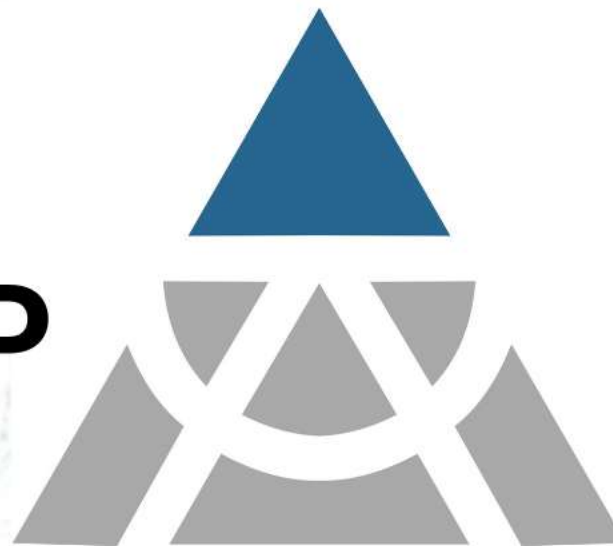


42ND INDIA FELLOWSHIP SEMINAR



Institute of Actuaries of India

16th & 17th December 2024
Institute of Actuaries of India

<https://actuariesindia.org>



42nd India Fellowship Webinar

Date: 16-17 December 2024

Health Insurance Technical Case Study

Presented by:

- 1. Radhika Rathi**
- 2. Ashutosh Kumar Rajesh**
- 3. Akshada Madhav Joshi**



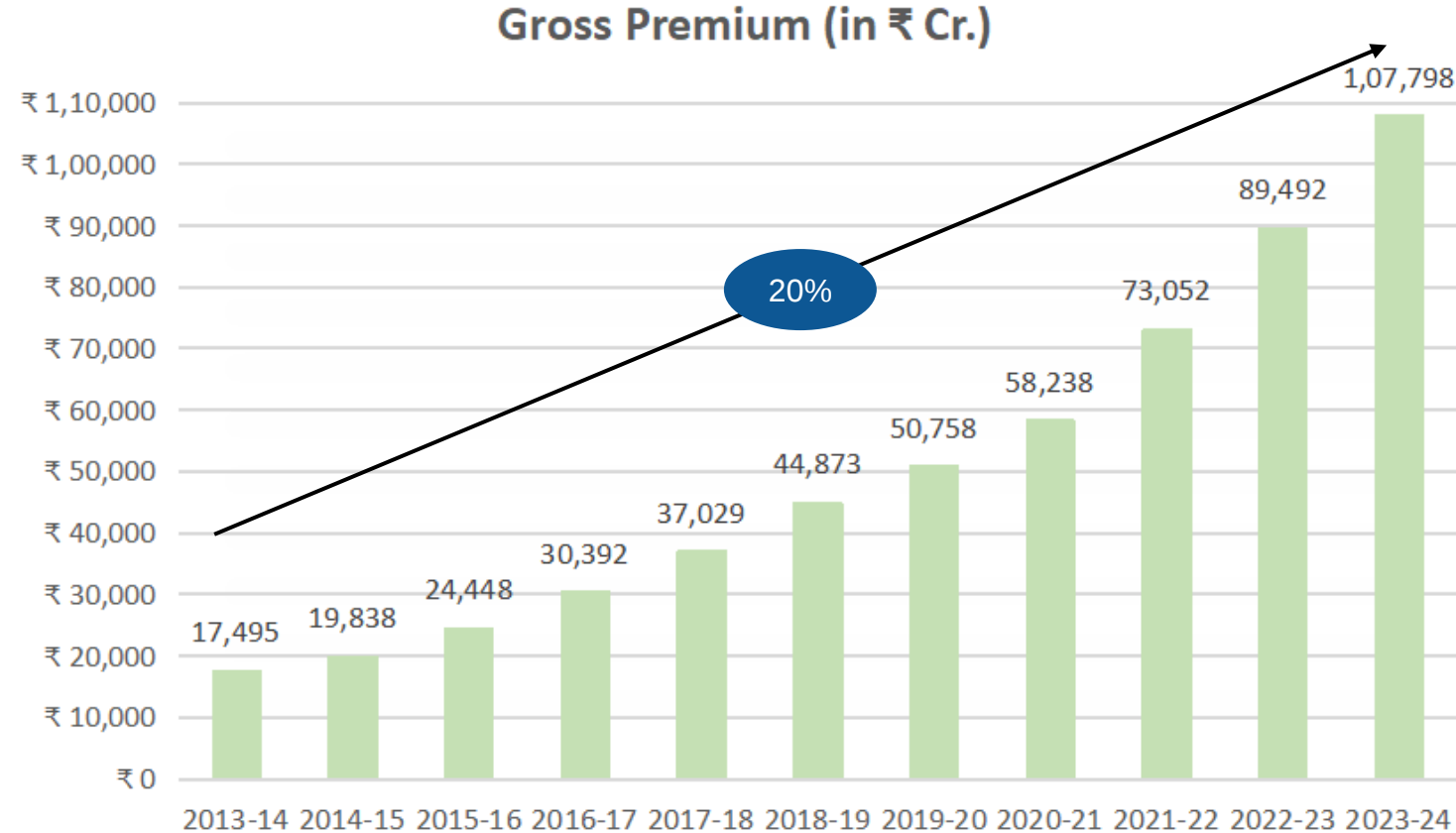
Master Circular 2024: A Step Towards Clearer Health Insurance Claims?

*“Given the **persistent** issue with health insurance where the customers find it difficult to understand **why a claim was rejected** or why were there **deductions from the full amount that was claimed**, how do think the recent master circular on health insurance release in May 2024 help **simplify things from a customer perspective**. Also, if you are of the opinion that there will be **no significant impact**, please provide your argument in favour of this statement.”*

Agenda

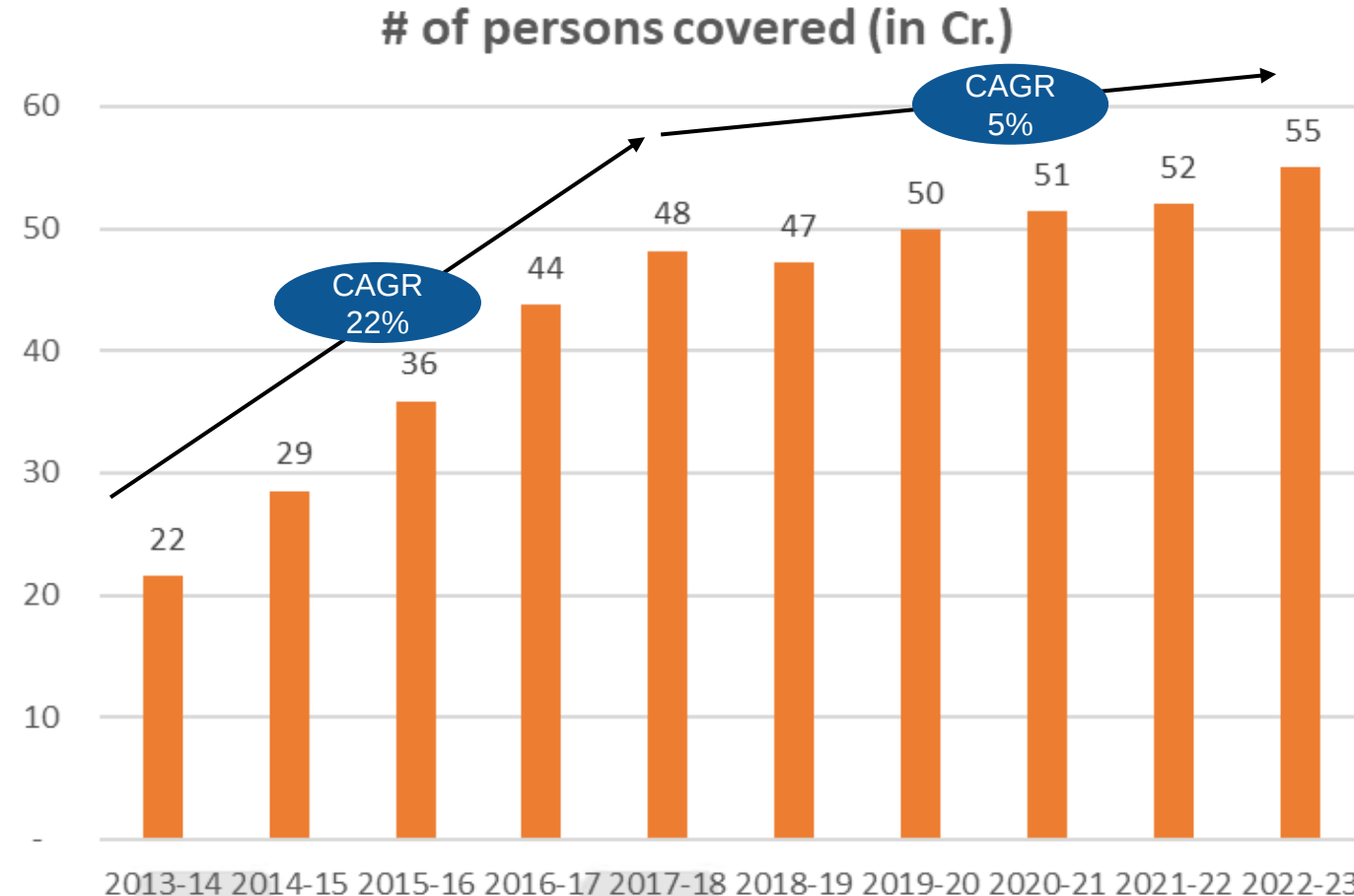
- Health insurance market in India: Overview
- Challenges faced by policyholders
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Steady growth in premium at 20% CAGR



Source: Handbook on Indian Insurance Statistics 2022-23 & General Insurance Council
Disclosure: Includes Govt. sponsored, group insurance schemes, individual family floater & individual other than family floater policies

Muted growth in persons covered in L5Y

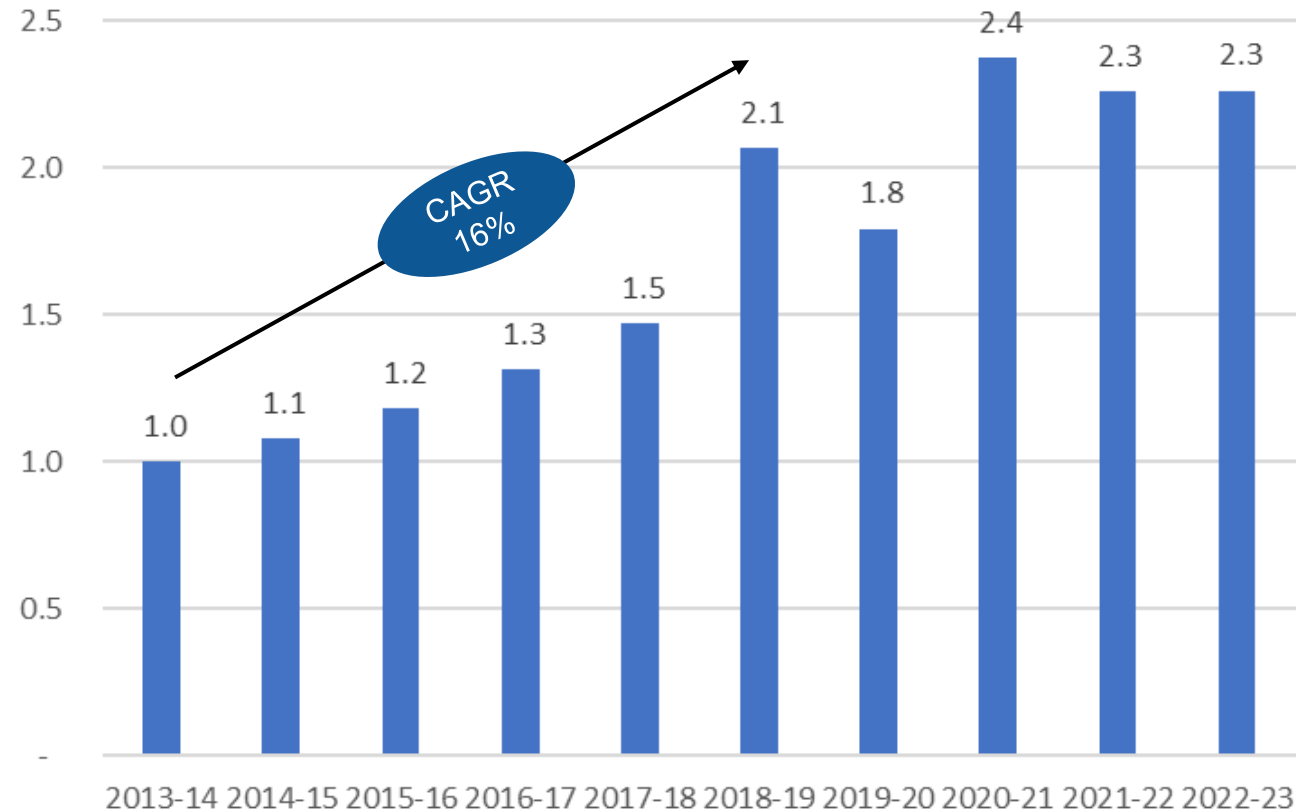


Source: Handbook on Indian Insurance Statistics 2022-23

Disclosure: Includes Govt. sponsored, group insurance schemes, individual family floater & individual other than family floater policies

Policies issued spiked in FY19; flat L2Y

of policies issued (in Cr.)



Source: Handbook on Indian Insurance Statistics 2022-23

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Dissatisfied



Health Insurance Claims: 43% policyholders faced difficulties, some had to wait an extra day at hospital, survey

By Neelanjit Das, ET Online - Last Updated: May 08, 2024, 11:33:00 AM IST

Synopsis

Health Insurance claim: Many people in India are facing difficulties in getting their health insurance claim processed. "43% health insurance policyholders who filed a claim in the last three years struggled with getting it processed," as per a report by LocalCircles.



Health Insurance policyholders are facing difficulties in getting their insurance claims processed.

Many **health insurance** claims in **India** have either been rejected or approved partially in the last three years, according to a recent **survey** by **Local Circles**. This conclusion was reached after taking inputs from 39,000 people in the 302 districts of India.

"Many **policyholders** cited their experience of getting a **health insurance claim** processed. Challenges faced ranged from **insurance companies** rejecting claims by classifying a health condition as a **pre-existing condition** to only approving a partial amount. 43% health **insurance** policyholders who filed a claim in the last three years struggled with getting it processed," reported the survey.

11 of 15 private health insurers paid less than 75% of amount claimed

GEORGE MATHEW
MUMBAI, NOVEMBER 26

AS MANY as 11 of the total 15 private health insurers shelled out less than 75 per cent of the amount claimed by the insured patients in 2022-23.

This means if an insured patient made a claim of ₹ one lakh as hospital bill, the insurer paid only less than ₹75,000 while the balance amount was paid by the patient. In the case of claims paid ratio — the amount paid during the year from the total amount of claims available for processing — New India Assurance leads with a payout of 98.74 per cent. Oriental Insurance came a close second with a payout of 97.35 per cent, data released by the Insurance Brokers Association of India (IBAI) on Thursday shows.

The claim ratio for the year 2024 is yet to be compiled.

The actual amount shelled out by HDFC Ergo was 71.35 per cent of the claimed amount and for ICICI Lombard, it was at 63.98 per cent, IBAI data says. Meanwhile

HOW INSURERS SETTLED HEALTH CLAIMS IN 2022-23

INSURER	Claims settled*	Claim amount**	Total No. of Claims
PSU INSURERS			
New India	95.04%	98.74%	90,56,011
Oriental Insurance	87.97%	97.35%	25,98,779
National Insurance	84.61%	87.95%	24,48,869
United India	84.28%	73.03%	45,24,241
PRIVATE SECTOR INSURERS			
IFFCO Tokio	91.70%	80.44%	6,70,026
Bajaj Allianz	90.29%	86.23%	9,56,559
SBI General	88.86%	88.30%	5,98,707
Go Digit	87.30%	79.50%	84,006
HDFC ERGO	86.90%	71.35%	9,06,914
Future Generali	83.83%	74.32%	1,42,952
ICICI Lombard	82.59%	63.98%	9,39,388
Tata AIG	75.56%	74.65%	2,46,126
Chola MS	69.53%	68.18%	1,31,546
Reliance General	58.06%	71.07%	4,78,120
STANDALONE HEALTH INSURERS			
Aditya Birla Health	94.52%	94.52%	94,52,000

IBAI data shows that New India Assurance leads with a claim paid ratio (on the number of claims) of 95.04 per cent, followed by Aditya Birla Health at 94.52 per cent, Iffco Tokio 91.70 per cent and Bajaj Allianz at 90.29 per cent for 2023. Claims paid ratio on number of claims means the number of claims paid during the year from the total number of claims available for processing. IBAI says that claims repudiation ratio of 23 insurers — mostly private players — was between 5 and 18 per cent for the year 2023. According to the IBAI Annual Report, during 2022-23, general and health insurers settled 2.36 crore number of health insurance claims and paid ₹70,930 crore towards settlement of health insurance claims.

The average amount paid per claim was ₹30,087. In terms of number of claims settled, 75 per cent of the claims were settled through TPAs and the balance 25 per cent of the claims were settled through in-house mechanisms. In terms of mode of settle-

Challenges faced by policyholders

PRE MASTER CIRCULAR

- ❑ Policyholder is not fully aware about inclusions & exclusions:
 - i. Diseases covered.
 - ii. Exclusions.
 - iii. Waiting period.

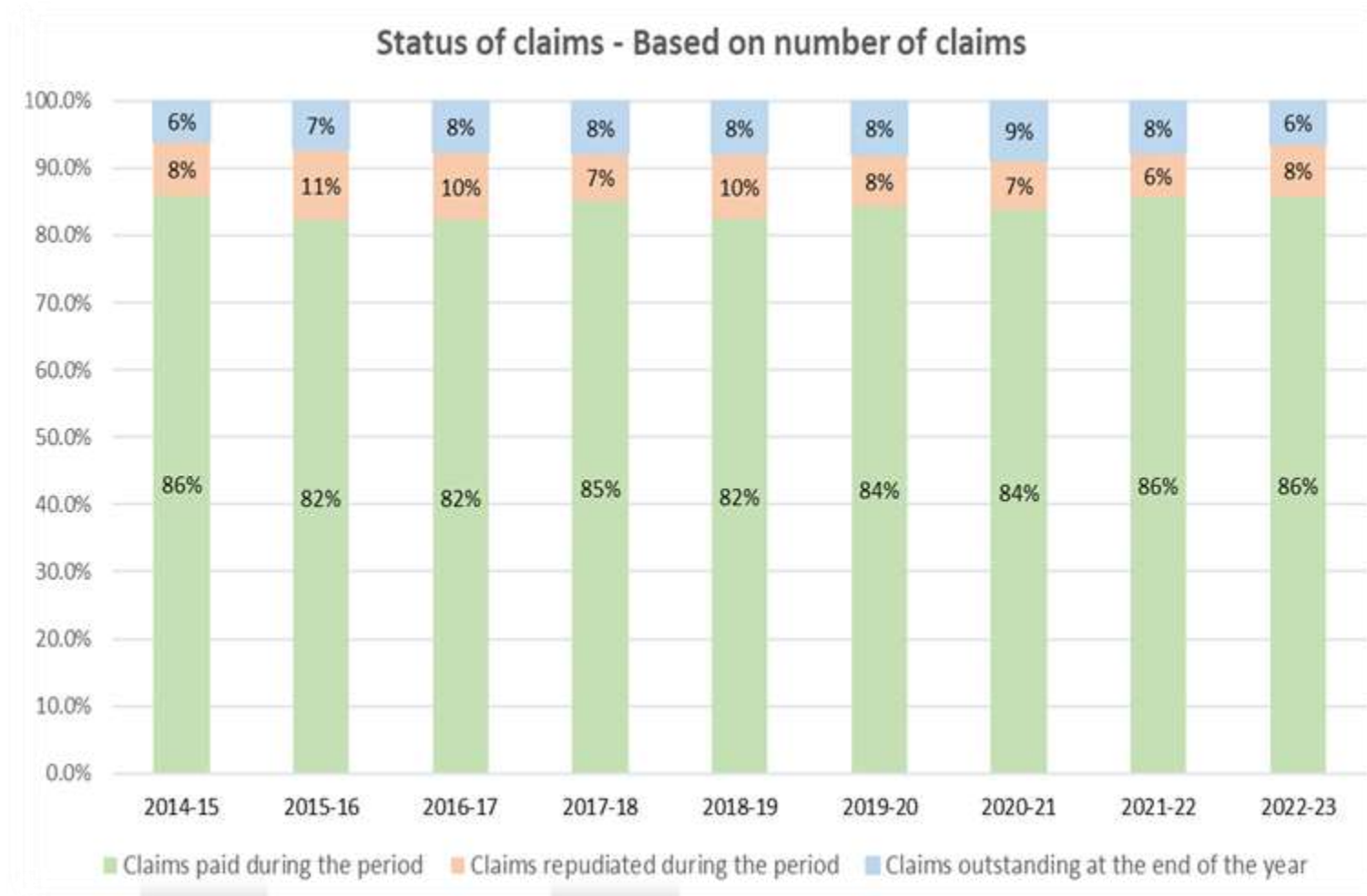
- ❑ Proper disclosure were not made at the time of sales.
 - i. Cost sharing arrangement between insurer & PH.
 - ii. Confusion: Deductibles, co-pay.
 - iii. Condition precedent.
 - iv. Pre and post hospitalization medical expenses.
 - v. Sum insured of the policy.
 - vi. Limit on benefits payable.
 - vii. Premium changes (e.g. age, changes to Sum Insured, portfolio experience etc)



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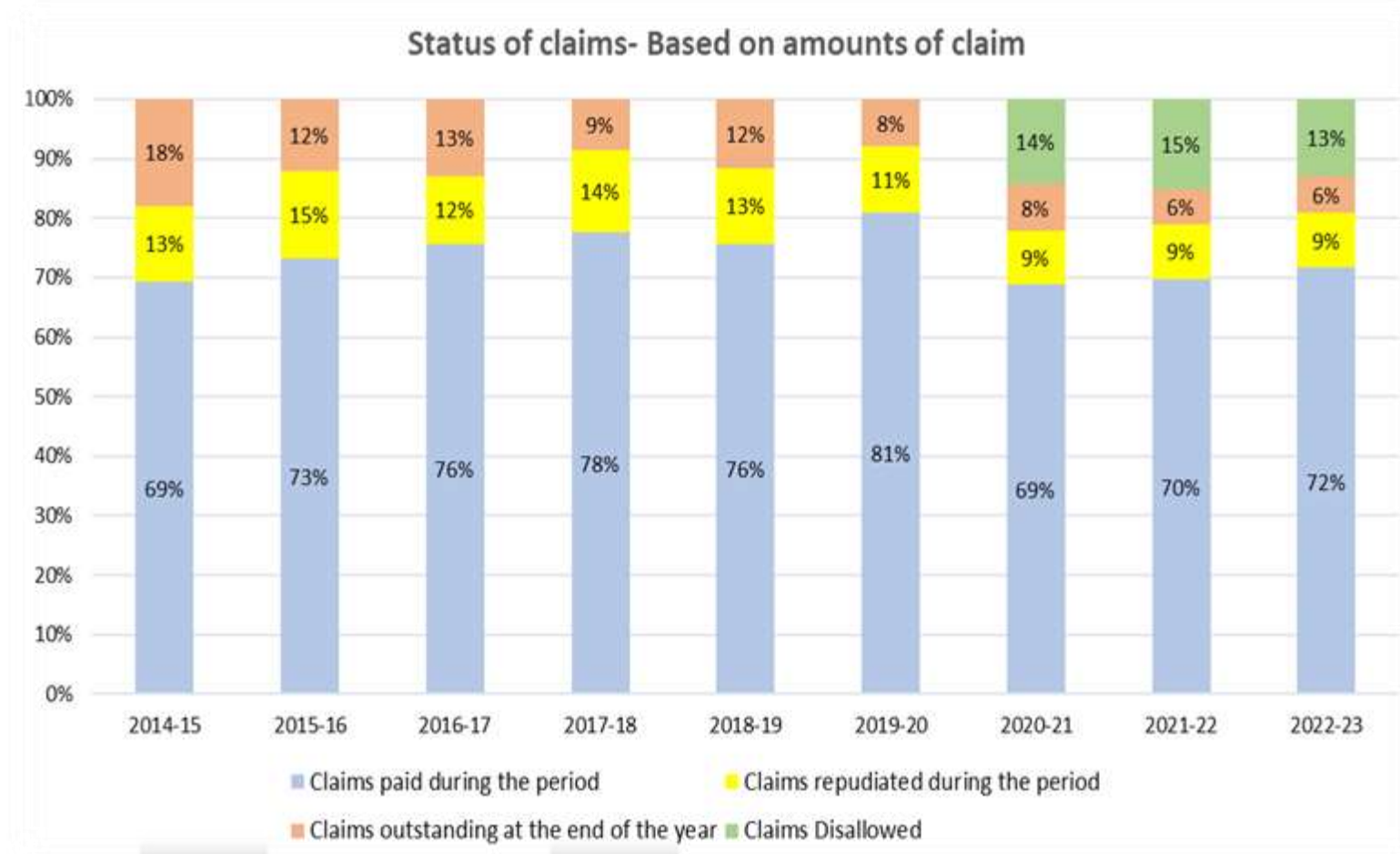
% of claims (#) paid constant in L9Y



Source: Handbook on Indian Insurance Statistics 2022-23

Disclosure: Includes Govt. sponsored, group insurance schemes, individual family floater & individual other than family floater policies

Lower proportion claims (₹) paid in L3Y



Source: Handbook on Indian Insurance Statistics 2022-23

Disclosure: Includes Govt. sponsored, group insurance schemes, individual family floater & individual other than family floater policies

Multiple reasons for rejections, lower payout

- Non-submission of documents or incorrect/ incomplete documentation.
- Benefits not covered under policy T&Cs
- Deductions/ co-pay.
- Policy exclusions.
- Claims during waiting periods.
- Non-disclosure of Material Information e.g. medical history
- Frauds.
- Sum insured/ limit exhausted.
- Policy is lapsed/expired.
- Consumable items.
- Cause of claim is beyond policy conditions

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Referred regulations and circulars

- 1 IRDAI (Insurance Products) Regulation (20th Mar 2024)
- 2 Protection of Policyholders' Interests, Operations & Allied Matters of Insurers Regulations (20th March 2024)
- 3 Master Circular on Protection of Policyholders' Interests (5th Sep 2024)
- 4 Master Circular on Operations & Allied Matters of Insurers (19th Jun 2024)



Overview

Customer
information
sheet 01

Approval
for Cashless
facility 02

Procedure
for
settlement
of claims 03

Penalty
under
Ombudsman
award 04

Rationalisation
of provisions 05

Long term
impact: PHs
& Insurer 06

Customer information sheet (CIS)

1. Important information and basic features of the policy issued at one place.
2. Duly signed by the Life Insured and authorized sales person.
3. Covers following key details-
 - a. Type of insurance, sum Insured, coverage provided, exclusions
 - b. Sub-limits ,deductibles and waiting period(s)
 - c. Information related to Claims Procedure,
 - d. Policy Servicing and Grievance Redressal
 - e. TAT for policy servicing, cashless approvals, claim processing etc.



Customer information sheet (CIS)

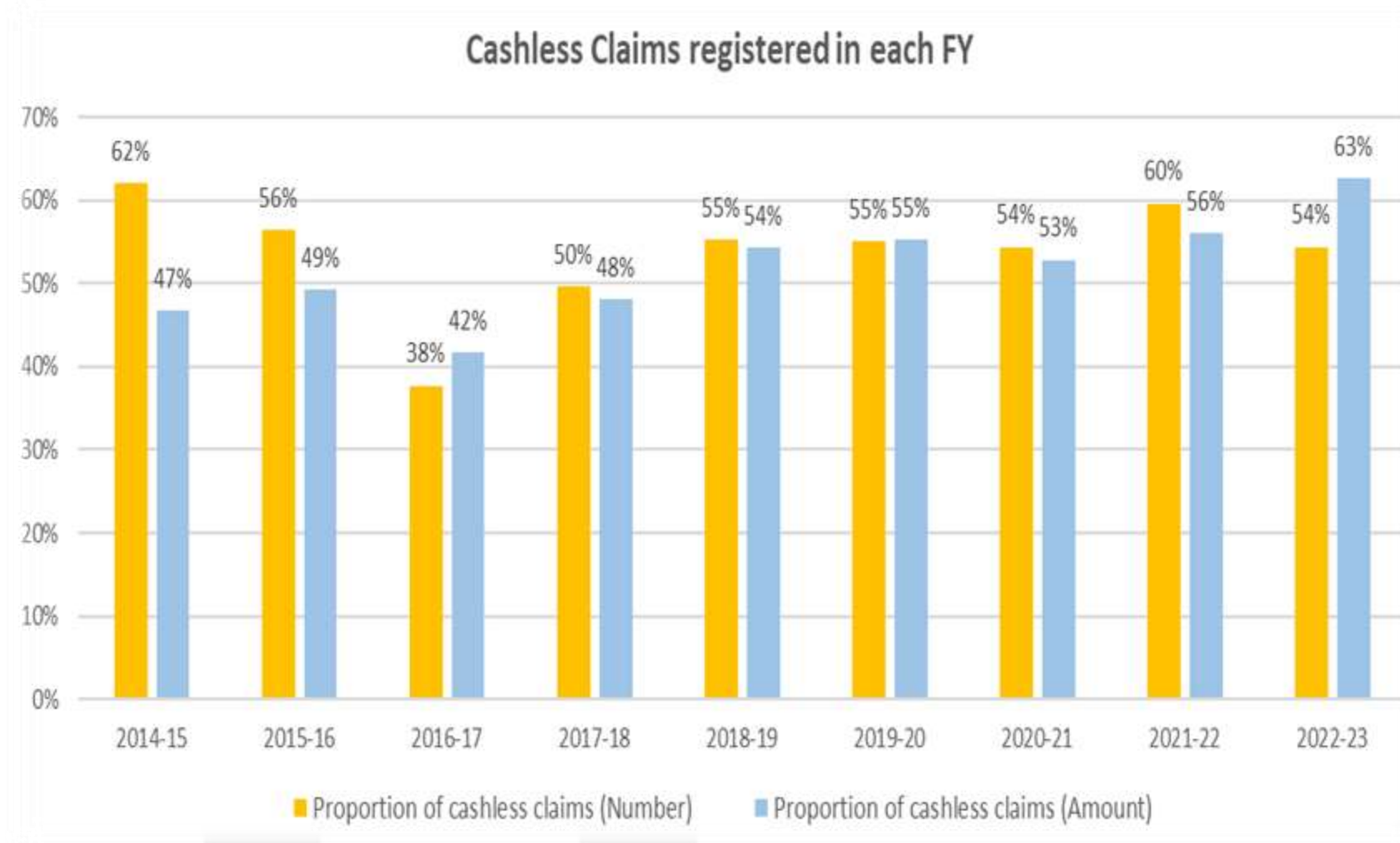
4. Classifications of exclusions:

- a. Standard exclusions applicable to all policies
- b. Specific to the policy which cannot be waived
- c. Can be opted for cover by paying additional premium

5. Categorization of policy conditions:

- a. Precedent to the contract
- b. Applicable during the contract
- c. When a claim arises

Cashless claims statistics



Source: Handbook on Indian Insurance Statistics 2022-23

Disclosure: Includes Govt. sponsored, group insurance schemes, individual family floater & individual other than family floater policies

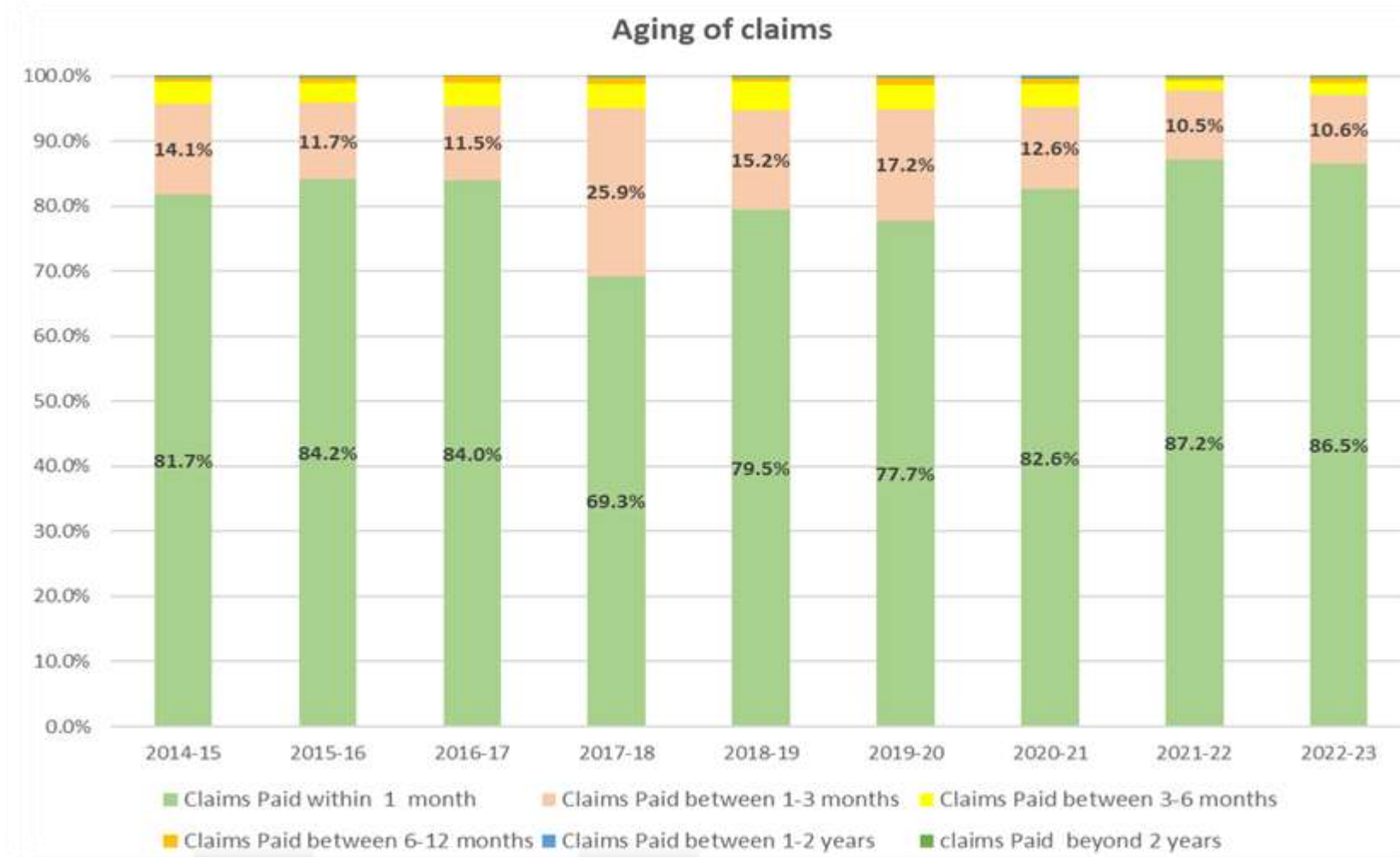
Approval for cashless facility

Insurer shall-

- Strive to achieve **100% cashless** claim settlement in a time bound manner.
- Decision on Authorization **not more than 1 hour** of receipt of request.
- Grant **final authorization within 3 hours** of the receipt of discharge authorization request from the hospital.
- Built **necessary systems and procedures** in place not later than 31st July, 2024.
- Dedicated Help desk in physical mode in hospitals.
- Pre-authorization to PHs through digital mode.



Marginal increase in claims paid in <1 mth



Source: Handbook on Indian Insurance Statistics 2022-23

Disclosure: Includes Govt. sponsored, group insurance schemes, individual family floater & individual other than family floater policies

Procedure for settlement of claims

- Well defined claims settlement procedures within prescribed TATs
- Settlement of claims (other than cashless) within 15 days from submission of claim documents.
- Insurers & TPA are responsible for collection of the required documents from the hospitals.
- Creation of Claims Review Committee (CRC) to oversee claim repudiation
- Detailed reasons for claim repudiation/partially settlement
- No claim shall be rejected or closed for
 - want of documents or for delayed intimation of claim.
 - non-availability of details of members of the group.

Procedure for settlement of claims

- No additional deductions from the claim amount in the name of any other exclusions if it is not made part of policy document .
- In case of multiple policies held by policyholders from different insurer the primary Insurer shall coordinate with other Insurers

Key changes vs. earlier guidelines

Clause	Current Provision	Earlier Provision
Pre-existing disease (PED)	Maximum 36 months prior to date of commencement of policy	Maximum 48 months prior to date of commencement of policy
Specific Waiting period	Maximum 36 months from date of commencement of policy	Maximum 48 months from date of commencement of policy
Moratorium period	Maximum 60 months from date of commencement of policy	Maximum 96 months from date of commencement of policy
Penalty under Ombudsman award	₹5,000/- per day payable if not complied within 30 days if not challenged by insurer.	No such penalty was applicable earlier

Impact on Policyholders

- Push for cashless settlements will bring in **convenience, eliminates need for upfront payments** during medical emergencies.
- Board approved policy for hospital empanelment to **improve quality of treatment offered.**
- **Reduced need for documentation** and hassle-free experience.
- Adoption of technology leading to **faster and accurate claim settlements** thus reducing grievances.
- Reduction in frauds, reduction in per claim processing cost can benefit via **lower premiums.**

Impact on Policyholders

- **Reduced mis-selling** due to increased disclosures, better understanding of the policy coverages and T&Cs.
- **Informed decision making** thereby fostering innovation and development of need based products (introduction of CIS).
- **Policyholder empowerment** thereby increasing trust in the insurance process & industry as a whole.



Impact on Insurers

- Striving for 100% cashless
 - Robust IT systems
 - Increased hospital empanelment
 - Deployment of increased workforce
 - Tariff arrangements, package agreements (administratively/operationally heavy activity)
- **High investments in technology** due to change in existing processes
- **System integrations** - interoperability between various platforms (e.g. driving settlements through NHCX)
- **Lack of appropriate product suite & data** to price diverse customer segments and develop tailor made products. (e.g. HIV Aids, Missing middle, PWD ,surrogate mother etc.)



Impact on Insurers

- Lower PED's waiting & moratorium periods can lead to **increase in cost & anti-selection**
- **Added responsibilities to Insurer**
 - To meet TATs to avoid penalty imposition
 - Enhanced disclosures
- **Increased regulatory, legal operational risks**

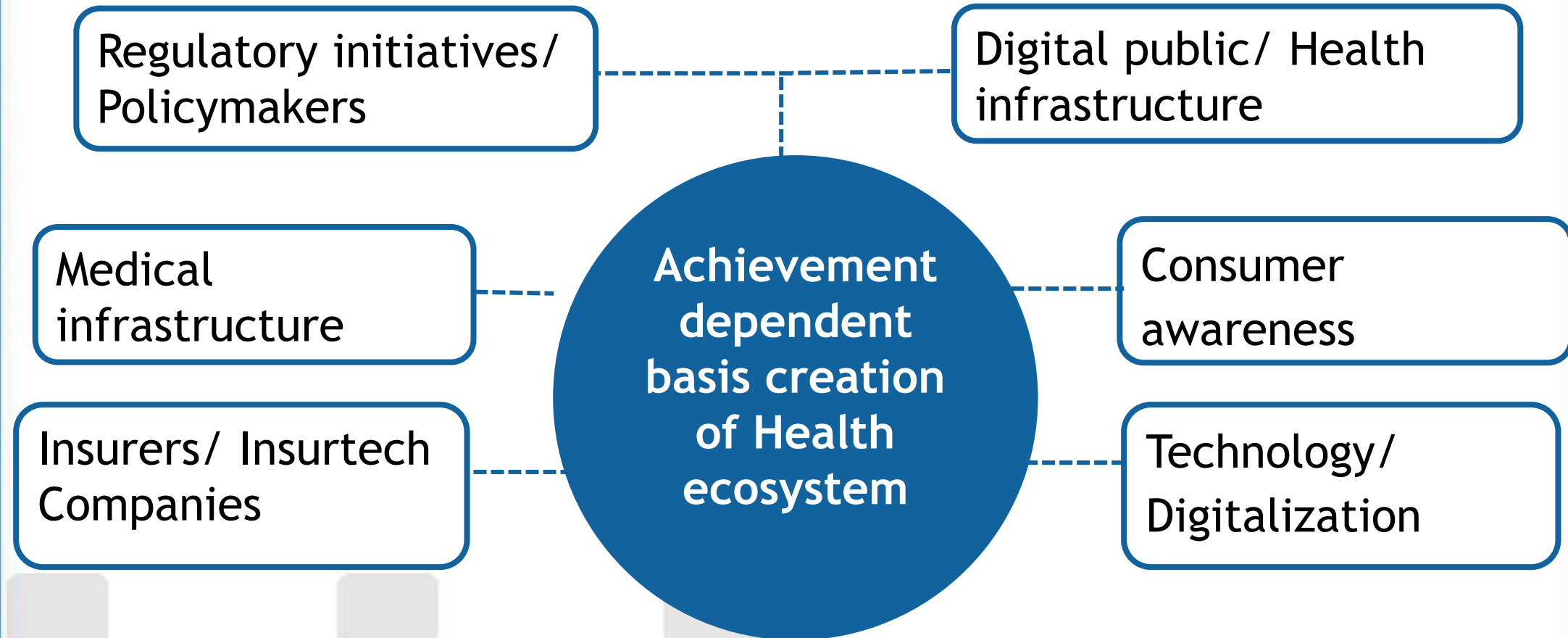


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The Path Forward



The Path Forward

➤ Regulatory/ Government Initiatives

- Launch of Ayushman Bharat Digital Mission (ABDM)- Digitalizing medical records, creation of unique patient id
- National Health Claims Exchange (NHCX) platform- Facilitate claim settlements between Health care providers and Insurers
- Digital Personal Data Protection (DPDP) Act- Ensure data privacy between policyholders and insurers

➤ Investments in technology

- E.g. AML, Block chain, system upgrades to deliver better results
- Drive real time claim settlements, minimize fraud & reduce TATs
- Ensure interoperability of systems between health care providers
- Data integration



The Path Forward

➤ Role Of Insurers

- Developing personalized, simple, & value-based products to address protection gaps, information gaps
- Regular communications with policyholders to increase transparency
- Creating dedicated helplines for vulnerable e.g. senior citizens
- Engaging & training distribution professionals to reduce policyholder grievances
- Increase in network hospitals to facilitate cashless facility.



The Path Forward

- Efforts to create & increase **consumer awareness** about insurance
- **Medical Infrastructure**
 - Increase in number of hospitals & medical professionals
- Engaging with **Insurtech companies** to jointly develop efficient claim solutions e.g. enhance user experience, improve systems, website accessibility, developing care management platforms etc.



THANK YOU!

