✓ World-wide excluding USA/ Canada

- ✓ World-wide including USA/ Canada

Some products provide cover for a group of countries. Examples are travel to Asian countries only, European countries only or travel to a particular country only.

Corporate Frequent Flyer plans

This is an annual policy whereby a corporate/ employer takes individual policies for its executives who frequently make trips outside India. This cover can also be taken by individuals who fly overseas many times during a year. An advance premium is paid based on the estimated man days of travel in a year by a company's employees. The above policies are granted only for business and holiday travels. Pre-existing diseases are usually excluded for Overseas Medical/ Travel Insurances.

N. Group Health cover

1. GROUP POLICIES

As explained earlier in the chapter a group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals. These policies are usually, one year renewable contracts.

Features of group policies - Hospitalisation benefit covers.

1. **Scope of coverage**

   The most common form of group health insurance is the policy taken by employers covering employees and their families including dependent spouse, children and parents/ parents in law.

2. **Tailor-made cover**

   Group policies are often tailor-made covers to suit the requirements of the group. Thus, in group policies, one will find several standard exclusions of the individual policy being covered under the group policy.

3. **Maternity cover**

   One of the most common extensions in a group policy is the maternity cover. Maternity cover would provide for the expenses incurred in hospitalization for delivery of child and includes C- section delivery. This cover is generally restricted to a certain amount within the overall sum insured of the family.

4. **Child cover**

   Coverage is given to babies from day one, sometimes restricted to the maternity cover limit and sometimes extended to include the full sum insured of the family.

5. **Pre-existing diseases covered, waiting period waived off**

   Several of the usual exclusions, such as the pre-existing disease exclusion, thirty days waiting period, two years waiting period, congenital diseases may be waived off, in tailor-made group policies.

6. **Premium calculation**

   The premium charged for a group policy is based on the age profile of the group members, the size of the group and most importantly the claims experience of the group.

7. Non-employer employee groups

In India, regulatory provisions strictly prohibit formation of groups primarily for the purpose of taking out a group insurance cover. When group policies are given to other than employers, it is important to determine the relation of the group owner to its members.

Example

A bank taking a policy for its saving bank account holders or credit card holders constitutes a homogenous group, whereby a large group is able to benefit by a tailor-made policy designed to suit their requirements.

8. Pricing

In group policies, there is provision for discount on premium based on size of the group as also the claims experience of the group

2. CORPORATE BUFFER OR FLOATER COVER

In most group policies, each family is covered for a defined sum insured, varying from Rs. One lac to five lacs and sometimes more. There arise situations where the sum insured of the family is exhausted, especially in the case of major illness of a family member. In such situations, if the buffer cover is opted for it brings relief, whereby the excess expenses over and above the family sum insured are met from this buffer amount.

Amounts are drawn from the buffer, once a family's sum insured is exhausted. However this utilization is usually restricted to major illness/ critical illness expenses where a single hospitalization exhausts the sum insured.

O. Special Products

1. Disease covers

In recent years, disease specific covers for cancer, diabetes, Covid-19 have been introduced in the Indian market. The cover is either short term or long term – 5 years to 20 years and a wellness benefit is also included – a regular health check-up paid for by the insurer. There is incentive for better control of factors like blood glucose, blood pressure etc. in the form of reduced premiums from second year of policy onwards. On the other hand, a higher premium would be chargeable for poor control.

2. Product designed to cover diabetic persons

This policy can be taken by persons between 26 and 65 years and is renewable up to 70 years. Sum Insured ranges from Rs. 50,000 to Rs. 5,00,000. Capping on Room rent is applicable. Product is aimed to cover hospitalization complications of diabetes like diabetic retinopathy (eye), kidney, diabetic foot, kidney transplant including donor expenses.

Test Yourself 1

Though the duration of cover for pre-hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for _____ pre-hospitalization.

I. Fifteen days

II. Thirty days

III. Forty Five days

IV. Sixty days

Key terms in health policies **(All the terms are as defined in IRDAI Master Circular on Standardization of Health Insurance Products dated 22.07.2020)**

1. Network Provider

Network provider refers to a hospital/ nursing home/ day care centre which is under tie-up with an insurer/ TPA for providing cashless treatment to insured patients. Patients are free to go to out-of-network providers but there they are generally charged much higher fees.

2. Preferred provider network (PPN)

An insurer has the option to create a preferred network of hospitals to ensure quality treatment and at best rates. When this group is limited to only a select few by the insurer based on experience, utilization and cost of providing care, preferred provider networks get formed.

3. Cashless service

A cashless service enables the insured to avail of the treatment up to the limit of cover without any payment to the hospitals. All that the insured has to do is approach a network hospital and present his medical card as proof of insurance. The insurer facilitates a cashless access to the health service and directly makes payment to the network provider for the admissible amount. However, the insured has to make payment for amounts beyond the policy limits and for expenses not payable as per policy conditions.

4. Third Party Administrator (TPA)

A major development in the field of health insurance is the introduction of the third party administrator or TPA. Several insurers across the world utilize the services of independent organizations for managing health insurance claims. These agencies are known as the TPAs. In India, a TPA is engaged by an insurer for provision of health services which includes among other things:

i. Providing an identity card to the policyholder which is proof of his insurance policy and can be used for admission into a hospital

ii. Providing a cashless service at network hospitals

iii. Processing of claims

TPAs service health policyholders starting from issuance of unique identity cards for hospital admissions up to settlement of claims either on cashless basis or reimbursement basis. Third party administrators enter into an MOU with hospitals or health service providers and ensure that any person who undergoes treatment in the network hospitals is given a cashless service. They are the intermediaries

between the insurer(s) and the insured(s), who co-ordinate with the hospitals and finalize health claims.

5. Hospital

A hospital means any institution established for in-patient care and day care treatment of sickness and/ or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a) Has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;

b) Has qualified nursing staff under its employment round the clock;

c) Has qualified medical practitioner(s) in charge round the clock;

d) Has a fully equipped operation theatre of its own where surgical procedures are carried out;

e) Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

6. Medical practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India or for homeopathy and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. However, insurance companies are free to make a restriction that the registered practitioner should not be the insured or any close family member. This is to ensure fraudulent claims are not lodged by taking treatment from relatives or by self or by hospitals owned by either.

Qualified nurse: Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

7. Reasonable and necessary expenses

A health insurance policy always contains this clause as the policy provides for compensation of expenses that would be deemed to be reasonable for treatment of a particular ailment and in a particular geographical area.

8. Notice of claim

Every insurance policy provides for immediate intimation of claim and specified time limits for document submission. In health insurance policies, wherever cashless facility is desired by the customer, intimations are given well before the hospitalization. However in cases of reimbursement claims the time limit for submission of claim documents is normally fixed at 15 days from the date of discharge.

9. Free health check

In individual health policies, a provision is generally available to give some form of incentive to a claim free policyholder. Many policies provide for reimbursement of the cost of health check-up at the end of four continuous, claim free policy periods.

10. Cumulative bonus

A cumulative bonus is given on the sum insured for every claim free year. This means that the sum insured gets increased on renewal by a fixed percentage say 5% annually and is allowed up to a maximum of 50% for ten claim-free renewals. Moreover, if a claim is made in any particular year, the cumulative bonus accrued can only be reduced at the same rate at which it is accrued.

Example

A person takes a policy for Rs. 3 lacs at a premium of Rs. 5,000. In the second year, in case of no claims in the first year, he gets a sum insured of Rs. 3.15 lacs (5% more than the previous year) at the same premium of Rs. 5,000. This could go up to Rs. 4.5 lacs over a ten year claim free renewal.

11. Malus/ Bonus

Just as there is an incentive to keep the health policy free of claims, the opposite is called a malus. Here, if the claims under a policy are very high, a malus or loading of premium is collected at renewal. However, in case of group policies, the malus is charged by way of loading the overall premium suitably to keep the claim ratio within reasonable limits.

12. No claim discount

Some products provide for a discount on premium for every claim free year instead of a bonus on sum insured.

13. Room rent restrictions

Some health plans place a restriction on the category of room that an insured chooses by linking it to the sum insured. Hence a person with a sum insured of one lac would be entitled to a room of Rs 1,000 per day if the policy has a room rent restriction of 1% of sum insured per day.

14. Renewability clause

The IRDAI guidelines on renewability of health insurance policies makes lifetime guaranteed renewal of the health policies compulsory, except on grounds of fraud and misrepresentation. In accordance to the provisions of IRDAI Health Insurance Regulation 2016, once a proposal is accepted in respect of a health insurance policy (except Personal Accident and Travel Policies) and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on the grounds of age of the Insured. Thus, health insurance policies are renewable lifelong.

15. Cancellation clause

An insurance company may at any time cancel the policy only on grounds of misrepresentation, fraud, and non-disclosure of material fact or non-cooperation by the insured.

When policies are cancelled by the insurer, a proportion of the premium corresponding to the unexpired period of insurance, is returned to the insured provided no claim has been paid under the policy. This is usually on pro-rata basis.

When annual policies are cancelled by the insured, insurers usually charge premiums at Short period scales, instead of pro-rata premiums. This would prevent anti-selection against the insurers and take care of the initial expenses of the insurer.

16. Grace period for renewal

As mentioned in Chapter 4, the Grace Period provision enables a policy that would otherwise have lapsed for non-payment of premium, to continue in force during the grace period.

Most of above key clauses, definitions, exclusions relating to grace period have been standardized under Health Regulations and Health Insurance Standardization Guidelines issued by IRDAI and updated from time to time.

Test Yourself 2

As per IRDA guidelines, a _____ grace period is allowed for renewal of individual health policies.

I. Fifteen days

II. Thirty days

III. Forty Five days

IV. Sixty days

Answers to Test Yourself

Answer 1 - The correct option is II.

Answer 2 - The correct option is II.

CHAPTER H-04
HEALTH INSURANCE UNDERWRITING

Chapter Introduction

This chapter aims to provide you detailed knowledge about underwriting in health insurance. Underwriting is a very important aspect of any type of insurance and plays a vital role in issuance of an insurance policy. In this chapter, you will get an understanding about basic principles, tools, methods and process of underwriting. It will also provide you the knowledge about group health insurance underwriting.

Learning Outcomes

A. What is underwriting?
B. Underwriting – Basic concepts
C. Other health insurance regulations of IRDAI
D. Portability of Health Insurance
E. Basic principles and tools for underwriting
F. Underwriting process
G. Health Insurance at Group Level
H. Underwriting of Overseas Travel Insurance
I. Underwriting of Personal Accident Insurance

After studying this chapter, you should be able to:

a) Explain what is meant by underwriting
b) Describe the basic concepts of underwriting
c) Explain the principles and the various tools followed by underwriters
d) Appreciate the complete process of underwriting individual health policies
e) Discuss how group health policies are underwritten

Look at this Scenario

Manish aged 48 years, working as a software engineer, decided to take a health insurance policy for himself. He went to an insurance company, where they gave him a proposal form in which he was required to answer a number of questions related to his physical build and health, mental health, pre-existing illnesses, his family health history, habits and so on.

On receipt of his proposal form, he was also required to submit many documents such as identity and age proof, proof of address and previous medical records. Then they told him to undergo a health check-up and some medical tests which frustrated him.

Manish, who considered himself a healthy person and with a good income level, started wondering why such a lengthy process was being followed by the insurance company in his case. Even after going through all this, the insurance company told him that high cholesterol and high BP had been diagnosed in his medical tests, which increased the chances of heart diseases later. Though they offered him a policy, the premium was much higher than what his friend had paid and so he refused to take the policy.

Here, the insurance company was following all these steps as part of their underwriting process. While providing risk coverage, an insurer needs to evaluate risks properly and also to make reasonable profit. If the risk is not assessed properly and there is a claim, it will result in a loss. Moreover, insurers collect premiums on behalf of all insuring persons and have to handle these moneys like a trust.

A. What is underwriting?

1. Underwriting

Insurance companies try to insure people who are expected to pay adequate premium in proportion to the risk they bring to the insurance pool. This process of collecting and analysing information from a proposer is known as underwriting. On the basis of information collected through this process, they decide whether they want to insure a proposer. If they decide to do so, then at what premium, terms and conditions so as to make a reasonable profit from taking such risk.

Definition

Underwriting is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted. Thus, it is a process of risk assessment and risk pricing.

2. Need for Underwriting

Underwriting is the backbone of an insurance company as acceptance of the risk carelessly or for insufficient premiums will lead to insurer's insolvency. On the other hand, being too selective or careful will prevent the insurance company from

creating a big pool so as to spread the risk uniformly. It is therefore critical to strike the correct balance between risk and business, thereby being competitive and yet profitable for the organization.

This process of balancing is done by the underwriter, in accordance with the philosophy, policies and risk hunger of the insurance company concerned. Although age affects the chance of sickness as well as death, it must be remembered that sickness usually comes much before death and could be frequent. Hence, it is quite logical that the underwriting norms and guidelines are much tighter for health coverage than death coverage.

3. Underwriting – Risk Assessment

In health insurance, there is a higher focus on medical or health findings than financial or income based underwriting. However, the latter cannot be ignored as there has to be an insurable interest and financial underwriting is important to rule out any adverse selection and ensure continuity in health insurance.

Example

An individual who is diabetic has a far higher chance of developing a cardiac or kidney complication requiring hospitalization than of death, and also health episodes can happen multiple times during the course of insurance coverage. A life insurance underwriting guideline might rate this individual as an average risk. However, for medical underwriting, he would be rated as a higher risk.

4. Factors which affect chance of illness

The factors which affect morbidity (risk of falling ill) should be considered carefully while assessing risk are as follows:

a) **Age:** Premiums are charged corresponding with age and the degree of risk. For e.g. the premiums for infants and children are higher than young adults due to increased risk of infections and accidents. Similarly, for adults beyond the age of 45 years, the premiums are higher, as the probability of an individual suffering from a chronic ailment like diabetes, a sudden heart ailment or other such morbidity is much higher.
b) **Gender:** Women are exposed to additional risk of illness during child bearing period. However, men are more likely to get affected by heart attacks than women or suffer job related accidents than women as they may be more involved in hazardous employment.
c) **Habits:** Consumption of tobacco, alcohol or narcotics in any form has a direct bearing on the morbidity risk.
d) **Occupation:** Extra risk to accidents is possible in certain occupations, e.g. driver, blaster, aviator etc. Likewise, certain occupations may have higher health risks, like an X-Ray machine operator, asbestos industry workers, miners etc.

e) **Family history:** This has greater relevance, as genetic factors influence diseases like asthma, diabetes and certain cancers. This does impact the morbidity and should be taken into consideration while accepting risk.
f) **Build:** Stout, thin or average build may also be linked to morbidity in certain groups.
g) **Past illness or surgery:** It has to be ascertained whether the past illness has any possibility of causing increased physical weakness or even recur and accordingly the policy terms should be decided. For e.g. kidney stones are known to recur and similarly, cataract in one eye increases possibility of cataract in the other eye.
h) **Current health status and other factors or complaints:** This is important to ascertain the degree of risk and insurability and can be established by proper disclosure and medical examination.
i) **Environment and residence:** These also have a bearing on morbidity rates.

Understanding Moral Hazard in Health Insurance

While factors like age, gender, habits etc. refer to the physical hazard of a health risk, there is something else that needs to be closely watched. This is the moral hazard of the client which can prove very costly to the insurance company.

An extreme example of bad moral hazard is that of an insured taking health insurance knowing that he will undergo a surgical operation within a short time but not disclosing this to the insurer. There is thus a deliberate intention of taking insurance just to collect a claim.

Test Yourself 1

Underwriting is the process of _____.
I. Marketing insurance products
II. Collecting premiums from customers
III. Risk assessment and risk pricing
IV. Selling various insurance products

B. Underwriting – Basic concepts

1. Purposes of Underwriting

There are two main purposes for Underwriting.
i. To prevent anti-selection, that is selection against the insurer
ii. To classify risks and ensure equity among risks

Definition

The term **assessment of risks** refers to the process of evaluating each proposal for health insurance in terms of the degree of risk it represents and then deciding whether or not to grant insurance and on what terms.

Anti-selection (or **adverse selection**) is the tendency of people, who suspect or know that their chance of experiencing a loss is high, to seek out insurance eagerly and to gain in the process.

Example

If insurers were not selective about whom and how they offered insurance, there is a chance that people with serious ailments like diabetes, high BP, heart problems or cancer, who knew that they would soon require hospitalization, would seek to buy health insurance, create losses for the insurer. In other words, if an insurer does not assess risk properly, it would be selected against and suffer losses in the process.

2. Equity among risks

Let us now consider equity among risks. "Equity" means that applicants who are exposed to similar types and degrees of risk be placed in the same premium class. Insurers would like to have some type of standardization to determine the premiums to be charged. The proposals that come to the underwriter are classified into following risk types:

i. Standard risks

These are the people whose expected morbidity (chance of falling ill) is average.

ii. Preferred risks

In some cases, the expected morbidity is significantly lower than average and hence are preferred risks. These could be charged a lower premium.

iii. Substandard risks

In some other cases, the expected morbidity may be higher than the average. Though these risks also may be insurable, insurers may charge higher premiums and/or accept them subject to certain conditions and restrictions.

iv. Declined risks

There are some persons who have certain medical or other conditions, which make them highly prone to sicknesses and making claims. It is highly probable that such persons fall sick and cause a disproportionate degree of liability on the common pool. In other words, while others in the pool have a more or less average chance of falling sick, these persons have a very high chance of falling sick making it difficult to insure them even at higher rates of premium. [Sometimes, such persons may be posing a Moral Hazard when they do not reveal their high probability of falling sick and try to get insured like other normal people.] Most insurers decline such risks and create a database of such people for future use.

Being a 'Declined Risk' means only that a particular insurer does not wish to insure a person for that type of insurance product, at that particular point in time. However, it is possible that another insurer might insure him/ her at a different premium and/or with different conditions. The same insurer might also

consider him/ her for another type of policy or even for the same policy at a later date, when the conditions change.

3. Underwriting process

The underwriting process takes place at two levels:

- ✓ At the primary or field level or
- ✓ At the underwriting department level

a) Primary Underwriting

Primary underwriting (or Field level underwriting) includes information gathering by an agent or company representative to decide whether an applicant is suitable for granting insurance coverage. The agent plays this critical role of **primary underwriting**. He is in the best position to know whether prospective client is insurable.

Some insurance companies require the agents to provide a statement or a confidential report, with specific information, opinion and recommendations with respect to the proposer.

A similar kind of report, which has been called as **Moral Hazard report**, may also be sought from an official of the insurance company. These reports typically cover the occupation, income and financial standing and reputation of the person proposed for health insurance.

4. Fraud monitoring role of Agent

Decisions regarding selecting a risk for insurance depends on the facts disclosed by the proposer in the Proposal Form. It would be difficult for an underwriter sitting in the office to know whether these facts are true or have been fraudulently misrepresented with an intention to cheat the insurer.

The agent, **as primary underwriter** plays a significant role here. Since the agent has direct personal contact with the proposer, he or she is in the best position to find out whether the information submitted is true and whether any wilful non-disclosure or misrepresentation has been made.

a) Role of the Underwriting department

The Underwriting department in the insurer's office does the major part of the underwriting. Here, specialists who are proficient in such work, consider and analyse all the relevant data on the particular risk and even some demographical data. They finally decide whether to accept the proposal for insurance, decide the terms, and charge the appropriate premiums.

C. Other Health Insurance regulations of IRDAI

The regulator has also brought in some changes for benefit of the Insured as given below.

a. The insured is to be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
b. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it has prescribed standard forms to be filled up by the insured which forms part of the policy document.
c. Insurers have come out with various mechanisms to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document.

D. Portability of Health Insurance

Portability is defined by IRDAI as **the right** accorded to individual health insurance policyholders (including all members under family cover), **to transfer** the credit gained for pre-existing conditions and time bound exclusions, **from one insurer to another insurer or from one plan to another plan of the same insurer**, provided the previous policy has been maintained without any break.

Portability is the provision by which an Insured can move from one insurer to another carrying with him/ her all the benefits earned over a period of time. Students may please read IRDAI's Consolidated Guidelines on Product filing in Health Insurance Business dated 22 July 2020 lays down norms for standardising many of the practices including Portability.

IRDAI mandates that Portability shall be allowed under all individual indemnity health insurance policies issued by General Insurers and Health Insurers including family floater policies.

However, porting can be done only at the time of renewal. Apart from the waiting period credit, other terms of the new policy including the premium would be decided by the new insurance company. Procedurally, the request for porting should be made by the insured to the old insurer at least 45 days before the renewal, specifying the company to which the policy has to be ported. The policy has to be renewed without a break (there is a 30 day grace period if porting is under process). IRDA has created a web-based facility that maintains data about all health insurance policies issued by insurance companies to individuals, to enable the new insurer to access and obtain data on the porting policyholder's health insurance history in a smooth manner.

E. Migration of Health Insurance

Migration is defined by IRDAI as the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance

policy), **to transfer** the credit gained for pre-existing conditions and time bound exclusions, **with the same insurer**.

IRDAI's Consolidated Guidelines on Product filing in Health Insurance Business dated 22 July 2020 revised the guidelines on Migration of health insurance policies. It provides that every individual policyholder (including members under family floater policy) covered under an indemnity based individual health insurance policy shall be provided an option of migration at the explicit option exercised by the policyholder. Migration from group policies to individual policy will be subject to underwriting.

A policyholder desirous of migrating his/ her policy shall be allowed to apply to the insurance company to migrate the policy along with all members of the family, if any, at least 30 days before the premium renewal date of his/her existing policy. However, if the insurer is willing to consider even less than 30 days period, then the insurer may do so. Insurers shall not levy any charges exclusively for migration.

F. Basic principles of insurance and tools for underwriting

1. Basic principles relevant to underwriting

In any form of insurance, whether it is life insurance or general insurance, there are certain legal principles which operate along with acceptance of risks. Health insurance is equally governed by these principles and any violation of the principles may result in the insurer deciding to avoid the liability. (These principles have been discussed in the common chapters.)

2. Tools for underwriting

These are the sources of information for the underwriter and the basis on which the risk classification is done and premiums finally decided. The following are the key tools for underwriting:

a) Proposal form

This document is the base of the contract where all the critical information pertaining to the health and personal details of the proposer (i.e. age, occupation, build, habits, health status, income, premium payment details etc.) are collected. Any breach or concealment of information by the insured shall render the policy void. (This has been discussed in the common chapters.)

b) Age proof

Premiums are determined on the basis of the age of the insured. Hence it is imperative that the age disclosed at the time of enrolment is verified through submission of an age proof.

Example

In India, there are many documents which can be considered as age proof but all of them are not legally acceptable. Mostly valid documents are divided into two broad categories. They are as follows:

a) Standard age proof: Some of these include school certificate, passport, domicile certificate, PAN card etc.
b) Non-standard age proof: Some of these include ration card, voter ID, elder's declaration, gram panchayat certificate etc.

Financial documents

Knowing the financial status of the proposer is particularly relevant for benefit products and to reduce the moral hazard. However, normally the financial documents are only asked for in cases of:

a) Personal accident covers or
b) High sum assured coverage or
c) When the stated income and occupation as compared to the coverage sought, show a mismatch.

c) Medical reports

Requirement of medical reports is based on the norms of the insurer, and usually depends upon the age of the insured and sometimes on the amount of cover opted. Some replies in the proposal form may also contain some information that leads to medical reports being asked for.

d) Reports of sales personnel

Sales personnel can also be seen as grassroots level underwriters for the company and the information given by them in their report could form an important consideration. However, as the sales personnel have an incentive to generate more business, there is a conflict of interest which has to be watched out for.

Test Yourself 2

The principle of utmost good faith in underwriting is required to be followed by _____.

I. The insurer
II. The insured
III. Both the insurer and the insured
IV. The medical examiners

Test Yourself 3

Insurable interest refers to _____.

I. Financial interest of the person in the asset to be insured
II. The asset which is already insured

III. Each insurer's share of loss when more than one company covers the same loss
IV. The amount of the loss that can be recovered from the insurer

G. Underwriting process

Once the required information is received, the underwriter decides the terms of the policy. The common forms used for underwriting health insurance business are as below:

1. Medical underwriting

Medical underwriting is a process in which medical reports are called for from the proposer to determine the health status of an individual applying for health insurance policy. The health information collected is then evaluated by the insurers to determine whether to offer coverage, up to what limit and on what conditions and exclusions. Thus medical underwriting can determine the acceptance or declining of a risk and also the terms of cover.

Example

Medical conditions like hypertension, overweight/ obesity and raised sugar levels have a high probability of future hospitalization for diseases of the heart, kidney and the nervous system. So, these conditions should be carefully considered while assessing the risk for medical underwriting.

Medical underwriting guidelines may also require a signed declaration of the proposer's health status by his/ her family physician.

Persons above the age of 45-50 years, enrolling for the first time are normally required to undergo specified pathological investigations to assess health risk profile and to obtain information on their current health status. Such investigations also provide an indication of prevalence of any pre-existing medical conditions or diseases.

2. Non-medical underwriting

Most of the proposers which apply for health insurance do not need medical examination.

Even, if the proposer were to disclose all material facts completely and truthfully and the same were checked by agent carefully, then also the need for medical examination could be much less.

Example

If an individual has to take health insurance coverage quickly without going through a long process of medical examinations, waiting periods and processing delays, then he can opt for a non-medical underwriting policy. In a non-medical underwriting

policy, premium rates and sum assured are usually decided on the basis of answers to a few health questions mostly based on age, gender, smoking class, build etc. The process is speedy but the premiums may be relatively higher.

3. Numerical rating method

This is a process adopted in underwriting, wherein numerical or percentage assessments are made on each component of the risk.
Factors like age, sex, race, occupation, residence, environment, build, habits, family and personal history are examined and scored numerically based on pre-determined criteria.

4. Underwriting decisions

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories. Based on the above tools and his judgment, the underwriter classifies the risk into the following categories:

a) Accept risk at standard rates
b) Accept risk at an extra premium (loading), though it may not be practiced in all companies
c) Postpone the cover for a stipulated period/ term
d) Decline the cover
e) Counter offer (either restrict or deny part of the cover)
f) Impose a higher deductible or Co-pay
g) Levy permanent exclusion(s)under the policy

If any illness is permanently excluded, it is endorsed on the policy certificate. This becomes an additional exclusion apart from the standard policy exclusion and shall form the part of the contract.

5. Use of general or standard exclusions

The majority of policies impose exclusions that apply to all their members. These are known as standard exclusions or sometimes referred to as general exclusions. Insurers limit their exposure by the implementation of standard exclusions. These have been discussed in an earlier chapter.

6. Zone wise premium

Normally, the premium would depend on the age of the insured person and the sum insured selected. Premium differential has been introduced in certain zones with higher claims cost e.g. Delhi and Mumbai form part of highest premium zone for certain products by some insurers. For e.g. Individual Policy for age group of 55-65 years would be rated higher in Metros and 'A Class' cities than a similar policy for the same age bracket in a city like Indore or Jammu.

Test Yourself 4

Which of the following statements about medical underwriting is incorrect?

I. It involves high cost in collecting and assessing medical reports.
II. Current health status and age are the key factors in medical underwriting for health insurance.
III. Proposers have to undergo medical and pathological investigations to assess their health risk profile.
IV. Percentage assessment is made on each component of the risk.

H. Health Insurance at Group Level

While accepting a group for health insurance, the insurers take into consideration the possibility of existence of a few members in the group who may have severe and frequent health problems.

1. Group Health Insurance

Underwriting of group health insurance requires analysing the characteristics of the group to evaluate whether it falls within the insurance company's underwriting guidelines as well as the guidelines laid down for group insurance by the insurance regulators.

Standard underwriting process for group health insurance requires evaluating the proposed group on the following factors:

a) Type of group
b) Group size
c) Type of industry
d) Eligible persons for coverage
e) Whether entire group is being covered or there is an option for members to opt out
f) Level of coverage – whether uniform for all or differently
g) Composition of the group in terms of sex, age, single or multiple locations, income levels of group members, employee turnover rate, whether premium paid entirely by the group holder or members are required to participate in premium payment
h) Difference in healthcare costs across regions in case of multiple locations spread in different geographical locations
i) Preference of the group holder for administration of the group insurance by a third party administrator (of his choice or one selected by the insurer) or by the insurer itself
j) Past claims experience of the proposed group

Example

A group of members working in mines or factories is at higher health risk than a group of members working in air-conditioned offices. Also the nature of diseases (thereby claims) are also likely to be quite different for both groups. Therefore, the insurer will price the group health insurance policy accordingly in both the cases.

Similarly to avoid adverse selection in case of groups with high turnover such as IT companies, insurers can introduce precautionary criteria requiring employees to serve their probationary period before becoming eligible for insurance.

2. Underwriting other than employer- employee groups

Employer-employee groups are traditionally the most common groups offered group health insurance, the character of the group composition is one of the important consideration while underwriting the group.

Health insurance can also be offered to Non Employer employee groups. The IRDAI has issued group insurance guidelines with a view to regulate the approach to be adopted by insurers in dealing with various groups. Such non-employer groups include:

a) Employer welfare associations
b) Holders of credit cards issued by a specific company
c) Customers of a particular business where insurance is offered as an add-on benefit
d) Borrowers of a bank and professional associations or societies

I. Underwriting of Overseas Travel Insurance

Since the main cover under Overseas Travel Insurance policies is the health cover, the underwriting would follow the pattern for health insurance in general.

The premium rating and acceptance would as per individual company guidelines but a few important considerations are given below:

1. Premium rate would depend on the age of the proposer and the duration of foreign travel.
2. As medical treatment is costly overseas, the premium rates are normally much higher compared to domestic health insurance policies.
3. Even among the foreign countries, USA and Canada premium is the highest.
4. Care should be taken to rule out the possibility of a Proposer using the policy to take medical treatment abroad and hence the existence of any pre-existing disease must be carefully considered at the proposal stage.

J. Underwriting of Personal Accident Insurance

The underwriting considerations for Personal Accident Policies are discussed below:

Rating

In personal accident insurance, the main factor considered is the occupation of the insured. The risks associated with profession or occupation varies in accordance with the nature of work performed. For example, an office manager is less exposed to risk at work than a civil engineer working at a site where a building is being constructed. To fix a rate, occupations are classified into groups, each group reflecting, more or less, similar risk exposure.

Classification of Risk

On the basis of occupation, the risks associated with the insured person may be classified into three groups:

- **Risk group I**
  Accountants, Doctors, Lawyers, Architects and persons engaged in administration functions, persons primarily engaged in occupations of similar hazards.
- **Risk group II**
  Builders, Contractors and Engineers engaged in superintending functions and persons engaged in occupation of similar hazards. All persons engaged in manual labour (except those falling under Group III),
- **Risk group III**
  Persons working in underground mines or engaged in activities like racing on wheels and persons engaged in occupations/ activities of similar hazard.
  Risk groups are also known in the form of 'Normal', 'Medium' and 'High' respectively.

Age Limits

General age limits for the working population (employer employee) is 18-70.However for students Minimum age could be 5 years too.
The minimum and maximum age for being covered and renewed varies from company to company.

Family Package Cover

The Personal accident policy also has a family package cover wherein Children and Non-earning spouse are covered for to death and permanent disablement (total or partial) only.

Premium Discount in Group Policies

A group discount is allowed off the premium, if the number of insured person exceeds a certain number say 100. Group policy however may be issued when number is smaller, say 25 but without any discount.

Group discount criteria

Group policies should be issued only in respect of the named groups. For the purpose of availing of group discount and other benefits, the proposed "Group" should fall clearly under one of the following categories, given below:

- Employer – employee relationship including dependents of the employee
- Members of a registered co-operative society
- Members of registered service clubs
- Holders of credit card of banks/ Diners/ Master/ Visa

In case of proposals relating to any further category different from the above categories, they may be deliberated and decided upon by the technical department of the respective insurers.

Premium

Varying rates of premium are applicable to named employees as per the classification of risks and the benefits selected.

On-duty cover

PA policies may have a cover for both on-duty and off-duty period or for either separately. The premium is dependent on the Sum Assured, the number of hours of duty etc. Some employers may like to restrict themselves to cover the duty period only.

Exclusion of death cover

It is possible to issue group P.A. policies excluding the death benefit, subject to individual company guidelines.

Group discount and Bonus/ Malus

Rating under renewal of group policies is determined with reference to the claims experience.

- Favourable experience is rewarded with a discount in the renewal premium (bonus)
- Adverse experience is penalised by loading of renewal premium (malus), according to a scale
- Normal rates will apply for renewal if the claims experience is, say, 70 percent

Test Yourself 5

1) In a group health insurance, any of the individual constituting the group could anti-select against the insurer.
2) Group health insurance provides coverage only to employer-employee groups.

I. Statement 1 is true and statement 2 is false
II. Statement 2 is true and statement 1 is false
III. Statement 1 and statement 2 are true
IV. Statement 1 and statement 2 are false

Answers to Test Yourself

Answer 1 - The correct option is III.
Answer 2 - The correct option is III.
Answer 3 - The correct option is I.
Answer 4 - The correct option is IV.
Answer 5 - The correct option is IV.

CHAPTER H-05

HEALTH INSURANCE CLAIMS

Chapter Introduction

In this chapter we will discuss about claim management process in Health Insurance, claims related procedures and documentation. Apart from this, we will also look into claims management under Personal Accident Insurance and understand the role of TPAs.

Learning Outcomes

A. Claims Management in insurance

B. Management of Health Insurance claims

C. Documentation in Health Insurance claims

D. Role of Third Party Administrators (TPA)

E. Claims Management – Personal Accident

F. Claims Management- Overseas Travel Insurance

After studying this chapter, you should be able to:

a) Explain the various stakeholders in insurance claims
b) Describe how health insurance claims are managed
c) Discuss the various documents required for settlement of health insurance claims
d) Explain how reserves for claims are provided for by insurers.
e) Discuss personal accident claims
f) Understand the concept and role of TPAs

A. Claims Management in Insurance

It is very well understood that insurance is a **'promise'** and the policy is a **'witness'** to that promise. The occurrence of an insured event leading to a claim under the policy is the true test of that promise. How well an insurer performs is evaluated by how well it keeps its claims promises. One of the key rating factors in insurance is the claims paying ability of the insurance company.

1. Stakeholders in claim process

One needs to understand the parties interested in the claims process before looking at how claims are managed.

Diagram 1: Stakeholders in claim process

Customer	The person who buys insurance is the first stakeholder and 'receiver of the claim'.
Owners	Owners of the insurance company have a big stake as the 'payers of the claims'. Even if the claims are met from the policy holders' funds, in most cases, it is they who are liable to keep the promise.
Underwriters	Underwriters within an insurance company and across all insurers have the responsibility to understand the claims and design the products, decide policy terms, conditions and pricing etc.
Regulator	The regulator (Insurance Regulatory and Development Authority of India) is a key stakeholder in its objective to: ✓ Maintain order in the insurance environment ✓ Protect policy holders' interest ✓ Ensure long term financial health of insurers.

Third Party Administrators	Service intermediaries known as Third Party Administrators, who process health insurance claims.
Insurance agents/ brokers	Insurance agents/ brokers not only sell policies but are also expected to service the customers in the event of a claim.
Providers/ Hospitals	They ensure that the customer gets a smooth claim experience, especially when the hospital is on the panel of the TPA the Insurer to provide cashless hospitalization.

Thus managing claims well means managing the objectives of the each of these stakeholders related to the claims. Of course, it may happen that some of these objectives can conflict with each other.

Reserving: In many cases, insurance companies may not be able to settle claims instantly and may have to wait for information or the results of disputes, litigation etc. So, they have to hold the claim amounts in reserve till the payments are due. Reserves are usually are actuarial estimates of the amounts that will be paid on outstanding claims.

Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

Test Yourself 1

Who among the following is not a stakeholder in Health insurance claim process?

I. Customers
II. Police Department
III. Regulator
IV. TPA

B. Management of Health Insurance Claims

1. Claim process in health insurance

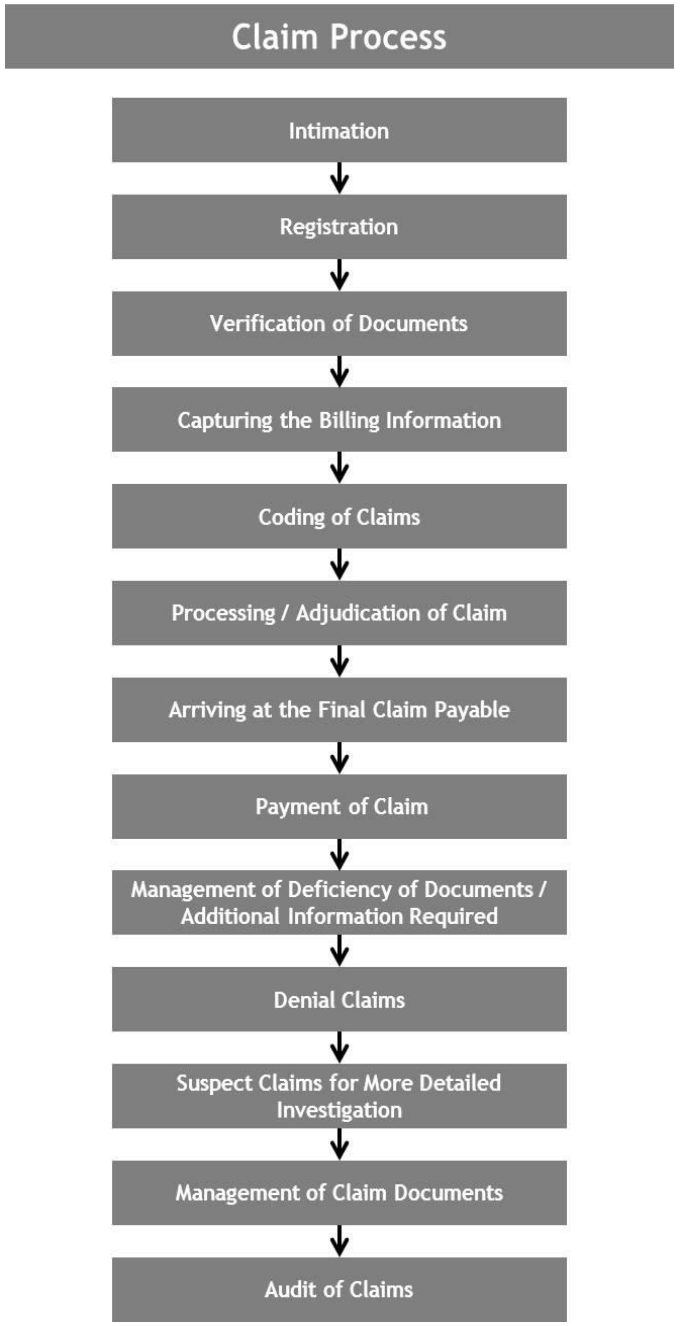
A claim may be serviced either by the insurance company itself or through the services of a Third Party Administrator (TPA) authorized by the insurance company.

From the time a claim is made known to the insurer/ TPA to the time the payment is made as per the policy terms, the health claim passes through a set of well-defined steps, each having its own relevance.

The processes detailed below are in specific reference to health insurance (hospitalization) indemnity products which form the major part of health insurance business.
The general process and supporting documents for a claim under fixed benefit product or critical illness or daily cash product etc. would be quite similar, except for the fact that such products may not come with cashless facility.

In both cases of indemnity as well as reimbursement type of claim, the basic steps remain the same.

Diagram 2: Claim process broadly comprises following steps (may not be in the same order)



a) Intimation

Claim intimation is the first instance of contact between the customer and the claims team. The customer could inform the company that he is planning to avail a hospitalization or the intimation would be made after the hospitalization has taken place, especially in case of emergency admission to a hospital.

Till recently, the act of intimation of a claim event was a formality. However, recently insurers have started insisting on the intimation of claim as soon as practicable. Typically it is required before hospitalization in case of planned admission, and within 24 hours of hospitalization in case of an emergency. Intimation is now possible through Mobile Apps/ call centres run by insurers/ TPAs open 24 hours as well as through the internet and e-mail.

b) Registration

Once the intimation is received by the company directly or through the TPA, the details thereof are matched for accuracy and a reference number or claim control number generated and intimated to the claimant. The documents are then scrutinized for prima facie coverage and pre-authorisation of likely expenditure is given to the Hospital in case the intimation is of a planned surgery under the Cash-less scheme (detailed in subsequent section).

The claims that come for the final settlement on the reimbursement basis are scrutinized in detail about admissibility, sum assured, deductibles, sub-limits etc. In case of deficiency in documents the same has to be communicated together, not in piecemeal. It is worth knowing that the claim processing involves not only ensuring that the terms of the contract have to be fulfilled, but also in ensuring that the Hospitals do not indulge in overcharging, double-charging etc.

Example

Hospitalization is typically associated with Allopathic method of treatment. However, the patient could undergo other modes of treatment such as:

- ✓ Unani
- ✓ Siddha
- ✓ Homeopathy
- ✓ Ayurveda
- ✓ Naturopathy etc.

Most policies now include these treatments, however there could be sub-limits.

Telemedicine: IRDAI has asked insurers to allow telemedicine wherever regular medical consultation is allowed, in the terms and conditions of medical insurance policies.

This will help policy holders who may prefer to consult medical practitioners online or telephonically to avoid going out of their homes or if they are in quarantine themselves due to the coronavirus infection.

Arriving at the final claim payable: The factors that decide the claim amount payable are:

a) Sum insured available for the member under the policy

b) Balance sum insured available under the policy for the member after taking into account any claim made already:

c) Sub-Limits

d) Check for any limits specific to illness

e) Check whether entitled or not to cumulative bonus

f) Other expenses covered with limitation:

What are finally paid are the Reasonable and Customary Charges meaning the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/ injury involved.

Earlier every TPA/ insurer had its own list of non-payable items, now the same has been standardized under IRDAI Health Insurance Standardization Guidelines.

c) Payment of claim

Once the payable claim amount is arrived at, payment is done to the customer or the hospital as the case may be. The payment may be made either by cheque or by transferring the claim money to the customer's bank account.

d) Denial of claims

The experience in health claims show that 10% to 15% of the claims submitted do not fall within the terms of the policy. This could be because of a variety of reasons some of which are:

i. Date of admission is not within the period of insurance.
ii. The Member for whom the claim is made is not covered.
iii. Due to Pre-existing illness (where the policy excludes such condition).
iv. Undue delay in submission without valid reason.
v. No active treatment; admission is only for investigation purpose.
vi. Illness treated is excluded under the policy.
vii. The cause of illness is abuse of alcohol or drugs
viii. Hospitalization is less than 24 hours.

Denial or repudiation of a claim (due to whatever reason) has to be informed to the customer in writing by the insurance company. Usually, such denial letter clearly states the reason for denial, narrating the policy term/ condition on which the claim was denied.

Apart from the representation to the insurer, the customer has the option to approach the following in case of denial of claim:

- ✓ Insurance Ombudsman or
- ✓ The Consumer Commissions or
- ✓ IRDAI or
- ✓ Law courts.

e) Suspect claims require more detailed investigation by the companies/ TPAs

Wherever the insurance company suspects foul-play it can get claims investigated. A few examples of frauds committed in health insurance are:

i. Impersonation, the person insured is different from person treated.
ii. Fabrication of documents to make a claim where there is no hospitalization.
iii. Inflation of expenses, either with the help of the hospital or by addition of external bills fraudulently created.
iv. Outpatient treatment converted to in-patient/ hospitalization to cover cost of diagnosis, which could be high in some conditions.

It is to be noted that in respect of claims that need to be investigated, investigations shall be initiated and completed at the earliest, in any case not later than 90 days from the date of receipt of claim intimation. The claim should be settled within 30 days of completing the investigation. (Pl refer to IRDAI (Protection of policyholder's), 2017 Regulations and updated accordingly)

f) Cashless settlement process by TPA

How does the cashless facility work? At the heart of this is an agreement that the TPA insurer enters into, with the hospital. There are agreements possible with other medical service providers as well. The process used for providing cashless facility are discussed in this section:

Table 3.1

Step 1	• A customer covered under health insurance suffers from an illness or sustains an injury and so is advised admission into a hospital. He/ she (or someone on his/ her behalf) approaches the hospital's insurance desk with the insurance details such as: i. TPA name, ii. Customer's membership number, iii. Insurer's name, etc.
Step 2	• The hospital compiles the necessary information such as: i. Diagnosis of illness ii. Treatment, iii. Name of treating doctor, iv. Number of days of proposed hospitalization and v. The estimated cost • This is presented in a format, called the cashless authorization form.
Step 3	• The TPA studies the information provided in the *cashless authorization form* and takes a decision on whether the cashless authorization could be provided and if so, for how much amount it should be authorized and it is communicated to the hospital without delay.
Step 4	• The patient is treated by the hospital, keeping the amount authorized by the TPA as credit in the patient's account. The member may be called on to make a deposit payment to cover the non-treatment expenses and any co-pay required under the policy.
Step 5	• When the patient is ready for discharge, the hospital checks the amount of credit in the account of the patient approved by the TPA against the actual treatment charges covered by insurance. • If the credit is less, the hospital requests for additional approval of credit for the cashless treatment. • TPA analyses the same and approves the additional amount.
Step 6	• Patient pays the non-admissible charges and gets discharged. He will be asked to sign the claim form and the bill, to complete the documentation.

Step 7	• Hospital consolidates all the documents and presents to the TPA the documents for processing of the bill
Step 8	• TPA will process the claim and recommend for payment to the hospital after verifying details.

g) Customer must make sure that he/ she has his/ her insurance details with him/ her.

This includes his TPA card, Policy copy, Terms and conditions of cover etc.

When these are not available, he can contact the TPA (through a 24 hour helpline) and seek the details.

i. Customer must check if the hospital suggested by his/ her consulting doctor is in the network of the TPA. If not, he needs to check with the TPA the options available where cashless facility for such treatment is available.

ii. He/ she needs to make sure that the correct details are entered into the pre-authorization form. This form has been standardized by IRDAI as per Guidelines on Standardization in Health Insurance issued in 2013. If the case is not clear, the TPA could deny the cashless facility or raise query.

iii. He/ she needs to ensure that the hospital charges are consistent with the limits such as room rent or caps on specified treatments such as cataract.

iv. The customer must inform the TPA in advance of the discharge and request the hospital to send to the TPA any additional approval that may be required before discharge. This will ensure the patient does not wait unnecessarily at the hospital.

It is also possible that the customer requests and takes an approval for cashless treatment at a hospital but decides to admit the patient elsewhere. In such cases, the customer must inform and ask the hospital to communicate to the TPA that the cashless approval is not being used.

If this is not done, the amount approved could get blocked in the customer's policy and could prejudice the approval of the subsequent request.

C. Documentation in Health Insurance Claims

This section explains the need for and content of each of the documents required to be submitted by the customers:

1. Discharge summary

Discharge summary can be termed as the most important document that is required to process a health insurance claim. It details the complete information about the condition of the patient and the line of treatment and helps the claim processing person immensely to understand the illness/ injury and the line of treatment. Where the patient unfortunately does not survive, the discharge summary is termed **Death Summary** in many hospitals. The discharge summary is always sought in original.

2. Investigation reports

Investigation reports assist in comparing the diagnosis and the treatment, thereby providing the necessary information to understand the exact condition that

prompted the treatment and the progress made during the hospitalization for e.g. Blood test reports, X-ray reports and Biopsy reports. The insurer may return the X-ray and other films to the customer on specific request.

3. Consolidated and detailed bills:

This is the document that decides what needs to be paid under the insurance policy. While the consolidated bill presents the overall picture, the detailed bill will provide the break up, with reference codes. The bills have to be received in original.

4. Receipt for payment

The reimbursement of a health insurance claim will also require the formal receipt from the hospital of the amount paid which must correspond to the total of the bill.

The receipt should be numbered and or stamped and be presented in original.

5. Claim form

Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer. The claim form has now been standardized by IRDAI.

Besides information on disease, treatment etc., the declaration the insured person makes in the claim form is the most important document in the legal sense.

6. Identity proof

With the increasing use of identity proof across various activities in our life, the general Proof of identity helps in verifying whether the person covered and the person treated are one and the same. Usually identification document which is sought could be voters' identity card, driving license, PAN card, Aadhaar card etc.

7. Documents contingent to specific claims

There are certain types of claims that require additional documents apart from what has been stated above. These are:

a) Accident claims, where FIR or Medico-legal certificate issued by the hospital to the registered police station, may be required.

b) Case indoor papers in case of complicated or high value claims.

c) Dialysis/ Chemotherapy/ Physiotherapy charts where applicable.

d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked

Test Yourself 2

Which of the following document is maintained at the hospital detailing all treatment done to an in-patient?

I. Investigation report

II. Discharge summary

III. Case paper

IV. Hospital registration certificate

Test Yourself 3

The amount of provision made for all claims in the books of the insurer based on the status of the claims is known as _____.

I. Pooling
II. Accounting
III. Reserving
IV. Investing

D. Role of Third Party Administrators (TPA)

The Role of TPA has been discussed in earlier chapters too. It is important to know the services offered by TPA so that the customer can be provided suitable services by the salesperson.

The scope of TPA services starts after the sale and issue of the insurance policy. In case of insurers not using TPAs, the services are performed by in-house team.

1. Post sale service of health insurance

a) Once the proposal (and the premium) is accepted, the coverage commences.
b) If a TPA is to be used for servicing the policy, the insurer passes on the information about the customer and the policy to the TPA.
c) The TPA enrols the members (while the proposer is the person taking the policy, members are those covered under the policy) and may issue a membership identification in the form of a card, either physical or electronic.
d) The membership with the TPA is used for availing cashless facility as well as processing of claims when the member requires the support of the policy for a hospitalization or treatment that is covered.
e) TPA processes the claim or cashless request and provides the services within the time agreed with the insurer.
f) The insured persons must carry an Identity Card that relates them to the policy and the TPA.
g) TPA issues a pre-authorization or a Letter of Guarantee to the hospital based on the information provided for requesting the cashless facility.
h) Where the information is not clear or not available, the TPA may reject the cashless request. In such cases the claim could be examined on reimbursement basis.

2. Customer relationship and contact management

Since TPAs are involved in claims servicing, they usually have a grievance redressal mechanism themselves.

E. Claims Management – Personal Accident

On receipt of the notification of the claim the following aspects should be looked into:

a) Person in respect of whom the claim is made is covered under the policy
b) Policy is valid as on date of accident and premium has been received
c) Loss is within the policy period

d) Loss has arisen out of "Accident" and not sickness
e) Check for any fraud triggers and assign investigation if need be
f) Register the claim and create reserve for the same
g) Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.

1. Claims Investigation

Claims Investigation is about determining the validity of the claim and finding out the real cause and extent of the loss. On receipt of the claim documents, if a claim appears suspicious, the claim may be assigned to an internal/ professional investigator for verification.

Example

Example of case guideline:
Road traffic accident

i. When did the incident take place – exact time and date place? Date and time
ii. Was the insured a pedestrian, traveling as passenger/ pillion rider or driving the vehicle involved in accident?

Some examples of possible fraud and leakage in personal accident claims:

i. Exaggeration in TTD period.
ii. Illness presented as accident e.g. backache due to pathological reasons converted into a PA claim after reported 'fall/ slip' at home

Discharge voucher is an important document for settlement of personal accident claim, especially those involving death claims. It is also important to obtain nominee details at the time of proposal and the same should form part of policy document.

2. Claim documentation- Each company gives a list

a) Duly completed Personal Accident claim form signed by the claimant's nominee/ family member
b) Original or Attested copy of First Information Report.
c) Original or Attested copy of Death certificate.
d) Attested copy of Post Mortem Report if conducted.
e) Attested copy of AML documents (Anti-money laundering) - for name verification (passport/ PAN card/ Voter's ID/ Driving license) for address verification (Telephone bill/ Bank account statement, Electricity bill/ Ration card).
f) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized
g) Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
h) Medical certificate from treating doctor mentioning the type of disability and disability period. Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer.

The above list is only indicative, further documents (including photographs of scar marks, site of accident etc.) may be required depending on particular facts of the case, especially the cases with suspected fraud angle to be investigated.

Test Yourself 4

Which of the following documents are not required to be submitted for Permanent Total Disability claim?

I. Duly completed Personal Accident claim form signed by the claimant.
II. Copy of Insurance Policy.
III. Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
IV. Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

F. Claims Management- Overseas Travel Insurance

The coverage under this policy has already been discussed under the product chapter. This section tries to explain how the claims arising during overseas travel are handled.

Claims services essentially include:

a) Taking down the claim notification 24*7 basis;
b) Sending the claim form and procedure;
c) Guiding customer on what to do immediately after loss;
d) Extending cashless services for medical and sickness claims;
e) Arranging for repatriation and evacuation, emergency cash advance.

Assistance companies – Role in overseas claims

Assistance companies have their own offices and tie up arrangements with other similar service providers world over. These companies offer assistance to the customers of insurance companies in case of contingencies covered under the policy.

These companies operate a 24*7 call centre including international toll free numbers for claim registration and information. They also offer the following services and charges for the services vary depending on agreement with the particular insurance company, benefits covered etc.

a) Medical assistance services:
    i. Medical service provider referrals
    ii. Arrangement of hospital admission
    iii. Arrangement of Emergency Medical Evacuation
    iv. Arrangement of Emergency Medical Repatriation
    v. Mortal remains repatriation
    vi. Compassionate visit arrangements
    vii. Minor children assistance/ escort
b) Monitoring of Medical Condition during and after hospitalisation
c) Delivery of Essential Medicines
d) Guarantee of Medical Expenses Incurred during hospitalization subject to terms and condition of the policy and approval of insurance company.
e) Pre-trip information services and other services:
    i. Visas and inoculation requirements
    ii. Embassy referral services
    iii. Lost passport and lost luggage assistance services
    iv. Emergency message transmission services
    v. Bail bond arrangement
    vi. Financial Emergency Assistance

f) Interpreter Referral
g) Legal Referral
h) Appointment with lawyer

a) Hospitalization Procedures

i. Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid health or overseas travel insurance policy.

ii. Hospitals start the treatment immediately. If there is insurance cover the insurance policy pays or the patient person has to pay. The hospitals tend to inflate charges since payments are delayed.

iii. Information regarding network hospitals and the procedures is available to the insured on the toll free numbers provided by the assistance companies.

iv. In event of the necessity of a hospitalization the insured needs to intimate the same at the call centre and proceed to a specified hospital with the valid travel insurance policy.

v. Hospitals usually contact the assistance companies/ insurers on the call centre numbers to check the validity of the policy and verify coverages.

vi. Once the policy is accepted by the hospital the insured would undergo treatment in the hospital on a cashless basis.

vii. Some basic information required by the insurer/ assistance provider to determine admissibility are:

1. Details of ailment

2. In case of any previous history ,details of hospital, local medical officer in India:

- ✓ Past history, current treatment and further planned course in hospital and request for immediate sending of
- ✓ Claim form along with attending physicians statement
- ✓ Passport copy
- ✓ Release of medical information form

b) Reimbursement of medical expenses and other non-medical claims:

Reimbursement claims are normally filed by insured after they return to India. Upon receipt of the claim papers, claim is processed as per usual process. Payments for all admissible claims are made in Indian Rupee (INR), unlike in cashless claims where payment is made in foreign currency.

While processing the reimbursement claims, currency conversion rate is applied as on date of loss to arrive at quantum of liability in INR. Then the payment is made though cheque or electronic transfer.

c) Claim documentation for Medical Accident and Sickness Expenses

i. Claim form

ii. Doctor’s report

iii. Original Admission/ discharge card

iv. Original Bills/ Receipts/ Prescription

v. Original X-ray reports/ Pathological/ Investigative reports

vi. Copy of passport/ Visa with Entry and exit stamp

The above list is only indicative. Additional information/ documents may be required depending on specific case details or depending upon claim settlement policy/ procedure followed by particular insurer.

Test Yourself 5

Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid _____ Insurance policy.

I. Legal Liability
II. Corona Rakshak
III. Overseas Travel
IV. Endowment

Answers to Test Yourself

Answer 1 - The correct option is II.
Answer 2 - The correct option is II.
Answer 3 - The correct option is III.
Answer 4 - The correct option is IV.
Answer 5 - The correct option is III.

Summary

a) Insurance is a 'promise' and the policy is a 'witness' to that promise. The occurrence of insured event leading to a claim under the policy is the true test of that promise.

b) One of the key rating parameter in insurance is the claims paying ability of the insurance company.

c) Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.

d) In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer/ TPA and later submits the documents for settlement of the claim.

e) In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer/ TPA for payment.

f) Claim intimation is the first instance of contact between the customer and the claims team.

g) If a fraud is suspected by insurance company in case of insurance claim, it is sent for investigation. Investigation of a claim could be done in-house by an insurer/ TPA or be entrusted to a professional investigation agency.

h) Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

i) In case of a denial, the customer has the option, apart from the representation to the insurer, to approach the Insurance Ombudsman or the consumer Commissions or even the legal authorities.

j) Frauds occur mostly in hospitalization indemnity policies but Personal accident policies also are used to make fraud claims.

k) The TPA provides many important services to the insurer and gets remunerated in the form of fees.
