D. Common clauses in all health insurance products

Based on the health insurance products currently available in India, some of the common insurance clauses are discussed in this Learning Outcome. Any of these clauses may be modified and/or adapted by insurance companies according to their requirements and so this section should be seen only as a general listing to help understand health insurance product conditions. However, an inquisitive student can read in detail about the various definitions and other health insurance clauses used for health insurance products on insurer's websites.

Insurance, as we have learnt, is a contract of indemnity. The insurance policy is the contract document. Generally, all insurance policies have a standard architecture, beginning with the Preamble. Then follows the operative clause which details how the policy proposes to indemnify the insured and under what circumstances. Then the exclusions are listed out. Finally, the conditions under which the policy operates are stated.

Health insurance policies also follow a similar structure. However, since health insurance is very critical to a large number of insured people in terms of securing their health care needs on a long term basis, the Insurance Regulatory and Development Authority of India (IRDAI) has prescribed detailed Regulations and Guidelines governing the conduct of health insurance business. Some of the guidelines also prescribe standard wording for some of the clauses relating to insurance. These standard wordings are to be used by all insurers. Such standardization helps the customers have a clear understanding of the implications of these clauses. Moreover, since the entire insurance industry uses the same clauses, such standardization facilitates comparison of different products to the extent that the critical terms used are uniform.

In this Chapter we will be referring to some of these Standard clauses and explaining their meaning. Besides these Standard clauses, there are also clauses which are common across all insurers. The wordings of the common clauses could differ from insurer to insurer. But generally, the intent and content of these clauses are common.

Before getting to know the various clauses we should also learn the specific features of health insurance:

1. SUM INSURED

The policy limits its liability to the Sum Insured. This means that the total payment of all admissible claims will be limited to the Sum Insured. A health insurance policy could be issued for individual Sum Insured or Floater Sum Insured.

For instance, take the case of Ram and Rekha who are covered under a Health insurance policy with individual sum insured of Rs. 200000 each.

They travel in a car and the car meets with an accident and both of them are hospitalized following the accident. The hospital expenses for Ram was 175000 and for Rekha it was 250000. In this case, since both of them were insured under individual Sum Insured of Rs. 200000 each, the insurance policy will pay Ram 175000. For Rekha, the amount payable will be 200000.

In a policy issued on Floater Basis, the total payment of all admissible claims for all insured persons will be limited to the Sum Insured.

Taking the same example of Ram and Rekha, if they had taken a Floater Policy for 300000, then the claim for **both of them**, will be limited to Rs.300000, being the Sum Insured.

2. DATE OF ACCIDENT

In Health Insurance, the Policy indemnifies the insured for hospitalization expenses incurred during the period of insurance. What is most significant in health insurance to determine whether the event is covered under the policy, is the date of admission to the Hospital. If the date of admission is within the period of insurance, the policy pays. If the date of admission is after the date of expiry of insurance, the policy does not pay.

The date of discharge could even be beyond the period of insurance. Still the policy will pay the Hospital costs incurred during the entire period of hospitalization, including the period beyond the date of expiry of the policy, provided the date of admission is within the period of insurance. See the following two examples:

Example
Sanjeev had taken a policy from 01.01.2016 to 31.12.2016. He meets with an accident on 31.12.2016, and gets admitted to the Hospital on 31.12.2016 itself. He is under treatment for ten days, and gets discharged on 10.01.2017. In this case, the Policy will pay the claim for the entire period of treatment, even though the date of discharge is after the policy expiry.

If in the above case, Sanjeev, who met with the accident on 31.12.2016, got admitted only on 01.01.2017, then the claim is not payable under the policy, as the date of admission did not happen during the period of insurance. What is important in a Health nsurance policy covering hospitalization is the date of admission and even if the date of accident which resulted in hospitalization is within the period of insurance, the hospitalization claim will not be payable, if the date of admission is beyond the period of insurance.

3. 24 HOURS HOSPITALISATION

Expenses on hospitalisation are generally admissible only if it is for a minimum period of 24 hours. However, there is an exception for cases of specialised treatment, which can now be undertaken in a shorter time (less than 24 hours)

due to technological advances called day care procedures. It usually includes hemodialysis, chemotherapy, eye surgery, D&C, angioplasty, hernia, hydrocele, surgery related to ENT etc. (this list is only indicative)

4. LIMITS OF USAGE

a) Hospitals where treatment under insurance cover is taken:

i. Should be duly licensed and registered
ii. Should be under the supervision of a registered medical practitioner, and
iii. Should have the prescribed minimum number of in-patient medical beds e.g. minimum 15 for Metros & larger cities, and 10 beds in smaller towns etc.

Such conditions ensure that the treatment is provided at a standard and established place and scope for frauds is reduced.

Standard Definition for the terms "Hospital" and "Hospitalisation" are mandated by the Authority and all health insurance policies shall adhere to these definitions.

b) Room rent: This is also a Standard Definition and Room Rent is defined as:

"Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses. "

Often, to balance the costs of medical necessity and luxury, as also to control costs for insurers, some limits for room charges are imposed, say 1% of sum insured etc.

Example

Swati has taken a health insurance policy with a cover of Rs.1 lakh recently which has a clause for limits on usage of some hospitalisation expenses such as:

- ✓ Room rent limit: 1% of the sum insured
- ✓ ICU charges: 2% of the sum insured subject to maximum of Rs.10,000
- ✓ Doctor's fees: 3% of the sum insured
- ✓ Cataract operation: Rs.20,000 per eye
- ✓ Angioplasty: Rs.60,000

5. Domiciliary hospitalisation benefit

This benefit was previously offered in mediclaim products and now is also included in some of the newer hospitalisation policies. It implies medical treatment for a period exceeding three days for such illness which in normal course would require care and treatment at a hospital/nursing home as in-patient but actually taken whilst confined at home in India due to any of the following circumstances:

a) The condition of the patient is such that he/she cannot be moved to the hospital/nursing home, or

b) The patient cannot be moved to the hospital due to lack of any place in the hospital.

However, many of the health insurance policies in India do not offer this benefit.

6.Cashless hospitalisation procedure

Cashless is a facility offered to the health insurance customers through insurers' in-house channels or through Third Party Administrators (TPA) who coordinate with the customer and the hospital to ensure that the admissible bills are not required to be paid in the hospital by the customer and are directly settled by the TPA/insurer in due course.

Admission should be in a listed hospital which is in the empanelment list of the insurer/TPA (network hospital) and is subject to the pre-authorisation being granted by the insurer/TPA. The TPAs will validate the incidence reported by the claimant and after satisfaction, will issue a pre-authorisation letter to the hospital guaranteeing the payment. The TPA may not necessarily approve all the claims and may require more information or documents. Denial of cashless does not affect the admissibility of claims and the customers can submit the claim papers later to the insurer/TPA for reimbursement.

7. Deductible

Deductible is a cost sharing mechanism. A deductible is the initial amount of an admissible claim which must be first borne by the insured, before the insurer starts paying for the claim.

Example

Girish has taken a health insurance policy which had a clause for deductible of Rs.10,000. This clause means that the first Rs.10,000 of every admissible claim will have to be borne by Girish and excess, if any will be paid by the insurance company. For example, if Girish has incurred hospitalisation expenses of Rs.25,000, then he will have to pay first Rs.10,000 from his own pocket as deductible and then the insurance company will pay excess sum of Rs.15,000.

8. Co-payment

Co-payment means the percentage of risk that the insured is required to bear in respect of each and every claim. .

Example

The health insurance policy taken by Vikas has a co-payment clause of 20%. It means that the insurance company will not bear the entire expenses. Vikas will have to pay Rs.20 from his own pocket for every Rs.100 claimed. Therefore, if Vikas will incur hospitalisation expenses of Rs.15,000, then he will have to pay 20% of it, i.e. Rs.3,000 from his own pocket and the insurance company will pay his share of 80%, i.e. remaining expenses of Rs.12,000.

DEDUCTIBLES AND CO-PAY NOT TO REDUCE THE SUM INSURED

In a claim where the admissible amount is more than the Sum Insured, a question may arise about the sequence of application of two clauses- Sum Insured and Deductible. For instance, if there was a policy with Rs. 200000 Sum Insured and a deductible of Rs. 25000, and if the claim is for Rs.250000, the question that arises is- which clause should be first applied first? The Deductible clause or the Sum Insured Clause? The amount payable would vary depending upon the sequence of application, as discussed in the following example.

The deductible amount of Rs. 25000 could be deducted from the admissible amount, ie 250000-25000= 225000, and then apply the Sum Insured Clause, and since 225000 is more than the Sum Insured, pay the Sum Insured Rs.200000.
Alternately, the Sum Insured Clause could be applied first. Here, the admissible claim is restricted to the Sum Insured of Rs. 200000, and then the Deductible Clause could be applied, reducing the claim payable by Rs. 25000, to 175000.(200000-25000).

IRDAI has therefore standardized the definition, stating that a Deductible Clause shall not reduce the Sum Insured. It means, the Deductible Clause should apply first. Therefore, the correct method is to apply the Deductible first, and then

restrict the amount payable to Sum Insured. The correct amount payable will, therefore, be Rs. 200000. A similar approach should also be applied for Co-Payment. Co-Payment Clause should be applied first, followed by Sum Insured Clause.

DIFFERENCE BETWEEN DEDUCTIBLE AND CO-PAYMENT

Both, Deductible and Co-Payment are intended to make the Insured a stakeholder in how the Hospitalisation expenses are incurred, so that some element of cost saving happens in the selection of Health Care Provider. While Deductible will be a fixed amount to be borne in each and every case, Co-Payment will be a fixed percentage of the cost to be borne. The difference in approach between the two methods is illustrated in the following Table:

ADMISSIBLE CLAIM AMOUNT		CLAIM PAYABLE UNDER	
		DEDUCTIBLE RS.10000	**CO-PAYMENT 10%**
SUM INSURED 200000	8000	0	7200
	12000	2000	10800
	100000	90000	90000
	150000	140000	135000
	200000	190000	180000
	220000	200000	198000
	240000	200000	200000

9. Waiting Period

The initial period within which any claims made will not be entertained. Normally, all the new policies come with a minimum 30 days waiting period wherein the insured person cannot make a claim for the diseases contracted during the first 30 days. This is to avoid someone taking a policy in order to get a hospitalisation claim immediately after purchase of the policy. The waiting period does not usually apply to accidental injuries, or to renewals of policies.

10. Pre-existing illness

The term Pre-existing illness should also be as per the Standard Definition laid down by IRDAI. It says:

"Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter."

A few points that should be noted are:

a) All insurers should adhere to this definition. They are free to reduce the waiting period for pre-existing illness from four years to a lesser period, but they cannot increase the waiting period.
b) After four years of continuous coverage, the clause will not apply.
c) Even during the first four years, a claim would fall under the Pre-existing illness clause if, and only if, the insured person:
   a. Had signs or symptoms or
   b. Was diagnosed or
   c. Received medical advice or treatment within forty-eight months prior to his first policy.

If the insured could not have had any of these three contingencies, then it could not be treated as pre-existing.

EXAMPLE:

Ram had taken a health insurance policy with ABC Insurance, from 01.01.2012. He had been regularly renewing the policy.

If a claim is reported in 2016, then pre existing illness exclusion will not apply, as he has continuous coverage of more than forty eight months.

'If a claim is reported in 2015, and if it is learnt that Ram had been treated for the same illness in 2008, then the claim is not payable as he had undergone treatment for the same illness within forty eight months prior to his first policy, ie, within 48 months from 01.01.2012. If the same claim is reported in 2016, the claim is payable, since pre-existing illness clause is not applicable after 48 months.

Similalry, if a claim is reported in 2015, and if it is learnt that Ram had been treated for the same illness in June 2007, then the claim is payable because pre-existing illness clause will not be applicable as he had undergone treatment for the same illness not within forty eight months prior to his first policy, but beyond. In this case he had undergone treatment fifty four months prior to the date of his first insurance, which is 01.01.2017. Hence, pre-existing illness is not applicable.

11. Exclusions

Insurance companies normally indicate various scenarios that cannot be entertained for claim payments. The rationale behind this is to avoid staged or fraudulent claims, misuse insurance for profit motive and to keep costs of claims low, and thus control insurance premium costs. However, customers usually do not fully understand the excluded conditions and this could be a trust issue between the customer and the insurer.

Some of the common exclusions (list is indicative and not exhaustive) are:

a) Pre-existing illness

b) Diseases contracted during initial waiting period

c) Expenses on treatment of specific ailments for a specific period like hernia, fistula, and cataract etc. (which are covered after the waiting period is over)

d) Injury or disease due to war, war like operations and similar scenarios

e) Cosmetic surgery, plastic surgery

f) Dental treatment

g) Abuse of drugs/alcohol usage

h) Naturopathy treatment

i) Non-medical expenses for personal comfort like television, telephone, toiletry items etc.

12. Cancellation clause

Usually, this clause can only be invoked by the insurer for reasons of fraud, moral hazard, misrepresentation or non-cooperation of the insured. Similarly, the customer may also cancel the policy based on the policy conditions and the insurance company is supposed to refund the premium on short-term cover scales of the insurer. However the company is liable for any claim, which arose prior to the date of cancellation.

13. Renewability clause

Current regulations mandate that renewal of policy can not be denied by an insurer except on grounds of fraud or misrepresentation. So all policies are renewable for life. While entry age for purchasing a policy can be restricted, renewal has to continue irrespective of age. Also a customer making a claim or multiple claims, would be entitled to renew his policy. However, benefit policies would terminate once the benefit amount is paid and hence the renewal regulations would not apply to them. The renewal regulations would not also apply in case the product is withdrawn.

IRDAI has also stipulated that a grace period of 30 days from the date of renewal should be provided with continuity in benefits. However, any illness contracted from the date of expiry of policy till payment of renewal premium (within the 30 day grace period) would not be covered.

Standardisation initiatives

In a unique multi- stakeholder initiative in India, the insurance industry, regulator, hospitals and industry chambers (along with other stakeholders, came together to undertake certain standardisation initiatives for the health insurance industry, in the year 2007. Taking this initiative forward, IRDAI has incorporated the standard definitions for some terms and clauses.

Some of these are discussed below.

a) Standardisation of definitions

There are differences in the definitions of certain terminology used in health insurance and in the nomenclature and definitions of critical illnesses adopted by the different insurers, which can create confusion in the minds of consumers and the industry. Lack of standard definitions also means that products are difficult to compare, and the availability of standard definitions thus can ensure better comparability and uniformity in the understanding of health insurance products. Hence the Health Insurance Regulations 2016, issued by the IRDAI in July 2016, mandate that phrases and terms used in all health insurance policies issued by Life insurers, General insurers and Health insurers shall have standard definitions and these definitions would be issued by IRDAI from time to time.

Please refer to IRDAI circular IRDA/HLT/REG/CIR/146/07/2016 dated 29.07.2016 where in definitions for standard terms to be used in health insurance policies are given.

b) Standardisation of forms

The majority of the insurers and TPAs require mostly the same information in their pre-authorisation and claims forms. However, each of them uses different formats and this means that a typical hospital would be expected to keep stock of 30 or 40 different forms and understand them well. The Health Insurance Regulations 2016 bestow the IRDAI with authority to prescribe a standard pre authorization approval form and a standard reimbursement claim form.

Standardisation initiatives on the non-medical expenses

Insurance companies providing hospitalisation indemnity cover generally exclude certain categories of expenses in their policy terms and conditions. However, there was no detailed listing of such excluded expenses, and the interpretation of these exclusions was highly varied across different insurers in the industry. There were many cases when various items under the claims filed by hospital providers or individual policyholders were repudiated by the insurers but were disputed by the claimants. This was, thus, one major cause of acrimony between insurance companies and healthcare providers and caused a

lot of confusion in the minds of consumer. Hence the stakeholders from the insurance, TPA, medical providers joined together to come to a consensus on the list of non-medical expenses to evolve an exhaustive list of such items. This list was notified by the IRDAI in 2013 Vide its circular reference **"Standard List of Expenses Generally Excluded ("non-medical expenses") in Hospitalisation Indemnity Policies IRDAI CIRCULAR NO: IRDA/HLT/CIR/036/02/2013 DATED 20.02.2013**

However, in the new health insurance regulations issued in 2016, this provision was amended. IRDAI came up with the circular IRDA/HLT/REG/CIR/146/07/2016 dated 29.07.2016 **where items for which insurers can provide optional coverage were listed. Insurers were also mandated to** specify up front what is being included and what is excluded by mentioning the same in the insurance policy. The detailed list should be put up on the website of the insurer.

Conclusion: There are no ideal product types and ideal clauses. Insurance companies keep on researching and inventing new product types and innovative clauses to attract customers. Students should keep on reading and analysing the policy clauses and conditions of various products floated by the insurance companies to appreciate the Unique Selling Proposition (USP) of the products in the offering. Students should also refer to the IRDAI website for the latest regulations.

Test Yourself 3

Which of the following clauses related to health insurance contract is incorrect?

I. Treatment can be taken in any hospital/nursing home.
II. The minimum number of beds in the hospital where the treatment is taken should be 15 for towns having a population of more than 10,00,000.
III. Minimum 24 hours hospitalisation is required except for a few specialised day care procedures.
IV. The treatment should be done under the supervision of a registered medical practitioner.

Test Yourself 4

_____ is a state of unconsciousness with no reaction to external stimuli or internal needs.

I. Cancer
II. Coma
III. Heart attack
IV. Paralysis