

Diploma in **INSURANCE SERVICES**

Module 4: Health Insurance



Open Vocational Educational Programme

Diploma in Insurance Services

4



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Welcome to the course "Diploma in Insurance Services".

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This one year programme provides individuals with specialized knowledge and skills related to the insurance industry. This course provides basic knowledge of Life, General and Health insurance that enable learners to understand and appreciate their professional career in the right perspective. Inputs that you receive in this course will assist you in comprehending how and why you could decide to pursue it as a career since Insurance Sector is one of the most demanding careers in today's market.

This course has five modules, namely Skill India and BFSI Introduction to Insurance, Life Insurance, Non-Life Insurance, Health Insurance and Regulatory Aspects in Insurance. Each module has been designed keeping in view the requirements of self-motivated learners like you. The texts are written in simple language, supplemented by pictures and figures to lend clarity to the content. You will find the lessons interesting and will be able to apply your knowledge in real-life situations. So, read all these lessons carefully and prepare well for the examinations. You ultimately have to enter the competitive world and your success at the place of work will depend on how skillfully you have performed your assigned job.

As this is a vocational course which is skill based so master your skills, practical training is must. So, we request you to kindly attend the Personal Contact Programme (PCP) at your allotted Accredited Vocational Institutes (AVIs).

I hope this study material will be very helpful to the learners who have registered for this course. Our sincere thanks go to the experts of the course writing and editing team (list given elsewhere in this booklet) who worked very hard in revising this self instructional material, particularly to Dr. Sunil Kadyan and his team, who had excellently revised the Qualification Packs (QPs) as per the BFSI Sector Skill Council.

In case you have any difficulty in your studies, do not hesitate to write to us at dirvoc@nios.ac.in

Wishing you good luck and success!

Ms. Anitha Nair

Deputy Director

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How to use the Learning Material

Congratulations! You have accepted the challenge to be a self-learner. It means, you have to organize your study, learn regularly, keep up your motivation and achieve your goal. Here it is solely you, who is responsible for your learning. NIOS is with you at every step. It has developed the material in Diploma in Insurance Services keeping only you in mind. A format supporting independent learning has been followed. You can take the best out of this material if you follow the instructions given below.



Title: will give a clear indication of the contents within. Do read it.



Introduction: This will introduce you to the lesson linking it to the previous one.



Objectives: These are statements that explain what you are expected to learn from the lesson. The objectives will also help you to check what you have learnt after you have gone through the lesson. Do read them.



Notes: Each page carries empty space in the side margins, for you to write important points or make notes.



Intext Questions: Very short answer self check questions are asked after every section, the answers to which are given at the end of the lesson. These will help you to check your progress. Do solve them. Successful completion will allow you to decide whether to proceed further or go back and learn again.



What You Have Learnt: This is the summary of the main points of the lesson. It will help in recapitulation and revision. You are welcome to add your own points to it also.



Terminal Questions: These are long and short questions that provide an opportunity to practice for a clear understanding of the whole topic.



Answers To Intext Questions : These will help you to know how correctly you have answered the questions.



Learning Outcomes: This box provides additional information. The text in boxes is important and must be given attention. It is not meant for evaluation, but only to improve your general knowledge.

Activities: Certain activities have been suggested for better understanding of the concept.

www Web site: These websites provide extended learning. Necessary information has been included in the content and you may refer to these for more information.

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Regulatory Aspects in Insurance

CAREER OPPORTUNITIES



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**1**

HEALTH INSURANCE IN INDIA (PART - 1)

1.0 INTRODUCTION

This chapter will brief you about the evolution of health insurance in India. It will also discuss about various levels of healthcare in India (primary, secondary and tertiary). The chapter also focusses upon the factors (demographic factors, social trends and life expectancy) affecting healthcare system in India. The chapter also lists various determinants of healthcare (lifestyle factors, environmental factors and genetic factors). Finally, it will brief about Employees State Insurance Scheme and Central Government Health Scheme prevailing in India.



1.1 OBJECTIVES

After reading this lesson, you will be able to:

- Discuss the evolution of health insurance in India.
- Explain the concept of healthcare and the types and levels of healthcare.
- Appreciate the factors affecting healthcare in India and the progress made since independence.

1.2 HEALTHCARE

Although everyone is aware that "Health is Wealth," have you ever looked into what "Health" actually entails? The word "health," which signifies "soundness of the body," was derived from the word "hoelth." In the past, good health was revered as a "Divine Gift," while people with illness were thought to have sinned their way into their illnesses. Hippocrates, the father of medicine and a Greek physician who lived from 460 to 370

Health Insurance



Notes

BC, claimed that environmental, sanitary, personal, and dietary variables all contribute to illness.

Ayurveda, an Indian medical system that predated Hippocrates by many years, saw health as a delicate balance of four fluids: blood, yellow bile, black bile, and phlegm. An imbalance of these fluids results in disease. Susruta, the Father of Indian Medicine, is renowned for performing intricate procedures at a period when the West was still in the dark about them. The World Health Organization provided a widely accepted definition of health in 1948, stating that "health is a condition of complete physical, mental, and social well being and not only the absence of sickness." It should be mentioned that Indian medical systems, such as Ayurveda, have long embraced such a comprehensive understanding of health.

Definitions

World Health Organization (WHO): Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease.

1.2.1 Determinants of Health

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

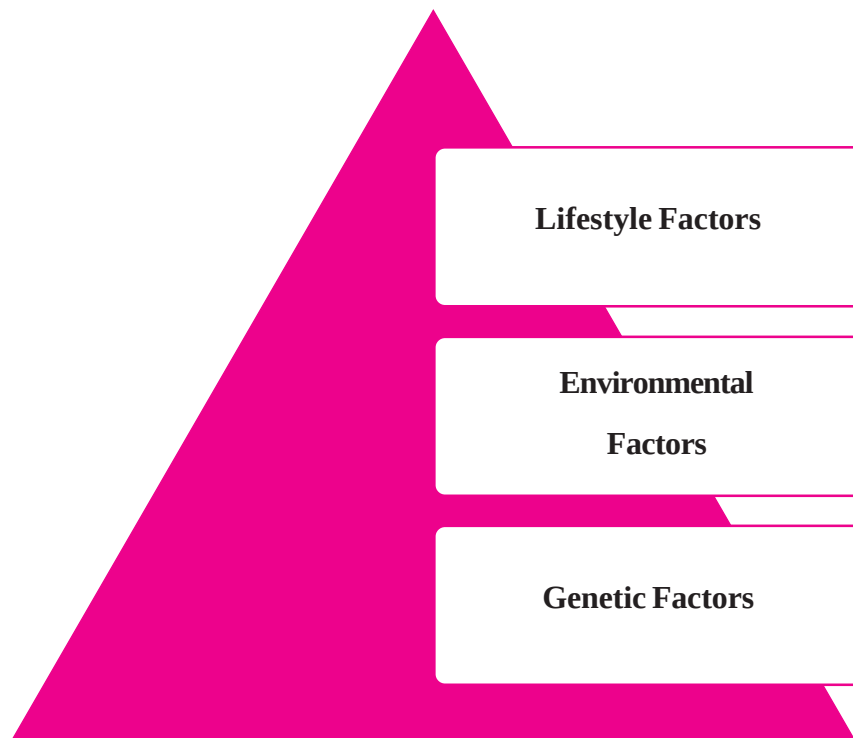


Figure 1.1: Determinants of health of an individual



Notes

a) Lifestyle Factors

Lifestyle factors are those that are largely within the individual's control, such as regular exercise, a healthy diet, and avoiding stress. Conversely, unhealthy lifestyles and habits, such as smoking, drug use, unprotected sex, and a sedentary way of life (with no exercise), can result in diseases like cancer, AIDS, obesity, hypertension, and diabetes.

b) Environmental Factors

Lack of access to safe drinking water, sanitary conditions, and nutritious food can result in major health problems, which are prevalent worldwide, but notably in developing nations. Certain diseases are also caused by environmental factors, for example, people working in certain manufacturing industries are prone to diseases related to occupational hazards, such as Asbestos in workers in asbestos manufacture and also diseases of the lungs in coal miners. Communicable diseases like influenza and chickenpox, etc., are spread due to poor hygiene, diseases like malaria and dengue are spread due to poor environmental sanitation, while certain diseases are also caused by environmental factors.

c) Genetic Factors

Diseases may be inherited genetically from parents to offspring. These genetic characteristics lead to varying health patterns among the population that is dispersed throughout the world based on race, geography, and even communities.

It goes without saying that a nation's social and economic development is largely based on how well its citizens are doing. A healthy population not only supplies important resources that are essential for a rising nation like India but also a productive workforce for economic activities. Individually, poor health can result in loss of income, incapacity to carry out everyday tasks that are necessary for survival, push people into poverty, or even lead to suicide.

1.2.2 Levels of Healthcare

Healthcare is a set of services provided by various agencies and providers including the government, to promote, maintain, monitor or restore health of people. The essentials of an effective healthcare are as follows.

- Suitable to the needs of the people
- Comprehensive

Health Insurance



Notes

- Adequate
- Easily available
- Affordable

Every person has a different health status. The need for a person suffering from fever, cold, cough, skin allergies etc. is different from the one suffering from jaundice or typhoid and the need for person suffering from chronic ailments like cancer, AIDS, etc. is entirely different from the former two.

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 health care 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 nearest health care provider system e.g. doctors for heart related disease may not be readily available in a village but may be in a district or a town
How much of the health care system is likely to be used
Socio-economic factors such as affordability

Figure 1.2: Indicators for setting up a healthcare

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 healthcare affordable and accessible to the population.

1.2.3 Types of Healthcare

Healthcare is broadly categorized as follows:

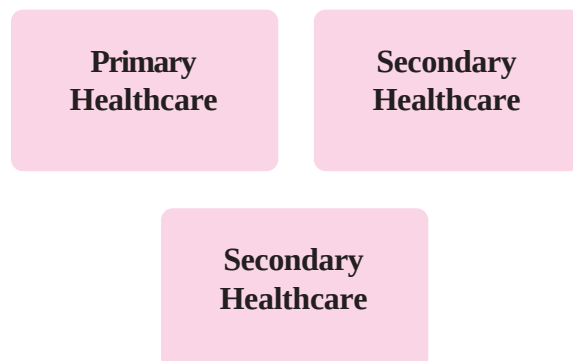


Figure 1.3: Types of healthcare

1. Primary Healthcare

Primary healthcare providers are the first point of contact for all patients within a health system, and they are defined as "the services provided by the doctors, nurses, and other minor clinics which are called first by the patient for any disease."

Primary healthcare receives a lot of attention in developed countries/nations in order to address health issues early on, before they spread nationwide, grow complicated, or become chronic. Primary healthcare facilities concentrate on preventative treatment, immunisations, education, medical counselling, etc. and refer patients to higher-level specialists as needed.

For instance, if a patient with fever seeks treatment at a primary healthcare facility and the primary healthcare physician determines that the patient has dengue fever, the primary healthcare physician will prescribe specific medications and, along with it, will advise the patient to be admitted to a hospital for specialised care that cannot be provided in a primary healthcare setting. When family members contact the doctor for minor health issues, the doctor serves as the "family doctor" in the majority of primary healthcare instances.

This technique aids the medical professional in prescribing for symptoms based on hereditary variables and providing appropriate medical recommendations. For instance, the doctor may counsel a patient with a family history of diabetes to monitor their lifestyle from an early age in order to prevent developing the disease.



Notes

Health Insurance



Notes

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



Figure: 1.4 Primary Healthcare Centres

2. Secondary Healthcare

When we talk about secondary healthcare, we mean "the healthcare services offered by medical specialists and other health professionals who typically do not have first contact with patient. It comprises emergency care, ambulance services, pathology, diagnostic, and other pertinent medical services, as well as acute care requiring treatment for a serious illness for a brief length of time, frequently (but not always), as an in-patient.

Most frequently, primary healthcare practitioners or primary physicians will refer patients to secondary care. To offer integrated services, secondary care providers in certain cases also operate a "in-house" primary healthcare centre.

Depending on the population size, secondary healthcare providers are often located at the Taluk or Block level.



Figure: 1.5 Secondary healthcare centres



Notes

3. Tertiary Healthcare

The specialist consultation healthcare, typically for inpatients and on referral from primary/secondary care providers is what is meant by "tertiary healthcare." The state capitals and several district offices house the majority of the tertiary care providers.

For instance, oncology (cancer therapy), organ transplant facilities, high-risk pregnancy specialists, etc., are examples of tertiary health care providers who have advanced medical facilities and medical professionals outside the purview of secondary health care providers.

It should be remembered that costs for care rise in direct proportion to the level of care. While consumers may find it relatively simple to pay for primary care, they find it more harder to spend money on secondary care and much harder on tertiary care. In addition to varying from country to country and from rural and urban locations, the infrastructure for various levels of care is also influenced by socioeconomic variables.



Figure: 1.6 Tertiary Healthcare Centres

S. No.	Basis of difference	Primary Health care	Secondary Health care	Tertiary Health care
1	Size (Clinic)	Small	Medium (Nursing home or Hospital)	Large (Super specialty Hospital)
2	Type of illness	Common fever, cold, cough etc.	Acute infections, diagnostic facilities, ICU, etc.	Cancer, Heart diseases Organ Transplant facilities, High risk pregnancy specialists, etc.

Module - 4

Health Insurance



Notes

HEALTH INSURANCE IN INDIA (PART - 1)

3	Location level	Village level	Taluka/ district	State capitals, few at the district headquarters
4	Cost of treatment	Economical	Moderate	Expensive

Table 1.1: Healthcare in brief



INTEXT QUESTIONS 1.1

- Who is the father of Indian medicine?
 - Aesculapius
 - Susruta
 - Samuel Hahnemann
 - Charaka Samhita
- The word "Health" was derived from the word "hoelth" which means
 - Soundness of the body
 - Wellness of the body
 - Healing of the body
 - Positivity of the body
- Who is the father of medicine?
 - Aesculapius
 - Susruta
 - Samuel Hahnemann
 - Hippocrates
- The Indian system of Ayurveda, considered health as a delicate balance of four fluids: _____, _____, _____ and _____ and an imbalance of these fluids causes ill health.
 - Blood, yellow bile, black bile and phlegm
 - blood, yellow bile, black bile, fibre
 - Blood, yellow bile, phlegm, fibre



- d) Yellow bile, black bile, fibre, phlegm
5. World Health Organisation (WHO): Health is a state of complete physical, _____ and social wellbeing and not merely the absence of disease.
- a) Mental
- b) Educational
- c) Cognitive
- d) emotional
6. What are the various determinants of healthcare?
- a) Lifestyle, environmental and genetic factors
- b) Lifestyle, environmental and educational factors
- c) Legal, environmental and genetic factors
- d) Lifestyle, social and genetic factors
7. Which of the following are not determinants of health systems in India?
- a) Lifestyle factors
- b) Environmental factors
- c) Genetic factors
- d) Legal factors
8. Which of the following is not an indicator of health care?
- a) Size of population
- b) Disability rate
- c) Social and mental health of the people
- d) Educational qualifications
9. Which of the following are types of health care?
- a) Primary healthcare, Secondary healthcare, Tertiary healthcare
- b) National healthcare, Secondary healthcare, Tertiary healthcare
- c) Primary healthcare, District level healthcare, Tertiary healthcare
- d) District level healthcare, State level healthcare, Central Level healthcare

Health Insurance



Notes

10. Which is the most expensive type of health care?
 - a) Primary healthcare
 - b) Secondary healthcare
 - c) Tertiary healthcare
 - d) All are equal
11. Which health care will provide treatment for a kidney transplant?
 - a) Primary healthcare
 - b) Secondary healthcare
 - c) Tertiary healthcare
 - d) None of the above
12. Which healthcare will provide treatment for cold and cough?
 - a) Primary healthcare
 - b) Secondary healthcare
 - c) Tertiary healthcare
 - d) None of the above

1.3 FACTORS AFFECTING THE HEALTH SYSTEMS IN INDIA

The Indian health system is continuously facing many problems and challenges. These, in turn, affect the nature and extent of the healthcare system and the requirement at the individual level and healthcare organization at the structural level. These are discussed below:

1. Demographic or Population related trends
2. Social trends
3. Life expectancy

**Demographic or
Population related
trends**

- India is second largest populated country in the world.
- High growth rate of population increase the poverty level effecting the people's capacity to pay for medical expenses

**Social trends**

- Increasing urbanisation rates and rural-to-urban migration have made it more difficult to provide healthcare.
- Rural areas continue to experience health difficulties because medical facilities are not readily accessible, affordable, or available.
- Lethargic lifestyle with less exercise has led to increase in diseases like diabetes and high blood pressure.

Life Expectancy

- It refers "to the expected number of years that a child born today will survive."
- Life expectancy has increased from 30 years at the time of independence to over 60 years today but does not address the issues related to quality of that longer lifespan which leads to a new concept of "healthy life expectancy."
- This requires the creation of infrastructure for "Geriatric" (old age related) diseases.

Figure 1.7: Factors affecting the health systems in India

1.4 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:

a) Employees' State Insurance Scheme

The health insurance in India was officially started after the introduction of Employees State Insurance Scheme" through the ESI Act, 1948 for blue-collar workers working in private sector offering services through various clinics and hospitals.

Employees State Insurance Corporation, the implementing agency, manages its own hospitals and pharmacies in addition to hiring public and private providers when its in-house resources are insufficient.

Under the contributory system, which involves employee and employer contributions of 1.75 and 4.75% of pay rolls, respectively, and state government contributions of 12.5% of medical costs, all employees earning salaries up to Rs. 15,000 are covered.

Health Insurance



Notes

The benefits covered include:

- Free comprehensive healthcare at ESIS facilities
- Maternity benefit
- Disability benefit
- Cash compensation for loss of wages due to sickness and survivorship and
- Funeral expenses in case of death of worker

Employees' State Insurance Scheme

- Introduced vide the ESI Act, 1948
- 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.
- All workers earning wages up to Rs.15,000 are covered under the contributory scheme where in employee and employer contribute 1.75% and 4.75% of pay roll respectively; state governments contribute 12.5% of the medical expenses.
- It covers benefits like free comprehensive healthcare at ESIS facilities, Maternity benefit, Disability benefit, Cash compensation for loss of wages due to sickness and survivorship and, Funeral expenses in case of death of worker

Central Government Health Scheme

- 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
- It is partly funded by the employees and largely by the employer (central government).
- Services are provided through CGHS's own dispensaries, polyclinics and empanelled private hospitals.
- It covers all systems of medicine emergency services in allopathic system, free drugs, pathology and radiology, domiciliary visits to seriously ill patients, specialist consultations etc.

Figure 1.8: Features of ESIS & CGHS

b) Central Government Health Scheme

The Central Government Health Scheme (CGHS), which was introduced in 1954 for central government employees, pensioners, and their family members working in civilian jobs. It aims at providing complete medicare to the workers and their family members. The CGHS has its own polyclinics, empanelled private hospitals, and dispensaries. It includes all medical specialties, allopathic emergency services, free medications, pathology and radiography, home visits for very ill patients, specialist consultations, etc.

**Notes****INTEXT QUESTIONS 1.2**

1. Life expectancy refers to the expected number of that a child born today will survive.
 - a) Weeks
 - b) Months
 - c) Years
 - d) Days
2. India is _____ largest populated country in the world
 - a) First
 - b) Second
 - c) Third
 - d) Fourth
3. Diseases like diabetes and high blood pressure are caused due to
 - a) Inactive Lifestyle
 - b) Hyperactive Lifestyle
 - c) Socially active Lifestyle
 - d) All of the above

Health Insurance



Notes

4. Life expectancy addressing the issues related to quality of longer lifespan is known as
 - a) Geriatric
 - b) healthy life expectancy
 - c) high life expectancy
 - d) None of the above
5. What is the full form of ESIS?
 - a) Employees' State Insurance Scheme
 - b) Employers' State Insurance Scheme
 - c) Employees'Subsidy Insurance Scheme
 - d) Employers'Subsidy Insurance Scheme
6. What is the maximum wage limits under ESIS?
 - a) 25000
 - b) 15000
 - c) 10000
 - d) 30000
7. Apart from employee who contributes funds in CGHS?
 - a) State Government
 - b) Central Government
 - c) None of the above
 - d) All of the above



INTEXT QUESTIONS

Government rules have helped India's insurance industry move through a number of stages. Governments play a significant role in developing an effective healthcare system since the health of their citizens is very essential. The level of healthcare offered is influenced by a variety of population-related factors. Depending on the amount of treatment needed, there are three types of healthcare: primary, secondary, and tertiary.

Each level of healthcare costs more, with tertiary care being the most expensive. India faces unique problems including urbanisation and population increase that call for appropriate healthcare. Two significant health insurance programmes in our nation are the Employees' State Insurance Scheme and the Central Government Health Scheme.



TERMINAL QUESTIONS

1. What do you understand by healthcare? Discuss in detail the determinants of health care.
2. Explain the levels of healthcare in detail using examples.
3. What are the factors affecting the health systems in India?
4. Explain in brief Employees' State Insurance Scheme.
5. Explain in brief Central Government Health Scheme.



ANSWERS TO INTEXT QUESTIONS

1.1

1. (b) Susruta
2. (a) soundness of the body
3. (d) Hippocrates
4. (a) blood, yellow bile, black bile and phlegm
5. (a) Mental
6. (a) Primary healthcare, Secondary healthcare, Tertiary healthcare
7. (d) Legal factors
8. (d) Educational Qualifications
9. (a) Primary healthcare, Secondary healthcare, Tertiary healthcare
10. (c) Tertiary healthcare
11. (c) Tertiary healthcare
12. (a) Primary healthcare



Notes

Health Insurance



Notes

1.2

1. (c) Years
2. (b) Second
3. (a) Inactive lifestyle
4. (b) Healthy life expectancy
5. (a) Employees' State Insurance Scheme
6. (b) 15000
7. (b) Central Government



LEARNING OUTCOMES

After studying this chapter, you are able :

- To explain how health insurance evolved in India with the concept of healthcare and the types and levels of healthcare.
- To explain the features of different types of health schemes implemented by the govt. in India.

2

HEALTH INSURANCE IN INDIA (PART-2)

**Notes**

2.0 INTRODUCTION

Healthcare industry in India is on the road of becoming one of the largest sectors - both in terms of revenue and employment in India. Healthcare comprises of hospitals, medical devices, pharmaceutical industry, outsourcing, telemedicine, medical tourism, health insurance and medical equipment. Etc. This chapter will discuss about commercial health insurance in the health insurance market. The chapter will focus upon the concept of insurance intermediaries-agents, brokers, TPA's (old), insurance marketing firms, web aggregators (new) available for distribution of health insurance products in India. The chapter will also explain the infrastructure setup of public, private and pharmaceutical industry to promote health insurance in India.

2.1 OBJECTIVES

After studying this chapter, you are able :

- Explain the concept of commercial health insurance
- Appreciate the types of health care facilities set up at different levels in the country
- Explain the concept of Health Insurance intermediaries
- Discuss the various entities associated with health insurance sector.

2.2 COMMERCIAL HEALTH INSURANCE

Pre and post nationalisation of the insurance industry, the non-life insurers proposed

Health Insurance



Notes

the concept of commercial health insurance. The commercial health insurance was mostly available for the corporate clients that too for a limited extent. This segment was largely a loss making segment for the insurers.

All four of the nationalised non-life insurance companies introduced the first standardised health insurance policy for people and their families in the Indian market in 1986 (these were then the subsidiaries of the General Insurance Corporation of India). The insurers developed the Mediclaim insurance policy, which offered risk coverage for hospitalisation costs up to a certain annual indemnity amount with some limitations, such as pregnancy and pre-existing conditions.

The year 2001 has marked entry of various private players in the insurance industry which lead to tremendous growth of health insurance business in India. But there is still a large scope of health insurance in the country as there is still a big untapped market for health insurance. The insurers introduced various significant covers, exclusions and add on covers that will be discussed in the later chapters. Today, more than 270 health insurance products are available in the Indian market.

2.3 HEALTH INSURANCE MARKET

The existing health insurance market in India is made up of a number of participants known as providers who offer important healthcare services as well as a number of middlemen. A few number of providers offer services in the form of the fundamental infrastructure, while others offer supporting infrastructure. Some work for the government, while others are employed by businesses. These are briefly described below:

2.3.1 Infrastructure

1. **Public Health Sector:** The Public health system operates at the national level, state level, district level and to a limited extent at the village level. The public system at village level is for implementing the national health policies in villages with the help of community volunteers to serve as a link between the village community and government infrastructure. Public system at village level includes:



Figure 2.1: Human Resource involved in public health sector at village level

- The Anganwadi workers (1 for every 1,000 population) are enrolled under the nutrition supplementation programme and the Integrated Child Development Service scheme (ICDS) of Ministry of Human Resource Development.
- The Trained Birth Attendants (TBA) and the Village Health guides (an earlier scheme of health departments in states).
- ASHA (Accredited Social Health Activist) volunteers are selected by the community under the NRHM (National Rural Health Mission) programme. ASHA volunteers are new, village-level, voluntary health workers trained to serve as a link for health care in the rural areas.

Sub-centres have been established for every 5,000 population (3,000 in hilly, tribal and backward areas). These sub-centres are managed by a female health worker, also called the Auxiliary Nurse Mid-wife (ANM) and a male health worker.

Primary Health Centres (PHCs) which are referral units. About six sub-centres have been established for every 27,000 population (20,000 in hilly, tribal and backward areas). All PHCs provide outpatient services, and the majority of these centres also have four to six in-patient beds. Their staff comprises of one medical officer and 14 para-medical workers (which includes a male and a female health assistant, a nurse-midwife, a laboratory technician, a pharmacist and other supporting staff).

Community Health Centres (CHCs) are the first referral units for four PHCs and also provides specialist care. According to the norms each CHC (for every 1 lakh population) should have at least 27 beds, one operation theatre, X-ray machine, labour room and laboratory facilities. It should be staffed by at least four specialists i.e. a surgeon, a physician, a gynaecologist and a paediatrician supported by 21 para-medical and other staff.

Rural Hospitals have also been set up which includes sub-district hospitals called as the sub-divisional / Taluk hospitals / specialty hospitals (estimated to be about 2000 in the country);



Notes

Health Insurance



Notes

Speciality and Teaching Hospitals are fewer and include the medical colleges (about 270 in number presently) and other tertiary referral centres. These are mostly in districts, towns and urban areas and some of these hospitals provide specialized and advanced medical services.

Other agencies belonging to the government, such as hospitals and dispensaries of railways, defence and similar large departments (Ports/ Mines etc.). These agencies also play an important role in providing health services. However, their services are often restricted to the employees of the concerned organizations and their dependents.”

Primary Health Centres	Community Health Centres	Rural Hospitals	Speciality and Teaching Hospitals	Other agencies belonging to the government
- Referral units for about six sub-centres - Established for every 27,000 population - Have 4-6 inpatient beds - Staff comprises of one medical officer and para-medical workers that includes a male and female health assistant, a nurse-midwife, a laboratory technician, a pharmacist and other supporting staff).	- First referral units for four PHCs and also provides specialist care. - Minimum 27 beds, one operation theatre, X-ray machine, labour room and laboratory facilities - Staffed by at least four specialists i.e. a surgeon, a physician, a gynaecologist and a paediatrician supported by 21 para-medical and other staff.	Includes the subdistrict hospitals called as the sub-divisional/ Taluk hospitals/ specialty hospitals	- These include the medical colleges - These are mostly in district towns and urban areas but some of them provide very specialized and advanced medical services.	- Hospitals and dispensaries of railways, defence and similar large departments (Ports/Mines etc.) - However, their services are often restricted to the employees of the concerned organizations and their dependents.

Figure 2.2: Public health care providers

2. Private Sector Providers

India has a sizable private healthcare industry that offers primary, secondary, and tertiary care services. These entities include non-profit organisations, for-profit businesses, corporations, trusts, sole practitioners, standalone specialty services, diagnostic centres, pharmacies, and unqualified providers (quacks).



Nearly 77% of allopathic (MBBS and above) physicians in India work for private practises. In India, private health expenditures makes up more than 75% of all health spending. 82% of all outpatient visits and 52% of hospital admissions in all of India are attributed to the private sector.

India also has the largest number of qualified practitioners in other systems of Medicine (Ayurveda/ Siddha/ Unani/ Homeopathy) which accounts for more than 7 lakh practitioners. These are located in the public as well as the private sector.

The community has access to health care services from NGOs and the voluntary sector in addition to for-profit private health care providers. More than 7,000 nonprofit organisations were reportedly active in health-related endeavours. Many secondary and tertiary hospitals are also registered as non-profit trusts or societies, and they make a considerable contribution to the provision of inpatient care to insured people.

3. Pharmaceutical Industry

India has a sizable pharmaceutical sector, which has expanded from a Rs 10 crore industry in 1950 to a Rs 55,000 crore enterprise today. This country is a major supplier of pharmaceuticals and health-related items (including exports). Over 6000 units are used for manufacturing, which employs about 5 million people.

The National Pharmaceuticals Pricing Authority (NPPA), which is under the Ministry of Chemicals, is the primary price regulator for this business. Out of the 500 or so bulk medications, only 76 are subject to price control, while the remainder medications and their manufacture are subject to a free-pricing system that is closely regulated by the price regulator. The Drug Controllers of the States manage the field force which oversees quality and pricing of drugs and production in their respective areas.



INTEXT QUESTIONS 2.1

1. In which year, the first standardized health insurance product for individuals and their families was launched in the Indian market?

a) 1956	b) 1972
c) 1912	d) 1986

Module - 4

HEALTH INSURANCE IN INDIA (PART - 1)

Health Insurance



Notes

2. How many subsidiaries of the General Insurance Corporation of India were there at the time of introducing the first standardised health insurance product?
 - a) 6
 - b) 7
 - c) 9
 - d) 4
3. Which of the following is not involved in the public health sector at village level?
 - a) The Anganwadi workers
 - b) Third Party Administrators
 - c) The Trained Birth Attendants (TBA)
 - d) ASHA (Accredited Social Health Activist)
4. What is the ratio of Anganwadi workers enrolled under the nutrition supplementation programme and the Integrated Child Development Service scheme (ICDS) of Ministry of Human Resource Development?
 - a) 1 for every 1,000 population
 - b) 10 for every 1,000 population
 - c) 100 for every 1,000 population
 - d) None of the above
5. What are the referral units for Sub centers called?
 - a) Community Health Centers
 - b) Primary Health Centers
 - c) Rural hospitals
 - d) Specialty and teaching hospitals
6. What are the referral units for Community Health Centre's called?
 - a) Sub Centres
 - b) Primary Health Centers
 - c) Rural hospitals
 - d) Specialty and teaching hospitals

- ## Notes

Insurance Companies especially in the general insurance sector provide the bulk of health insurance services. There are stand-alone health insurance companies also which provide these services. These were five standalone companies in the year 2019 which were providing health insurance in India with a likelihood of a few more to increase the health insurance provider network.

A number of people and organizations providing services as part of the insurance industry which are also the part of the health insurance market. All such intermediaries are governed by IRDAI. These include traditional and modern intermediaries:

Traditional	Modern
☐ Insurance Brokers	☐ Insurance Web Aggregators
☐ Insurance Agents	☐ Insurance Marketing Firms
☐ Third Party Administrators	

Figure 2.3: Insurance Intermediaries

2.6 OTHER IMPORTANT ORGANIZATIONS

There are a few more entities which are the part of health insurance market and these include:

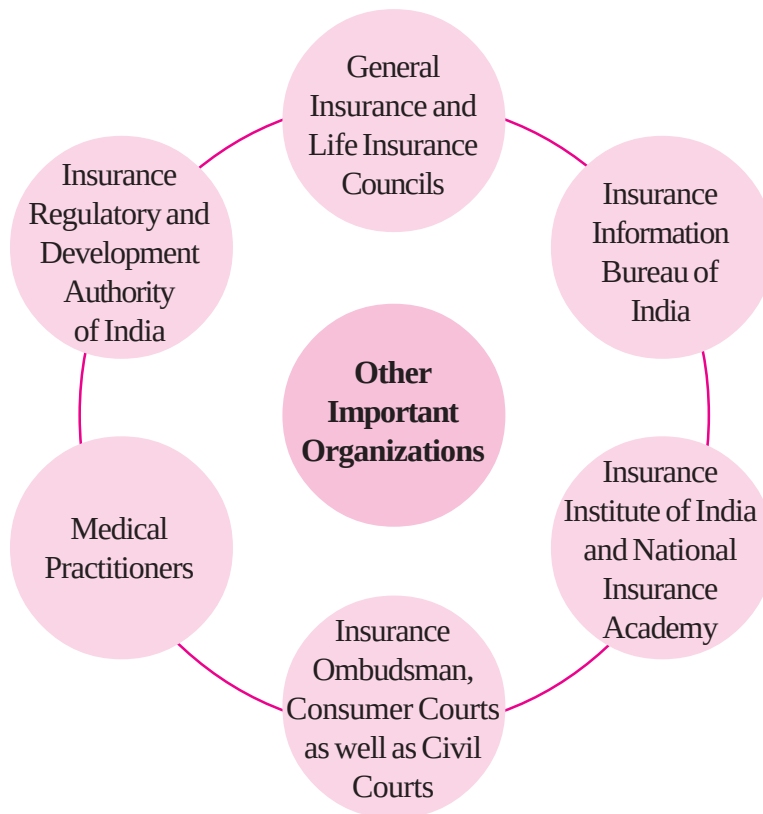


Figure 2.4: Other important organisations of Health Insurance Industry

1. The Insurance Regulatory and Development Authority of India (IRDAI), established by a law passed by the Indian Parliament, is the market regulator for the insurance industry. It was established in the year 2000 and is tasked with promoting the insurance industry as well as regulating it.
2. Councils for General Insurance and Life Insurance, which also advise IRDAI on how to run their respective life or general insurance businesses.
3. IRDAI promoted the Insurance Information Bureau of India in 2009; it is a recognised society with a governing council made up of 20 individuals, the majority of whom work in the insurance industry. For the insurance industry, it gathers, examines, and produces various sector-level reports to enable data-based and scientific decision making, including pricing and structuring of business plans. Additionally, it gives the Government and the Regulator important inputs to help them make policy. For the benefit of the industry, the Bureau has produced a large number of reports, both recurring and one-time.

4. Educational institutions that offer a variety of insurance and management-related training, including the Insurance Institute of India and National Insurance Academy, as well as a number of private training institutions that offer training for insurance careers
5. Medical professionals also help insurance companies and TPAs determine the potential clients' health insurance risks during risk acceptance and offer guidance to insurance firms in the event of challenging claims.
6. In the health insurance industry, legal entities including the Insurance Ombudsman, Consumer Courts, and Civil Courts also play a significant role in resolving consumer complaints.

**Notes****INTEXT QUESTIONS 2.2**

1. Which of the following is the price regulator for the Pharmaceutical industry in India?
 - a) National Pharmaceuticals Pricing Authority (NPPA)
 - b) Ministry of Chemicals
 - c) Health Ministry
 - d) None of the above
2. Which among the following is not an insurance intermediary
 - a) Agent
 - b) Broker
 - c) TPA
 - d) IRDAI Secretary
3. Which of the following cannot carry business for more than one insurance company?
 - a) Broker
 - b) TPA
 - c) Agent
 - d) All of the above
4. Which among the following is the latest type of intermediaries in insurance sector?
 - a) Agents & Brokers
 - b) Insurance Web Aggregators & Insurance Marketing Firms
 - c) Agents & Insurance Marketing Firms
 - d) Brokers & Insurance Web Aggregators

Health Insurance



Notes

5. Which among the following is the function of Insurance marketing firms?
 - a) Insurance Selling Activities
 - b) Insurance Servicing Activities
 - c) Financial Products Distribution
 - d) All of the above
6. Which is the Insurance regulator formed by an Act of Parliament which regulates all business and players in the insurance market?
 - a) GIC
 - b) SEBI
 - c) IRDAI
 - d) None of the above
7. Which amongst the following is not the function of Insurance Information Bureau?
 - a) collects analyses and creates various sector-level reports for the insurance sector
 - b) enable data-based and scientific decision making including pricing and framing of business strategies
 - c) Provides key inputs to the Regulator and the Government to assist them in policymaking.
 - d) All of the above
8. Which of the following is an educational institution that provides wide variety of insurance and management related training?
 - a) Insurance Institute of India
 - b) National Insurance Academy
 - c) Both a) and b)
 - d) None of the above
9. Which of the following are the legal entities that play a role in the health insurance market when it comes to redressal of consumer grievances?
 - a. Insurance Ombudsman
 - b. Consumer courts
 - c. Civil courts
 - d. All of the above



WHAT YOU HAVE LEARNT

Government health insurance programmes were also the first, with commercial insurance from private insurance firms following later. The health insurance market is made up of a wide range of participants, some of whom provide the infrastructure while others offer insurance services. In addition, brokers, agents, and third-party administrators serve as intermediaries for the health insurance industry, and other legal, regulatory, and educational organisations also play a part.

The Insurance Regulatory and Development Authority, General Insurance and Life Insurance Councils, Insurance Information Bureau, Educational Institutions, Medical Practitioners, Legal Entities such as the Insurance Ombudsman, Consumer Courts, as well as Civil Courts are additional entities that make up the health insurance market. Insurance One of the most recent categories of service providers to fall under IRDAI laws is Web Aggregators. They can use distance marketing to entice customers to buy insurance through their website and/or telemarketing. The most recent intermediary kinds to be subject to IRDAI regulation are insurance marketing firms. They can carry out the tasks by hiring people who are authorised to market and distribute goods.



TERMINAL QUESTIONS

1. Discuss the concept of Commercial Health insurance in India.
2. Explain the Health Insurance market in India with special reference to private health sector & public health sector infrastructure.
3. Explain the Health Insurance market in India with special reference to pharmaceutical industry.
4. Describe the various intermediaries that are available for distribution of health insurance products in India.
5. Discuss the various entities associated with health insurance sector in India.



ANSWERS TO INTEXT QUESTIONS

2.1

1. (d) 1986
2. (d) 4
3. (b) Third Party Administrators



Notes

Health Insurance



Notes

4. (a) 1 for every 1000 population
5. (b) Primary Health Centers
6. (b) Primary health centers
7. (b) 4&27
8. (d) All of the above
9. (d) Keto

2.2

1. (a) National Pharmaceuticals Pricing Authority (NPPA)
2. (d) IRDAI Secretary
3. (c) Agent
4. (b) Insurance Web Aggregators & Insurance Marketing Firms
5. (d) All of the above
6. (c) IRDA
7. (d) All of the above
8. (c) Both (a) and (b)
9. (d) All of the above



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To describe the types of health care facilities set up at different levels in our country.
- To explain the functions of intermediaries involved in Indian insurance market.



HEALTH INSURANCE PRODUCTS

3.0 INTRODUCTION

Nobody anticipates getting sick or injured, but the majority of individuals eventually require medical attention. These expenses are covered by health insurance, along with many other significant benefits. Due to high inflation in health care expenses especially in private sector it is important for an individual to take health insurance policy covering family members. The different features and types of health insurance plan can confuse individuals. This chapter thus focuses on explaining the terms used in health insurance industry. You will also learn about the different types of health insurance policy in this chapter.



3.1 OBJECTIVES

After reading this lesson, you will be able to:

- Classify different types health insurance products available in India
- Explain the Features of health policies
- Explain the IRDAI guidelines on standardization in health insurance
- Explain terms like Top up covers, fixed benefit covers, hospital cash, etc.

3.2 INTRODUCTION TO HEALTH INSURANCE PRODUCTS

The Health Insurance Regulations of IRDAI define health cover as follows

Health Insurance Definition- This is a contract between insured (policy holder)

Health Insurance



Notes

and the insurer (insurance company) that requires the health insurance company to pay the policyholder health care expenses in exchange of insurance premium.

Since the introduction of first retail health insurance product- Mediclaim by four public sector insurance companies in 1986, the health insurance segment has progressed a lot. Now there are hundreds of products offered by all general insurers and standalone health insurance companies. In 2001, the health insurance sector was opened up for private insurance companies in India.

Generally health insurance products available in Indian market are hospitalization products in nature. The most lucrative feature of health insurance product is cashless benefit availed in network hospital. These health insurance policies cover hospitalization expenses of an individual. There is very high inflation in health care industry leading to steep rise in expenses. Due to advancement in medical technology, increase of health care expenses, cost of new medicines and advanced surgical procedures it's become a very difficult for common man to have access to quality health care treatment without health insurance policy.

3.3 CLASSIFICATION OF HEALTH INSURANCE PRODUCTS

In 2001 when insurance market was opened for private players many insurance companies came into health insurance market. Standalone health insurance companies also came after 2001 whose are specialized in health insurance business. With opening of health insurance sector to private players a lot of innovations, affordability, and variations came to Indian customers.

3.3.1 Broad Classification of Health Insurance Products

- a) **Indemnity Covers-** These plans comprise bulk of health insurance market segment and cover actual medical expenses related to hospitalization. For example:- A person has taken a health insurance policy of Rs 8 lakhs sum insured and due to accident he was hospitalized for three days where the medical expenses incurred was Rs 80000 only. In this case he is only entitled to get maximum Rs 80000 in form of claim amount although the total sum insured is Rs 8 lakhs, nothing more than this will be paid as per the indemnity principle applied in general insurance.
- b) **Fixed benefit Covers-** This is also known as hospital cash where insured is paid per day fixed amount during the hospitalization period. For example:- Shared accommodation in hospital where a insured patient is entitled to get daily cash



Notes

per day during hospitalization for choosing shared accommodation in hospital. There is a limit in number of days or consolidated maximum amount per hospitalization under this product.

- c) **Critical Illness Cover-** On the occurrence of predefined major/critical illness like cancer, heart attack, stroke etc, the insured/nominee is paid full sum insured. This product is sold in form of rider or exclusive product.

The personal accident cover is sold as independent policy in India whereas worldwide health and disability cover is sold together.

The health insurance policy usually covers the hospitalization expenses incurred only in India. Travel insurance policy or overseas Mediclaim policy covers the health expenses incurred abroad partially. But recently we came across few health insurance products sold by private payers where they covers healthcare expenses incurred outside country subject to certain terms and conditions.

3.3.2 Customer segment-based classification

Products can be designed or customized according to the target customer segment. Product classifications on the basis of customer segments are as follows-

- a) **Individual cover-** This cover is sold to retail customers and their family members in form of individual and family floater policies.
- b) **Group cover-** This cover is sold to corporate clients where employees are covered under group insurance policy.
- c) **Mass policies for government schemes** like RSBY, Ayushman Barat etc covering vulnerable sections of population.

3.4 IRDAI GUIDELINES ON STANDARDIZATION IN HEALTH INSURANCE

There was lot confusion in the insurance market due to different definitions of various terms and conditions and different types of health insurance products with different coverage and exclusions offered by health insurers. It was very difficult for an individual to compare products as well as difficult situation for TPA for settling the claim against products of health insurance companies.

There was difficulty in maintaining electronic data of health insurance industry. There was also confusion regarding benefits, terms, conditions and exclusions of critical illness cover.

Health Insurance



Notes

By providing standardization in health insurance, several organizations, including Indian insurance regulator (IRDAI), service providers, hospitals, and the Health Advisory Committee of FICCI, came together to remove the confusion between insurers, service providers, Third Party Administrators, and hospitals as well as the complaints of the insuring public by providing standardization in health insurance. IRDAI issued guidelines on standardization in health insurance in 2016 after common understanding of various stake holders.

The guidelines provide standardization of:

1. Standard definitions of commonly used basic terms in Health Insurance policies
2. Definitions, standard nomenclature and procedures for Critical Illnesses
3. List of excluded 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. Standards and benchmarks for hospitals in the provider network

This has been a significant step towards raising the standard of quality provided by hospitals and the insurance sector, and it will aid in the gathering of useful data on health and health insurance.

3.5 HOSPITALIZATION INDEMNITY PRODUCT

In India, the most common and largest selling health insurance plan is an indemnity-based health insurance plan. The first Mediclaim policy was introduced by four PSU non-life insurance companies in 1986 and was the first standard health insurance product in India. This product was available in Indian market for long. After 2000, when private players came in to sell health insurance policy the product undergone a lot of changes in term of features, terms and condition due to competitive market. This product is sold by different insurers with some changes in feature and still a popular product in Indian market.



Notes

It is an indemnity product where the policy holder will get the claim amount out of defined sum insured upto medical expenses incurred while hospitalization. The general features of Mediclaim policy are explained in the following points. There may be variations in different health insurance policies like benefits, additional exclusions or some riders available with policy. The students should read the health insurance policy of the particular insurance company for better understanding of the topic as following features will give the general idea. The student is advised to go through some basic medical terminology also so that it would be useful in knowing the features of indemnity based Mediclaim policy.

1. Inpatient hospitalization expenses

Because of insured accident or illness, the hospitalization expenses are paid to him by insurance company under indemnity health insurance policy. It normally includes:

- i. It only covers medical expenses if an insured patient is hospitalized for at least 24 hours in the hospital except day care procedures.
- ii. Covers Room, boarding, nursing expenses, ICU, Doctor fees, Medicines, OT charges.
- iii. Hospital expenses of organ donor
- iv. Cost of artificial limbs and prosthetic devices
- v. Cost of relevant laboratory/ diagnostic tests
- vi. Cost of dialysis, chemotherapy, radiotherapy
- vii. Coverage of ambulance charges

Only when the insured patient is admitted to the hospital for a minimum of 24 hours are these medical costs covered. But due to medical advancement there are various medical procedures where the insured patient need not to be admitted in hospital for 24 hours, the patient may be discharged on the same day of hospitalization. These treatments are carried out at specialised day care facilities or hospitals and are referred to as “day care procedures”. The procedure like chemotherapy, eye surgeries etc comes under day care. Right now many health insurers are covering more than 140 day care procedures and list is going more.

The OPD expenses are not covered generally by health insurer. There are very few health insurance companies offering OPD coverage.

Health Insurance



Notes

2. Pre and post hospitalization expenses

- i. Pre hospitalization expenses- There are two type of hospitalization, either emergency hospitalization or planned. In planned hospitalization the insured patient take prior approval before getting hospitalization. He/she might have incurred the expenses like doctor fees, diagnostic test fees and medicines before admission. Whenever a insured patient go for planned hospitalization he/she will incur expenses before hospitalization.

Definition

“IRDAI Health Insurance Standardization guidelines define Pre-hospital expenses as:

Medical expenses incurred immediately before the insured person is hospitalized, provided that:

- 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”.

The expenses related to diagnostic tests conducted, doctor’s prescription fees and medicines etc comes under pre hospitalization expenses. These expenses are covered if they are related to hospitalization illness and are covered by all health insurance companies.

ii. Post hospitalization expenses-

In this, the expenses incurred after discharge from hospital are covered. The expenses related to recovery and follow up of insured patient after discharge from the hospital are covered under this.

Definition

“Medical Expenses incurred immediately after the Insured Person is discharged from hospital, provided that:

- 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”.



There are specified numbers of days in post hospitalization expenses of the health insurance policy. The post-hospitalization benefit pays for the necessary medical costs incurred after the insured patient gets discharged from the hospital.

The Insured's medical expenses related to doctor's prescription fees, medicine prescribed and diagnostic test conducted after discharge from hospital are covered under post hospitalization. . The costs must be correlated to the medical care received while being hospitalised and covered by health insurance.

Typically, coverage lasts for 30 days prior to and 60 days following hospitalisation. The duration of cover may vary from insurance company to insurance company and is mentioned in policy.

Pre and post hospitalization can be reimbursed by the insured. The students should suggest or opt for those health insurance products where pre and post hospitalization number of days are more and there should be no capping or limit on this benefit.

3. DOMICILIARY HOSPITALIZATION

In health insurance policy there is a provision for insured policyholders to claim medical treatment expenses incurred at home without being admitted at hospital. Generally, this benefit is not used by the insured.

To avail this benefit there are some conditions which need to be fulfilled by the insured patient. These are as follows-

The condition of a patient needs immediate hospitalization due to illness but cannot be moved to hospital or lack of accommodation in hospitals.

This benefit has the condition where domiciliary hospitalization is generally covered after excess clause of 3-5 days. It means that the medical treatment expenses incurred at home under this benefit has to be borne by insured patient for first 3-5 days. This benefit excludes treatments like asthma, bronchitis, diarrhea, diabetes mellitus, cough and cold etc.

4. COMMON EXCLUSIONS

The common exclusions are as follows:

i. Pre-existing diseases

Health Insurance



Notes

Definition

The IRDAI guidelines on standardization define Pre-existing as “Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer.”

There is a specific time period where the health insurance companies don't cover the illness/disease. This is generally 48 months from taking the policy. These are those illness/diseases which a proposer declares that he/she was suffering from or is suffering while taking insurance policy. The decision to accept or reject the proposal is made by the underwriter based on the proposer's disclosure of any prior illnesses or conditions.

- ii. **Waiting periods:** The standard 30-day waiting period is in all the new health insurance policy. This means that the insured policy holder is not covered for any claim in the first 30 days of purchasing a new or fresh health insurance policy. The only exception to this is hospitalization due to accident. The accident hospitalization is covered from day one of purchase of health insurance policy.

Other waiting periods:

This is applied for certain illness/ailments/disease which are not covered for certain time as per terms and conditions of the health insurance policy. The waiting period under health insurance policy can be one/two/three/four years from the inception of new policy. The common diseases which come under waiting period are cataract, renal calculus, gall bladder stone, hip replacement, prostate surgery etc. This means that these diseases are not covered for an initial 1/2/3/4 years. The number of years under waiting period may vary from insurer to insurer or policy to policy. An individual should choose that health insurance policy where the number of years and number of diseases are less.

Example

Raj took the fresh health insurance policy and was hospitalized for three days due to viral fever on 20th day of taking the policy. When he filed his cashless claim to insurance company he was denied because there was initial 30 days waiting period in fresh health insurance cover. And finally he had to pay the hospitalization expenses from his pocket.

5. Coverage Options Available

i. Individual Coverage

The policy holder can take individual sum insured for him where a pre- defined sum insured is allocated to him. The family members can also take the individual cover on each member under a single policy. In this format each family member will have their individual sum insured. During the policy duration which is generally one year each insured member can avail claim up to maximum sum insured allocated to him. Here the premium is charged on the age and sum insured opted by the family members. Generally a family taking individual sum insured policy gets some discount in total premium from Health Insurance Company. The major drawback in this format is that the single insured member can not avail the sum insured of other family members if sum insured is exhausted within a year.

ii. Family Floater: In this health insurance plan, the whole family (spouse, dependent children and dependent parents) is offered a single-family floater health insurance plan with single sum insured which float over entire family in specified policy time period.



Notes

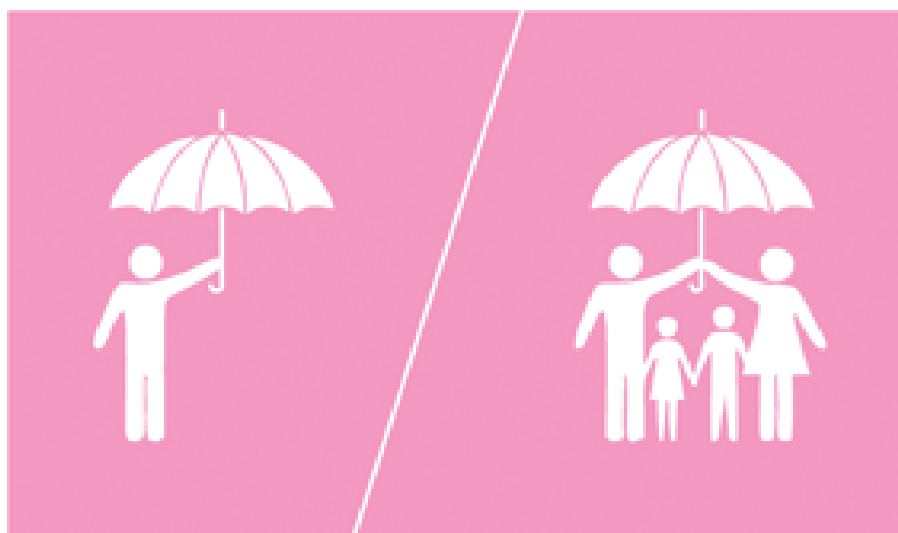


Figure 3.1 : Individual and Family floater health insurance policy.

Example

If a family of four, 2 adults and 1 child has taken floater health insurance plan for Rs 15 lacs for one year policy period, then insurer will pay the medical expenses

Health Insurance



Notes

up to Rs 15 lacs within policy period for single or multiple claims of an individual family member or whole family. But the total claim amount of all members should not exceed Rs 15 lacs sum insured in the policy period.

The premium for this type of policy depends on the age of the oldest member of the family. The family floater policy is more popular in the market because the full family can be covered under single sum insured. The coverage and exclusions are similar generally in both individual and family floater policy.

6. Special Features

In health insurance product apart from existing cover there are more special features have been added. All health insurance products do not cover all below mentioned special features. It differs from insurer to insurer and product to product. Some of the special features are as follows-

i. Sub limits and Disease specific capping

Some of the health insurance products have sub limits like 1% of sum insured capping on room rent per day and 2% sum insured capping on ICU charges per day. It means if insured have opted for less sum insured in that case he/she is entitled to room or ICU in hospital of lesser amount and in these type of policies the policy holder have to pay from his pocket if the room rent or ICU charges exceeded this sub limit. Some health insurance products have disease specific capping for example appendicitis, cataract etc. The individual should choose a health insurance policy with no limit and sublimit.

For example- If a person has a health insurance policy with a sum insured of Rs 300,000 and a 1% of sum insured room rent cap. And if he is admitted in a room with rent of Rs 5000 per day for next five days. The total bill of room rent comes to Rs 25000 but he will only get Rs 15000 due to 1% of room rent condition in the health insurance policy.

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

Co-payments means a specified percentage of every claim amount that is to be paid by insured and the rest by the insurance company. This can be compulsory or voluntary and varies from product to product. This is generally found in senior citizen policies.

For example- If a person has taken a health insurance policy where there is a provision for 20 % co- payment. The claim amount came out to be Rs



Notes

50000 then Rs 10000 (20% of Rs 50000) will be paid by insured and Rs 40000 will be paid by Insurance Company.

iii. New exclusions have been introduced and later standardized by IRDAI:

- Genetic disorders and stem cell implantation / surgery.
- External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, slings, braces, stockings etc. of any kind, diabetic foot wear, glucometer / thermometer and similar related items etc. and also any medical equipment which is subsequently used at home etc.
- Any kind of Service charges, Surcharges, Admission fees / Registration charges etc. levied by the hospital
- Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period

iv. Zone wise premium

Generally the premium of health insurance policy depends upon age and sum insured opted by insured. But insurer can put zone wise premium pricing due to higher claim cost in specified region/zone. For example, in comparison to Tier II and Tier III cities, metropolitan areas like Mumbai and New Delhi are included in the highest premium zone for specific policies by a few health insurers.

v. Coverage of pre-existing diseases

Generally the disease disclosed at the time of proposal is covered after 4 years in health insurance under preexisting disease clause. But few insurers have reduced this time period from four to 2/3 year. The students can opt or suggest those health insurance policies where number of years under pre-existing disease clause is less.

vi. Renewability

In the beginning there was an age limit for renewal of health insurance policy. Initially long-life renewal feature was offered by few insurers but due to interventions by IRDAI now this is compulsory for all insurers health insurance products.



Notes

vii. Coverage for Day care procedure

Generally in health insurance policy it's compulsory to be in hospital for minimum 24 hours to avail cashless or reimbursement claim but day care procedures are exception to this condition. When, as a result of advancements in medical science, the insured patient is admitted and discharged on the same day after a medical operation. For example, dialysis, chemotherapy etc. Initially insurers were covering only seven-day care procedures, but these days insurers are covering more than 140-day care procedures and the list keep growing.

xiii. Duration of pre and post hospital cover

Generally insurers cover pre hospitalization cover for 60 days and post hospitalization cover for 90 days. Before hospitalization the insured under pre hospitalization might have incurred the expenses like doctor fees, diagnostic test fees and medicines before admission. Similar kind of expenses can be incurred by Insured after discharge from hospital under post hospitalization. A few insurance companies have also set a maximum limit on these costs and connected them to a particular percentage of claim payout. These days few insurers under pre and post hospitalization the number of days are extended to 90 to 120 days.

ix. Add on covers

The following are a few new add-on or extra cover options that some insurance companies have introduced:

- **Maternity cover:** The maternity cover in retail policies are offered by few insurers only and generally is under exclusions.
- **Critical illness cover:** Few insurers are offering critical insurer cover as an optional add on cover or rider. It covers life threatening ailments and are expensive too.
- **Automatic reinstatement of sum insured:** Under this benefit if the insured sum insured get exhausted within policy period it will automatically get reinstated or restored with full sum insured (original sum insured limit).
- **Coverage for AYUSH - Ayurvedic - Yoga - Unani - Siddha - Homeopath:** Initially this benefit was under exclusions but afterwards

few insurers started covering AYUSH treatment up to a certain percentage of the sum insured.

x. Value added covers

The benefits under this are payable up to a pre-defined limit of sum insured. The few value added covers are as follows:

- **Outpatient cover:** Generally OPD covers are under exclusions for maximum health insurance companies but few insurers provide limited cover for OPD expenses for some high end plans.
- **Hospital cash:** These days this benefit is provided by all the insurers. Under this feature fixed lump sum payment is given to insured patient per day for a specified time period for choosing shared accommodation. And in some insurance policies hospital cash is given as add on covers or inbuilt in the health insurance policy. Generally, hospital cash is given for 7 days with a deductible of 2/3 days.
- **Donor's expenses:** According to the terms and conditions of the health insurance policy, the policyholder's major organ transplant policy also covers the costs of the organ donor.
- **Reimbursement of ambulance:** The expenses of ambulance charges are reimbursed up to a specified amount under health insurance policy.
- **Expenses for accompanying person:** Health insurance policies will pay for the costs of an accompanying person's food and transportation while they are caring for the insured patient while they are in the hospital. A specified amount per day with limit of number of days is reimbursed to insured.



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INTEXT QUESTIONS 3.1

1. Pre-hospitalization duration varies from insurance company to insurance company and is mentioned in health insurance policy, generally this is for _____
 - a) Fifteen days
 - b) Thirty days
 - c) Forty-Five days
 - d) Sixty days

Health Insurance



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2. In India the health insurance sector has undergone many changes up until the opening of the market for private insurance companies in
 - a) 2010
 - b) 2005
 - c) 2001
 - d) 2015
3. First Mediclaim policy in India was introduced in which year?
 - a) 1986
 - b) 2000
 - c) 1956
 - d) 1972
4. Broad Classification of Health Insurance Products is/are:
 - a) Indemnity Cover
 - b) Fixed Benefit cover
 - c) Critical Illness Cover
 - d) All of the above
5. _____ is an amount which is borne by the policy holder each time the claim is made due to sickness and /or accident defined in the policy.
 - a) Co- Payment
 - b) Co- Insurance
 - c) Waiting period
 - d) None of the above

3.6 TOP-UP COVERS OR HIGH DEDUCTIBLE INSURANCE PLANS

High deductible insurance is another name for a top-up policy. If a policy holder wants to take the health insurance policy with appropriate sum insured (high Sum Insured) he has to see his pocket also to pay the hefty premium. Due to this, insurance



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companies created top-up plans, which provide coverage for significant sums insured over and above a predetermined amount (called threshold). The insured can go for a high deductible plan where he can take a health insurance policy from insurance company and can take an additional policy with same or different insurance with deductible cover. This deductible insurance plan can be utilized with basic health insurance policy which has less sum insured and the premium for this policy is comparatively less. In this way the insured will be covered for an appropriate sum insured with lesser premium as compared to the single policy with higher sum insured. This can be helpful in the unfortunate event of high-cost treatment. This plan can be purchased as individual or family floater form. Medical expenses must exceed the deductible (or threshold) level selected by the plan in order to qualify for a claim under the top-up policy.

Example-

If Raj has taken a health insurance policy of Rs 10 lacs sum insured from A health insurance company where he pays X premium. Now the agent suggested him to go for deductible plan. Where he took health insurance cover of 3 lakh sum insured from A health insurance company and took the another top up policy with same insurer or another insurance for Rs 7 lacs sum insured (in excess of 3 lacs). He will disclose to the same/another insurer regarding basic health insurance policy of Rs 3 lacs and will take additional cover of Rs 7 lacs. The premium for this type of provision would be less. Because whenever the health insurance claim comes up to Rs 3 lac sum insured policy the A insurer will always come first and if it exceeds three lacs rupees than 7 lakh sum insured policy will come into picture. In this way insured can be covered for high sum insured with comparatively less premium.

3.7 SENIOR CITIZEN POLICY

Senior citizen policies are for elderly people over 60 years of age which were generally denied for health insurance coverage. This plan's exclusions and coverages are very similar to those of a hospitalisation policy.

The entry age for senior citizen policy is after 60 years and there is provision for life long renewal. Generally the sum insured range from Rs. 100,000 to Rs. 5,00,000. There are variations in waiting period of certain ailments/diseases. For example cataract may be covered after one year waiting period for one insurance company or 2 year waiting period for some other insurance company.

Health Insurance



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There is a standard waiting period of 30 days in fresh policy and preexisting disease clause of 4 years for the illness disclosed by insured at the proposal stage. Under maximal policies, there is a limit or capping for various diseases. Pre- and post-hospitalization costs are covered either as a portion of hospital claims or a sublimit, depending on which is higher. The pre and post hospitalization period is generally 30/60 days or 60/90 days.

In many senior citizen health insurance policy there is provision of co-payment where some portion is paid by insured rest is paid by insurer. But there are some insurance policies where cover is given without co-payment to senior citizen. The premium in this case is more than the policy with co-payment provision. In maximum cases the pre policy medical tests are done.

“IRDAI has mandated special provisions for insured persons who are Senior Citizens:

1. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront.
2. The insured shall be informed in writing 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.
3. All health insurers and TPAs shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.”

3.8 FIXED BENEFIT COVERS - HOSPITAL CASH, CRITICAL ILLNESS

Sometimes the hospitals inflate the hospitalization bills unnecessarily and unreasonably in the form of extending hospital stays and ordering unnecessary diagnostic and laboratory procedures resulting in huge claim amount. This generally happens when hospital comes to know that patient is insured with health insurance policy. The expense of healthcare is constantly rising, typically faster than premium rate increase.

Fixed benefit covers are the solution to the aforementioned problems. The maximum payout for each of them is specified in the policy. With this product, frequently occurring procedures are mentioned under each system, including ENT, ophthalmology, obstetrics, and gynaecology, etc.

The insured get the fixed amount as claim amount irrespective of amount spend on treatment. These days package treatment costs are famous where all stake holders are happy. The insured is happy because he knows that under this provision he needs

not to pay the difference claim amount. The hospital officials are satisfied because they know that under these provisions there will be no deduction in the final amount. The TPA/Insurance companies are also satisfied because they know that hospital will not inflate the bills.

The package charges would include all components of the cost such as:

- a) Room rent,
- b) Doctor's fees,
- c) Diagnostics tests,
- d) Medicines,
- e) Pre and post hospitalization expenses etc.
- f) Medical procedures

Depending on the product, the package charges might even cover things like diet, transportation, ambulance costs, etc. These plans are easy to manage because all that is required to process a claim is proof of hospitalisation and the condition being covered by the policy.

Some of the fixed benefit insurance plans are:

- Hospital daily cash insurance plans
- Critical illness insurance plans

3.8.1 Critical Illness Policy

Critical insurance plan is sometimes referred to as a trauma care cover or the dreadful disease cover.

Individuals with major diseases like cancer, heart attack etc is surviving due to advancement in medical sciences. But the treatment cost for these dreaded diseases is very high and in many cases it led the insured to fall below poverty line. Unfortunately, overcoming a serious illness requires significant financial outlays for both treatment and post-treatment living costs.

- a) A benefit policy known as a “critical illness policy” provides the insured with a lump sum payment upon diagnosis of a specific, designated critical illness.
- b) This cover is available in form of:



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Health Insurance



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- ◆ Separate or standalone insurance policy or
- ◆ Rider in few health insurance policies or
- ◆ Rider in some life insurance policies

Generally in India life insurers are selling critical illness cover in form of rider. Two types of covers are offered to them- accelerated CI benefit plan and standalone CI benefit plan.

For selling critical illness insurance, a clear grasp of what constitutes a covered ailment and strong underwriting are essential. IRDAI Health Insurance Standardization guidelines have led to the standardization of the definitions of the 20 most prevalent critical illnesses.

This is very significant for the insurer to ascertain the health status of proposers as there is a high chance of adverse selection in critical illness policy at the proposal stage. The current pricing of critical illness plans are supported by reinsurance data as there is a lack of sufficient data.

- c) Critical illness may require lengthy care following hospitalisation and may result in large hospitalisation expenditures. It also may result in disability, limb loss, loss of income, total dependence on others, etc.
- d) It is advisable that the critical illness policy should be taken additional to health insurance policy so that health insurance take care of hospitalization expenses and the sum insured of critical illness policy take care of financial burden of the insured family.
- e) The critical illnesses covered vary across insurers and products, but the common ones include:
 - ◆ Cancers of specified severity
 - ◆ Acute myocardial infarction
 - ◆ Coronary artery surgery
 - ◆ Heart valve replacement
 - ◆ Coma of specified severity
 - ◆ Renal failure
 - ◆ Stroke resulting in permanent symptoms



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- ◆ Major organ / bone marrow transplant
- ◆ Multiple sclerosis
- ◆ Motor Neuron disease
- ◆ Permanent paralysis of limbs
- ◆ Permanent disability due to major accidents

The numbers of diseases vary from insurer to insurer in critical illness cover. It is suggested to go for critical illness cover where numbers of illness covered are more. Sometimes terminal illness is also included for coverage though premium would obviously be very high.

- f) The majority of critical illness policies offer a lump sum payment or amounts insured upon diagnosis of the condition; however, a select policy also offer reimbursement for inpatient costs. Few insurance plans offer coverage for both patient hospitalization costs and a lump sum payout upon the diagnosis of serious illnesses included in the policy.
- g) This policy is generally available for the 21-65 years age group.
- h) In most cases, these policies pay 100% of the insured amount in the event that a critical illness is diagnosed. Depending on the terms and conditions of the insurance and the seriousness of the illness, compensation may range from 25% to 100% of the amount insured in specific circumstances.
- i) The critical illness policy there is a 'waiting period' of 90 days for fresh policy from the inception of the policy. And there is a 30 day 'survival clause' after the diagnosis of the illness.
- j) Compulsory pre-issue policy medical checkups in critical illness policy are conducted on proposers especially those who are older than 45. Standard exclusions resemble health insurance policies quite a bit.
- k) The insurance policy may only make one payout to the policy holder for any one or more of the diseases covered by the policy, or it may offer many payouts, but only up to a specific maximum number. After benefits are paid out under the policy for any insured person, the coverage expires.
- l) This policy may be offered in form of group policy where employer can take this for their employees.



Notes



INTEXT QUESTIONS 3.2

1. When an insured person is diagnosed with a certain critical illness, benefit plans give them a lump sum payment. This benefit plan is known as _____
 - a) Accident riders
 - b) Indemnity
 - c) Critical illness
 - d) Cashless
2. Which one of the following products is particular useful for the person covered for health by employers, where employers health schemes may not bear many of the incidental costs associated with hospitalization?
 - a) Daily Hospital cash benefit
 - b) Disease management covers
 - c) Outpatient coverage
 - d) BhavishyaArogya
3. In which year, did the health insurance sector open up for private insurance companies in India?
 - a) 2002
 - b) 2001
 - c) 2005
 - d) 1995
4. High deductible hospital indemnity is best suited for:
 - a) Senior citizens
 - b) Persons suffering from critical illness
 - c) Person with low sum insured in indemnity policies
 - d) None of the above



5. Which expenses of an individual are covered by Mediclaim policy to a predefined annual limit of indemnity?
 - a) Doctors' consultation
 - b) Medicine
 - c) Hospitalization
 - d) Surgery and operation theatre
6. Hospitalization indemnity products provide for a _____ before any benefit commence
 - a) Waiting period
 - b) Cost sharing by insured
 - c) Check up by registered doctor
 - d) Routine blood test
7. Which of the following statements about critical illness products is false?
 - a) They provide insurance against dreaded diseases such as cancer, heart attack or kidney failure
 - b) They cover the actual cost of the treatment related to critical illness
 - c) They are available as standalone products or as a packaged health insurance product.
 - d) They provide for high sum insured limits with lump sum payouts.
8. As a standard condition in critical illness policy there is a 'waiting period' of _____ days for fresh policy from the inception of the policy.
 - a) 90 days
 - b) 30 days
 - c) 60 days
 - d) 120 days

Health Insurance



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9. As a standard condition in critical illness policy there is a survival clause of _____ days after the diagnosis of the illness.
- a) 90 days
 - b) 30 days
 - c) 60 days
 - d) 120 days



WHAT YOU HAVE LEARNT

Health Insurance is a contract between insured (policy holder) and the insurer (insurance company) that requires the health insurance company to pay the policyholder health care expenses in exchange of insurance premium.

In the event of any disease, health insurance is crucial for giving financial support to pay for medical facilities. Also, it aids in protecting an individual's funds, which may otherwise be lost due to illness. Health insurance products are broadly categorized as Indemnity covers, Fixed benefit covers and Critical Illness cover, Or Individual cover, Group cover and Mass policies for government schemes, if categorization is based on customer segments.

Guidelines for uniformity in health insurance were released by Insurance Regulator (IRDAI) in 2016 to clear up any misunderstandings between insurers, service providers, TPAs, and hospitals. In India, the most common and largest selling health insurance plan is an indemnity-based health insurance plan. It only covers medical expenses if an insured patient is hospitalized for at least 24 hours in the hospital except day care procedures.

There are two types of hospitalization, either emergency hospitalization or planned. There are terms like Waiting periods, Individual coverage, Family floater, Co-payment, Day care procedure, etc. which are important in understanding health insurance products. High deductible insurance is another name for a top-up policy. This deductible insurance plan can be utilized with basic health insurance policy which has less sum insurance and the premium for this policy is comparatively less. There are other important types of covers and policies which should be known to you as a Health Insurance expert like Top-Up Covers, Senior Citizen Policy, Hospital Cash, Critical Illness covers, Hospital Daily Cash Policy and Critical Illness Policy.



TERMINAL QUESTIONS

1. What do you understand by Health Insurance? Why health insurance is important?
2. Classify the health insurance products according to the broad categories and on the basis of customer segments.
3. Write a note on IRDAI Guidelines on Standardization in Health Insurance
4. Write a note on Pre hospitalization and pro-hospitalization expenses.
5. What are pre- existing diseases? Give examples.
6. Write a note on the following:
 - a) Waiting periods
 - b) Individual coverage
 - c) Family floater
 - d) Co-payment
 - e) Day care procedure
7. Write a detailed note on Top-Up Covers and Senior Citizen Policy
8. Explain the Hospital Cash, Critical Illness covers with examples
9. Write detailed note on Hospital Daily Cash Policy and Critical Illness Policy.



ANSWERS TO INTEXT QUESTIONS

3.1

1. (b) Thirty days
2. (c) 2001
3. (a) 1986
4. (d) All of the above
5. (a) Co- Payment



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3.2

1. (c) Critical illness
2. (a) Daily Hospital cash benefit
3. (b) 2001
4. (c) Person with low sum insured in indemnity policies
5. (c) Hospitalization
6. (a) Waiting period
7. (b) They cover the actual cost of the treatment related to critical illness
8. (a) 90 days.
9. (b) 30 days.



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain the different types of health insurance products available in India and the features of health policies.

4

MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

**Notes**

4.0 INTRODUCTION

India has achieved a significant growth and developments in healthcare access over the past few decades. The health sector is one of the largest and fastest growing sectors in India but also faces many challenges. It is characterized by high out-of-pocket expenses, poor financial protection, and inadequate health insurance coverage among both rural and urban populations. More than 60% of people in our country have to pay for their medical care and hospital stays because they lack any type of health insurance. People borrow money or sell their assets to pay for healthcare, which has an impact on their income and savings and causes more than 4% of the population to fall below the poverty line. The Indian government is working to guarantee that everyone in the country has access to high-quality healthcare without suffering any financial hardships as a result.

In this regard, few schemes are launched by the government like Rashtriya Swasthya Bima Yojana (RSBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), Pradhan Mantri Jan-Dhan Yojana (PMJDY) and Pradhan Mantri Jan Arogya Yojana (PMJAY). There are many more schemes launched by the Government of India, but the focus of this chapter will be on few schemes mentioned above which provides Health protection or insurance for economically weaker sections.



4.1 OBJECTIVES

After reading this lesson, you will be able to:

- Describe the micro insurance and health insurance schemes available for economically weaker in India

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Health Insurance



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MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

- Explain the features of Jan Arogya Bima Policy
- Explain the features of Universal Health Insurance Scheme (UHS)
- Explain the features of Rashtriya Swasthya Bima Yojana (RSBY)
- Explain the features of Pradhan Mantri Suraksha Bima Yojana (PMSBY)
- Explain the features of Pradhan Mantri Jan-Dhan Yojana (PMJDY)
- Explain the features of Pradhan Mantri Jan Arogya Yojana (PMJAY)

4.2 MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

A special category of insurance policies called micro-insurance policies has been created by Insurance Regulatory and Development Authority of India (IRDAI) to promote insurance coverage among economically weak sections of the society. The purpose of micro insurance regulations was to make it easier for lower income groups to access insurance. It offers a platform for the distribution of low-cost insurance products to the underprivileged in both urban and rural areas. It also aims at enabling micro insurance to play a significant role in financial inclusion. According to the IRDAI micro-insurance regulations from 2005, insurance products covered by micro-insurance have a modest premium and a sum insured that is less than Rs. 30,000. Many community organisations or Non-governmental Organisations (NGOs) typically purchase these covers in bulk for their members. In order to expand access of insurance, insurance companies must sell a specific percentage of their insurance policies as micro-insurance products under the IRDAI's rural and social sector requirements.

Through the marketing of microinsurance products, Non-Governmental Organisations (NGOs) and Self-Help Groups (SHGs) may represent insurance companies. IRDAI has notified the amended regulations in 2015 wherein it has permitted several more entities like District Co-operative Banks, Regional Rural Banks including Business Correspondents of Scheduled Commercial Banks to be appointed as Micro Insurance agents facilitating better penetration of Micro Insurance business and included additional policyholder protection measures.

The following is a description of two policies specifically designed by PSUs to serve the lower segments of society:

1. Jan Arogya Bima Policy
2. Universal Health Insurance Scheme (UHS)

4.2.1 Jan Arogya Bima Policy

The goal of this programme is to give less fortunate members of society affordable health insurance. The salient features of Jan Arogya Bima Policy are listed below:

1. Sum Assured: The sum insured is Rs.5000 per individual.
2. Eligibility: The minimum eligibility age is 5 years while the maximum age is 70 years.
3. Three months to five-year age group children can be covered under this policy provided one or both parents are covered at the same time.
4. This insurance policy is available for one year duration.
5. Claim settlement: The insurance company will settle claims within 30 days of receiving the required documentation. After accepting the claim, the insurer will transfer the money within seven days.
6. Redress of grievances: The insured may file a complaint with the Office of the Insurance Ombudsman's grievance cell.
7. There is a 15-day free look period for this health insurance policy.
8. Cancellation: This policy may be cancelled by providing the insured with a 30-day notice period. If no claims have been filed up to the cancellation term, the insured may also cancel the life insurance policy at any time, in which case his payment will be returned (short period rates).
9. Facility of medical check-ups and cumulative bonus is not offered under this policy.
10. Section 80D of the Income Tax Act of 1961 allows for a tax benefit on the premiums paid for this policy.

4.2.2 Universal Health Insurance Scheme (UHS)

The Government of India introduced the Universal Health Insurance Scheme (UHS) in 2003 with the goal of providing healthcare to the economically weaker segments of society. It aims at providing health insurance coverage for the economically weaker and backward classes of the country. It has several unique features including general health insurance, maternity insurance, death benefits and so on. This scheme is accessible to families who are both below the poverty line and above the poverty line.



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Notes

MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

Features of the Universal Health Insurance Scheme (UHS) are as follows:

1. The Universal health insurance policy is available to both individuals as well as in a group.
2. The individual policy will be in the name of the earning head of the family with details of other insured members.
3. The Group policy will be issued in the name of the Group/Association/Institution with a simple list of names of the members including his/her eligible family members forming part of the policy.
4. Members covered in one group policy cannot be covered in any other group in the same health scheme.
5. People between the ages of 5 to 70 years can be enrolled in this health insurance scheme. Children between the age of 3 months to 5 years can be covered provided one or both the parents are covered simultaneously.
6. The coverage offers an individual or family reimbursement for hospitalisation costs up to Rs. 30,000, subject to the following sublimit.

Particulars	Limit
Room, boarding expenses	Up to Rs.150/- per day
If admitted in ICU	Up to Rs.300/- per day
Surgeon, Anesthetist, Consultant, Specialists fees, Nursing expenses	Up to Rs.4,500/- per illness/ Injury
Anesthesia, Blood, Oxygen, OT charges, Medicines, Diagnostic material and X-Ray, Dialysis, Radiotherapy, Chemotherapy, Cost of pacemaker, Artificial limb, etc.	Up to Rs.4,500/- per illness/Injury
Maternity Benefit - ONE CHILD ONLY (with 12 months waiting period)	Rs.2,500/- for normal delivery and Rs.5,000/- for caesarean delivery.
Total expenses incurred for any one illness (other than Maternity Benefit)	Up to Rs. 15,000/-

Note: Company's Liability in respect of all claims including Maternity Benefit admitted during the period of Insurance shall not exceed the Sum Insured of Rs.30,000/- per person or family as mentioned in the schedule)

Table 4.1: Reimbursement of hospitalization expenses under (These rates are subject to change by the Government of India)



7. On the death of the bread earner of the family Rs 25000 is given by insurance company under personal accident cover.
8. On the hospitalization of the bread earner of the family due to accident/ ailment, Rs 50 per day of hospitalization is given by insurance company under disability cover. And this benefit is paid maximum up to fifteen days after three days of waiting period.
9. Premium rates are as follows:

Coverage	Premium	Insured s Share	Govt. of India Subsidy
Individual	Rs.300/-	Rs.100/-	Rs.200/-
Family upto 5 members	Rs.450/-	Rs.150/-	Rs.300/-
Family upto 7 members	Rs.600/-	Rs.200/-	Rs.400/-

Table 4.2: Premium rates under (These rates are subject to change by the Government of India)



INTEXT QUESTIONS 4.1

1. The Duration of the Jan Arogya Bima Policy is_____
 - a) 1 year
 - b) 2 years
 - c) 1.5 years
 - d) 3 years
2. The Jan Arogya Bima Policy has a free look period of _____
 - a) 45 days
 - b) 30 Days
 - c) 15 days
 - d) 90 Days
3. The Universal health insurance policy is available for_____
 - a) Individuals
 - b) Groups
 - c) Both Individuals and Group
 - d) None of the above
4. Universal Health Insurance Scheme (UHS)provides reimbursement of hospitalization expenses up to _____
 - a) Rs. 5,000
 - b) Rs. 15,000
 - c) Rs. 30,000
 - d) Rs. 50,000



Notes

4.3 RASHTRIYA SWASTHYA BIMA YOJANA

The Government of India has introduced a lot of health insurance programmes, some of which are specific to certain states.

To increase the population's access to health benefits, Ministry of Labour and Employment, Government of India has launched the Rashtriya Swasthya Bima Yojana for BPL families in association with insurance companies. Following are the features of Rashtriya Swasthya Bima Yojana:

- This programme is available to any Below Poverty Line (BPL) family whose information is listed on the district BPL list created by the State government.
- Beneficiaries just have to pay a registration fee of Rs. 30. This sum will be used to cover scheme-related administrative costs.
- The Rashtriya Swasthya Bima Yojana offers a family of five floater coverage for hospitalisation costs up to Rs. 30,000. As well as being covered up to a limit of Rs. 1,000, transportation costs are also covered, at Rs. 100 each visit
- Pre-existing diseases to be covered.
- Cashless coverage of all eligible health services.
- Provision of smart card.
- Pre and post hospitalization expenses are covered in this plan.
- Government pays the RSBY premium. 75% of the entire premium is paid by the central government (90% of it is paid in case of Jammu & Kashmir and the Northeast States) while the rest insurance premium paid by State Government.
- The State Government chooses insurance companies after receiving competitive bids.
- Choice to the beneficiary between public and private hospitals.
- The programme will begin on May 1 and run for one year, ending on April 30 of the following year. The plan would expire on this day. For instance, if the card is issued in May, June, or July, the beneficiaries' insurance coverage will begin the very next day and expire on April 30 of the following year.
- The insurer or one of the TPAs listed in the schedule will settle insurance claims. As much as possible, the settlement will be handled cashless through the hospitals on the list.

4.4 PRADHAN MANTRI SURAKSHA BIMA YOJANA

An accident insurance plan called Pradhan Mantri Suraksha Bima Yojana (PMSBY) provides a one-year accidental death and disability protection that can be renewed annually. This scheme was launched in May 2015.

For those who have a bank account and are between the ages of 18 and 70, this scheme is available. The account holder must consent to enrol in or allow auto-debit on or before May 31 for the coverage period of June 1 through May 31 on an annual basis.

Everyone can participate in this programme with just one savings account. He won't receive any additional benefits if he enrolls in more than one bank, and any additional premiums paid will be forfeited.

The primary KYC for the bank account would be Aadhar.



Notes

PMSBY
Pradhan Mantri
Suraksha Bima Yojna

Achievements
up to 16.11.2022

Cumulative enrolment
30.92 crore

Cumulative no. of claims disbursed
1,06,238
for
₹ 2,109 crore

Premium of ₹ 20/-
per year
auto deducted from the bank account

Accidental insurance and disability cover
for individuals
in the age group of
18 to 70 years

Accident insurance cover of
₹ 2 lakh

Enrolment at Bank Branches/
BC points/ Post Office
Renewable annually

Figure 4.1: Pradhan Mantri Suraksha Bima Yojna

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MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

For accidental death and total disability, the risk coverage under the plan is Rs. 2 lakhs, and for partial disability, it is Rs. 1 lakh.

#	Risk	Sum Insured
I.	Accidental Death	Rs. 2 Lakh
II.	Full Disability: 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 one hand or one foot	Rs. 2 Lakh
III.	Partial Disability: Total and irrecoverable loss of sight of one eye or loss of use of one hand or one foot	Rs. 1 Lakh

Note: The total amount that can be claimed under the policy is INR 2 lakh only

Table 4.3: Sum Insured under PMSBY

The account holder's bank account will be debited in one installment for the annual premium of Rs. 20 using the "auto-debit" feature. Previously the premium for PMSBY was Rs 12 only for Rs 2 lakh sum insured.

Public Sector General Insurance Companies, or any other General Insurance Company prepared to offer the product on similar terms with necessary approvals and tie up with banks for this purpose.

There are certain exclusions in this policy. Major Exclusions will include Intentional self-injury, suicide or attempted suicide whilst under the influence of intoxication liquor or drugs, any loss arising from an act made in breach of law with or without criminal intent."

As per one of the reports nearly 30.92 crore people had enrolled under PMSBY as on November, 2022.

4.5 PRADHAN MANTRI JAN DHAN YOJANA

The Pradhan Mantri Jan Dhan Yojana (PMJDY), which was announced on August 15 and launched on August 28, is one of the largest financial inclusion efforts in the world. The goal of the Pradhan Mantri Jan Dhan Yojana (PMJDY), a national initiative for financial inclusion, is to guarantee that everyone has affordable access to financial services such banking, savings and deposit accounts, remittance, credit, insurance, and pensions.

This scheme has set a world record by opening 18,096,130 Accounts during a week as part of the Financial Inclusion Campaign. 48.56 Crore beneficiaries were banked till 2022. Rs.195,474.54 Crore Balance was recorded in beneficiary accounts. 6.55 lakh Bank Mitras were delivering branchless banking services in Sub-Service Areas. The main features of PMJDY are as follows:

1. Account can be opened in any bank branch or Business Correspondent (Bank Mitra) outlet.
2. Joint account can be opened.
3. No minimum balance required, i.e. Accounts created with PMJDY are created with a zero balance. Nonetheless, the account holder must meet minimum balance requirements in order to receive a chequebook.
4. Document required for opening an account under Pradhan Mantri Jan-Dhan Yojana: An account can be opened by presenting an officially valid document.
 - a) the passport,
 - b) the driving licence,
 - c) the Permanent Account Number (PAN) Card,
 - d) the Voter's Identity Card issued by Election Commission of India,
 - e) job card issued by NREGA duly signed by an officer of the State Government,
 - f) the letter issued by the Unique Identification Authority of India containing details of name, address and Aadhaar number, or
 - g) any other document as notified by the Central Government in consultation with the Regulator
5. Interest on deposit.
6. Accidental insurance cover of Rs. 2 lakhs
7. The scheme provides life cover of Rs. 30,000/- payable on death of the beneficiary, subject to fulfilment of the eligibility condition.
8. Easy Transfer of money across India
9. Direct Benefit Transfer will be made to government scheme beneficiaries in these accounts.



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MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

10. An overdraft facility will be allowed once the account has been operating satisfactorily for six months.
11. Access to Pension, insurance products.
12. The Claim under Personal Accidental Insurance under PMJDY shall be payable if the Rupay Card holder have performed minimum one successful financial or non-financial customer induced transaction at any Bank Branch, Bank Mitra, ATM, POS, E-COM etc. Channel both Intra and Inter-bank i.e. on-us (Bank Customer/rupay card holder transacting at same Bank channels) and off-us (Bank Customer/Rupay card holder transacting at other Bank Channels) within 90 days prior to date of accident including accident date will be included as eligible transactions under the Rupay Insurance Program 2019-2020.
13. One account per home, primarily the lady of the house, may have an overdraft of up to Rs. 10,000.

Banks have been permitted to engage individuals / entities as Business Correspondent(Bank Mitra) like (i) Retired Bank Employees (ii) Retired Teachers (iii) Retired Govt.Employees (iv) Ex-Servicemen (v) Individual owners of Kirana / medical/ fair price shops, individual Public Call Office (PCO) operators, Agents of Small Savings Scheme of Government of India / Insurance Companies, 'for profit' companies registered under the Indian Companies Act. Since 24.06.2014, RBI has permitted Non-Deposit taking NBFCs as BCs in addition to above.

4.6 PRADHAN MANTRI JAN AROGYA YOJANA

The Pradhan Mantri Jan Arogya Yojana (PMJAY), also known as the National Health Protection Scheme or Ayushman Bharat Yojana, is an Indian government-sponsored programme that was introduced in 2018 as part of the Ayushman Bharat Mission. This programme was designed to lessen the financial burden placed on economically weaker and disadvantaged groups as a result of unfortunate hospital episodes and to guarantee their access to high-quality medical care. In order to achieve Universal Health Coverage (UHC) and Sustainable Development Goal 3 (SDG3), PMJAY aims to hasten India's development.

The following are the main advantages of PM-JAY at the beneficiary level:

1. Under this scheme, health insurance cover of up to Rs. 5,00,000 per family per year is provided by the Government.
2. Over 10.74 crore low-income and vulnerable families (roughly 50 crore beneficiaries) are covered nationwide.



Notes

3. All families listed in the SECC database (Socio-Economic Caste Census) as per defined criteria will be covered. There is no capping on family size and age of members.
4. In this programme, women, senior citizens, and young girls are given priority.
5. In times of necessity, all public and accredited private hospitals offer free care.
6. Pays for hospitalisation for secondary and tertiary care.
7. There are 1,350 medical packages that include surgery, prescription medication, day care procedures and diagnostic tests.
8. Coverage for all pre-existing disorders. Hospitals are unable to refuse care.
9. Access to high-quality healthcare services with cashless and paperless facility.
10. No extra amount will be charged by hospital for the medical treatment from the beneficiaries.
11. Services are available to eligible beneficiaries throughout India, providing the advantage of national portability. can call the 14555 24-hour helpline for information, support, complaints, and grievances.

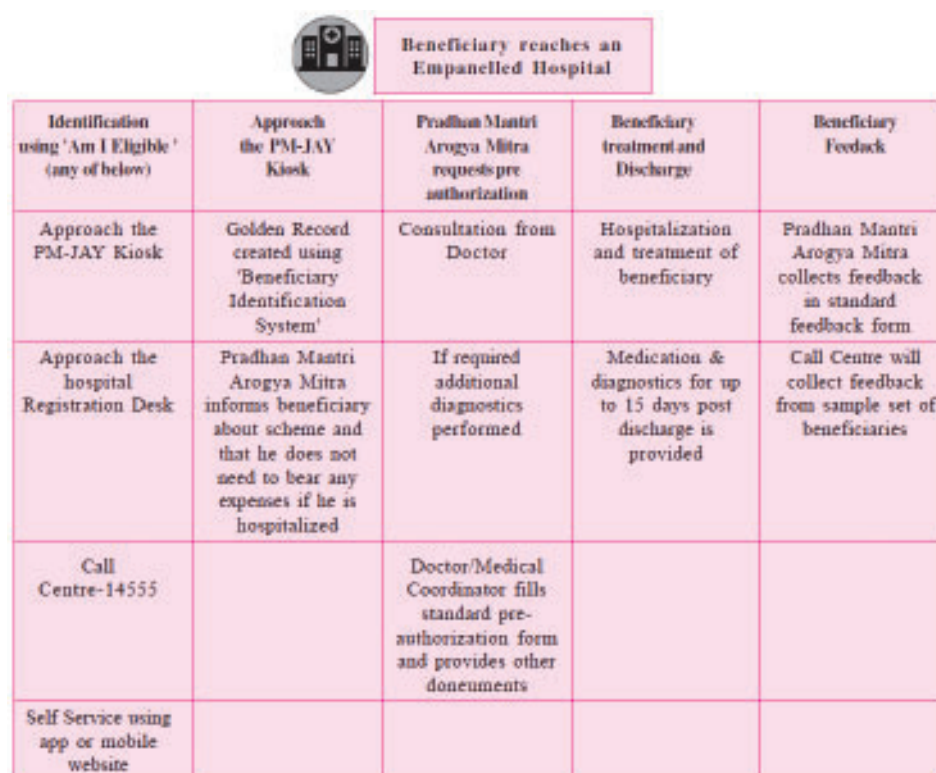


Figure 4.2 PMJAY Process Flow at Empanelled Hospital

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Notes

MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS



INTEXT QUESTIONS 4.2

1. Rashtriya Swasthya Bima Yojana (RSBY) covers hospitalization expenses up to _____
 - a) Rs. 5,000
 - b) Rs. 15,000
 - c) Rs. 30,000
 - d) Rs. 50,000
2. Which of the following covers are offered under Pradhan Mantri Suraksha Bima Yojana (PMSBY)?
 - a) Accidental death cover
 - b) Accidental disability cover
 - c) Accidental death and disability cover
 - d) None of the above
3. As part of the Pradhan Mantri Suraksha Bima Yojana (PMSBY), which of the following document would serve as the primary KYC for the bank account?
 - a) Aadhar
 - b) Driving License
 - c) Passport
 - d) Pan Card
4. The risk coverage under Pradhan Mantri Suraksha Bima Yojana (PMSBY) for accidental death and full disability is _____
 - a) Rs. 50,000
 - b) Rs. 1 lakh
 - c) Rs. 2 lakh
 - d) Rs. 5 lakh
5. The Pradhan Mantri Suraksha Bima Yojana's (PMSBY) Annual Premium is _____
 - a) Rs. 12
 - b) Rs. 30



Notes

- c) Rs. 120
 - d) Rs. 300
6. The Pradhan Mantri Jan Dhan Yojana allows for the opening of accounts with which of the following document?
- a) Passport
 - b) Driving license
 - c) Permanent Account Number (PAN) Card
 - d) all of the above
7. Under Pradhan Mantri Jan Arogya Yojana (PM-JAY), government provides health insurance cover to each family per year up to _____
- a) Rs. 30,000
 - b) Rs. 50,000
 - c) Rs. 1,00,000
 - d) Rs. 5,00,000



WHAT YOU HAVE LEARNT

The health sector is one of the largest and fastest growing sectors in India but also faces immense challenges. A large section of the people in our country must pay for their medical care and hospital bills because they are not protected by any type of health insurance. More people fall below the poverty line as a result of borrowing money, selling assets, and using their income and savings to pay for healthcare. Several programmes, including the Rashtriya Swasthya Bima Yojana, Pradhan Mantri Suraksha Bima Yojana, Pradhan Mantri Jan Dhan Yojana, and Pradhan Mantri Jan Arogya Yojana, have been introduced by the Indian government. The purpose of these schemes is to provide Health protection or insurance for economically weaker sections.



TERMINAL QUESTIONS

1. Write a note on Micro Insurance and Health Insurance for economically weaker sections in India.
2. Explain the features of 'Jan Arogya Bima Policy' and 'Universal Health Insurance Scheme (UHS)'.

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MICRO INSURANCE AND HEALTH INSURANCE FOR ECONOMICALLY WEAKER SECTIONS

3. Write a detailed note on Rashtriya Swasthya Bima Yojana (RSBY).
4. Explain the features of Pradhan Mantri Suraksha Bima Yojana (PMSBY).
5. Highlight the achievements of Pradhan Mantri Jan Dhan Yojana (PMJDY).
6. Write a detailed note on Ayushman Bharat Yojana or Pradhan Mantri Jan Arogya Yojana (PM-JAY).



ANSWERS TO INTTEXT QUESTIONS

4.1

1. (a) 1 year
2. (c) 15 days
3. (c) Both Individuals and Group
4. (c) Rs. 30,000

4.2

1. (c) Rs. 30,000
2. (c) Accidental death and disability cover
3. (a) Aadhar
4. (c) Rs. 2 lakh
5. (a) Rs. 20
6. (d) all of the above
7. (d) Rs. 5,00,000



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain the key features of the schemes launched by the government, mainly Rashtriya Swasthya Bima Yojana; Pradhan Mantri Suraksha Bima Yojana; Pradhan Mantri Jan Dhan Yojana; and Pradhan Mantri Jan Arogya Yojana.

5

DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

**Notes**

5.0 INTRODUCTION

Due to increasing life expectancy in the world, importance of long term care insurance and health insurance is increasing with an ageing population. You can buy health insurance which may provide support in fulfilling your specific health related needs. There are different types of health insurance policies like long term care insurance, combi-products, package policy, Personal Accident Insurance, Critical illness cover, travel policies or overseas health and accident policies, etc. which are available. This chapter will help you in learning about these policies.



5.1 OBJECTIVES

After reading this lesson, you will be able to:

- Describe the need of long term care insurance
- Explain the features of Combi-products and package policies
- Explain the features of Personal Accident and disability cover
- Explain the need of Group Personal Accident and Overseas Insurance

5.2 LONG TERM CARE INSURANCE

The population of aged people is increasing due to increasing life expectancy in the world. Importance of long term care insurance is increasing with an ageing population. The senior citizens and people with disability require long term care insurance.

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DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

Long-term care is any type of ongoing personal or nursing care provided to someone whose health is not expected to improve in the near future and who is unable to care for themselves without some level of assistance.

The following are the two different kinds of long-term care plans:

- a) Pre-funded plans that healthy insured people acquire to cover their prospective medical costs and
- b) Plans for immediate need, which are purchased with a lump sum of money when the insured needs long-term care.

The extent of the disability (as well as the expected survival period) determines the benefit amount. In the Indian market, long-term care goods have not yet been created.

5.3 BHAVISHYA AROGYA POLICY

Four PSU general insurers introduced the first pre-funded insurance plan in India with the Bhavishya Arogya policy. This policy was introduced in 1990. In this plan the policy holder pays the premium in his productive life and is covered for health care needs after his retirement. This plan is similar to a life insurance policy, but instead of covering death costs, it covers future medical bills.

a) Deferred mediclaim

The age range for proposers is 25 to 55 years old. This is deferred plan where policy holder medical expenses are covered after specified tie period.

b) Retirement age

The retirement age specified in an insurance policy schedule and chosen by the policyholder when the policy was purchased. This age cannot be advanced. The retirement age opted by insured can be between 55-60 years. There should be a minimum of 4 years between the date of joining and the chosen retirement age.

c) Pre-retirement period

The time period between date of proposal acceptance and policy retirement age specified in policy schedule. As per the terms and conditions of the policy, the policy holder would be paying the insurance premium or single premium during this time period. The premium might be paid in one go or in installments by the policyholder.

**d) Withdrawal**

The insurance company will repay the insurance premium as long as there were no claims made under the policy in the event that a policy holder chooses to withdraw from the policy, or he passed away before the retirement age or after the retirement age selected. If a renewal is delayed for a valid reason, a grace period of seven days is granted for premium payment.

e) Assignment

Provision of assignment is given in this policy.

f) Exclusions

Because it is a future Mediclaim policy, this coverage does not include any exclusions for pre-existing conditions, a 30-day waiting period, or first-year exclusions for select specific diseases.

g) Group insurance variant

This policy can be given in form of group cover and group discount facility is also available.

5.4 COMBI-PRODUCTS

Products for life insurance can occasionally be coupled with those for health insurance. By collaborating and coming to an agreement, two insurers can effectively promote more goods in a packaged manner. With a greater selection of products available to policyholders, the product class is expected to increase the penetration of the personal lines insurance business.

Hence, "Health plus Life Combi Products" refers to products that combine a life insurance policy provided by a life insurer with a health insurance policy provided by a non-life and/or stand-alone health insurance provider. For the purposes of this product category, "health insurance" refers to the execution of contracts that solely provide sickness benefits or medical, surgical, or hospital expense benefits, whether in-patient or out-patient, on an indemnity or reimbursement basis.

The proposed product innovation is expected to make it easier for policy holders to select an integrated product of their choice under a single roof rather than searching the market for two different insurance coverages from two different insurers as insurers leverage the marketing and operational network of their partner-insurers. As a result, it is expected of the insurance companies to provide the attractive coverage as an alluring offer to the insured.

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DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

The two insurance companies collaborate on the product design, and both insurance companies' distribution networks are used to promote the products. This obviously requires a partnership between two businesses, and according to present regulations, such a partnership is only allowed between one life insurer and one non-life insurer at any given moment. For the way of marketing, policy servicing, and sharing of common expenses will be carried out, as well as for policy servicing criteria and premium transmission, these organisations must have a Memorandum of Understanding in place. Each one of the insurers may request IRDAI's approval for the alliance. The contract should be long-term, and only exceptional conditions that are acceptable to the IRDAI will allow for a break from the tie-up. Commission and Claim payouts in respect of 'Combi Products' shall be by respective insurers only.

It may be mutually agreed upon for one of the insurance companies to serve as the lead insurer and play a crucial part in facilitating the policy service by serving as a contact point for providing different services as necessary for combi products. Underwriting and insurance service may be greatly facilitated by the lead insurer. Depending on which part of the insurance is impacted, the respective insurance companies are in charge of handling the claims and commission payments.

The "Combi Product" file must adhere to the current, individually cleared File and Usage criteria. Both before and after the sale, as well as in all documents such as the policy document and sales literature, the policyholders must be made aware of the premium components for each risk separately.

The insurance policy may be issued on a group or individual insurance policy basis. However, with regard to health insurance floater policies, pure term life insurance coverage is permitted on the life of one of the family members who is employed and who is also the health policy proposer, provided that they meet the insurers' underwriting requirements for insurable interest and other relevant factors.

The insured has access to the Free Look option, which is to be used to the "Combi Product" as a whole. However, the health insurance component of the "Combi Product" will be renewable at the policyholder's discretion from the relevant General/Standalone Health Insurance Company.

Combi Products may be marketed directly, through brokers, and through composite individual and corporate agents shared by both insurers, but not through bank referral programmes. They cannot be, however, intermediaries who are not permitted to advertise either of the insurers' products.



In particular, features like the involvement of two insurers, the fact that each risk is unique, who will handle claims, issues relating to the renewability of both or just one of the covers at the insured's discretion, servicing facilities, etc., must be specifically disclosed in the proposal and sales literature.

The IT system that supports this company needs to be reliable and efficient because it involves extensive data integration between the two insurance companies and data creation for IRDAI as needed.

5.5 PACKAGE POLICIES

"A package policy is an insurance product that includes coverage for more than one type of insurance".

Under package policy a combination of insurance covers can be taken in a single policy.

For example- Various physical assets like building, contents etc are covered under single insurance policy like shopkeeper's policy, office package policy, householder's policy etc. The most typical Package Policy combines liability coverage, such as premises liability or product liability, with property coverage, such as for buildings or business contents.

Critical illness covers or personal accident or hospital cash can be combined with Mediclaim policy as package policies.

A package policy that covers health insurance, accidental death or disability benefits, lost or delayed checked baggage, lost passport and documentation, third-party liability for property/personal damages, and trip cancellation is known as an overseas mediclaim policy or travel policy.



INTEXT QUESTIONS 5.1

1. The proposer can join the Bhavishya Arogya policy any time between the age of _____
 - a) 25 and 55 years
 - b) 25 and 50 years
 - c) 25 and 60 years
 - d) None of the above

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DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

2. A product called _____ combines life insurance and health insurance into one package.
 - a) Personal Accident and Disability Cover
 - b) Family package cover
 - c) Health plus Life Combi Product
 - d) BhavishyaArogya policy
3. Combi products marketing shall not be done through _____.
 - a) Direct marketing channels
 - b) Brokers and Composite Individual and Corporate Agents common to both insurers
 - c) Bank referral arrangements
 - d) All of the above

5.6 PERSONAL ACCIDENT AND DISABILITY COVER

Definition of accident is "An unexpected and undesirable event, especially one resulting in damage or harm".

As we know, accidents are unexpected and can happen at any time. Getting personal accident coverage is the only way we can effectively plan for accidents.

Personal accident insurance is a benefit policy that pays benefits in the event that the policyholder passes away or becomes disabled due to an unforeseeable accident. This means that in the event of an accident, the insured will receive a set amount of compensation. Together with accident compensation, personal accident policies frequently offer some kind of medical insurance coverage.

In a personal accident policy, the policyholder is entitled to a claim payment equal to 100% of the amount insured in the event of death. In the case of permanent disability for temporary disablement the benefit varies from a specific percentage of sum insured to weekly compensation. The term "weekly compensation" refers to the payment of a defined amount for each week of disability, up to a maximum number of weeks for which the compensation would be payable.

Basic Coverage

The policy basically covers 'Death' and 'Disablement' resulting solely and directly from bodily injuries sustained in an accident, caused by external violent and visible means.

Important Terminologies**a) Bodily injury**

- i. This definition eliminates sickness from natural causes, yet disease directly brought on by an accident is still considered bodily injury. (unless specifically excluded by the policy).
- ii. The definition of bodily injury excludes mental shock, fright, or grief unless they result in a physical illness or injury, but the recent trend is to include any disablement put on by shock.

b) Solely and directly

- i. This term has the effect of requiring that the physical harm was brought on exclusively and immediately by accident.
- ii. Additionally, the physical harm must cause death or disability directly and independently of any other cause.

- c) An accident** is an occurrence that is totally unanticipated, unintended, or contrived. It excludes the total impact of a number of minor incidents. Additionally, the physical harm must cause death or disability directly and independently of any other cause.

Included are specific voluntary activities that cause physical harm when the insured's act is the outcome of a series of incidents that started with an accident.

d) External, violent and visible means

Accident results may not be external, but the means that caused the accident must be within the scope of the definition as a whole. Injury, for instance, could occur internally (inside the body). However, the outcome must meet the policy's requirements for death or disability.

In other words, as long as there is bodily injury, the means or cause of the accident must fall under the definition, but the consequence or effect need not be visible or external.



Notes



Notes

e) Disablement

A person is considered to be disabled and his inability to attend to any occupation or business is referred to as disablement if an unintentional bodily harm prevents him from engaging in any occupation or business.

The physical inability of the person to attend to his or her occupation or business, not his or her earning capacity, is what is being discussed here. It should be noted that even while there might not be any loss of earning capability, the insurance still allows for the possibility of disability.

Death may be the direct outcome of an accident even if it causes a disease to develop first, meaning that there was no interruption in the line of causality.

The compensation payable is as decided during the inception of the policy for the specified contingencies that are:

- Death
- Permanent total disablement
- Permanent partial disablement
- Temporary total disablement
- Medical expenses resulting from accident are reimbursed on an actual basis, if covered as an extension.

Types of disability covered- The different types of disability covered are as follows:

- i. **Permanent Total Disability (PTD):** The term "Permanent Total Disability" (PTD) refers to a condition that is completely and irreversibly incapacitating, preventing the covered individual from engaging in any type of gainful activity. For instance, having all four of your limbs paralysed.

What constitutes total disablement?

The following are considered to be the same as total permanent disability-

- i. Loss of sight of both eyes
- ii. The actual loss by physical separation of the two entire hands or two entire feet or one entire hand and one entire foot
- iii. Loss of sight of one eye and such loss of one entire hand / foot



- ii. **Permanent Partial Disability (PPD):** A lifelong partial disability is referred to as a Permanent Partial Disability (PPD). With the exception of the fact that the disablement is just partial not total, this is comparable to permanent total disablement. For instance, losing a finger or toe.

The policy uses a table to display the applicable percentage of compensation for specific losses. It will be necessary to pay the appropriate percentage of the insured amount. For PPD that isn't listed in the table, a doctor's evaluation would serve as the basis.

For instance, the table states that the compensation for losing a little finger is 4% of the sum insured, losing four fingers is 35%, losing the ability to hear in both ears is 75%, and so forth.

- iii. **Temporary Total Disability (TTD):** This is the term used for total disabled person for temporary period of time. For a specific period of time, the insured individual is temporarily restricted from engaging in any occupation or business. The loss of income is covered under this section during disability period. Normally, the policy provides for weekly compensation for TTD, for a maximum number of weeks specified.

Example

For better comprehension, a sample table of benefits is provided below, indicating the amounts of compensation payable upon the occurrence of various situations. It is estimated that the policy's sum insured is Rs. 800000.

Only for example purposes has this sum been chosen. The proposer may select any sum insured provided that it is reasonable in relation to his income from gainful occupation and that the insurance company agrees to insure him for this amount.

No.	Contingency	Amount of Benefit payable under Policy
1	Death	Rs. 8,00,000 (i.e. 100% of capital sum insured)
2	Loss of two limbs or both eyes or one limb and one eye.	Rs. 8,00,000 (i.e. 100% of capital sum insured)
3	Loss of one limb or one eye	Rs. 400,000 (i.e. 50% of capital sum insured)
4	Permanent total disablement other than the above	100% of capital sum insured

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5	Permanent partial disablement	Percentage as shown in the table in the policy.
6	Temporary Total disablement	Weekly payment at 1% of the capital sum insured subject to a maximum of 104 weeks. The amount of weekly payment is restricted to an amount decided by each insurer, whatever be the capital sum insured. E.g. Rs 3000 per week or Rs 5000 per week. This limit applies to all policies held by the insured

The benefits (1-5) above are referred to as capital benefits, and benefit (6) as weekly benefit.

Note:

- The benefits mentioned above can vary from one insurer to another
- Insurance policy may be issued on the request of insurance company or on underwriting consideration covering all the above benefits or the benefits (1) to (5), or (1) to (3) or only (1) etc.
- The insurance companies can make their products with different combination as mentioned above.

Sum insured

Personal accident policy sum insured depends upon the gross monthly income of policy holder. Generally sum insured is 60 times of gross monthly income. Some insurance companies can consider other factors also. The premium of the PA policy depends upon occupation and income of the policy holder. If the occupation is hazardous the underwriter may enhance the premium in for of loading or may deny the proposal.

While providing insurance to those who are not in a job, such as housewives, students, etc., the insurance company will ensure that only capital benefits are covered and that no weekly compensation is given.

Benefit plan

The principle of contribution is not applied in personal accident policy. An individual who has multiple PApolicies with various insurance companies will receive claim amount from all insurance companies in the event of accidental death, PTD, or PPD.



Notes

Value added benefits

Several insurers pay value-added benefits including hospital cash in case of accidental hospitalisation, mortal remains transportation expenses, education benefits, and ambulance charges based on actual or fixed limits, whichever is lower.

Exclusions

Common exclusions under PA cover are as follows:

- a) Intentional self-injury, suicide or attempted suicide
- b) Under the influence of intoxicating liquor or drugs
- c) engaging in aviation or ballooning when getting into, getting out of, or travelling in a balloon or an aircraft other than as a passenger (for a fee or otherwise) in any conventional type of aircraft that has been properly licensed and is operating anywhere in the world.
- d) Death or disability due to mental disorders, any venereal diseases, sexually transmitted diseases, AIDS or insanity.
- e) resulting from or resulting from any intentional criminal law violation by the insured.
- f) War and kindred peril and nuclear risks
- g) Resulting directly or indirectly from child birth or pregnancy h). Directly or indirectly caused by venereal diseases or insanity
- i) Any existing disability prior to the inception of policy
- j) While the policy holder is serving in any arm of the armed forces, in times of peace or war, or while engaging in professional sports competition or training.

Some insurer excludes a loss arising from driving a vehicle without a driving license (DL) under PA cover.

Individuals, families, and groups can all receive personal accident insurance policy.

Family package cover

This may be given in the following manner:

- a) **Earning member (Persons Insured) and Spouse, if earning:** Independent sum insured coverage for each, as desired, subject to the same restrictions as in individual

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DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

- b) **Spouse (if not an earning member):** The non-earning spouse is entitled to get 50% of the sum insured subject to the specified maximum sum insured. For example- Rs one lakhs to Rs three lakhs.
- c) **Children (between the age of 5 years and 25 years):** The children are entitled to 25% of sum insured of earning parent subject to specified maximum limit. For example- Rs 50000 per child.

Notes:

- i. The coverage is only available for death and total or partial permanent disability for children and the non-earning spouse, though the Table of Benefits may be taken into account depending on the policies of the specific company. Some businesses permit unlearning spouses to receive TTD coverage up to a certain amount as well.
- ii. Generally, a 5% reduction is given on the gross premium.

5.7 GROUP PERSONAL ACCIDENT POLICIES

Because firms recognize the value of providing welfare benefits to their employees, group insurance policies have grown in popularity. Associations, clubs, and other organisations that find it administratively convenient to set up a group policy to cover their members may also use these plans. In a group policy, "insured" refers to the employer, association, group leader, etc., while "insured persons" refers to those who will benefit from the insurance.

A common relationship between the insured parties and a designated administrator of the insurance plan are prerequisites for a group insurance policy.

Usually, group Personal Accident (PA) policies are issued for one year duration and renewal is done on anniversary. However, the group personal accident policies may be issued for less than one year duration also to cover any specific event by general or standalone health insurance companies.

A group discount on premiums is offered by the insurer if there are more than 100 insured individuals in the group. The group policy may be issued to a group of 25 people also with no discount in premium.



Notes

5.7.1 Following are different types of group policies

Employer and Employee relationship

These insurance policies are provided to organisations, businesses, etc. to cover:

- Named employees
- Unnamed employees

Non Employer-Employee relationship

These policies are granted to associations, societies, clubs, etc. to cover:

- Named members
- Members not identified by name

(Note: Employees may be covered separately)

Broken bone policy and compensation for loss of daily activities

This particular PA policy is made to offer protection against certain mentioned fractures.

- i. At claim time, fixed specified benefit or percentage of sum insured is paid to insured as per the fractured bone.
- ii. The amount of benefit depends on the type of covered bone and the type of fracture that occurred.
- iii. To further explain, a compound fracture would fetch more claim amount than a simple fracture. The percentage of benefit for thigh bone (femur bone) would have higher percentage over benefit of finger bone.
- iv. In order for the insured to cover the costs involved in maintaining his or her life, the insurance also includes a fixed benefit that is defined in the policy for loss of everyday activities such as eating, going to the toilet, dressing, continence (ability to hold urine or stools).
- v. It also includes benefits for hospital cash and accidental death insurance. There are many insurance plans with various insured amounts and benefit payouts.

5.8 OVERSEAS TRAVEL INSURANCE

1. Need for the policy

An Indian citizen who travels abroad for business, vacation, or academic purposes faces the possibility of being ill, having an accident, or getting hurt. The medical expenses in countries like USA and Canada are very high. If someone visiting these nations got sick or had an accident, he will be in major financial

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problems due to high medical costs. The overseas travel insurance policies are available to cover these unfortunate events.

2. Scope of coverage

The covers offered are:

- i. Accidental death / disability
- ii. Medical expenses due to illness / accident
- iii. Loss of checked in baggage
- iv. Delay in arrival of checked in baggage
- v. Loss of passport and documents
- vi. Third party liability for property / personal damages
- vii. Cancellation of trips
- viii. Hijack cover

3. Types of plans : The Business and Holiday Plans, Study Plans, and Employment Plans are the most prominent travel policies.

4. Travel Plan offered by : These policies are offered by general and standalone health insurers. It can be available as individual cover or in form of rider (add-on benefit) with health insurance policy. The premium for rider benefit should be approved by IRDAI under files and use procedure.

5. Who can take the policy?: This insurance policy is available to Indian citizens travelling abroad on business, vacation, or for academic purposes. Indian employers who send their workers abroad on assignments may also be covered.

6. Sum insured and premiums: The amount of the cover, which is given in US dollars, often ranges from \$100,000 to \$500,000. The primary component of the section deals with medical bills, evacuation, and repatriation. With the exception of the liability cover, other parts have a lower Sum Insured. Except for the employment plan, where premiums must be paid in dollars, premiums can be paid in Indian rupees. The plans are usually of two types:

- World-wide excluding USA / Canada
- World-wide including USA / Canada

Some products provide for cover in Asian Countries only, Schengen Countries only etc.



Notes

7. **Corporate frequent travelers plans:** This type of annual policy is taken by the employers/corporate for their employees as individual cover who travels abroad very frequently. This policy can also be taken by the persons who travel abroad many times in a year. The policy has particular restrictions, such as a cap on the number of visits per year and the maximum number of days for each trip. An annual declaration policy, in which an advance premium is paid according to the anticipated number of travel days made by a company's employees each year, is a type of insurance that is becoming more and more popular nowadays.

Weekly or biweekly reports on employee travel days are made, and the premium is deducted from the advance. There is also a provision for an increase in the number of man days while the insurance is in effect because it runs out upon payment of an extra advance premium. Only business and vacation trips are permitted under the aforementioned policies.

The overseas Medclaim coverage frequently excludes pre-existing conditions. Those who already have medical conditions are not eligible for this policy for taking medical treatment abroad.

Health-related claims made under these plans are completely cashless because each insurer has a partnership with a global service provider that services policies abroad and has a network in many nations.



INTEXT QUESTIONS 5.2

1. Which of the following is covered in case of an unforeseen accident, if an insured has taken a Personal accident insurance?
 - a) Death of the insured person
 - b) Disablement to the insured persons
 - c) Both a and b
 - d) None of the above
2. Which of the following are covered in the Overseas Travel Insurance?
 - a) Cancellation of trips
 - b) Third party liability for property / personal damages
 - c) Loss of passport and documents
 - d) All of the above

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DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

3. Which of the following changes needs to be notified to the insurer in case of personal accident policies.
 - a) Changes in salary
 - b) Change in occupation
 - c) Changes in marital status
 - d) None of the above
4. Which of the following groups is not eligible for coverage under group personal accident policies?
 - a) Employees of an organisation
 - b) Members of a club/association
 - c) Group of unrelated individuals
 - d) None of the above
5. Raj has two personal accident insurance policies with a sum insured of Rs 5,00,000 and Rs 3,00,000 each. He dies in an accident. What is the amount he is eligible to receive?
 - a) Rs 8, 00, 000
 - b) Rs 5, 00, 000
 - c) Rs 3, 00, 000
 - d) Rs 2, 00, 000
6. An insurance plan called _____ includes cover for multiple insurance types.
 - a) Package policy
 - b) Double insurance
 - c) Co insurance
 - d) None of the above
7. The types of travel insurance plans are
 - a) Business and vacation Plans
 - b) Academic purpose
 - c) Employment Plans
 - d) All of the above



WHAT YOU HAVE LEARNT

Due to increasing life expectancy in the world, importance of long-term care insurance is increasing with an ageing population. There are two types of long-term care plans, i.e. Pre-funded plans and Immediate need plans. Bhavishya Arogya Policy was first pre-funded insurance plan in India marketed by four PSU general insurers. In this plan the policyholder pays the premium in his productive life and is covered for health care needs after his retirement.

Combi-products are the products where the life insurance can occasionally be coupled with those for health insurance. By collaborating and coming to an agreement, two insurers can effectively promote more goods in a packaged manner.

A package policy is an insurance product that includes coverage for more than one type of insurance. Under package policy a combination of insurance covers can be taken in a single policy. Critical illness covers or personal accident or hospital cash can be combined with Mediclaim policy as package policies.

Personal accident insurance covers the insured person's death or disabling injury resulting from an unexpected accident. While the death benefit under a PA policy is payment of 100% of the insured amount, in the event of disability, compensation can range from a fixed percentage of the insured amount to weekly compensation for temporary disability in the case of permanent disability with certain exclusions. Because firms recognise the value of providing welfare benefits to their employees, group insurance policies have grown in popularity.

If a person travelling to these nations were to suffer an unexpected accident or illness, the medical care expenses particularly in nations like the USA and Canada, is very high and could result in serious financial troubles. There are travel insurance policies and overseas health and accident coverage available to safeguard against such terrible occurrences.



TERMINAL QUESTIONS

1. Explain the need of Long Term Care Insurance. Also explain the types of long term care plans.
2. What are the features of Combi-Products? When marketing combo products, what specific disclosures must be given in the proposal and sales literature?



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DIFFERENT HEALTH INSURANCE POLICIES AND KEY TERMS OF HEALTH POLICIES

3. Write a note on the coverage of Personal accident insurance. What are its exclusions?
4. Explain the need for the Overseas Travel Insurance policy. Explain the covers which are available or covered in this product.



ANSWERS TO INTEXT QUESTIONS

5.1

1. (a) 25 and 55 years
2. (c) Health plus Life Combi Product
3. (c) Bank referral arrangements

5.2

1. (c) Both of the above
2. (d) All of the above
3. (b) Change in occupation
4. (c) Group of unrelated individuals
5. (a) Rs 8, 00, 000
6. (a) Package policy
7. (a) All of the above



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To assist the client in selecting an appropriate health Insurance policy as per the need of the client.

6

GROUP HEALTH INSURANCE COVER AND KEY TERMS OF HEALTH POLICIES



Notes

6.0 INTRODUCTION

There are different terms that are used in health insurance, which may sound confusing to the client like Network Provider, Preferred Provider Network (PPN), Third Party Administrator (TPA), Cumulative Bonus, Pre-Existing Disease, Co-Payment, Free Look Period and many others. It is important for you to understand these terms so that the same would be explained to the client at proper times. This chapter will help you learn about these terms, which are often used in health insurance. You will also learn about the need and features of group health insurance in the beginning of the chapter.



6.1 OBJECTIVES

After reading this lesson, you will be able to:

- Describe the need of Group Health Insurance Cover
- Explain the key terms used in health insurance policies

6.2 GROUP HEALTH COVER

Group health insurance policy is an insurance policy, which is generally taken by the owner of the group for insuring the members of the group. Group owners can be employer/ association/ trust, where one insurance policy known as master policy is issued covering whole group of members and is subject to minimum number of person covered. This policy is issued for one year which can be renewed every year. The policy is also known as group Mediclaim cover.



Notes

6.2.1 Features of Group Health Insurance

1. Scope of coverage

Generally, group health insurance policy is called Corporate Mediclaim policy where employees of a particular group (members) are covered. This policy may also provide coverage for the employee's spouse and dependent children, which depends on the contract between the Insurer and the owner/employer. In some cases, even parents/parents in law are covered under the same cover.

2. Tailor-made cover

This policy is called tailor made policy because the benefits, terms and conditions can be customized according to the requirement of a group. In the group Mediclaim cover, both parties to the contract (group owner and insurer) sit together and negotiate terms, conditions, exclusions and price. And finally, they came up with customized health insurance cover. The group health insurance plan covers a lot of exclusions that were not covered by individual health insurance policies.

3. Maternity cover

Generally maternity cover is under exclusion in individual health cover but may be covered under group Mediclaim cover depending upon mutually agreed terms and conditions. Maternity coverage comes with a nine-month waiting time under group Mediclaim coverage, though this condition is occasionally lifted. The medical expenses covered under this policy are related to Caesarian and normal delivery of child. Generally, there are restrictions to the amount paid under this category like Rs 30000 to Rs 50000. In some circumstances, this is an optional coverage option that must be purchased together with an additional premium or a 10% loading of the total premium from all policyholders in the insurance policy. The benefit provided to the covered member falls within the health insurance policy's insured sum. If an insured person already has more than 2 children, he may not be eligible for this benefit due to a provision that claims will only be paid for the first two children of the insured member.

4. Child cover

In a group health insurance plan, infants are covered from day one; however, in an individual health insurance plan, an infant is only insured after three months.



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

In group Medclaim cover, several exclusions like waiting period of 30 days or two years waiting period for specific diseases are waived off and even congenital diseases may be covered. The preexisting diseases are also covered from day one in group Medclaim policy as it is tailor made policy.

6. Premium calculation

The premium in group insurance policy is decided on the basis of:

- Age profile of group members
- Group Size
- Past claim experience of the group
- Loading or discount given (if any)
- Many other factors

Note: Factors affecting the premium in case of group health policies you will study in the coming chapters

As previously stated, a number of factors, including the member's age profile and the size of the group, determine the insurance price for the group Medclaim coverage. When choosing a renewal premium, the claim history is also crucial. Depending on the claim history, the group Medclaim policy renewal premium may change. If the claim ratio is low or has a favorable risk experience, then insurer may give discount in premium and for unfavorable experience or high claim ratio, the insurance company may put loading or enhance the premium.

7. Non-employer employee groups

The IRDAI guidelines state that the group shouldn't be established exclusively for the purpose of obtaining group insurance coverage. Whenever the group health insurance policies are given to non-employer employee groups like trust/associations etc., it is very important for the insurer to ascertain the group owner relationship with its insured members.

8. Pricing

Depending on the total number of insured people covered by the group policy at its beginning, group discounts are permitted for group plans on a scale. While the policy is in effect, the group's size may increase or decrease. As the whole

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group in group mediclaim policy is covered and at the same time, there is intense competition among insurers regarding group insurance business, the group owner can always negotiate on price (premium) with the insurer for better deal. In today scenario, group Mediclaim business is loss making business for insurance companies due to very high claim ratio and underpricing of premium due to intense competition.

The premium is very less for group Mediclaim policy as compared to individual health insurance policy. The reason for low premium is very less administrative expenses as well as no separate policy issued to individuals.

9. Premium payment

The premium payment can be in two forms, that is, contributory and non-contributory schemes. Contributory schemes means the whole premium would be paid by both employer and group members (employees) on contributory basis. The maximum portion of the premium is paid by employer and a nominal amount is taken from employees. And in non- contributory scheme, the full premium is paid by the employer only.

10. Add-on benefits

There are lots of medical procedures and expenses like dental care, vision care, health checkups etc., which are not covered under individual health insurance policies but are covered under group Mediclaim policies at additional premium (riders) or sometimes as complimentary benefits. As it is tailor made policy, all these benefits depends upon negotiated terms and conditions mentioned in the group insurance contract.

6.3 CORPORATE BUFFER OR FLOATER COVER

Typically, each family covered by a group health insurance policy has a sum insured of between Rs. 1 lakh and Rs. 5 lakhs. This amount may be more in the case of some corporate houses. It can happen that a major illness causes the insured family's group policy sum insured to be depleted within a year. In this situation, the corporate buffer or floater cover comes to rescue for such a family, where this protection covers the additional medical costs over and beyond the baseline family sum insured.

According to the contract, the sum insured for this particular insurance might be even higher, ranging from Rs. 10 lakhs to Rs. 1 crore.

Once the family sum insured is exhausted, the excess amount can be drawn from the corporate buffer. However, use of this coverage is typically limited to serious illness or critical illness costs when one hospitalisation uses up the entire amount insured.

There is the capping or limit on the buffer amount utilized by each insured family member. This limit is often up to the original sum insured. Generally this type of cover should be given for medium sized policies not for very low sum insured policy.

**Notes**

6.4 SPECIAL PRODUCTS IN HEALTH INSURANCE

6.4.1 Specific Disease Covers

The general insurers have recently provided coverage for specific conditions including cancer, dengue, and COVID 19 in the Indian insurance market. The cover for these type of diseases can be for a limited time. In some policies, the sum insured have some specific limit in form of sum insured. It's important for the underwriter to check the current health status of proposer because a proposer may be already diagnosed for the illness and would take the policy to take the claim very soon.

6.4.2 Diabetes Policy

There are large number of diabetic patients in India, which may increase at a high speed in the coming future. There are other co morbidities connected to this lifestyle disorder. Complications related to neuropathy, nephropathy, retinopathy, cardiac disease and diabetic foot may occur subsequently if blood sugar is not controlled timely. These days, disease specific diabetes health insurance policy is available, where complications related with diabetes are also covered. Those interested in this policy must be between the ages of 25 and 65. The pre policy medical check-ups will be conducted to see the current health status of the patient. The sum insured ranges from Rs 1 lakh to 10 lakhs. This policy is especially for the applicants who are already diagnosed with diabetes. The premium is costly when compared to other health insurance policies. Insured can take benefit from wellness program of insurance company where the regular (quarterly or half yearly) medical checkups expenses related to diabetes are paid by insurer. The insurers may offer incentives in the form of reduced premiums if some of the factors like blood glucose, LDT, blood pressure, etc. are controlled. There are certain mobile phone apps, which are available for tracking your routine exercise habits or the number of steps you have achieved in a day, the data of which is used for offering you discounts during the renewal of policy. On the other side, inadequate control over these factors would result in a larger premium.



Notes



INTEXT QUESTIONS 6.1

1. Group health insurance policy is also known as:
 - a) Group Mediclaim policy
 - b) Tailor made policy
 - c) Both a and b
 - d) None of the above
2. The premium payment in group health insurance policy is in form of
 - a) Contributory
 - b) Non Contributory
 - c) Both a and b
 - d) None of the above
3. Premium in group insurance policy is decided on the basis of:
 - a) Age profile of group members
 - b) Group Size
 - c) Past Claim experience of the group
 - d) All of the above

6.5 KEY TERMS IN HEALTH POLICIES

6.5.1 Network Provider

Definition- According to IRDAI(Third Party Administrators - Health Services) (Amendment) Regulations, 2019

"Network Provider means hospital enlisted by an insurer, a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility."

Network provider is a hospital/nursing home/day care center which have signed MOU with insurance company or TPA for providing cashless treatment to policy holder. The insurer or TPA can bargain with such hospitals, who also promise a high level of service, on the cost of medical care.



6.5.2 Preferred Provider Network (PPN)

The insurer might establish a PPN, or preferred provider network, of hospitals to offer high-quality care at reasonable costs. Based on their experience, quality health care facility, utilization, and cost of providing care, the insurance company can select these hospitals.

6.5.3 Cashless Service

According to IRDAI (Third Party Administrators - Health Services) (Amendment) Regulations, 2019

Definition- "Cashless facility means a facility extended by the insurer or TPA on behalf of the insurer to the insured, where the payments for the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved".

If a person with health insurance is admitted to a network hospital or an empaneled hospital owing to an illness or disease or accident, he need not pay medical expenses to hospital and can avail cashless treatment. Policy holder has to show the proof of insurance at hospital to avail this service. The TPA/Insurer will make payment directly to the hospital for the sanctioned amount.

If the health care expenses exceed the policy sum insured or expenses not payable as per policy conditions, then that amount need to be paid by insured.

6.5.4 Third Party Administrator (TPA)

According to Insurance Regulatory and Development Authority of India (Third Party Administrators - Health Services) (Amendment) Regulations, 2019

"Third Party Administrator (TPA) means a company registered with the IRDAI, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services."

The introduction of TPA was the significant development in the health insurance sector. TPA was introduced to provide the health services, especially health insurance claim settlement to health insurance policyholders.

Apart from settling and processing claim settlement (both cashless and reimbursement), TPA is also engaged in issuing TPA card for health insurance policy holder which is an

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identification proof and is useful at the time of claim. For the purpose of processing and handling health insurance claims, TPAs are selected by the insurer. Another work of TPA is to sign a MOU with hospitals (health care providers) for empanelment, where policyholder can avail cashless facility for hospitalization.

6.5.5 Hospital

According to the IRDAI Guidelines on Standardization in Health Insurance 2016, 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."

6.5.6 Medical Practitioner

According to the IRDAI Guidelines on Standardization in Health Insurance 2016,

"Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. Insurance companies may specify additional or restrictive criteria to the above e.g. that the registered practitioner should not be the insured or close member of the family".

6.5.7 Qualified Nurse

According to the Guidelines on Standardization in Health Insurance 2016, 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".

6.5.8 Reasonable and Necessary Expenses

A health insurance policy always contains this clause where 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.

According to the Guidelines on Standardization in Health Insurance 2016, Reasonable Charges as "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".

This provision safeguards the insurance company from frauds in which the healthcare provider inflates medical bills. Additionally, it stops policy holders from seeking treatment for common illnesses in expensive hospitals when it may be done at comparatively low cost.

6.5.9 Notice of Claim

Every insurance contract stipulates that a claim must be reported immediately to the insurer, and there is Turn Around Time (TAT) for submitting documents. A minimum of 72 hours before a planned hospitalisation, the insured must give the insurer written notice in a Cashless Hospitalisation Facility in a Network Hospital. The length of time may change between insurers. The insured person must give written notice to the insurer of any emergencies within 48 hours of hospitalisation or before hospital release, whichever comes first. The insured may, however, submit the claim documents in cases of reimbursement claims within 15 days (or 30 days, in the case of a select few insurers) of the patient's discharge. However, it is always advised to notify the insurer of the claim as soon as possible and provide the required paperwork. As a result, claims can be reported quickly and accurately, and the insurer can conduct investigations as needed. Delay in submission of bills could lead to frauds where the bills are inflated by insured / hospital, etc.

According to IRDAI norms, if a claim notification or paper submission is made after the allotted period has passed, a legitimate explanation should be taken into account.

6.5.10 Free Health Check

Certain incentives are given to those policyholders who do not take any claim. Many insurance companies give reimbursement to policy holder for health checkup after



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four continuous claim free years. This typically has a cap of 1% of the insured amount after four consecutive claim-free years.

6.5.11 Cumulative Bonus

Cumulative bonus is to incentivize the policy holder for not taking any claim and this is given on sum insured for every claim free year. If a policy holder has not taken any claim or has a claim free year, then insurance company enhance the sum insured on same premium at the time of renewal. The enhancement in the sum insured is the pre-defined fixed percentage of sum insured. The cumulative bonus can enhance from 10% to 50% for every claim free year and it could vary from insurance company to insurance company.

As per IRDAI guidelines, this bonus can be provided only on indemnity-based health insurance policies and not under the benefit policies (except Personal accident policies).

According to Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016

- i. The provisions regarding cumulative bonus should be mentioned in policy prospectus and insurance policy document.
- ii. The cumulative bonus that has accrued may be reduced if a claim is submitted in any given year at the same rate at which it has accrued.

For Example- For every claim free year, the cumulative bonus enhances to 50% of sum insured at renewal. The policy holder aged 25 years purchases a new health insurance policy for a sum insured of Rs. 5 lakhs with a Rs. 8,000 premiums. If there are no claims in the first year, his sum insured will enhance to 7.50 lakh rupees (50 percent more than the previous year) for the same 8,000-rupee insurance premium in the second year. This sum insured may enhance to Rs. 10 lakh next year if again it is a claim free year.

6.5.12 Pre-Existing Disease

Definition

The IRDAI guidelines on standardisation define Pre-existing as "Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer."

6.5.13 Co-Payment

According to the IRDAI Guidelines on Standardization in Health Insurance 2016, Co-payment means "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-payments means a specified percentage of every claim amounts that is to be paid by insured and rest by insurance company. This can be compulsory or voluntary and varies from product to product. Co-payment brings in a certain discipline among the insured to avoid unnecessary hospitalizations. This is generally found in senior citizen policies.

For example: if in a health insurance there is a provision of 20 % copayment and the claim amount is Rs 1,00,000. In this case, 20% of Rs one lakh (Rs 20,000) will be paid by insured and rest 80% or Rs 80,000 will be paid by insurance company. The health insurance policy with co- payment have less premium.

6.5.14 Room Rent Restrictions

According to the Guidelines on Standardization in Health Insurance 2016, Room Rent means "the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses".

In some health insurance policy there is room rent restrictions that is linked to the sum insured opted by insured. It is generally 1% of sum insured per day. For example- A person has taken Rs 3 lakh sum insured policy and have 1% room rent restriction. He/she is entitled to have maximum Rs 3,000 room rent per day. If this person is admitted in metropolitan cities then he/she won't be getting even semi /private room resulting paying from their pocket. So it is very important that an insured should take appropriate sum insured and check room rent restrictions while buying a health insurance policy.

6.5.15 Renewability Clause

Customers, particularly senior ones, have expressed significant concern about insurance firms refusing to renew health insurance policies. Health insurance coverage must always be renewed unless there has been fraud, moral hazard (deliberately purchasing an insurance policy in order to submit a false claim), or misrepresentation, according to IRDAI regulations.



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The policyholder has a lifetime renewal option after the insurance is issued. Even if there were claims in the year before, lifetime renewability would be available. Insurer cannot refuse renewal for arbitrary reasons and must provide written justifications if it does.

6.5.16 Free Look in Period

After purchasing a new health insurance plan, a policyholder may discover that the benefits or other terms and conditions are not what he had hoped for. In this case he/she can return back the policy within 15 days to insurance company under free look period.

According to Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016, "All new individual health insurance policies issued by Life Insurers, General Insurers and Health Insurers, except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy and

1. The insured will have at least 15 days after receiving the policy to evaluate the terms and conditions and return the insurance if they are not satisfactory.
2. If the insured has not made any claim during the free look period, the insured shall be entitled to-
 - a) A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
 - b) Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
 - c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period".

6.5.17 Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)

AYUSH Coverage:

According to Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016:



"General Insurers and Health Insurers may endeavor to provide coverage for one or more systems covered under 'AYUSH Treatment' provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health".

Initially the AYUSH treatment were under exclusions and after some years insurance company started covering AYUSH treatment partially in form of pre-defined percentage of sum insured. Now insurers have started covering these treatments with some conditions.

6.5.18 Grace Period for Renewal

According to the Guidelines on Standardization in Health Insurance 2016, Grace period means "the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received".

The policy should continue without any break in between. Generally health insurance policy is of one year. The renewal premium need to be paid timely by insured on due date mentioned in the policy. If due to any circumstances, policy holder is not able to pay insurance premium on due date, all the benefits under the policy will not be forfeited. Individual health insurance policy renewals are permitted within a 30-day grace period, in accordance with IRDAI norms.

If policy holder pays the insurance premium within 30 days from expiry of policy, then all the benefits of insured are intact in the health insurance. Claims (if any), during the break period will not be considered. These days the insured have the option to pay two years premium in one go for purchasing health insurance policy.

6.5.19 Day Care Treatment

As per the Guidelines on Standardization in Health Insurance 2016, "Day care treatment means medical treatment, and/or surgical procedure which is:

- i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
- ii. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition. Insurers may, in addition, restrict coverage to a specified list"

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Generally to avail cashless or reimbursement claim, the insured patient need to be hospitalized at least for 24 hours, except day care procedures. The insured patient can be discharged from day care treatments on the same day thanks to advancements in medical science technology. The condition for 24 hour hospitalization is waived off.

6.5.20 Wellness Benefits

These days, insurance companies are giving incentives or rewards to insured for staying active. The incentive or reward can be given in form of discount in the renewal premium after achieving average steps count target on mobile application provided by insurer within specified time period. For example if insured completes 10,000 steps in a day, they get six percent discount in renewal premium. This way the insured is physically active and getting benefit in form of discounted premium. Moreover, the insurer can reduce their high claim ratio by paying small amount in form of discount, which also enhances the loyalty of the policyholder with the insurer.



INTEXT QUESTIONS 6.2

1. Individual health policy renewals are permitted with a _____ day grace period as per IRDAI norms.
 - a) Fifteen
 - b) Thirty
 - c) Forty Five
 - d) Sixty
2. Which of the following statements is/are true?
 - a) Master policy is issued in group health policy
 - b) Pre policy medical tests are not conducted in group health policy
 - c) The premium is very less in group policy as compared to individual policy
 - d) All of the above
3. Which of the following is incorrect with regards to cashless facility in health insurance?
 - a) The policy holder is required to settle the hospitalisation expenses at the time of discharge from hospital.
 - b) Provided only at the paneled or network hospitals.



- c) Under the planned cashless claims, the policy holder is aware of the hospitalisation 2-3 days in advance.
 - d) The claim amount is given by TPA or Insurer to network hospital.
4. Wellness programmes prolong the disease-free state of individuals as it advocates:
- a) Case management
 - b) Medical management
 - c) Claims management.
 - d) Lifestyle management



WHAT YOU HAVE LEARNT

Group health insurance policy is an insurance policy, which is generally taken by the owner of the group for insuring the members of the group. Family members of the employees (Spouse and dependent children) may also be covered in this policy, which depends on the contract between the Insurer and the owner/employer. This policy is called tailor made policy because the benefits, term and conditions can be customized according to the requirement of group. There are benefits like maternity cover, child cover, pre existing disease cover and other add on benefits in group health insurance policy.

There are few terms, which you need to understand like Network Provider; Preferred Provider Network (PPN); Cashless Service; Third Party Administrator (TPA); Cumulative Bonus; Co-Payment; Room Rent Restrictions; Free Look In Period; Grace Period for Renewal, etc. These terms have specific meanings and are defined in the health insurance regulations. It is important for you to understand these terms so that the same would be explained to the client at proper times.



TERMINAL QUESTIONS

1. Write a note on the Group Health Insurance Cover explaining its salient features.
2. Write a note on the following:
 - a) Preferred Provider Network (PPN)
 - b) Cashless Service
 - c) Third Party Administrator (TPA)
 - d) Cumulative Bonus

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- e) Co-Payment
- f) Room Rent Restrictions
- g) Free Look In Period
- h) Grace Period for Renewal



ANSWERS TO INTEXT QUESTIONS

6.1

- 1. (c) Both (a) and (b)
- 2. (c) Both (a) and (b)
- 3. (d) All of the above

6.2

- 1. (b) Thirty
- 2. (d) All of the above
- 3. (a) The policy holder is required to settle the hospitalisation expenses at the time of discharge from hospital.
- 4. (d) Lifestyle management



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain the importance of group health insurance cover to the prospect or client.
- To explain the terminologies used in health insurance which may sound confusing to the prospect or client.

7

HEALTH INSURANCE DOCUMENTATION PROPOSAL FORM

**Notes**

7.0 INTRODUCTION

There are many intermediaries in the insurance industry which are involved in selling the insurance policy. These intermediaries include agents, brokers or web aggregators. It is possible that there is no direct contact between the insured and his insurer while buying an insurance policy. There are different documents which are to be submitted while buying an insurance policy by the customer. These documents help insurance company to know about their customers and their needs. The insurance agent generally has a face to face contact with the customer and he/she is the one having the close contact with the customer. The agent has to clarify the doubts of the client regarding the documents and should also help them filling these documents. The first stage in the process of Insurance documentation is basically filling the proposal form with the help of which insurer collects important information about the prospect. This chapter focuses on the components of proposal form and will explain the nature of questions in a proposal form.



7.1 OBJECTIVES

After reading this lesson, you will be able to:

- Explain the components of a proposal form in health Insurance
- Recall the nature of questions being asked in a proposal form
- Explain the role and duty of an intermediary towards prospect (client)



Notes

7.2 PROPOSAL FORM

The proposal form is the first document which an Insurance company uses for collecting the important information about the prospect. Every Life Insurer, General Insurer and Health Insurer develops their proposal form to be submitted by a person (proposer) seeking a health insurance policy.

The Proposal form is used by the insurers for collecting all material information regarding the risk associated with the prospect or a client. The information collected from client will help in deciding whether to accept or reject the risk. It also helps in determining the rates, premium, terms and conditions of the cover to be granted in case of acceptance of risk.

Information collected from the proposal form shall not be shared with any third party, except with the statutory authorities or in case it is required for the purpose of underwriting the policy of the same individual or claim settlement.

Proposal forms are printed by the insurance company with its name, logo of the company, address of the company, etc. It also mentions the class or type of insurance and the product that it issued for.

7.3 STANDARD FORM OF DECLARATION

The IRDAI has specified the format of the standard declaration in the health insurance proposal which is to be followed by all the insurance companies. The declarations include:

1. The declaration by the authorised persons regarding the complete and true information
2. Declaration regarding their understanding about information provided will form the basis of the insurance policy.
3. Declaration regarding communication of changes in the occupation or general health (if any) after the proposal and before the risk acceptance by the company.
4. Declaration giving their consent to the company for medical information from any current and past doctors/employers of the insured/proposer.
5. Declaration regarding authorization to the company for sharing information mentioned in proposal including the medical records to any Governmental and/or Regulatory authority.

The declaration is to be signed by the Proposer (On behalf of all the Persons to be insured under the policy) with Date, Place and Signature of the Proposer. Figure 7.1 shows the Sample of Standard Declaration in Health Insurance.

7.4 NATURE OF QUESTIONS IN A PROPOSAL FORM

Proposal form would contain different number and types of questions that may vary according to the insurer and the concerned class/ type of insurance.

In personal lines of insurance like health insurance, personal accident insurance and travel insurance, questions related to the health of the prospect, lifestyle and habits, medical history, hereditary traits, pre-existing health conditions, past insurance, details of proposed to be insured, optional covers, etc. are included. This information will help the underwriter in accessing the risk associated with the health of the client.

7.5 ELEMENTS OF PROPOSAL

- i. **Full name of the Proposer:** The proposer should clearly fill his/her name while filling the proposal form. The purpose of knowing the name of the insured by the insurance company is to make sure that only the insured person would receive the benefits of the policy.
- ii. **Proposer's contact details and address :** These details are again required by the insurance company to make sure that the benefits under the policy would be received only by the insured. The another reason would be to contact the insured in future as and when there is a need to do so.
- iii. **Proposer's Date of birth, age, gender, marital status and other personal details**
- iv. **Profession, occupation or business of the Proposer:** It is important for the Insurance companies offering health insurance and personal accident to know the profession/occupation/business of the prospect as these are important for calculating risk.

Example: "A food delivery guy delivering food on motor bikes in the cities generally drives at high speed and has to travel more frequent than normal drivers. They are more exposed to the accidents than a person citing on the restaurant counter taking the orders. Similarly, risk associated with a Taxi driver is more as compared to any other normal person driving his/her car.
- v. **Details and identity of the subject matter of insurance:** It is important to state the identity and related details of the subject matter that is proposed for the insurance.



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For example, the proposer is required to state if it is:

- i. An overseas travel (for whom insurance is taken, time of journey, to which country, for what purpose, etc.) or
- ii. A person's health (with person's name, address and identification) etc. depending on the case

- vi. Sum insured :** The sum insured is the amount for which you are seeking coverage under your health insurance policy. It is also the limit to which the insurer is liable. Sum insured has to be indicated in all proposal forms.

Example: 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.

- vii. Previous and present insurance:** The main purpose of seeking this information is to understand the insurance history of the client. The insurer is also interested in knowing whether the insured or the client's proposal in the past was declined by some insurer or whether some special conditions were imposed while giving the insurance coverage with increased premium, etc.

Details of the current insurance policies are required to check the amount of coverage already taken from some other insurance companies. The information is required especially in case of property insurance as the insured may have taken policies from different insurers. At the time of claim, principle of contribution may be applied and it will be ensured that the insured is indemnified for the loss and is not making any profits by claiming the amount from different insurance companies.

- viii. Claims history:** This has an influence on underwriter's decision and must, therefore, be truthfully answered. Details of all previous related losses, whether insured or not, must be correctly given.

- ix. Declaration by insured**

Every proposal form contains a declaration to the effect that;

- "The answers given in the proposal form are true and nothing has been concealed or misrepresented.
- The proposer agrees to pay the premium and accept a policy that is usually issued by the insurer for that class of business.
- The proposal form and the declaration shall form the basis of the contract."

Other sections common to all proposal forms are related to signature, date and in



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some cases, the agent's recommendation.

- x. **Where a proposal form is not used**, the insurer shall record the information obtained from the client, orally or in writing through its agents or any other mode. The same should be confirmed within a period of 15 days thereof with, the proposer and incorporate the information in its policy. Where the insurer later claims that the proposer did not disclose any material information or provided misleading or false information on any matter material to the grant of a cover, the burden of proving it falls on the insurer.

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.

- xi. **Statutory Warning for Prohibition of Rebates** (Section 41 of the Insurance Act 1938)

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

- "No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance policy in respect to any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.
- Any person making default in complying with the provisions of the Section 41 of the Insurance Act 1938, as amended, shall be liable for a penalty which may extend to Ten Lakh Rupees."

Contents of Health Insurance proposal Form

Basic Information • Name • Address PhoneNo. • Emailid • Gender • MaritalStatus • Date of Birth • DetailsofFamilyMembers	Key Information • Age • Occupation • Past Surgery/illness/hospitalisation • Current healthStatus • Place ofResidence • Sum Insured/Planopted	Self Declaration by the Applicant Contains specific questions about any existing illnessin various systems of human body
Required to register customer details under KYC norms	Required to decide acceptance or rejection of the proposal and calculate premium	Required to record detailed facts for the contract and decide if medical examination is required

Figure 7.1: Contents of Health Insurance Proposal Form

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Health Insurance



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HEALTH INSURANCE DOCUMENTATION PROPOSAL FORM

As per 'IC - 38: Insurance Agents Health booklet', Given below are some of the details of proposal form for a health insurance policy:

1. "The proposal form includes a prospectus which provides important information related to the coverage, exclusions, provisions, additional riders etc. The prospectus forms a part of the proposal form and the proposer has to sign it as a declaration that he has studied its contents.
2. The proposal form collects information relating to the name, address, contact details, occupation, date of birth, gender, 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 day's 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 insured person has 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. Details like sum insured and details of the identity of the subject matter of insurance is also collected through the proposal form.
9. The special features of the declaration to be signed by the proposer must be noted.



Notes

10. The insured person agrees and authorizes 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.
11. The insured person confirms that he has read the prospectus forming part of the form and is willing to accept the terms and conditions.
12. The declaration includes the usual warranty regarding the truth of the statements and the proposal form as the basis of the contract.
13. Proposal Form also contains information related to Details of Nominee, optional covers, Agent Declaration and a Statutory Warning for Prohibition of rebates (Section 41 of the Insurance Act 1938)"



INTEXT QUESTIONS 7.1

1. _____ is used by the insurers for collecting all material information in respect of a risk associated with the prospect, which helps them in deciding whether to accept or reject to risk.
 - a) Prospectus
 - b) Declaration
 - c) Proposal form
 - d) None of the above
2. Which of the following is not the element of the Proposal Form in Health Insurance?
 - a) Proposer's profession, occupation or business
 - b) Details and identity of the subject matter of insurance
 - c) Previous and present insurance
 - d) Wealth of the proposer
3. Where a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of _____.
 - a) 15 days
 - b) 30 days
 - c) 45 days
 - d) 60 days



Notes

4. Any person making default in complying with the Statutory Warning for Prohibition of Rebates under Section 41 of the Insurance Act 1938 shall be liable for a penalty which may extend to _____
- a) 1 Lakh Rupees
 - b) 2 Lakh Rupees
 - c) 5 Lakh Rupees
 - d) 10 Lakh Rupees

7.6 MEDICAL QUESTIONNAIRE

In case of adverse medical history in the proposal form, a detailed questionnaire is to be completed that will contain questions related to the diseases such as Diabetes, Hypertension, Chest pain or issues related to heart etc. The questionnaire is to be supported by a form completed by a doctor/consulting physician.

The underwriting department takes the help of the company's panel doctor who examines the form, based on whose opinion, acceptance, exclusion, etc. are decided. The proposal form and its annexures shall be attached to the policy document as per the regulations of IRDAI and the same should also be sent to the insured for his/her records.

7.7 ROLE OF INTERMEDIARY

The intermediary has a responsibility towards both parties i.e. insured and insurer. Insurance intermediaries serve as a bridge between consumers (seeking to buy insurance policies) and insurance companies (seeking to sell those policies).

An intermediary has a distinct role to play in the entire life cycle of a product, from the point of sale through policy servicing, up to claim servicing or settlement. An intermediary must give a prospect all relevant information about a suggested insurance so they can choose the best one. Moreover, he or she is accountable for ensuring that the insured gives the insurer access to all relevant information concerning the risk. The intermediary is expected to advise the prospect with complete disclosures and transparency. After the sale, the intermediary must coordinate effectively between the customer and the insurer for policy servicing as well as claim settlements.

7.8 DUTY OF AN INTERMEDIARY TOWARDS PROSPECT (CLIENT)

As per the IRDAI regulations "An insurer or its agent or any other intermediary shall provide all material information to the prospect in respect of a proposed cover so that the prospect can decide the best cover for him/her. If the prospect is relying on the advice of the insurer or his agent or an insurance intermediary, advice to the prospect must be provided in a fair manner.

If for any reason, customer is not filling the proposal form or any other related documents, a certificate may be incorporated at the end of proposal form stating that the contents of the form and documents were fully explained to him, and he has understood it well including the terms and conditions of the proposed contract.

7.9 ACCEPTANCE OF THE PROPOSAL

We have seen that a complete 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 loss

In the event of a health insurance proposal, the insurer may additionally suggest that the potential client, who is over 50 years old, visit a doctor and/or have a physical. The insurer makes a choice based on the data in the proposal form, the medical report, and the doctor's advice in cases where a medical check-up has been indicated. A supplementary questionnaire to gather more information from the potential customer may be necessary in some cases where the medical history is unsatisfactory.

The insurer then chooses the rate to be applied to the risk factor and computes the premium using a variety of variables, which is then communicated to the insured. The insurer processes proposals quickly and effectively, and it promptly notifies applicants in writing of any decisions made in connection with such proposals.



Notes



Notes

7.10 NOTES ON UNDERWRITING AND PROCESSING OF PROPOSALS

As per IRDAI guidelines, the insurer has to process the proposal within 15 days. The agent is expected to keep track of these timelines, follow up internally and communicate with the prospect / insured as and when required by way of customer service. This entire process of scrutinizing the proposal and deciding about acceptance is known as underwriting.



INTEXT QUESTIONS 7.2

1. In case you have an adverse medical history in the proposal form _____
 - a) You will be denied to get an insurance cover
 - b) Insurance policy may be given after filling a detailed questionnaire related to the disease
 - c) Both of the above
 - d) None of the above
2. Which of the following entities is an Insurance Intermediary?
 - a) Agents and Brokers
 - b) Surveyors
 - c) Third Party Administrators (TPAs)
 - d) All of the above
3. Which of the following statement is true with respect to the role of insurance intermediaries?
 - a) The intermediary has a responsibility towards both parties i.e. insured and insurer
 - b) Intermediary has an important role at the point of sale through policy servicing
 - c) Role of intermediary is important in claim settlement
 - d) All of the above

4. As per guidelines, an insurance company has to process an insurance proposal within _____
- a) 7 days
 - b) 15 days
 - c) 30 days
 - d) 45 days



WHAT YOU HAVE LEARNT

The proposal form is the first document which an Insurance company uses for collecting the important information about the prospect. Information collected from the proposal form shall not be shared with any third party, except with the statutory authorities or in case it is required for the purpose of underwriting the policy of the same individual or claim settlement. The IRDAI has specified the format of the standard declaration in the health insurance proposal which is to be followed by all the insurance companies.

Proposal form would contain different number and types of questions that may vary according to the insurer and the concerned class/ type of insurance. In personal lines of insurance like health insurance, personal accident insurance and travel insurance, questions related to the health of the prospect, lifestyle and habits, medical history, hereditary traits, pre-existing health conditions, past insurance, details of proposed to be insured, optional covers, etc. are included. This information will help the underwriter in accessing the risk associated with the health of the client.

In case of adverse medical history in the proposal form, a detailed questionnaire is to be completed that will contain questions related to the diseases such as Diabetes, Hypertension, Chest pain or issues related to heart etc. The questionnaire is to be supported by a form completed by a doctor/consulting physician.

Insurance intermediaries serve as a bridge between consumers (seeking to buy insurance policies) and insurance companies (seeking to sell those policies). An intermediary has a distinct role to play in the entire life cycle of a product, from the point of sale through policy servicing, up to claim servicing or settlement. As per IRDAI guidelines, the insurer has to process the proposal within 15 days. The agent is expected to keep track of these timelines, follow up internally and communicate with the prospect / insured as and when required by way of customer service.



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Health Insurance



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HEALTH INSURANCE DOCUMENTATION PROPOSAL FORM



TERMINAL QUESTIONS

1. Explain why a Proposal form is an important instrument for collecting information about the client?
2. What information is collected in a Proposal form and how the information collected is utilized by the Insurance Company?
3. What are the different elements of a Proposal form in health Insurance?
4. Explain the role and duties of an intermediary towards prospect (client).



ANSWERS TO INTEXT QUESTIONS

7.1

1. (c) Proposal form
2. (d) Wealth of the proposer
3. (a) 15 days
4. (d) 10 Lakh Rupees

7.2

1. (b) Insurance policy may be given after filling a detailed questionnaire related to the disease
2. (d) All of the above
3. (d) All of the above
4. (b) 15 days



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain the content of a proposal form to the client
- To assist your client in effectively filling the proposal form for a health insurance policy

8

HEALTH INSURANCE DOCUMENTATION PREMIUM & OTHER CONCEPTS



Notes

8.0 INTRODUCTION

In the previous chapter you have understood that the insurance company gets to know about their customer and their insurance needs only through the documents like proposal form, that are submitted by the customer. Along with the proposal form some other documentation is also required which includes Premium receipts, Policy document, Conditions, Warranties and Endorsements, etc. There are Anti -Money laundering and know your customer guidelines which are important and shall be adhered to at the time of getting business for the company. This chapter will focus on these concepts and will help you in learning the importance of these concepts.



3.1 OBJECTIVES

After reading this lesson, you will be able to:

- Explain the meaning and importance of Premium receipts
- Describe the Methods of payment of premium
- Explain the concepts like Conditions, Warranties and Endorsements
- Explain the Anti -Money laundering and know your customer guidelines

8.2 PREMIUM

8.2.1 Premium Receipts

A receipt given by the insurance agent on behalf of the insurer or by insurer itself, which provides confirmation, that payment has been received is known as Premium



Notes

Receipt. A receipt is also to be issued in case any advance payment of premium. Policyholder will get the receipt for the payment of First Premium as well as Renewal Premium.

8.2.2 Payment of Premium in Advance

As per the section 64VB of the Insurance Act 1938, premium is to be paid in advance by the client for starting an insurance contract. No insurance company will assume the risk until the premium is received or guaranteed. So it is necessary for the prospect or a client to first pay the premium, and then only the contract between the insured and insurer will be started. As per the IRDAI, "No risk to be assumed unless premium is received in advance." The important information of section 64VB is mentioned below for your reference and understanding:

1. No insurer shall assume any risk in India in respect of any insurance business unless the premium is paid or is guaranteed to be paid by the prospect/insured in a prescribed manner.
2. In the case of risks for which premium can be ascertained in advance, the risk may be assumed not earlier than the date on which the premium has been paid in cash or by cheque to the insurer. Where the premium is tendered by postal money-order or cheque sent by post, the risk may be assumed on the date on which the money-order is booked or the cheque is posted, as the case may be.
3. Any refund of premium which may become due to an insured on account of the cancellation of a policy or alteration in its terms and conditions or otherwise shall be paid by the insurer directly to the insured by a crossed or order cheque or by postal money order and a proper receipt shall be obtained by the insurer from the insured, and such refund shall in no case be credited to the account of the agent.
4. Where an insurance agent collects a premium on a policy of insurance on behalf of an insurer, he shall deposit with, or despatch by post to, the insurer, the premium so collected in full without deduction of his commission within twenty-four hours of the collection excluding bank and postal holidays.
5. There are exceptions to the above pre-condition payment of premium. The IRDAI may, from time to time, specify, by the regulations made by it, the manner of receipt of premium by the insurer.

8.2.3 Method of Payment of Premium

The premium is to be paid by the prospect or client for buying an insurance policy or by the existing policyholder to an insurer. As per the 'Insurance Regulatory Development Authority (Manner of Receipt of Payment) Regulations, 2002', the payment of premium may be made in any one or more of the following methods:

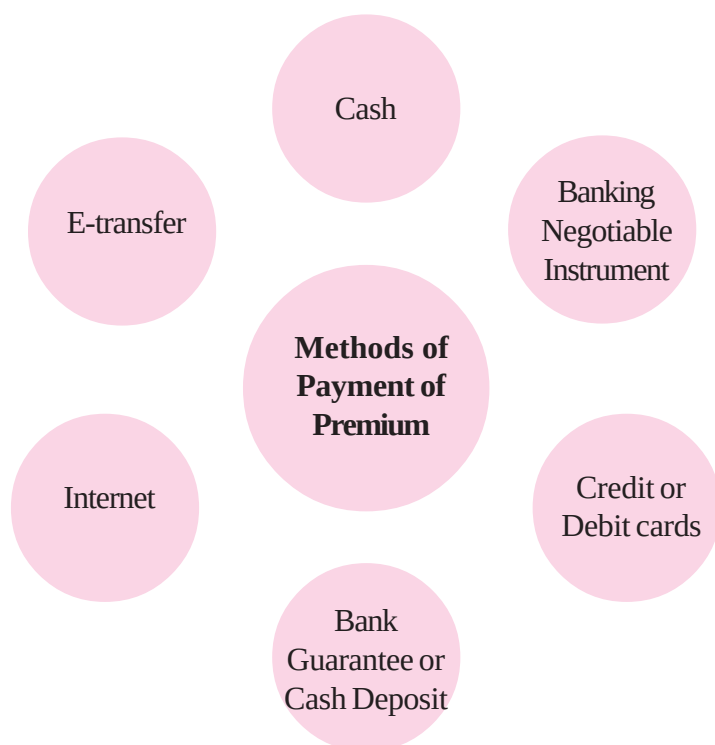


Figure 8.1: Methods of Payment of Premium

- a) Cash;
- b) Any recognized banking negotiable instrument such as cheques, including demand drafts, pay order, banker's cheques drawn on any schedule bank in India;
- c) Postal money orders;
- d) Credit or debit cards held in his/her name;
- e) Bank Guarantee or Cash Deposit;
- f) Internet;
- g) E-transfer;
- h) Direct credits via standing instructions of proposer or the policyholder or the life insured through bank transfers;

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HEALTH INSURANCE DOCUMENTATION PREMIUM & OTHER CONCEPTS

- i) Any other method of payment as may be approved by the IRDAI from time to time;"

As per IRDAI Regulations, in case the proposer / policyholder opts for premium payment through net banking or credit / debit card, the payment must be made only through net banking account or credit / debit card issued in the name of such proposer / policyholder.

8.3 POLICY DOCUMENT

The policy is a formal document which provides an evidence of the contract of insurance. Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017 specifies what a health insurance policy should contain:

"A health insurance policy shall clearly state:

- (i) The name of the policyholder and the names of each beneficiary covered, Unique Identification Number of the product, name, code number, contact details of the person involved in sales process;
- (ii) Date of birth of the insured and corresponding age in completed years;
- (iii) The address of the insured;
- (iv) 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;
- (v) The sums Insured;
- (vi) The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross-reference to the concerned policy section;
- (vii) Co-pay limits if any;
- (viii) The Pre-Existing Disease (PED) waiting period, if applicable;
- (ix) Specific waiting periods as applicable;
- (x) Deductible as applicable - general and specific, if any;
- (xi) Cumulative Bonus, if any;
- (xii) Periodicity of payment of premium instalment;
- (xiii) Policy period;
- (xiv) Policy terms, conditions, exclusions, warranties;



- (xv) Action to be taken on the occurrence of a claim for cashless and reimbursement options separately;
- (xvi) Details of TPA, if any engaged, their address, toll free number, website details;
- (xvii) Details of Grievance Redressal mechanism of insurer;
- (xviii) Free look period facility and portability conditions;
- (xix) Policy migration facility and conditions where applicable;
- (xx) That, on renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate;
- (xxi) Provision for cancellation of the policy; and
- (xxii) Address and other contact details of Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

In addition to the above, as per Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016, "the policy document shall also contain:

1. Procedure for claims submission, time lines and possible course of action, if time lines for claims submission are not adhered to along with all the claims documents required for claim processing.
2. Sub-limits applicable on any of the covers offered in the health insurance product and the impact of such sub-limits on other covers provided in the product, if any, shall be clearly spelt out.
3. Penal interest provision shall invariably be incorporated in the policy document
4. The TPA(s) details, if any along with the complete address and contact numbers shall be attached to the policy document. It shall also be mentioned that the updated list of the TPAs will be available in the website of the Insurers."

8.4 CONDITIONS AND WARRANTIES

Conditions and warranties are two important elements which are used in policy wordings. You should have clarity about these two terms as these are to be explained to the prospect while explaining the insurance product.

8.4.1 Conditions

A condition is a provision in an insurance contract which forms the basis of the agreement. A condition indicates that event or a situation on the occurrence or

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HEALTH INSURANCE DOCUMENTATION PREMIUM & OTHER CONCEPTS

nonoccurrence of which rights of insurer or insured may be empowered or denied. A condition may be either implied or express. Express conditions are specifically mentioned in the contract whereas implied conditions are unwritten conditions which are derived from the basic principles of insurance namely, Utmost Good Faith, Insurable Interest, etc.

EXAMPLES:

- a. One of the most common standard conditions available in most insurance policies states that if in any case if the claim is found to be fraudulent or any false declaration is made by the insured or his representative or loss or damage be occasioned by the wilful act, or with the involvement of the Insured, the 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 where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
- c. Exclusion condition in a Health Insurance policy specify that any ailment/disease/injuries that the person is suffering from, (treated/ untreated, declared or not declared in the proposal form) while taking policy for the first time are excluded. Further any complications arising from pre-existing ailment/disease/injuries will be considered as a part of that pre-existing health condition.
- d. Special condition of Co-Payment: There may be a copayment condition in some health insurance policy where you have to bear 20% of the final claim amount if the entry age / age of the insured person at the time of first buying of insurance policy is greater than or equal to 61 years. The liability of the insurance company is restricted to remaining 80% of the claim amount, subject to the available sum insured.

A breach of condition makes the policy voidable at the option of the insurer. As per 'IRDAI (Protection of Policyholders' Interests) Regulations, 2017', "The insurers may also attempt to broadly categorize policy conditions into following, so as to give clarity and understanding of the conditions to the policyholder:

- (i) Conditions precedent to the contract;
- (ii) Conditions applicable during the contract;

- (iii) Conditions when a claim arises;
- (iv) Conditions for renewal of the contract."

8.4.2 Warranties

A warranty clause in an insurance policy stipulates that specific conditions, events, or facts must exist either before or after the contract comes into effect. Warranties are used in insurance contracts to restrict the insurer's liability in specific situations. To lessen the risk, insurers also add warranties in a policy. With a warranty, the insured is required to fulfil a number of requirements within a set time frame and during the duration of the policy; the insurer's liability is contingent upon the insured's adherence to these obligations. The importance of warranties in managing and reducing risk cannot be overstated.

A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract. It is specifically specified in the policy. Warranty is a part of this agreement. It is a section in the policy manual. It is a prerequisite to the contract (which takes precedence over other clauses). Whether or not it is relevant to the risk, it must be followed and adhered to strictly and literally.

Even where it is amply proved that the violation has not caused or contributed to a specific loss, the policy may be voided at the insurers' discretion if a warranty is not upheld.

For example, to obtain a Health Insurance policy, an insured party may have to warrant that he does not suffer from a terminal disease. If a warranty made by an insured party turns out to be untrue, the insurer may cancel the policy and refuse to cover claims.

Another example from Fire insurance would be where an insured party warrants that the property which is covered by a fire insurance policy will never be used for mixing of explosives, the insurer may cancel the policy if the insured party decides to start mixing explosives on the property. Or, warranty may be related to fixing of Fire Extinguishing Appliances in the property and if the insured has not installed the fire extinguisher, the claim may be rejected by the Insurer.



INTEXT QUESTIONS 8.1

1. _____ is given to a policy holder, by the insurer or an agent on behalf of the insurer, which provides confirmation, that payment has been received.



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- a) Conditions
 - b) Renewal Notice
 - c) Endorsements
 - d) Premium Receipt
2. If a premium is paid by the cheque, then which of the following statement is true?
- a) The risk may be assumed by the company on the date the cheque is posted
 - b) The risk may be assumed by the company on the date insurance company deposited the cheque
 - c) The risk may be assumed by the company on the date insurance company received the cheque
 - d) The risk may be assumed by the company on the date proposer issued the cheque
3. An insurance agent shall deposit or dispatch the premium collected by post to the insurer within _____
- a) 24 Hours
 - b) 36 hours
 - c) 48 hours
 - d) 72 hours
4. The premium can be made by which of the following mode?
- a) Cash
 - b) Credit or Debit Cards
 - c) E Transfers
 - d) All of the above
5. Which of the following document provides an evidence of the contract of insurance?
- a) Warranty
 - b) Renewal Notice
 - c) Policy
 - d) Endorsement



6. Which of the following document is not a part of a health insurance policy?
 - a) Date of birth of the insured
 - b) Details of the pre-existing disease (PED)
 - c) Horoscope of the insured
 - d) Details of TPA
7. Which of the following is a provision in an insurance contract that forms the basis of the agreement?
 - a) Warranty
 - b) Renewal Notice
 - c) Condition
 - d) Endorsement
8. The liability of the insurer under certain circumstances in an insurance contract can be limited using_____
 - a) Warranties
 - b) Renewal Notice
 - c) Condition
 - d) Endorsement
9. Which of the below statement is correct with regards to a warranty?
 - a) A warranty is a condition which is implied without being stated in the policy
 - b) A warranty is a condition expressly stated in the policy
 - c) A warranty is a condition expressly stated in the policy and communicated to the insured separately and not as part of the policy document
 - d) If a warranty is breached, the claim can still be paid if it is not material to the risk

8.5 ENDORSEMENTS

It is the general practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others. There is less scope available to customize the policy for an individual client. But still, if certain terms and conditions of the policy

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need to be changed at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement. Thus, "an insurance endorsement is an amendment or addition to an existing insurance contract which changes the terms or scope of the original policy. An insurance endorsement may be used to add, delete, exclude or otherwise alter coverage".

It is attached to the policy and forms part of it. The policy and the endorsement together make up the contract. With the change in the material information, an insured must inform the said changes to the insurer who will incorporate the change in the insurance contract through endorsement.

Endorsements in a policy are normally required in the following cases:

- a) If there is a change or Variations in sum insured
- b) If an insurance policy is mortgaged to a bank or if there are changes in the insurable interest
- c) If there is an Extension of insurance by way of additional perils or extension of policy period
- d) If there is any change in the risk to be covered, e.g. change of destinations in the case of an overseas travel policy, etc.
- e) If the property is transferred to another location
- f) Cancellation of insurance
- g) Change in the name or address of insured, etc.

SPECIMEN ENDORSEMENTS

Examples of certain endorsements' phrasing are given below for your reference:

Cancellation of policy

At the request of the insured, the insurance by this Policy is hereby declared to be cancelled as from <date>. The insurance having been in force for a period over nine months, no refund is due to the Insured.

Extension of cover to additional member in the Policy

At the request of the insured, it is hereby agreed to include Miss. Rama Mehta, daughter of the insured and aged 4 years with a sum insured of Rs. 5 lakhs in the policy with effect from <date>. In consideration, thereof an additional premium of Rs..... is hereby charged to the insured.

8.6 INTERPRETATION OF POLICIES

Insurance policies are written by insurers, and insurance contracts are expressed in writing. These policies must be read in accordance with specific guidelines for construction or interpretation that have been set forth by numerous courts. The most important construction principle is that the parties' intentions must take priority; this intention can be found in the policy itself. The general rule that the policy was drafted by the insurer will be applied by the courts to interpret unclear policies in favour of the insured and against the insurer. Policy wordings are understood and interpreted as per the following rules:

- a) An express or written condition overrides an implied condition except where there is inconsistency in doing so.
- b) In the event of a contradiction in terms between the standard printed policy form and the typed or handwritten parts, the typed or handwritten part is deemed to express the intention of the parties in the particular contract, and their meaning will overrule those of the original printed words.
- c) If an endorsement contradicts other parts of the contract the meaning of the endorsement will prevail as it is the later document.
- d) Clauses in italics over-ride the ordinary printed wording where they are inconsistent.
- e) Clauses printed or typed in the margin of the policy are to be given more importance than the wording within the body of the policy.
- f) Clauses attached or pasted to the policy override both marginal clauses and the clauses in the body of the policy.
- g) Typewritten text or text produced by a rubber stamp imprinted with ink replaces printed text.
- h) Handwritten text is given preference over typed or stamped text.
- i) In the event of uncertainty or unclear communication, standard grammar and punctuation standards are used.

1. Construction of policies

A contractual agreement between the insurer and the insured is documented by an insurance policy. Contracts for insurance are subject to the standard principles of construction and interpretation used by courts like any other



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contract. The main principle of contract interpretation is that the parties' intentions are what matter most and the policy statement itself must be used to determine that objective. A proposal form, provisions, endorsements, warranties, and other documents are attached to the policy document and are regarded as a component of the contract.

2. Meaning of wordings

The words used should be interpreted in their common and popular sense. The meaning of the words should be interpreted in the same way that an ordinary person would. Words with a common business or trade meaning, on the other hand, will be interpreted with that meaning unless the context of the sentence indicates otherwise. Where words are defined by law, the meaning of that definition will be applied in accordance with the law. Many terms used in insurance policies have been the subject of previous legal decisions that will be followed in most cases. Again, a higher court's decision is binding on a lower court's decision. Unless otherwise specified, technical terms must always be given their technical meaning.

8.7 RENEWAL NOTICE

The majority of non-life insurance policies are issued on an annual basis. There is no legal requirement for insurers to notify the insured that his policy is due or will expire on a specific date. However, as a matter of courtesy and good business practise, insurers generally send out a renewal notice prior to the policy's expiration date, inviting renewal. The notice contains all of the policy's pertinent information, such as the sum insured, the annual premium, and so on. It is also customary to include a note informing the insured that any material changes in the risk should be reported.

The insured's attention should also be drawn to the statutory requirement that no risk be assumed unless the premium is paid in advance.

8.8 ANTI -MONEY LAUNDERING AND KNOW YOUR CUSTOMER GUIDELINES

Money laundering is the process of passing illegally obtained cash through financial systems so that it appears to be legally obtained. Money laundering is the process by which criminals transfer funds in order to conceal the true origin and ownership of criminal proceeds. Money can lose its criminal identity and appear legitimate through this process.



Criminals attempt to launder money by using financial services such as banks and insurance. They conduct transactions under false identities, such as purchasing insurance and then withdrawing the money before disappearing once their purpose is completed.

Steps to prevent such money laundering attempts have been made by governments all over the world, including India. The Prevention of Money Laundering Act was passed by the government in 2002. Soon after, the IRDAI issued Anti-Money Laundering guidelines, which indicated appropriate measures to determine the true identity of customers requesting insurance services, reporting of suspicious transactions, and proper record keeping of cases involving or suspected of involving money laundering.

Given the potential risk of a money launderer using financial services, insurance companies should make reasonable efforts to determine the true identity of customers. Every customer must be properly identified, according to the Know Your Customer guidelines, by collecting the following documents:

1. Address verification
2. Recent photograph
3. Financial status
4. Purpose of insurance contract

To establish the identity of customers, the agent is responsible for collecting documents at the time of bringing in business:

1. **In case of Individuals** - Details like full name, address, contact numbers of insured with ID and address proof, PAN number, Aadhar Card, full bank details for NEFT purposes and proof of residence are to be collected
2. **In case of corporates** - Certificate of Incorporation, Memorandum and Articles of Association, Resolution of the Board of Directors, Power of Attorney to transact the business, copy of PAN card, etc. are to be collected
3. **In case of Partnership firms** - Registration certificate (if registered), Partnership deed, Power of Attorney, Proof of identity of individuals with Power of Attorney, etc. are to be collected
4. **In case of Trusts and foundations** - Registration certificate (if registered), Power of Attorney granted to transact business on its behalf, Proof of identity of the trustees, settlers, beneficiaries and those holding Power of Attorney, founders/managers/directors and their addresses, and Resolution of the managing body of the foundation/association, etc. are to be collected.



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INTEXT QUESTIONS 8.2

1. Terms and conditions of the policy can be modified by setting out the amendments through_____.
 - a) Warranty
 - b) Endorsement
 - c) Alteration
 - d) Modifications are not possible
2. Identify the correct statement?
 - a) A renewal notice shall be sent to the insured 30 days before the expiry of the policy as a legal obligation on insurers
 - b) A renewal notice shall be sent to the insured 15 days before the expiry of the policy as a legal obligation on insurers
 - c) A renewal notice shall be sent to the insured 7 days before the expiry of the policy as a legal obligation on insurers
 - d) As per regulations there is no legal obligation on insurers to send a renewal notice to insured before the expiry of the policy
3. As per the Know Your Customer (KYC) guidelines, identification of the customer should be properly done by collecting which of the following documents?
 - a) Address verification
 - b) Recent photograph
 - c) Purpose of insurance contract
 - d) All of the above
4. _____is moving illegally acquired cash through financial systems so that it appears to be legally acquired.
 - a) Know your Customers
 - b) Money Laundering
 - c) Anti-Money Laundering
 - d) None of the above



WHAT YOU HAVE LEARNT

A Premium receipt given out to a policy holder, by the insurer or an agent on behalf of the insurer, which provides confirmation, that payment has been received. As per Insurance Act, premium is to be paid in advance, before the start of the insurance cover. There are many methods by which you can pay your premium. The policy is a formal document which provides an evidence of the contract of insurance. This document has to be stamped in accordance with the provisions of the Indian Stamp Act, 1899.

A condition is a provision in an insurance contract which forms the basis of the agreement and a breach of condition makes the policy voidable at the option of the insurer. Warranties are used in an insurance contract to limit the liability of the insurer under certain circumstances. Insurers also include warranties in a policy to reduce the hazard. It is the practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others. 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. There is no legal obligation on the part of insurers to advise the insured that his policy is due or expire on a particular date.

The Anti-Money Laundering guidelines issued by IRDAI indicate suitable measures to determine the true identity of customers requesting for insurance services, reporting of suspicious transactions and proper record keeping of cases involving or suspected of involving money laundering. According to Know your Customer Guidelines, the agent is required to collect certain documents at the time of bringing in business to establish the identity of customers.



TERMINAL QUESTIONS

1. Explain the provisions related with the payment of premium in advance.
2. What should be the contents of the Health Insurance Policy?
3. What do you understand by Conditions and Warranties? Explain the importance of Conditions and Warranties.
4. Explain the purpose of endorsement in an insurance policy. Give examples of endorsements.
5. Write a detailed note on Anti -Money Laundering and Know Your Customer Guidelines.



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ANSWERS TO INTEXT QUESTIONS

8.1

1. (d) Premium Receipt
2. (a) The risk may be assumed on the date on which the cheque is posted
3. (a) 24 Hours
4. (d) All of the above
5. (c) Policy
6. (c) Horoscope of the insured
7. (c) Condition
8. (a) Warranties
9. (b) A warranty is a condition expressly stated in the policy

8.2

1. (b) Endorsement
2. (d) As per regulations there is no legal obligation on insurers to send a renewal notice to insured before the expiry of the policy
3. (d) All of the above
4. (b) Money Laundering



LEARNING OUTCOMES

After reading this chapter, students will be able:

- I To explain the conditions and warranties of the insurance contract to the prospect while explaining the insurance product.
- II To recall and explain the Anti -Money laundering and know your customer guidelines

9

HEALTH INSURANCE UNDERWRITING

**Notes**

9.0 INTRODUCTION

You have already understood the meaning and process of underwriting in the previous chapters. The role of an underwriter is to evaluate a risk of insuring an individual in the case of life insurance or health insurance. If it's profitable for an insurance company to take the chance on providing insurance, the underwriter then sets a price and establishes the insurance premium that will be charged in exchange for taking on that risk. This chapter will help you understand how the underwriting is done in health insurance.



9.1 OBJECTIVES

After reading this lesson, you will be able to:

- Describe the concept and process of Underwriting in case of Health Insurance
- Explain the classification of the risk
- Explain the need of Underwriting in Health Insurance
- Describe and apply the guidelines related with Health Insurance Underwriting

9.2 BASICS OF UNDERWRITING

9.2.1 Meaning of Underwriting

Underwriting is the process where an underwriter assesses the risk and decides the premium and terms on which the insurance cover shall be granted to the insured or a client. Thus, it is a process of selection of risk and accordingly price that risk.

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Insurers collect information from the client or proposer and then analyze this information for assessing the risk, on the basis of which a decision is taken whether to insure a proposer or reject his/her proposal form. If an insurer decides to insure a proposer, the next step is to decide the premium, terms and conditions of an insurance policy in order to make a reasonable profit from taking such risk. This entire process is known as Underwriting.

Let us now understand how underwriting is done in Health Insurance. The major factor that is considered in life insurance underwriting is Mortality rate, or death rate. But in case of Health insurance underwriting, the concept of morbidity is used. The practical definition of morbidity used in Health Insurance is the incidence or prevalence of a disease or all diseases in a defined population. Here morbidity is defined as the likelihood and risk of a person becoming ill or sick thereby requiring treatment or hospitalization. Statisticians also define the morbidity as the rate of occurrence or development of a disease in a defined population. Morbidity is always expressed as a rate.

To a large extent, morbidity is generally influenced by the age of the person as chances of becoming ill or sick are higher in senior citizens than in young adults because of weakening immunity. Morbidity also increases due to various other adverse factors, such as being overweight or underweight, personal history of certain past and present diseases or ailments, genetic diseases, personal habits like smoking, drinking alcohol, current health status and also occupation of the proposer if it is deemed to be hazardous. Conversely, morbidity also decreases due to certain favorable factors like lower age, a healthy lifestyle etc.

9.2.2 Need for Underwriting

Underwriting is assumed to be the back bone of insurance industry. In health insurance, underwriting is often viewed from two different perspectives. Insurers that focus on technical soundness and are being too selective and careful while taking a risk, limit the intake of new customers and prevent the insurance company from creating a big pool for spreading the risk uniformly. On the other hand, if the risk is accepted carelessly or for insufficient premiums, it will lead to the insurer being insolvent. It is therefore important for an insurance company to strike a correct balance between the risk and generating business.

The underwriter has to strike a balance between both approaches according to its company policies, philosophy and risk appetite. The main task of underwriter is to classify the risk, decide whether to accept or reject the proposal and decide the terms of acceptance at appropriate pricing.

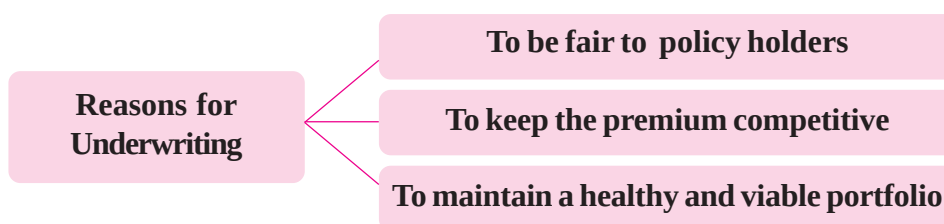


Figure 9.1: Reasons for underwriting

Some of the reasons for Underwriting are:

- To be fair to policyholders
- To keep the premium competitive
- To maintain a healthy and viable portfolio

9.2.3 Underwriting - Risk Assessment

Underwriting is the process by insurers for evaluating and assessing the risks associated with an individual or a group in an insurance policy. It helps in calculating the correct premium for an insured. Every identical risk should be rated equally and without any partiality, and the risk acceptance procedure should be fair and based on an equitable basis. Standard acceptance charts are typically used for this classification, where each depicted risk is quantified, and premiums are determined in accordance.

As already explained, the age of a person is an important factor which affects both mortality and morbidity. It is important to keep in mind that disease can occur frequently and typically occurs long before death. Therefore, it makes sense that the underwriting standards and rules for health coverage are substantially stricter than those for death coverage.

Example

A diabetic person having uncontrolled high sugar level have higher chance of having cardiac or kidney complications which requires multiple hospitalization during course of insurance coverage than of death. This person would be rated at a high risk for medical underwriting in health insurance.

In health insurance, underwriter lay more emphasis on medical factors (medical underwriting) as compared to financial underwriting. Although underwriter of Health Insurance Company cannot ignore financial underwriting as it is important to ascertain insurable interest as well as to check the acceptance of adverse selection for ensuring continuity in health insurance.



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9.2.4 Factors affecting Morbidity (Chance of Illness)

The factors affecting morbidity should be taken up with utmost care while assessing risk. They are as follows:

- a) **Age:** Generally it is assumed that as the age advances the morbidity also increases. The chance of becoming ill or contracting with disease is higher in case of senior citizens as compared to young adults because of poor immunity. On the basis of degree of risk and age of insured, the insurance premium is decided. For example: the premium is higher for the person who is more than 45 years of age because the probability of occurrence of chronic disease like hypertension, diabetes, heart disease or alike morbidity is much higher. The insurance premium rates of infants and children are also higher as compared to young adults due to higher probability of infection and accident risks.

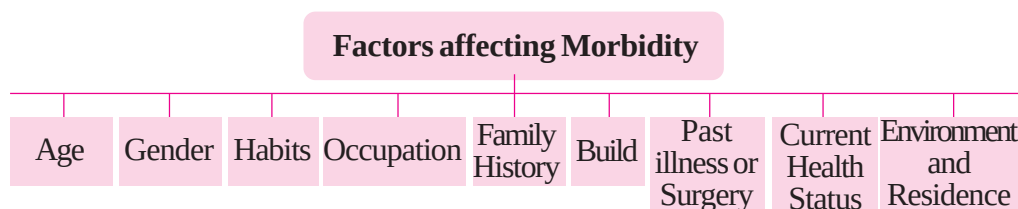


Figure 9.2: Factors affecting Morbidity

- b) **Gender:** There are some risks associated with a particular gender. There are lot of scientific studies which shows there are some diseases more prone to specific gender. For example: Women are exposed to extra risk of morbidity during pregnancy time. The males are more prone to heart attacks as well as job related accidents as compared to women as they are more engaged in hazardous occupation.
- c) **Habits:** Consumption of tobacco in any form, alcohol or narcotics in any form has a direct bearing on the morbidity risk. There is high morbidity rate for the person who has a habit of consuming these substances.
- d) **Occupation:** In some occupations like driver, blaster, chemical factories etc. there are higher chances of meeting with an accident as compared to other occupations. Similarly, in some occupations like X ray machine operator, asbestos industry workers, miner etc. have higher health related risk. These are called occupational hazards or risk which enhances high morbidity.
- e) **Family history:** Genetic factors can influence diseases like asthma, diabetes and certain cancers and has greater relevance. These factors impact morbidity and should be considered while accepting the risk. The underwriter comes to



- know about these risk through the specific questions asked in proposal form specific to family history.
- f) **Build:** Strong, thin or average build may also be linked to morbidity in certain groups. Body Mass Index (BMI) is also an indicator to assess the risk which help in ascertaining underweight, overweight or obesity.
 - g) **Past illness or surgery:** This is required because there is possibility of reoccurrence of previous illness which can cause physical impairment. According to this, terms and conditions are decided. For example- a person suffering from cataract disease have high possibility of having it in other eye. If proposer disclose any past illness or surgery, then that disease comes under preexisting disease clause which get covered after 4 years after taking the health insurance policy.
 - h) **Current health status and other factors or complaints:** The insurability factor and degree of risk are ascertained through proper disclosure and medical examination. The current medical history of proposer is also significant for a underwriter to ascertain the kind of risk possessed by proposer.
 - i) **Environment and residence:** These also have relationship with morbidity rates. The person residing in densely populated area, high polluted industrial area, having less infrastructure and medical facilities possess high morbidity rate.

9.3 UNDERWRITING - BASIC CONCEPTS

9.3.1 Underwriting Purpose

Two goals are involved:

- i. To avoid anti-selection that is adverse to the insurer.
- ii. To categorize risks and maintain fairness among them.

Definition

"The process of assessing each health insurance proposal in terms of the level of risk it represents, then selecting whether or not to give insurance and under what conditions, is referred to as the selection of risks."

"People who believe or know that they have a significant risk of sustaining a loss have a tendency to engage in anti-selection, also known as adverse selection, which results in their actively seeking insurance and gaining as a result."

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Example

If the insurance companies do not take adequate precautions in selecting the risks, there is a probability that applicants with serious medical conditions like hypertension, heart disease, cancer or diabetes who knows about their medical conditions and needs for hospitalization would like to take the health insurance policy and can cause huge losses to insurance companies.

In other words, we can say that if insurance company does not exercise selection than it would be selected against and suffer losses in the process.

9.3.2 Equity among Risks

Definition- The term equity refers to the need that candidates who face comparable levels of risk be assigned to the same premium class.

To ascertain the insurance premium to be charged, insurance company would like to follow some standardization. So the applicants with average or standard risk should pay standard or similar insurance premium but applicants with high or substandard risk should pay higher or extra premium. Insurance companies would like to be more focused on rating the risks which are riskier and apply standardization to majority of average risk applicants.

a) Risk classification

"Risk classification refers to the categorization of people into various risk classes according to the level of risk they represent". Insurer's underwriter is involved in this process to usher equity. Risk classification is a part of overall process of Underwriting where risk can be categorized in four major types of risk, which are as follows:

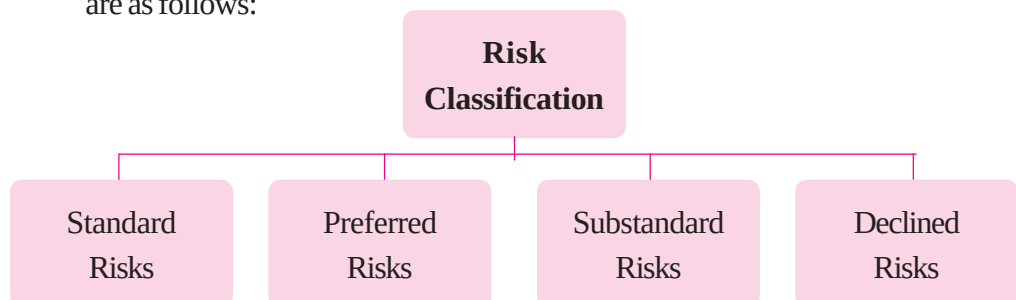


Figure 9.3: Risk Classification

i. Standard risks

The applicants posing this type of risk have average anticipated morbidity or the possibility of falling ill is average. It exhibits similar morbidity rate than what is



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assumed in pricing. Standard or same premium is charged from standard risk people.

ii. Preferred risks

The applicants posing this type of risk have significantly lower than average anticipated morbidity or the possibility of falling ill is very less. The discount in standard premium or lower premium can be charged from these applicants. It exhibits lower morbidity rate than what is assumed in pricing. For example, a person following a healthy lifestyle and has a good routine of exercise has lesser chances of becoming ill.

iii. Substandard risks

The applicants posing this type of risk have significantly higher than average anticipated morbidity or the possibility of falling ill is very high. But still these applicants may be covered under the policy. The extra premium or loading or higher premium may be charged from these applicants. Some restrictions can also be imposed on these applicants.

iv. Declined risks

The applicants who pose this kind of risk have extra morbidity expectations that are so high that they cannot be covered at a reasonable price. If an applicant has just undergone a medical procedure, such as surgery, their application may occasionally be temporarily rejected.

9.3.3 Selection Process

Underwriting or the selection process may be said to take place at two levels:

- a) At field level
- b) At underwriting department level

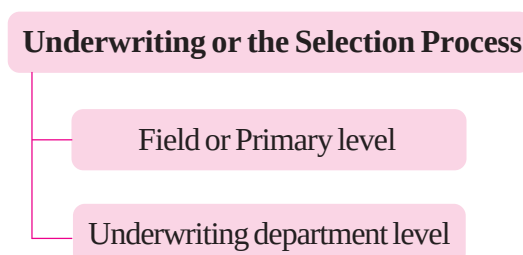


Figure 9.4: underwriting or the selection process

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a) Field or Primary level

This is also known as primary underwriting. Insurance agent is also known as primary underwriter because he gets the first-hand information about the risk, possessed by a proposer to be insured. This helps the underwriter of the insurance company to assess the risk and take decision regarding granting of insurance coverage to prospective client or proposer.

There is a column named Agent's confidential report in the proposal form which is to be filled by insurance agent. This report relates to specific information, an agent's judgement, and suggestions regarding the proposer.

Similar to this, an insurer representative may be asked for a moral hazard report. This inputs from insurance agent consist of occupation, income, financial status and reputation of the proposer.

Moral Hazard

Definition: "Moral hazard is a situation in which one party with insurance takes greater risks than they normally would without insurance, knowing that it is protected against the risk and the insurer will pay the cost".

For example-A proposer who is suffering from disease which requires surgical operation would like to take health insurance policy without disclosing health condition to insurer at the time of proposal stage. This is perfect example of moral hazard where proposer deliberately wants to buy health insurance just to take claim out of it.

Insurance company should focus on moral hazard because this can prove costly affair to them.

Morale hazard

Definition: "Circumstance that increases the probability of occurrence of a loss, or a larger than normal loss, because of an insurance-policy applicant's indifferent attitude after the issuance of policy".

For example: he or she might have careless attitude towards his/her health because of having health insurance policy and knows that hospitalization expenses would be paid by insurer.

Fraud monitoring and role of agent as primary underwriter

The decision of underwriter whether to accept or reject the risk depends upon the information or facts disclosed in proposal form by the applicant. It's difficult



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for the underwriter of the insurance company who sits in the office to know the authenticity of facts and information disclosed in proposal form.

The insurance agent plays a significant role in ascertaining the untrue facts disclosed in proposal form as he is in direct contact with proposer and knows him very well. Agent can monitor willful non-disclosure or misrepresentation made by proposer with intent to mislead or do fraud with insurance company.

b) Underwriting department level

These involved specialist underwriter and people who are efficient in such work. Underwriting is done at department or office level. And on the basis of pre decided parameters they take the decision whether to accept or reject the proposal and if accepted on what terms.

File and use Guidelines

It must be kept in mind that every insurance company must develop its insurance products before marketing them, and the underwriting department performs this task.



INTEXT QUESTIONS 9.1

1. _____ is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted.
 - a) Morbidity
 - b) Underwriting
 - c) Pooling
 - d) None of the above
2. The main reason(s) for Underwriting is /are:
 - a) To be fair to policyholders
 - b) To keep the premium competitive
 - c) To maintain a healthy and viable portfolio
 - d) All of the above
3. Which of the factors will not affect morbidity (risk of falling ill)?

a) Age	b) Gender
c) Occupation	d) None of the above

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4. The basic purpose of underwriting is:
 - a) To prevent anti-selection that is selection against the insurer
 - b) To classify risks and ensure equity among risks
 - c) Both of the above
 - d) None of the above
5. _____ means that applicants who are exposed to similar degrees of risk must be placed in the same premium class.
 - a) Morbidity
 - b) Equity
 - c) Underwriting
 - d) Pooling
6. Which of the following factor does not affect the morbidity of an individual?
 - a) Gender
 - b) Spouse job
 - c) Habits
 - d) Residence location
7. Health Insurance is based on the concept of _____.
 - a) Accident Benefit
 - b) Death Benefit
 - c) Morbidity
 - d) Mortality
8. The process of balancing is done by the _____ in accordance with the philosophy, policies and risk appetite of the insurance company concerned.
 - a) Actuary
 - b) Claim Manager
 - c) Underwriter
 - d) Customer
9. The job of the _____ is to classify the risk and decide the terms of acceptance at appropriate price.
 - a) Actuary
 - b) Claim Manager
 - c) Underwriter
 - d) Customer
10. Underwriting is the process of _____.
 - a) Marketing insurance products
 - b) Collecting premiums from customers
 - c) Risk selection and risk pricing
 - d) Selling various insurance products

9.4 IRDAI (HEALTH INSURANCE) REGULATIONS, 2016 AND IRDAI (HEALTH INSURANCE) (AMENDMENT) REGULATIONS, 2019

Guidelines on Migration and Portability of health insurance policies

Policyholder of some other insurance company may like to port its policy to your company. Thus, it is important for an underwriter to understand the guidelines on Migration and Portability of health insurance policies. According to IRDAI (Health Insurance) Regulations 2016 and IRDAI (Health Insurance) (Amendment) Regulations, 2019

Definition: "Portability means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer". (IRDAI)

Regarding the transferability of life and health insurance policies, IRDAI has published very precise guidelines. They are as follows:

Portability in health insurance is allowed in following circumstances-

- a. This must be permitted in all the health insurance policies (individual and family floater indemnity based) offered by non- life insurers and standalone health insurers.
 - b. Any individual covered by a group health insurance policy issued by general insurer, including family members, has the right to switch from such coverage to an individual health insurance policy or a family floater policy with the same insurance company. After that, at the following renewal, they will receive the portability privilege.
 - c. Every individual member, including family members covered under an indemnity based group health insurance policy shall be provided an option of migration at the time of exit from group or in the event of modification of the group policy (including the revision in the premium rates) or withdrawal of the group policy to an individual health insurance policy or a family floater policy.
1. Portability can be opted by the policyholder only at renewal and not during currency of the policy.



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2. 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.
3. Migration may be subject to underwriting as follows:
 - a. For individual policies, if the policyholder is continuously covered in the previous policy without any break for a period of four years or more, migration shall be allowed without subjecting the policyholder to any underwriting to the extent of the sum insured and the benefits available in the previous policy.
 - b. Migration from group policies to individual policy will be subject to underwriting.
4. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'T' to the IRDAI guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.
5. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.
6. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDAI.
7. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDAI within 7 working days of the receipt of the request.
8. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it shall be viewed as violation of directions issued by the IRDAI and the insurer shall be subject to penal provisions under the Insurance Act, 1938.
9. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal within 15 days and convey its decision to the policyholder in accordance with the Regulation 8(6) of IRDAI (Protection of Policyholders' interests) Regulations 2017.



10. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.
11. Where the outcome of acceptance of portability is still awaited from the new insurer on the date of renewal
 - a. the existing policy shall be allowed to be extended, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and
 - b. the existing policy shall not be cancelled until such time a confirmed policy from new insurer is received or at the specific written request of the insured
 - c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.
 - d. if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.
12. In case the policyholder has opted short period extension as stated above and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claim is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.
13. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.
14. No commission shall be payable to any intermediary on the acceptance of a ported policy.
15. For any health insurance policy, waiting period already elapsed under the existing policy with respect to pre-existing diseases and time bound exclusions shall be taken into account and reduced to that extent under the newly ported policy.

Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.



Notes

Note 2: For group health insurance policies, the individual members shall be given credit as stated above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions.

16. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For example - If a person had a SI of Rs. 2 lakhs and accrued bonus of Rs. 50,000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs. 2.50 lakhs by charging the premium applicable for Rs. 2.50 lakhs. If insurer B has no product for Rs. 2.50 lakhs, insurer B would offer the nearest higher slab say Rs. 3 lakhs to insured by charging premium applicable for Rs. 3 lakhs SI. However, portability would be available only up to Rs 2.50 lakhs.

17. Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:
 - a. all health insurance policies are portable;
 - b. policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer".

9.5 BASIC PRINCIPLES OF INSURANCE AND TOOLS FOR UNDERWRITING

9.5.1 Basic principles relevant to Underwriting

There are specific legal principles applied in insurance and are helpful in acceptance of risk. These principles are also applied in health insurance and any violation of these principles results in declinature of liability by insurance company. The main principles of insurance are as follows:

- 1) **Utmost Good faith:** - "Uberrima fides is a Latin phrase meaning utmost good faith. This means that all parties to an insurance contract must deal in good faith, making a full declaration of all material facts in the insurance proposal."



Notes

Definition- "A positive duty voluntarily to disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not".

A minimum standard that requires both the buyer and seller in a transaction to act honestly toward each other and to not mislead or withhold critical information from one another. The duty of full disclosure rests on both the parties. Proposer to supply all material information to the Insurer for enabling him to decide. Insurer is also duty bound to disclose or explain to the proposer because he may be having lack of technical knowledge and is depending on the good faith of the Company that the terms and condition of the cover are fair and reasonable.

- 2) **Insurable Interest:** - The legal right to insure arising out of a financial relationship recognized by law, between the insured and the subject-matter of insurance. The principle states that the insured must be in a position to lose financially if a loss occurs, or incur some kind of harm if the loss takes place.
- 3) **Indemnity:** - The objective of Insurance is to compensate the insured by placing him in the same financial position after the loss where he was earlier; insurance company pays nothing more or nothing less.
- 4) **Contribution:** - In most cases each insurance company share of loss is based on proportion that its insurance policy bears to total amount of insurance (rateable proportion basis)
- 5) **Proximate Cause:** - This principle is applied to determine whether the loss was caused by a risk covered, not covered or excluded in the policy.

9.5.2 Tools for Underwriting

These are the sources of data that the underwriter uses to determine the final premiums and the foundation for risk classification. The essential instruments for underwriting are as follows:

a) **Proposal form**

Proposal form is a document through which proposer's all important information pertaining to his health status and personal details can be ascertained. This is the basis of insurance contract between insured and insurance company. It also includes family history, hobbies, occupation, details of other policies, signature of proposer.

According to the type of health insurance policy and needs of the insurance company, there could be simple questions or it may contain detailed questionnaire in proposal form to ascertain that all material facts are disclosed and the insurance



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policy is given accordingly. On the basis of this, policy is issued and if there is any breach or concealment of information on the part of policy holder then the insurance policy becomes void.

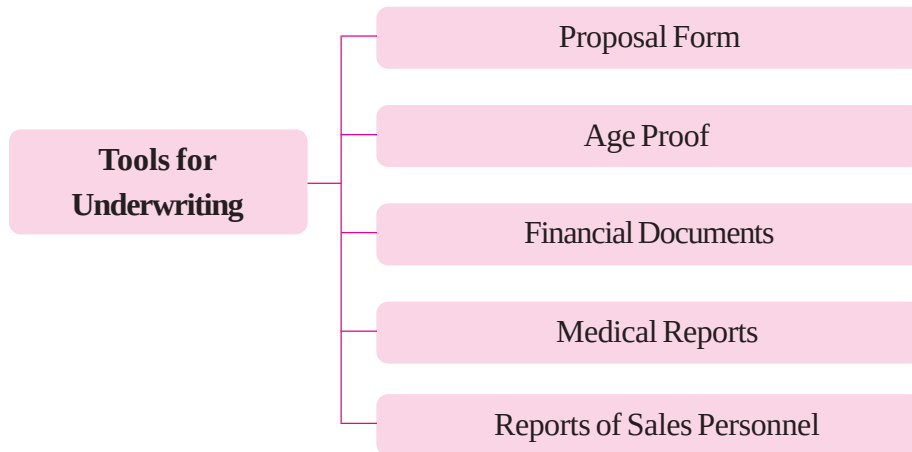


Figure 9.5: Tools for Underwriting

b) Age proof

The insurance premium is established based on the policy holder's age. By submitting a legitimate age proof, the proposer's age that was stated at the proposal stage is confirmed. The valid age proof is of two types. They are as follows:-

c) Standard age proofs

Some documents considered as standard age proofs are:

- Certified extract from School or college records
- Birth certificate extracted from municipal records
- Passport within validity period
- PAN card
- Certified extract from Service register in case of employees of Government or quasi Government institutions and reputed commercial and educational institutions.
- Certificate of baptism
- Aadhar Card
- Identity card issued by Defence Department in case of defence personnel



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- Driving license within validity period
- Any other document where date of birth has been proved on the basis of one of the other standard proofs of age acceptable to the insurance companies.

d) Non-standard age proofs

If standard age proofs mentioned above is not available with proposer, then insurer allows them to submit the nonstandard age proof. Insurance company may charge some extra premium for nonstandard age proofs or restrict the terms to safeguard against the possibility of the correct age being higher than what is stated.

Some documents considered as non-standard age proofs are:

- Horoscope
- Ration card
- An affidavit by way of self-declaration
- Certificate from village panchayat

e) Financial documents

The financial documents are required for financial or non-medical underwriting as it is relevant to ascertain the insurable interest of proposer and it also helps in reducing moral hazard. For example- Salary slip, Form 16, Income tax returns etc. are required as financial documents in insurance. These documents are required in cases of:

- a) Personal accident covers where the coverage is given on basis of occupation and is multiple of income of proposer
- b) High sum assured coverage or
- c) When there is a mismatch between the sum insured sought and the declared income and occupation of proposer.

f) Medical reports

On the basis of age, type of insurance policy, declaration of disease in proposal form and sum insured opted by proposer the requirement of medical reports are ascertained. The requirement of medicals also depends upon underwriting



Notes

policy of insurance company. For example: A proposer above 55 years of age has to undergo for medical examination for taking health insurance policy.

g) Sales personnel reports

Sales representatives can also be seen as the company's grassroots underwriters, and the information they provide in their report may be taken into consideration. However, there is a conflict of interest that needs to be watched out for because the sales staff is motivated to bring in more business.



INTEXT QUESTIONS 9.2

1. The principle of utmost good faith in underwriting is required to be followed by _____.
 - a) The insurer
 - b) The insured
 - c) Both the insurer and the insured
 - d) The medical examiners
2. Insurable interest refers to _____.
 - a) Financial interest of the person in the asset to be insured
 - b) The asset which is already insured
 - c) Each insurer's share of loss when more than one company covers the same loss
 - d) The amount of the loss that can be recovered from the insurer
3. According to the principle of indemnity, the insured is paid for _____.
 - a) The actual losses to the extent of the sum insured
 - b) The sum insured irrespective of the amount actually spent
 - c) A fixed amount agreed between both the parties
 - d) The actual losses irrespective of the sum assured



4. The first and the primary source of information about an applicant, for the underwriter is his _____.
- a) Age proof documents
 - b) Financial documents
 - c) Previous medical records
 - d) Proposal form
5. _____ is defined as the likelihood and risk of person becoming ill or sick thereby requiring treatment or hospitalization.
- a) Accident Benefit
 - b) Death Benefit
 - c) Morbidity
 - d) Mortality
6. For adults beyond the age of 45 years, the premiums are steeper as the probability of an individual suffering from a chronic ailment like diabetes, a sudden heart ailment or other such morbidity is much _____.
- a) Higher
 - b) Lower
 - c) Equal
 - d) None of the above
7. _____ has greater relevance as genetic pre disposition eg asthma, diabetes etc does impact the morbidity and should be taken into consideration while accepting risk.
- a) Family History
 - b) Current medical history
 - c) Proposal form
 - d) Other policy
8. The principle of _____ is applied to determine as to whether the loss was caused by the risk covered, not covered or excluded in the policy.
- a) Proximate Cause
 - b) Utmost Good faith
 - c) Indemnity
 - d) Insurable interest



Notes



WHAT YOU HAVE LEARNT

Underwriting is the process where an underwriter assesses the risk and decides the premium and terms on which the insurance cover shall be granted to the insured or a client. Thus, it is a process of selection of risk and accordingly price that risk. In case of Health insurance underwriting, the concept of morbidity is used. Morbidity is defined as the likelihood and risk of a person becoming ill or sick thereby requiring treatment or hospitalization.

The factors which affect morbidity (risk of falling ill) should be considered carefully while assessing risk, which are Age, Gender, Habits, Occupation, Family History, Build, Past illness or Surgery, Current Health Status, Environment and Residence.

The term Equity means that applicants who are exposed to similar degrees of risk must be placed in the same premium class. To usher risk, Risk classification is done which is a part of overall process of Underwriting where risk can be categorized in four major types of risk which are Standard Risks, Preferred Risks, Substandard Risks and Declined Risks.

Underwriting or the selection process may be said to take place at two levels a) at field level and b) at underwriting department level. It must be remembered that every insurer has to create its products before marketing them and take a prior approval of IRDAI. This is also one of the functions of the underwriting department. Underwriter must follow the File and use procedure for health insurance products as per IRDAI guidelines. Policyholder of some other insurance company may like to port its policy to your company. Thus, it is important for an underwriter to understand the guidelines on Migration and Portability of health insurance policies.

There are certain tools of underwriting that are the sources of information for the underwriter and the basis on which the risk classification is done and premiums finally decided. These includes Proposal Form, Age Proofs, Financial Documents, Medical Reports, and Reports of Sales Personnel.



TERMINAL QUESTIONS

1. Explain the need and importance of underwriting for Insurance Company.
2. What do you understand by the term 'Morbidity'? What are the factors that affect morbidity?

3. Individuals are categorized and assigned to different risk classes depending on the degree of risks they pose in underwriting. Explain the statement using different Risk Classes.
4. Explain the File and use procedure for health insurance products as per IRDAI guidelines.
5. What are those legal principles which operate along with acceptance of risks? Give examples.
6. Write a note on the tools available for an underwriter which provides information and helps in riskclassification and on the basis of which premiums are finally decided.



Notes



ANSWERS TO INTEXT QUESTIONS

9.1

1. (b) Underwriting
2. (d) All of the above
3. (d) None of the above
4. (c) Both of the above
5. (b) Equity
6. (b) Spouse job
7. (c) Morbidity
8. (c) Underwriter
9. (c) Underwriter
10. (c) Risk selection and risk pricing

9.2

1. (c) Both the insurer and the insured
2. (a) Financial interest of the person in the asset to be insured
3. (a) The actual losses to the extent of the sum insured
4. (d) Proposal form

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Health Insurance



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HEALTH INSURANCE UNDERWRITING

5. (c) Morbidity
6. (a) Higher
7. (a) Family History
8. (a) Proximate Cause



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain how underwriting is done in case of health insurance.
- To execute a role of primary underwriter as an insurance agent.

**10**

METHODS OF HEALTH INSURANCE UNDERWRITING

10.0 INTRODUCTION

Insurer needs information about the client, which would help in making underwriting decisions and deciding the terms of the policy. The information is collected from different sources and then risk assessment is done by an underwriter to decide whether to accept or deny the proposal. There are different methods used by the underwriters while assessing the risk or during the process of health insurance underwriting. This chapter will help you understand these methods of understanding and clarifies the process of underwriting used in health insurance. You will also learn how the underwriting is done for Group Health Insurance, Overseas Travel Insurance and Personal Accident Insurance.



3.1 OBJECTIVES

After reading this lesson, you will be able to:

- Describe the Underwriting Process
- Explain the concept of Group Health Insurance
- Describe the process of underwriting in overseas travel insurance
- Describe the process of underwriting in personal accident insurance

10.2 UNDERWRITING PROCESS

"Underwriting is the process of properly evaluating the risk and choosing the conditions under which the insurance coverage will be provided." In simple words, we can say that the Underwriting is the process of risk selection and then pricing the risk after its selection. For this, insurer collects information about the client from different sources already explained in previous chapters. The insurance underwriter then takes the decision regarding acceptance or rejection of the proposal. This process helps in deciding the terms of the policy. There are different methods, which may be used in health insurance underwriting that are as follows:

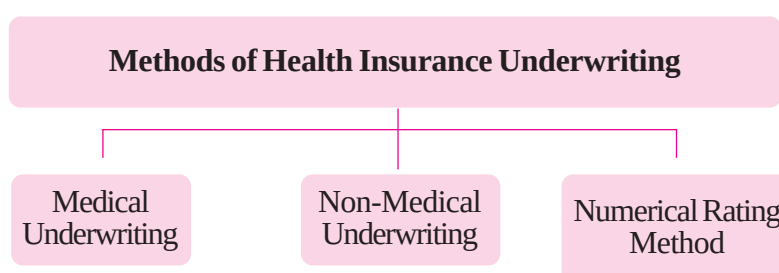


Figure 10.1: Methods of Health Insurance Underwriting

10.2.1 Medical Underwriting

In the medical underwriting procedure, the proposer is required to provide medical records in order to ascertain the applicant's health state and eligibility for a health insurance policy. It refers to the underwriting process where the insurance companies provide insurance cover to the prospects on a medical basis. It refers to the underwriting process whereby underwriters use health related information through a pre insurance medical screening of a prospect to take a decision regarding acceptance or rejection of the application, or the amount of insurance cover to be provided to the insured.

If underwriter focuses on accepting the good risk or best risk only and ignores the proposals with other kind of risks, this approach is called cream skimming of risk. This is done through high degree of medical underwriting. This approach is not considered good in underwriting because this can cause frustration among proposers and reduces the number of applicant willing to take insurance. High costs are involved in conducting pre policy medical test for proposer. If underwriting becomes very liberal and accepts all proposals with same premium without conducting medical test, this approach can also be disastrous as lot of claim may occur frequently and insurer may incur losses.

So underwriter need to adopt balanced approach according to the underwriting policy of the Insurer.

In individual health insurance, status of proposer's health and age are important underwriting considerations. Other factors like current medical conditions of the proposer, medical history of the family and hereditary diseases in the family, etc. helps an underwriter to ascertain presence of any pre-existing diseases, resulting in high possibility of future ailments that may require surgery or hospitalization.

Underwriter extracts the information regarding past treatment, surgery conducted and hospitalization from well-designed proposal form. The information from the proposal form helps an underwriter to estimate the possibility of recurrence of an earlier disease. Any past disease may affect the current and future health status of the proposer. This would increase the risk and the underwriter would accordingly increase the price for insuring that risk. In case the risk is high, underwriter has no option but to reject the case.

Example

There is higher possibility of occurrence of diseases like cardiac problem, nervous system, kidney disease, etc. if a person is having medical conditions like high blood pressure, obesity/overweight and diabetes mellitus. This means that possibility of future hospitalization for proposer with these diseases is higher. Therefore, the medical underwriter needs to be very vigilant while dealing with these types of risk.

Generally, an adverse change in the health of proposer occurs after 40 years of age because of normal ageing process. The insurance companies generally do not require the conduct of medical examination up-to 45 years of age. (50 or 55 years by some insurers). A signed declaration regarding the proposer's health by the family physician may also be required as per the medical underwriting guidelines.

These days, some health insurance companies are not conducting medical test up to 60 years of age. They only conduct tele underwriting where a person from underwriting team calls proposer before the issuance of policy and ask some specific questions pertaining to current, past and family medical history. They telephonically verify the information mentioned by proposer in proposal form. The insurer may have a tie up with some hospitals or diagnosis labs or may engage some doctor for completing this process.

There are certain challenges in the underwriting of health insurance policies, which makes the job of an underwriter difficult. One of the challenge in underwriting is the



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non-disclosure of alcohol or drug abuse. It is a challenging task to detect the drugs, alcohol and tobacco consumption when the proposer does not declare it in proposal form. The major challenge in underwriting of health insurance is non-disclosure of these facts. Obesity is on the path of becoming another major problem in the area of public health. Unbalanced diet, poor lifestyle and minimal exercise routine is adding to this problem. Underwriters need to develop adequate tools that can help them in pricing the complications, which may arise due to these problems.

Pre policy medical tests are conducted in the network hospitals or the diagnostic labs. The proposer can ask the agent regarding the type of diagnostic tests to be conducted and how much amount would be deducted from the premium, if the proposal would be rejected due to adverse medical conditions.



INTEXT QUESTIONS 10.1

1. Which of the following is a method of health insurance underwriting?
 - a) Medical Underwriting
 - b) Non-Medical Underwriting
 - c) Numerical rating Method
 - d) All of the above
2. Which of the following method uses the health related information through a pre insurance medical screening of a prospect?
 - a) Medical Underwriting
 - b) Non-Medical Underwriting
 - c) Numerical rating Method
 - d) All of the above
3. Cream skimming of risk approach is where:
 - a) underwriter focuses on accepting the good risk or best risk only
 - b) underwriter focuses on accepting the bad risk
 - c) both of the above
 - d) none of the above



4. The underwriter while assessing the risk shall:
 - a) Be too liberal and accepts all proposals
 - b) Be too strict and accepts only good risk
 - c) Adopt a balanced approach to cater both good and bad risks
 - d) None of the above
5. In individual health insurance, which of the following is/are important underwriting considerations?
 - a) Age and health of a proposer
 - b) Medical history of the family
 - c) Pre-existing diseases
 - d) All of the above
6. Which of the following is not a challenge in the underwriting of health insurance policies?
 - a) non-disclosure of alcohol or drug abuse by the prospect
 - b) understanding the complications which may arise due to obesity and substance abuse
 - c) conducting pre medical check-ups of prospect
 - d) develop adequate tools that can help them in pricing the complications

10.2.2 Non-Medical Underwriting

There is no need of medical examination, in case of most of the proposers who buys health insurance policy. The policy is issued on the basis of non- medical underwriting only. A proposer would need a medical checkup far less frequently if they accurately disclosed all relevant information, and the insurance agent properly verified it. In fact, a slight increase in the claims ratio would be acceptable to the insurer if non-medical underwriting helps you in saving the costs of medical checkup and other expenses, which is comparably higher. The use of non-medical underwriting will also reduce the inconvenience caused to the proposer.

These days generally up to a specified age limit, the medical tests are not conducted for issuance of health insurance policy. Insurance companies have medical grid, which tells at what stage and age, medical underwriting should be done or medical tests

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would be conducted for issuance of health insurance policy. The decision to conduct or not to conduct the medical tests shall be carefully taken to strike a right balance between the business and risk. If you are too strict while accepting the risk, you may lose a business. Too liberal approach can result in high claims, which would result in losses. The acceptance of non-medical cases depends on the age, type of policy and sum insured. Higher the age and sum insured more will be the premium and more will be the chances of medical tests to be conducted. Medical or non-medical cases entirely depend upon underwriting philosophy of the company.

Example

If you want to take a health insurance policy without going through the process of medical underwriting, i.e. without medical check-ups and tests, then you may opt for those policies, which work on non-medical underwriting. You need to provide the information related to your health in a proposal form regarding your age, gender, build, smoking habits and medical conditions. The premium of the policy and the amount of sum assured is decided based on the information provided in the proposal form. The principle of utmost good faith is an important principle on which the insurers issue these policies. If any false information is provided in the proposal form, these policies will be treated as void. The premium is generally high in these policies if compared with those, which use medical underwriting.

10.2.3 Numerical Rating Method

This is an underwriting procedure where each component of the risk is given a numerical or percentage rating. Decision to accept or decline the risk depends upon numerical rating employed by underwriters.

- It was originally devised in USA in 1960s.
- The biggest advantage is it ensures consistency in risk classification.
- It is employed by underwriters for taking decisions to accept or decline the risk.
- This method uses mortality ratings as the basis of selection and classification of lives.

Age, sex, race, occupation, place of residence, environment, build, habits, family history, and personal history are all assessed and quantitatively scored in accordance with preset standards.



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Let us try to understand this method. For example, if an applicant is 5 feet 7 inches and is overweight say more than 100 kg, his mortality expectation based on the height-weight ratio may be 160% of a standard risk who weighs 65-70 kg at that height. In this instance, a debit of 60 percentage points would be listed next to the weight factor on the applicant's underwriting sheet. If the applicant has an excellent family history (no hereditary diseases such as diabetes), his mortality expectation based on this factor is 90% of the standard risk. Here a credit of 10 percentage points would be listed next to the family history factor. Upon completion of the debiting/crediting process for all important factors, debits and credits would be totaled for a final rate, which would classify the applicant as standard, substandard, or an uninsurable risk.

Advantages of Numerical Rating Method-

- Establishes a standard method of underwriting.
- The factors are rated on the basis of documented manuals.
- It eliminates personal judgement of the underwriters to a large extent.
- It helps in assessing the combined effects of multiple adverse factors together.
- It increases speed and efficiency in handling large volumes of business and helps in maintaining consistency in decision making in the underwriting process.

Disadvantages of Numerical Rating Method-

- It has not been possible to fix percentage of increased claim experience for all adverse features
- Fixing of extra percentage for each adverse feature is also arbitrary though consistent.



INTEXT QUESTIONS 10.2

1. Which of the following method uses the health related information through a proposal form submitted by a prospect?
 - a) Medical Underwriting
 - b) Non-Medical Underwriting
 - c) Numerical rating Method
 - d) All of the above



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2. The decision to conduct or not to conduct the medical tests shall be carefully taken:
 - a) To strike a right balance between the business and risk
 - b) To charge higher premium
 - c) To practise skim the cream approach of underwriting
 - d) All of the above
3. Medical or non- medical cases entirely depend upon the:
 - a) Choice of the prospect
 - b) Underwriting philosophy of the company
 - c) Choice of the agent
 - d) Underwriting practices of the competitors
4. Which of the following is the method where numerical or percentage assessments are made on each component of the risk?
 - a) Medical Underwriting
 - b) Non-Medical Underwriting
 - c) Numerical rating Method
 - d) All of the above
5. Which of the following is not an advantage of a Numerical rating Method?
 - a) It helps in maintaining consistency in decision-making
 - b) The factors are rated on the basis of documented manuals
 - c) The underwriter uses his subjective knowledge to rate the factors
 - d) It helps in assessing the combined effects of multiple adverse factors together

10.3 UNDERWRITING DECISIONS

The information received through various sources is carefully assessed and then the underwriter does risk classification. The underwriting process is completed after the final decision is taken by the underwriter regarding the acceptance or rejection of proposal. The various decisions taken by underwriters are as follows:



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- Accept risk at normal or standard rates
- Accept risk at an extra premium (loading) if risk is high
- Delay the coverage of specific diseases for a predetermined amount of time or longer
- Refuse the coverage
- Counteroffer (restrict or deny a portion of the coverage)
- Increase the deductible or co-pay
- Charge the policy's permanent exclusion (s)

If apart from the standard policy exclusions, any other specific illness is excluded after underwriting, it is endorsed in the policy, which becomes part of the insurance contract.

Underwriters' risk evaluation is crucial to insurance firms because it maintains the stability of the insurance system. With the help of the experienced underwriters, the same level of expected risk is grouped together and the same amount of premium from the prospects of this group will be charged. The benefit of this for the policyholder is availability of insurance at a fair and competitive price.

Risk Classification

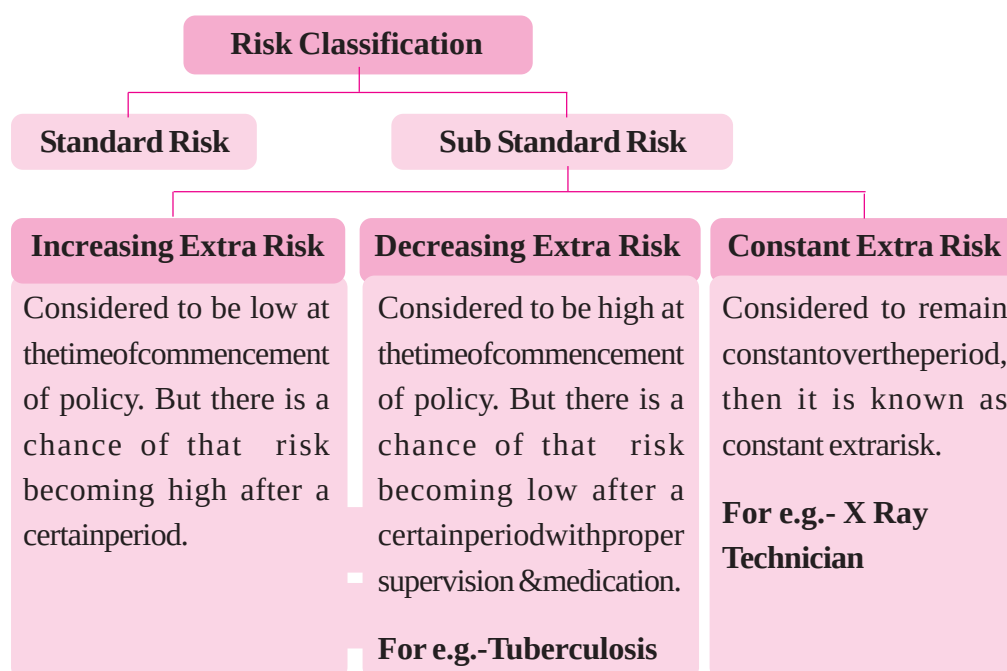


Figure 10.2: Risk Classification: Standard and Sub Standard Risks

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Health Insurance



Notes

METHODS OF HEALTH INSURANCE UNDERWRITING

- Standard Risk**- If is a risk associated with an individualis considered low and insurable at standard premium rates by insurance companies, then it is known as standard risk.
- Sub Standard Risk**- If is the risk associated with an individualis considered high and cannot be insured at standard premium rates by insurance companies, then it is known as sub-standard risk. Higher premium is charged for these risks.

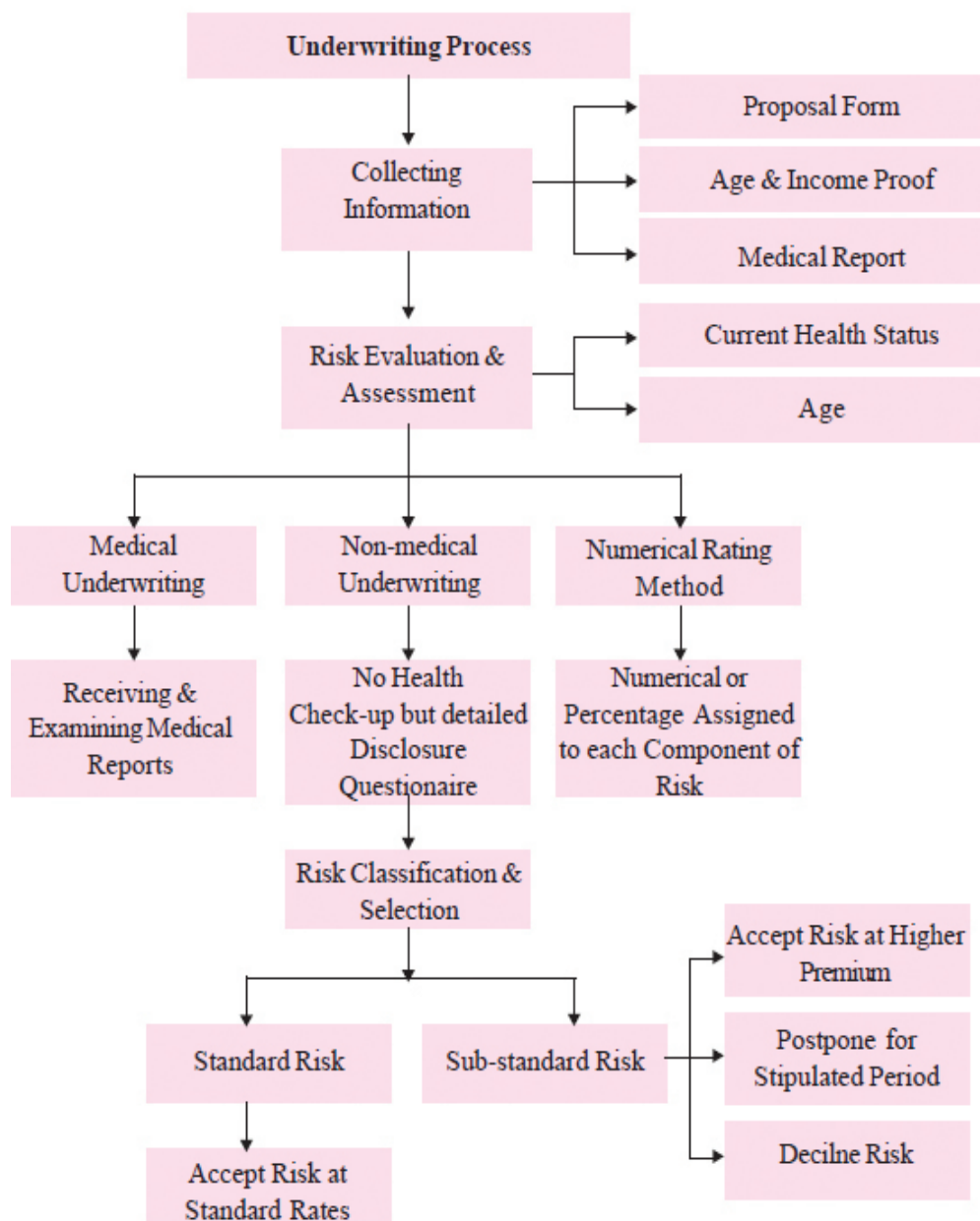


Figure 10.3: Underwriting Process (Source: IC-38: Insurance Agents Health, Insurance Institute of India, Mumbai)

Sub Standard Risk Classification

- a) **Increasing Extra Risk-** It is a risk associated with an individual that is considered to be low at the time of commencement of policy, but there is a chance of that risk becoming high after a certain period. For e.g.- obese person.
- b) **Decreasing Extra Risk-** It is the risk with an individual that is considered to be high at the time of commencement of policy, but there is a chance of that risk becoming low after a certain period with proper supervision & medication. For e.g.- tuberculosis
- c) **Constant Extra Risk-** If the risk associated with an individual is considered to remain constant over the period, then it is known as constant extra risk. For e.g.- X Ray Technician, Pilot, differently abled person.



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10.4 USE OF GENERAL OR STANDARD EXCLUSIONS

Insurance companies generally impose exclusions to all policyholders, to limit their exposure to risk by implementing standard or general exclusions.

Examples of standard exclusions in most health insurance policies include-

- All pre-existing diseases / injuries at the time of taking a policy
- Any disease contracted by the insured person during the waiting period from the commencement date of the policy.
- There may be exclusions for one or two years, for the expenses on the treatment of some specific diseases. These diseases may include Cataract, Hernia, Hydrocele, Fistula in anus, Piles etc. The expenses related to these diseases are not covered during the waiting period of one or two years, as mentioned in the policy document.
- War and similar perils and nuclear weapons materials.
- Vaccination, immunization
- The price of hearing aids, contact lenses, and eyeglasses. These could be considered regular maintenance costs.
- Any type of dental surgery or treatment, unless it necessitates hospitalisation
- Expenses related to intentional self-injury and use of intoxicating drugs/ alcohol
- Any treatment related to HIV, AIDS or sexually transmitted disease



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- Expenses related to any preventive health checkups or any laboratory examinations
- Expenses on vitamins and tonics if not a part of any treatment for injury or disease as certified by the attending physician.
- Treatment arising from or traceable to pregnancy, childbirth including caesarean section (can be removed if maternity benefit is covered) and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.

The above examples are indicative and the exact wordings and exclusions may differ among insurers.

10.5 GROUP HEALTH INSURANCE

Group health insurance plans are those that provide coverage to a group of individuals who are a part of a recognized group. A single policy called the 'Master Policy' is issued in the name of the group. All the members of the group are then covered under the policy.

There exists considerable difference in Underwriting approach and methodology between retail and group health insurance. Retail health underwriting focuses on the individual's data, whereas group underwriting looks at the data for the group.

Underwriting depends upon characteristics of the group and the kind of risk the group possess. Group health insurance underwriting is done based on insurance company's underwriting guidelines and guidelines of IRDAI regarding group insurance. The data for group health insurance is collected through the request for quote (RFQ)/ request for proposal (RFP) form.

The factors responsible for group health insurance underwriting are as follows:

1. **Group existence-** The policy is available to those groups which are already in existence for a purpose. If a group is created only for the purpose of buying a group medicaid policy, such a group would not be covered. If this criterion is not followed, then it may lead to adverse selection against the insurers and eventually results in high claim ratios.
2. **Group size-** The group should have a minimum number of members to be eligible for a group health insurance plan. This requirement of minimum members varies across different plans. Usually, most group health insurance plans require a minimum membership of 20 or 25 individuals.



Notes

3. **Types of industry-** Some industry are found to have high risk. Therefore, the group insurance provided to industry like chemical industry etc. would have higher premium.
4. **Type of group-** Voluntary or compulsory
5. **Eligible persons for coverage-** In order to be eligible for the coverage in a group health insurance policy, there are certain requirements that must be met by a new member to be added in the group as per the provisions of many group insurance policies. For example, actively-at-work provision states that the person or employee should be actively at work rather than ill or on leave on the day the insurance coverage is to take effect and probation period is completed for that employee.
6. **Option for opting out-** whether entire group is being covered under the policy or there is an option for members to opt out
7. **Graded cover-** whether uniform cover (sum insured) for all group members or different sum insured for various designations in same organization or group. For example, the organization having A Class officers having same sum insured like 5 lakhs per annum and for B Class officers having 3 lakh sum insured per year.
8. **Group composition-** It is based on gender, age, locations, income levels of group members, employee turnover rate, etc.
9. **Premium payment-** whether it is contributory or non-contributory, i.e. premium paid entirely by the group owner or by members along with group owners
10. **Difference in healthcare costs** across regions in case of locations spread in different geographical locations.
11. **Specific Third Party Administrators (TPA) preference** by the group head for the group insurance administration according to choice by group head or insurer.
12. **Past claim experience-** The proposed people past health insurance claims experience is also very important underwriting factor. If any organization have any past claim experience, the underwriter would consider it as one of the parameter for deciding premium/price. If there is high claim ratio, the underwriter can revise the group health insurance at the time of renewal after one year.



Notes

13. **Number of dependents covered-** Some group insurance policies provide coverage both for group members and for the dependents of covered group members. Premium will differ accordingly.
14. **According to IRDAI guidelines** on Migration and Portability of health insurance policies (2020), every individual member covered under the policy shall be provided an option of migration at the time of exit from the group. Similarly in the event of modification of group policy (including the revision of premium) and at the time of withdrawal of the group policy, or the conversion of group policy into an individual health insurance policy or a family floater policy, option of migration shall be given. Migration from group policies to individual policy will be subject to underwriting.
15. Some policies are subject to copayment where premium charged by the insurance company is on a lower side.

The group members working in chemical factories or mines have higher risk as compared to the group members working as white colored jobs like senior managers working in air conditioned offices. The occurrence of disease/illness would be different in the both the groups as well as the claim experience would also be different. Thus, the health insurance company would charge different prices for the group health insurance policy for these groups.

10.6 UNDERWRITING OTHER THAN EMPLOYER-EMPLOYEE GROUPS

A group of employer and employee is the most common group for group health insurance. There are other types of groups, who are also eligible for health insurance cover. Thus, it is important for an underwriter to ascertain the group characteristics for prudent underwriting.

Apart from giving group health cover to employee-employer groups, the insurance company has given cover to various group like:

- a) Creditor - Debtor group
- b) Professional group like association of professionals like doctors, lawyers, accountants, engineers, journalists, pilots, insurance agents, etc.
- c) Labor unions (union buys coverage for its labourers/members)
- d) trust

- e) cooperative societies,
- f) members of resident society,
- g) franchisee dealers
- h) Credit card Holders of a specific company

Governments in different countries have been buyers of group health insurance coverage for the poor section of the society. In India, governments both at the central and state level have aggressively been sponsoring group health insurance schemes for the poor like Rashtriya Swasthya Bima Yojana (RSBY), Ayushman Bharat, etc.

The IRDAI has issued group insurance guidelines with a view to regulate the approach to be adopted by insurers in dealing with various groups. The insurance companies have experienced very high claim ratio in 'group health insurance' segment. Insurers have to be very careful while accepting the business from this segment.



Notes



INTEXT QUESTIONS 10.3

1. Which of the following decision underwriters cannot take?
 - a) Accept risk at normal or standard rates
 - b) Offer commission to the agent for bringing good cases for underwriting
 - c) Accept risk at an extra premium (loading) if risk is high
 - d) Postpone the coverage of some diseases for a stipulated period/term
2. Risks which are considered low at the time of commencement of policy, but which may increase after a certain period are known as _____
 - a) Increasing Extra Risk
 - b) Decreasing Extra Risk
 - c) Constant Extra Risk
 - d) Standard Risk
3. Insurance companies generally impose exclusions to all policyholders:
 - a) For limiting their exposure to risk
 - b) For charging higher premium
 - c) As per the recommendation of the agents
 - d) All of the above



Notes

4. Which of the following is not an example of standard exclusions in most health insurance policies?
 - a) All pre-existing diseases
 - b) Cost of spectacles and contact lenses, hearing aids, etc.
 - c) Any treatment related to sexually transmitted disease like HIV, AIDS, etc.
 - d) None of the above
5. Which of the following is not an important factor for group health insurance underwriting?
 - a) Owner of the Group
 - b) Size of the Group
 - c) Composition of the Group
 - d) Preference for Third Party Administrators (TPA)

10.7 UNDERWRITING OF OVERSEAS TRAVEL INSURANCE

The general pattern of underwriting in overseas travel insurance is similar to health insurance because in overseas travel insurance policy the main cover is the health cover.

As per the individual insurance companies' guidelines, the premium and acceptance can vary. Few important considerations are as follows:

1. The premium for overseas travel insurance would depend upon age and foreign travel duration of proposer.
2. The medical treatment in foreign destination is very high as compared to India. Therefore, the premium for overseas travel insurance is high as compared to domestic travel insurance policies
3. There are two plans for general cover, for countries excluding USA and Canada and another for USA and Canada. The expenses for USA and Canada are highest and the premium is also high as compared to other countries.
4. The underwriter needs to be more careful while accepting the proposal for this policy because a policy holder may take the policy for availing medical treatment abroad. Therefore, underwriter should carefully check the existence of any pre-existing disease at the proposal stage.

10.8 UNDERWRITING OF PERSONAL ACCIDENT INSURANCE

The underwriting considerations for personal accident policies are:

Rating: The main underwriting factor considered for the personal accident policy is occupation of proposer. The other factor considered is income of the proposer because underwriter allows the sum insured as per the income of proposer. In general terms, the exposure to personal accidents at home, streets, etc. is same for all persons. However, the risk may vary according to the nature of work performed, occupation or profession of the proposer. For example- an assistant professor working in an academic institution engaged in academic work is less exposed to risk as compared to worker of chemical factory, which is assumed as a hazardous occupation.

It is practically very difficult for underwriter to rate each occupation or profession in a personal accident policy. Therefore, occupations are classified into different groups with similar kind of risks. The following system of classification is simple and found to be feasible in practice. Individual companies may have their own basis of classification.

The change of the insured occupation (especially from less to high hazard occupation) needs to be notified to the insurer in case of personal accident policies.

Risk Classification: The risk groups of insured person are classified on the basis of occupation. They are:

a) Risk group I: Normal Risk

Teachers, accountants, lawyers, consulting engineers, doctors, people engaged in administration functions, architects, bankers, people engaged in similar kind of occupation hazard.

b) Risk group II: Medium Risk

Engineers, builders and contractors engaged in superintending functions only, motor vehicle paid drivers and light motor, veterinary doctors and people engaged in similar kind of occupation hazard. Cash carrying employees, Machine operators, professional athletes and sportsmen, garage and motor Mechanics, Drivers of trucks or Lorries and other heavy vehicles, woodworking Machinists and persons engaged in occupations of similar hazards. All persons engaged in manual labour (except those falling under Group III)



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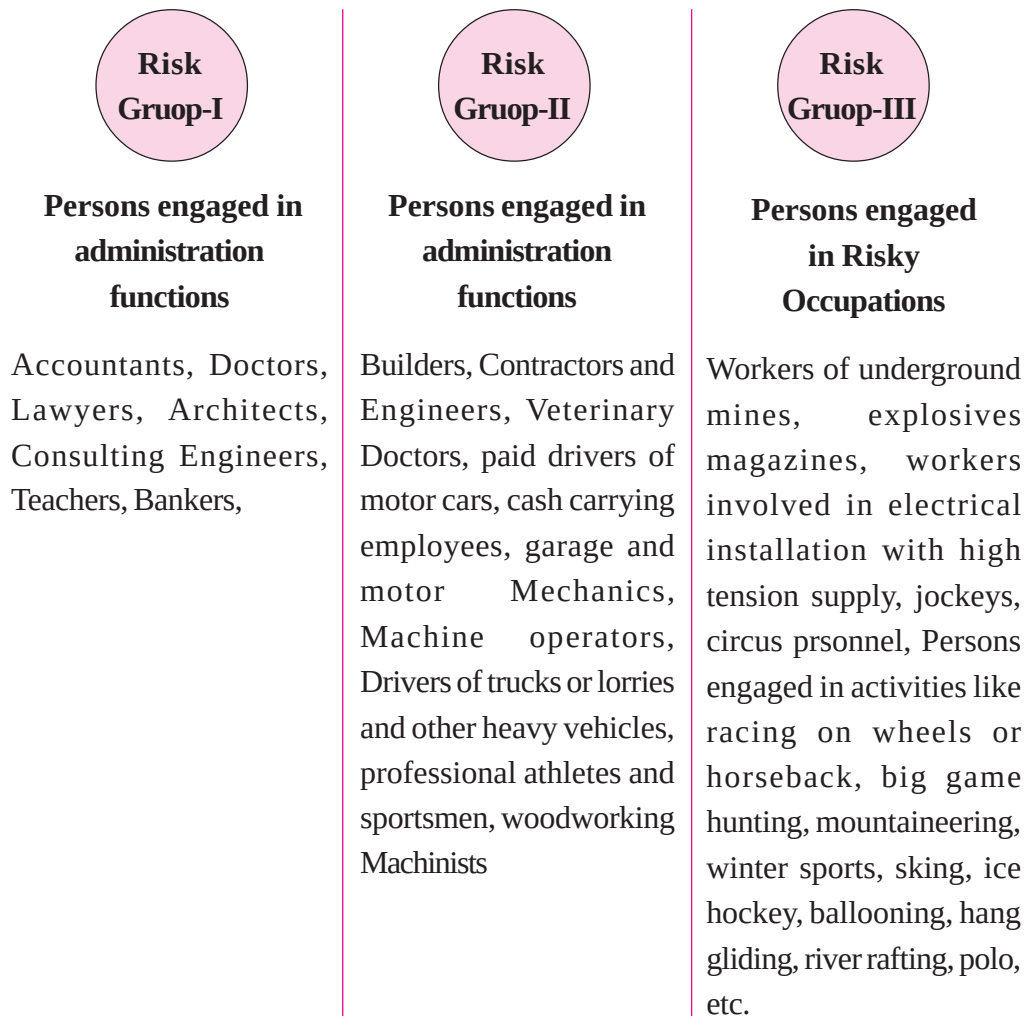


Figure 10.4: Risk classification in Personal Accident Insurance

c) Risk group III: High Risk

Workers working in underground mines, involved in electrical installation with high tension supply, working in circus, big game hunting, winter sports, ice hockey, hang gliding, polo, Jockeys, explosives magazines, persons engaged in activities like racing on wheels or horseback, mountaineering, skiing, ballooning, river rafting and persons engaged in occupations/ activities of similar hazard.

Age Limits

Generally, the age limit is minimum 5 years and maximum 70. However, this range may vary in different insurance company. For an existing policyholder, the personal accident policy may be renewed up to the age of 80 years subject to a loading of the renewal premium. No medical examination is usually required for renewal or fresh cover.



INTEXT QUESTIONS 10.4

1. Which of the following changes needs to be notified to the insurer in case of personal accident policies.
 - a) Changes in salary
 - b) Change in occupation
 - c) Changes in marital status
 - d) None of the above
2. What step is most likely to be taken in case of adverse claim ratio for a group health policy?
 - a) All the claims beyond a certain value are rejected.
 - b) Loading is applied to renewal premium.
 - c) Policy is discontinued with immediate effect
 - d) None of the above



WHAT YOU HAVE LEARNT

Underwriting is the process of properly evaluating the risk and choosing the conditions under which the insurance coverage will be provided. In simple words, we can say that the Underwriting is the process of risk selection and then pricing the risk after its selection. There are different methods, which may be used in health insurance underwriting. These are medical underwriting, non-medical underwriting and numerical rating method.

Medical underwriting is a process in which underwriters use health related information through a pre insurance medical screening of a prospect to take a decision regarding acceptance or rejection of the application. An underwriter need to adopt a balanced approach where he is neither too liberal nor too strict while assessing the risk. Age of the proposer, health status, current medical conditions of the proposer, medical history of the family and hereditary diseases in the family, etc. are important underwriting considerations.

If you want to take a health insurance policy without going through the process of medical underwriting, i.e. without medical check-ups and tests, then you may opt for those policies, which works on non-medical underwriting. There is another method,



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which is known as numerical rating method where numerical or percentage assessments are made on each component of the risk. This method ensures consistency in risk classification.

Risk assessment by underwriters is vital to insurance companies as it keeps the insurance system in balance. Risk is classified into standard and sub-standard risks. Insurance companies generally impose exclusions to all policyholders, to limit their exposure to risk by implementing standard or general exclusions, which one must be aware about.

Group health insurance plans are those that provide coverage to a group of individuals who are a part of a recognized group. The factors which are responsible for group health insurance underwriting are: Existence and size of the group; Types of industry; Type of group; Eligible persons for coverage; Option for opting out; Graded Cover; Group composition; person paying the premium; Difference in healthcare costs across regions; preference for Specific Third Party Administrators (TPA); Past claim experience; Number of dependents covered; and guidelines of IRDAI.

The general pattern of underwriting in overseas travel insurance is similar to health insurance because in overseas travel insurance policy the main cover is the health cover. There are two plans for general cover, for countries excluding USA and Canada and another for USA and Canada. The expenses for USA and Canada are highest and the premium is also high as compared to other countries.

The main underwriting factor considered for the personal accident policy is occupation of proposer. The risk groups of insured person are classified on the basis of occupation. No medical examination is usually required for renewal or fresh cover.



TERMINAL QUESTIONS

1. What are the most common methods of underwriting in Health Insurance? Explain with the help of examples.
2. Explain the factors affecting the Medical Underwriting.
3. Explain the factors affecting the Non-Medical Underwriting.
4. What are the Advantages and Disadvantages of using Numerical Rating Method for underwriting?
5. Explain the process of underwriting used in health insurance through a flow chart.
6. What are the different underwriting decisions, which an underwriter has to take?

7. Explain why majority of policies impose exclusions. Give examples of standard exclusions used in most health insurance policies.
8. Explain the factors that affect the underwriting process for group health insurance.
9. How the underwriting is done for the Overseas Travel Insurance policies? What are the important considerations that should be considered while underwriting Overseas Travel Insurance policies?
10. Explain the process of underwriting Personal Accident Insurance policies. On the basis of Occupation, how the risks associated with the insured person are classified into different categories?

**Notes**

ANSWERS TO INTEXT QUESTIONS

10.1

1. (d) All of the above
2. (a) Medical Underwriting
3. a) underwriter focuses on accepting the good risk or best risk only
4. (c) Adopt a balanced approach to cater both good and bad risks
5. (d) All of the above
6. (c) conducting pre medical check-ups of prospect

10.2

1. (b) Non-Medical Underwriting
2. (a) To strike a right balance between the business and risk
3. (b) Underwriting philosophy of the company
4. (c) Numerical rating Method
5. (c) The underwriter uses his subjective knowledge to rate the factors

10.3

1. (b) Offer commission to the agent for bringing good cases for underwriting
2. (a) Increasing Extra Risk
3. (a) For limiting their exposure to risk

Module - 4

Health Insurance



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METHODS OF HEALTH INSURANCE UNDERWRITING

4. (d) None of the above
5. (a) Owner of the Group

10.4

1. (b) Change in occupation
2. (b) Loading is applied to renewal premium.



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain the factors that may affect the underwriting in case of group health insurance, overseas travel insurance and personal accident insurance
- To use the knowledge gathered about health insurance underwriting in the underwriting department

**11**

HEALTH INSURANCE CLAIMS

11.0 INTRODUCTION

A health insurance claim is a request that a health insurance policyholder submits to the Insurance Company in order to obtain the services that are covered in their health insurance policy. In this way, one can either submit the claim form for reimbursement or request the health insurance provider for a cashless service. For both the cases, a process is to be followed with which every insurance agent or a customer must be aware. This chapter will focus on explaining the health insurance claim process.



11.1 OBJECTIVES

After reading this lesson, you will be able to:

- Explain the Claims management process in health insurance
- Recognize the Stakeholders in claim process
- Explain the Role of claims management in insurance company
- Discuss the Challenges in health insurance

11.2 CLAIMS MANAGEMENT IN INSURANCE

The insurance is a "promise" and the policy is a "witness" for that promise. Claim is the event when insurance company needs to fulfil their promise which they did at the proposal stage. The claim occurring due to insured event is the right true test of that promise. The performance of insurance company is evaluated by how well it keeps its claims promises. The claim paying ability of insurer is one of the main factors in health insurance.



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11.3 STAKEHOLDERS IN CLAIM PROCESS

The stakeholders in claim process are as follows: -

- a) **Customer-** The insurance policy buyer is the first stakeholder and "receiver of the claim". The proposer subsequently become policy holder who takes policy.
- b) **Owners-** The owners are also the promoters of the insurance company. They have big stake in the insurance company as they pay the claims. They are liable to keep the promise of paying the insurance claim.
- c) **Underwriters-** Underwriters have the responsibility to analyze, classify the risk and decide policy terms, conditions and do appropriate pricing etc. The underwriter takes the decisions regarding acceptance, declining or loading on insurance policy. They are called the backbone of insurance industry.
- d) **Regulator-** The insurance regulator, IRDAI (Insurance Regulatory and Development Authority of India) is a key stakeholder. The objective IRDAI is:
 - To maintain order in the insurance environment
 - To protect the interest of policy holders.
 - To ensure long term financial health of insurance company.
- e) **Third Party Administrators-** Third Party Administrator are insurance intermediaries, who process health insurance claims. They process both cashless and reimbursement health insurance claim. They are licensed by IRDAI to provide the health services to health insurance policy holder.
- f) **Insurance Agents / Brokers-** Apart from selling insurance policies the Insurance agents or brokers are also expected to provide after sales services to customers like at the time of claim.
- g) **Providers / Hospitals-** The panel hospital or providers must ensure smooth claim experience to customers. These panel hospitals have collaboration with third party administrator or health insurance Company to provide cashless treatment. Hospital also play vital role in customer satisfaction regarding health insurance claim.



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Figure 11.1: Stakeholders in Claim Process

11.4 ROLE OF CLAIMS MANAGEMENT IN INSURANCE COMPANY

As per IRDAI Annual Report 2018-19- "The health insurance incurred claim ratio of various insurance companies ranges from 60% to 109%, with an average above 92% loss ratio of whole health insurance ,market". Most of the insurance companies are making underwriting losses in health insurance business. Many health insurance companies are undergoing underwriting losses due to high claim ratio.

It is very important to adopt good underwriting practices and efficient claim management is required for underwriting profit.

11.5 MANAGEMENT OF HEALTH INSURANCE CLAIMS

11.5.1 Challenges in Health Insurance

The challenges in health insurance are:

- As most of the health insurance policies are for hospitalization where the subject matter covered is health care of human being. This brings the emotional touch that is not normally faced in other types of insurance.
- India presents very different approach of people towards their illness, its treatment and follow up. Due to this some people are very cautious and others are careless about their illness and treatment.

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- c) Health insurance can be taken by an individual, a group like corporate organization or through a retail selling channel like a bancassurance. So we have a health insurance product which is being sold as a standard product at one end while other being customized to satisfy needs of the customer at the other end.
- d) Due to different treatment methods, billing patterns, variations in charges of health care facilities it become the challenge for claims department to settle the claims.
- e) Evolution of new diseases, advancement in health care industry, development in new treatment methods brings challenge to health insurance claims personals. They need more technical skills and constant improvement to handle the claims.
- f) Health insurance frauds related to claims are one of the biggest challenges for industry.
- g) The steep inflation in health care industry is possessing challenge for health insurance industry resulting in inflation of claim bills.
- h) Non standization of health care industry is also a challenge to health industry.

The health insurance portfolio is rapidly growing. There are lots of general insurance and standalone health insurance companies offering various products. There are more than 100 products in health insurance market and even one insurer is offering many different type of health insurance products. Due to variations in terms conditions of policy there is a need for in-depth study before handling the claim.

There is a significant growth in health insurance portfolio which bring the major challenge to health insurance for providing claim settlement service to policy holders. The claim department need to be fulfil the expectation of policy holders by fast claim settlement. The health claims manager meets these challenges using expertise, experience and various tools available to him.



INTEXT QUESTIONS 11.1

1. Who among the following is not a stakeholder in insurance claim process?
 - a) Insurance company share holders
 - b) Human Resource Department



- c) Regulator
 - d) TPA
2. Which of the following takes the decisions regarding acceptance, declining or loading on insurance policy?
- a) Regulator
 - b) Third Party Administrators
 - c) Underwriters
 - d) Insurance Brokers
3. Which of the following are involved in selling of Insurance policies?
- a) Regulator
 - b) Third Party Administrators
 - c) Underwriters
 - d) Insurance Agents/ Brokers
4. Which of the following are insurance intermediaries, who process health insurance claims?
- a) Regulator
 - b) Third Party Administrators
 - c) Owners
 - d) Insurance Agents/ Brokers

11.5.2 Claim process in Health Insurance

The claim settlement in health insurance is serviced by insurer itself/ in house TPA or through the services of Third Party Administrator (TPA) authorized by insurer.

The health insurance passes through well-defined steps starting from the time a claim is intimated to insurance company or TPA to the time claim payment is done according to policy terms. Each step has its own importance.

The processes which is explained below is specific to health insurance (hospitalization) indemnity products which makes the majority of health insurance business.

Health Insurance



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There are two types of claim settlement under health insurance policy. They are as follows:

- a) **Cashless Claim:** The customer need not to pay the expenses at the time of admission or treatment. A paneled or network hospital provides the cashless services based on a pre authorization send by insurance company or Third Party Administrators and later the claims documents and later submits the documents to the insurer/TPA for settlement of the claim. This type of claim facility can be availed only in network hospital.
- b) **Reimbursement Claim:** In this type of claim the insured will pay the claim amount from his pocket and then submit all claim settlement documents along with bills to TPA or Insurer. The TPA or insurer will reimburse the claim amount incurred during hospitalization after due verification in accordance with terms and condition of the policy. This type of claim is settled when the policyholder avail the claim benefit at non network/paneled hospital.

11.5.3 Steps in Health Insurance Claims

In both cases, the basic steps remain the same.

- (a) **Intimation :** This the first time when insured and insurer claims team contact each other. The policy holder can prior intimate the insurance company about availing hospitalization services before hospitalization in case of planned hospitalization and intimation can also be given after hospital admission in emergency hospitalization. The policy holder should intimate the insurer within 24 hours of hospitalization in case of emergency and before 4 days in case of planned hospitalization. The timely intimation helps insurer to verify the hospitalization claim. It helps the insurer to verify the genuineness of claim and ensure that there is no impersonation or fraud. Intimation can be done through 24 hours call centers run by insurers and TPAs. The intimation can also be given through internet/e mail/ fax.
- (b) **Registration:** Claim registration is the process of entering the claim in the system and creating the reference number. It is used to trace the claim. This is also known as claim reference no, claim control no or claim no. The claim number can be alpha numeric or numeric. Once the claim notification is received and the relevant policy number and the received, person's information are matched, registration and the generation of a reference number usually gets completed.



A reserve amount is generated the moment the claim is registered in claim system in the accounts of the insurer. The exact amount or estimate is not known at the time of registration or intimation. Mostly on the basis of historical average claim size initial reserve amount or standard reserve is formed. The reserve is revised downwards or upwards once the estimate or expected amount of liability is known.

11.6 PRE AUTHORIZATION AND AUTHORIZATION FORM

The pre-approval form is send by the hospital to Insurance Company or TPA for initial cashless. The TPA card along with the Id proof is also send along with this form. The TPA will issue the authorization letter for the cashless claim service to hospital as per the terms and conditions of the insurance policy. The pre authorization give following information:

- Treating doctor,
- Condition of patient at the time of hospitalization,
- Proposed diagnosis,
- Proposed length of stay and
- Line of treatment.
- Proposed expenses

The moment the pre authorization form is received by TPA they will start the verification of claim. Firstly they will see the policy running status, policy terms and conditions, proposal form (match with the declaration by the patient in the pre auth form). After convinced the TPA will release the initial cashless.

Verification of Customer- The policy holder who is admitted in the hospital for cashless treatment is verified by the TPA to insure that the person insured and the person hospitalized are the same. This exercise is done to prevent impersonation which is commonly encountered fraud in health insurance. This can be verified with TPA card and authentic valid Id proof.

11.7 VERIFICATION OF DOCUMENTS

The next step after registering a claim is to verify that all the necessary paperwork has been received for processing.



Notes

Claim process broadly comprises of following steps (not in exact order)

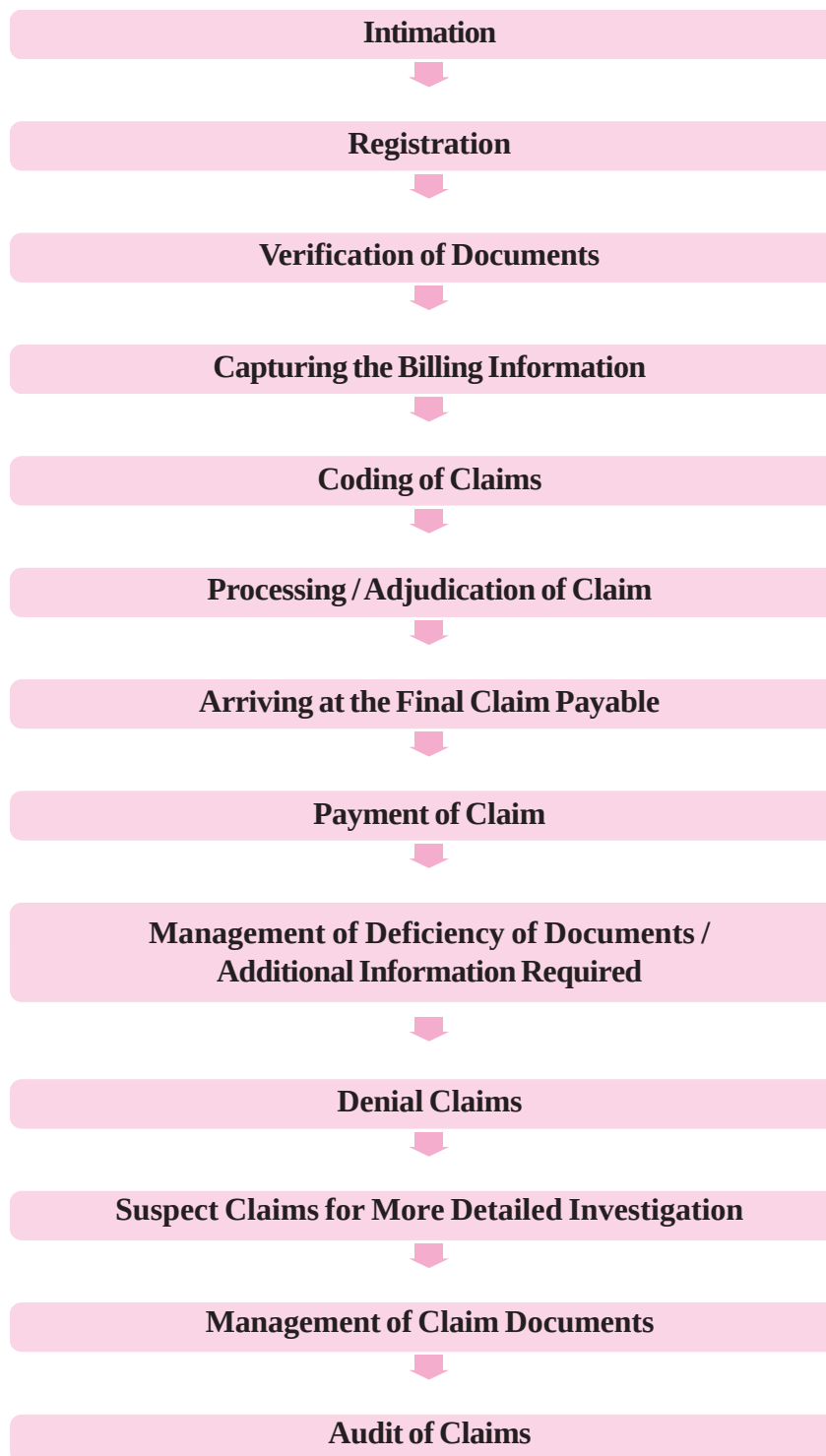


Figure 11.2: Process of Claim Management

It must be understood that the following conditions must be met in order for a claim to be processed:

1. Proof of the illness with documentary evidence.
2. Treatment provided at hospital
3. In-patient duration of hospitalization
4. Diagnostic Reports of patient
5. Payment made to the hospital
6. Treatment advice
7. Evidence of Payment made for medical implants etc.

The claim processor checks out the documents with the help of checklist. Check lists are part of the processing documents in most of the insurance companies.

At this stage any missing documentation is noted. The missing documents are requested from customer or hospital who has not submitted. Firstly insurance companies do scrutiny of all the documents submitted and afterwards request for addition information or documents if required for customer convenience.

11.8 CAPTURING THE BILLING INFORMATION

In claim process cycle billing is very important step. Generally health insurers provide indemnifying expenses incurred in medical treatment as per terms and condition of the policy. There are various heads under which the billing is done. Generally the treatment charges are classified into:

- Room, board and nursing expenses including registration and service charges.
- Charges for ICU and any intensive care operations.
- Operation theatre charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and any medical expenses incurred which is integral part of the operation.
- Surgeon, anesthetist, medical practitioner, consultant's, specialists' fees.
- Ambulance charges.
- Investigation charges covering blood test, X-ray, scans, etc.



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- Medicines and drugs.

In order to accurately settle claims, information under these headings is captured from customer-submitted documents through an examination process.

The challenges involved with each hospital using a separate technique for billing are as follows, despite efforts to standardise the billing pattern of hospitals:

- Some non-payables, including service fees or dietary expenses, may be included in room rates.
- A single bill may contain various categories or a lump sum payment for all investigations or all medications.
- The use of uncommon names, such as calling nursing charges "service charges."
- The use of terms in the bill such "similar charges," "etc.," and "allied costs"

Where the billing is not clear, the processor seeks the breakup or additional information, so that the doubts on the classification and admissibility are resolved.

To address this issue, IRDAI issued Health Insurance Standardization Guidelines which have standardized the format of such bills and the list of non-payable items.

Package Rates

These days TPA/ Insurance companies have entered into package rates with panel/ network hospitals which are known as agreed package rates for the treatment of some specific diseases. This was made for standardizing the treatment procedure and pricing for treatment. Previously there was dispute between various stake holders of health insurance viz. policy holders, hospitals, TPA/Insurance companies regarding payment of claims. Some hospitals were inflating the bills resulting in denial or partial settlement of claims. Due to this the policy holder was not satisfied. These days, for treatment at Preferred Provider Network and also in case of Ayushman Bharat, package cost of many procedures has been pre-fixed.

Package rates includes

- a) Room charges
- b) OT Charges
- c) Investigations based on standard protocol
- d) Medicines during the in-patient period
- e) Surgeon other doctor fees



Some examples of Package rates are-

- a) Angioplasty, CABG or Open heart surgery package
- b) Normal delivery, Caesarean delivery, hysterectomy package
- c) Appendectomy package
- d) Gastro intestinal disorder packages

If any additional costs due to complications after surgery is incurred that are charged separately on actual basis if incurred over and above agreed amount.

11.9 CODING OF CLAIMS

World Health Organization (WHO) developed International Classification of Diseases (ICD) codes are the most important set of code used worldwide.

Procedure codes, like Current Procedure Terminology (CPT) codes, are used to record the condition in a standardised format. They record the procedures carried out to treat the sickness.

Insurance Information Bureau (IIB), a division of the Insurance Regulatory and Development Authority (IRDAI), has established an information bank where such data may be analysed as insurers increasingly rely on coding.

11.10 PROCESSING OF CLAIM

There are two important question during claim settlement process. They are:

- Is the claim payable under the health insurance policy?
- If yes, what is the net payable amount under the policy?

Understanding a variety of policy terms and conditions as well as the rates set forth by the hospital, in the event that treatment was carried out at a network hospital, is necessary for answering each of these questions.

Acceptance of a claim

The following requirements must be met for a health claim to be accepted.

- i. **The patient needs to be covered by the health insurance plan-** It is important to check and match the names, photograph, insured age and hospitalized person. There have been instances where the names of the person insured does not match with the person hospitalized. It is important that both the person is same.

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This type of fraud is very common in health insurance. This can be verified by sending an official representing health insurance company or TPA.

- ii. **Insured patient admission within policy period-** The date of admission should be within policy period. The health insurance policy is generally issued for one year. The expenses involved relating to the illness such as investigations or medicines just before the hospitalization and for the period after the hospitalization are also covered in most of the policy as expenses related to pre and post hospitalization. The pre and post hospitalization expenses should pertain to the same illness for which hospitalization takes place.
- iii. **Hospital definition-** The policy holder should check the network hospital before admission in planned and cashless hospitalization. This can be done by calling the concerned TPA or health insurance company. It can also be verified by agent or visiting insurer/TPA website. All hospitals display the TPA names associated with them on the display board at reception area. The hospital definition is very relevant in case of reimbursement cases. The hospital in which the policy holder is admitted should come under the category of hospital as prescribed by IRDA regulations. The hospital should be registered with local authorities, should have at least 15 beds (in class C towns it should be 10), well equipped operation theatre, well qualified nursing staff and qualified Doctors employed round the clock. The purpose of this definition is to ensure that the treatment carried out was for a proper hospitalization and not an outpatient treatment. The health regulations and standardization guidelines both have defined the requirements as regards Medical Establishment and Hospital.
- iv. **Domiciliary hospitalization**

Health insurance policies cover domiciliary hospitalization. It means if the treatment is taken at home in India for a period exceeding 3 days for a disease which normally requires treatment at hospital/nursing home.

Domiciliary hospitalisation is only covered if the insured patient's condition makes it impossible for them to be transferred to a hospital or nursing home or if they are unable to be transferred due to a lack of space.
- v. **Hospitalisation Period**

Generally, the insured person needs to be hospitalized for at least 24 hours to avail the benefit under health insurance. The date, time of admission as well as discharge is really very important for settlement of claims. The only exception to the above condition is Day Care procedures. Due to advancement of technology



in healthcare industry, it led to many procedures simplification where long hospitalization was required. Many medical procedures like cataract removal, dialysis, kidney stone removal etc which can be done within 24 hours on day care basis. In many day care treatments pre agreed rate are decided between insurance company or TPA with network hospital which led to medical cost certainty.

Day-care treatments

Many medical treatments that were formerly quite complex and necessitated lengthy hospitalisation have been made simpler as a result of technological improvement in the medical sector. There are now many medical procedures which do not require the need for hospitalization exceeding 24 hours which is a condition to avail health insurance claim. Some treatments can now be performed in a day care basis, thanks to medical advancements. The majority of day care treatments follow a pre-agreed package pricing basis, which provides cost certainty.

vi. OPD treatment

Few health insurance policies cover outpatient treatment or consultations subject to a specified sum insured. The premium for these policies is on higher side. OPD coverage varies from policy to policy. The requirement requiring a minimum of 24 hours of hospitalisation does not apply to these reimbursements.

vii Treatment procedure or line of treatment

All health insurance companies cover allopathic treatment based hospitalization expenses. Some companies cover AYUSH benefits partially with sub limits or put the treatments under exclusions. AYUSH benefits are as follows:

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

Majority of health insurance policies put these treatments under exclusions while some insurance policies cover one or more of these treatments with sub-limits attached to it.

Health Insurance



Notes

viii. Pre-existing illnesses

It refers to conditions, any disease or any related conditions for which the policy holders had shown any signs or symptoms and or diagnosed for any disease or received medical treatment or opinion within 4 years prior to health insurance policy. If a person discloses any disease or ailment at the time of taking the policy, it comes under the pre-existing clause and insurance company will not cover that particular ailments upto next four years.

In health insurance there are two modifications to this condition.

- The first is in the case of group insurance where the entire group of people is insured, with no selection against the insurer.
- The second modification is that pre-existing illnesses are covered after a certain period of continuous coverage. This follows the principle that even a condition is present in a person, if it does not show up for a certain period of time, it cannot be treated as a certainty.

ix. Initial waiting period

All new health insurance policy have initial 30 days exclusion period(except accident related hospitalization). There are particular diseases which are not covered for first one/two or maximum up to 4 years which entirely varies from company to company product. The claims manager will check the ailments which comes under waiting or exclusions period.

Some of examples for waiting period are hernia, cataract, piles etc

x. Exclusions

There are set of excluded illness which are not covered under health insurance policy. The list varies from companies product to product. The diagnosis is carefully examined to check if the illness falls in any of the excluded conditions.

General exclusions under the health insurance policies are:

- Maternity (but covered in very few policies).
- OPD and Dental treatments.
- HIV, Hormone therapy, obesity treatment, fertility treatment, cosmetic surgeries, etc.
- Illness caused by alcohol/drug abuse.



Notes

- Medical treatment taken outside India.
- High hazard activities,
- suicide attempt,
- radioactive contamination.
- Admission for tests/investigation purpose only.

xi. Adherence to terms with regard to the claims

The insurance policy also specifies various measures that the Insured must take in the event of a claim, some of which are crucial for the claim's acceptance.

(Note: The remaining process will be discussed in the next chapter)



INTEXT QUESTIONS 11.2

1. Cashless claim facility can be availed in
 - a) Network hospital
 - b) Any Hospital
 - c) Non-Network Hospital
 - d) None of the above
2. _____ is the process of entering the claim in the system and creating a reference number using which the claim can be traced any time.
 - a) Intimation of Claim
 - b) Registration of a claim
 - c) Coding of Claim
 - d) Denial of Claim
3. In Health Insurance, ICD Codes stands for _____
 - a) International Classification of Diseases (ICD) codes
 - b) Internal Classification of Diseases (ICD) codes
 - c) International Classification of Doctors (ICD) codes
 - d) Internal Classification of Doctors (ICD) codes

Health Insurance



Notes

4. A hospital, which has an agreement with a TPA/Insurer for providing cashless treatment is referred to as a _____
 - a) IRDAI
 - b) Network hospital
 - c) Ombudsman
 - d) Insurance repository
5. _____ are those which do not have tie up with TPA and any policy holder seeking treatment in these hospitals would have to pay the treatment and later claim as per the reimbursement procedure.
 - a) Central hospital
 - b) Non Network hospital
 - c) Cashless hospitals
 - d) Panel hospital
6. An insurance company settles the claim through its own claim processing department (in house) or ties up with a _____ which undertakes to do this on behalf of the insurance company.
 - a) IRDAI
 - b) Network Hospital
 - c) Ombudsman
 - d) Third Party Administrator
7. The first step in health insurance claim settlement process is:
 - a) Intimation
 - b) Billing
 - c) Pre authorization
 - d) Authorization

8. Exclusions under health insurance policy is/are:

- a) HIV
- b) Attempt to suicide
- c) Both a) and b)
- d) None of the above



WHAT YOU HAVE LEARNT

There are different stakeholders involved in the process of health insurance claims like Insurance Company; Underwriters; Third Party Administrators; Regulators; Hospitals; Insurance Agents / Brokers; Customers, etc. To improve outcomes for the organisation and policyholders, strong underwriting practises and effective claim handling must be adopted. Any practitioner must have a thorough understanding of the peculiar characteristics of the health insurance portfolio in order to manage health claims efficiently.

A claim may be handled by the insurance company directly or by a Third-Party Administrator (TPA) that the insurance company has authorised. The claim under an indemnity policy could be a Cashless Claim or a Reimbursement Claim. In both the cases, basic steps remain the same, which are: Intimation; Registration; Verification of Documents; Capturing the Billing Information; Coding of Claims; Processing / Adjudication of Claim.

The remaining steps you will learn in the next chapter which will include: Arriving at the Final Claim Payable; Payment of Claim; Management of Deficiency of Documents / Additional Information Required; Denial Claims; Suspect Claims for More Detailed Investigation; Management of Claim Documents; and Audit of Claims.



TERMINAL QUESTIONS

1. List down the stakeholders involved in the process of claim process in health insurance.
2. Briefly explain the challenges in the health insurance claim management.
3. Explain the claim process in health insurance.
4. Write a note on Cashless claim and Reimbursement claim.
5. What are the conditions for the Admissibility of a claim in health insurance?



Notes

Health Insurance



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6. Write a note on a) Pre-existing illness, b) Initial waiting period.
7. How does the cashless facility work? Explain using examples.



ANSWERS TO INTEXT QUESTIONS

11.1

1. (b) Human Resource Department
2. (c) Underwriters
3. (d) Insurance Agents/ Brokers
4. (b) Third Party Administrators

11.2

1. (a) Network hospital
2. (b) Registration of a claim
3. (a) International Classification of Diseases (ICD) codes
4. (b) Network hospital
5. (b) Non Network hospital
6. (d) Third Party Administrator
7. (a) Intimation
8. (c) Both (a) and (b)



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain the role of different stakeholders in the process of claim management and the important terms used in the process of managing a claim.

**12**

HEALTH INSURANCE CLAIMS PART-II

12.0 INTRODUCTION

In the previous chapter you have studied that for both Cashless Claim or a Reimbursement Claim, basic steps which needs to be followed remains the same, which are: Intimation; Registration; Verification of Documents; Capturing the Billing Information; Coding of Claims; Processing / Adjudication of Claim and many more. This chapter will focus on the remaining steps which you will learn in this chapter. The remaining steps of claim management process will include: Arriving at the Final Claim Payable; Payment of Claim; Management of Deficiency of Documents / Additional Information Required; Denial Claims; Suspect Claims for More Detailed Investigation; Management of Claim Documents; and Audit of Claims.

12.1 OBJECTIVES

After reading this lesson, you will be able to:

- Explain the Claims management process in health insurance
- Explain how the amount of final claim is calculated in Health Insurance
- Describe the Cashless settlement process by TPA

12.2 CLAIM PROCESS IN HEALTH INSURANCE

You have studied in the previous chapter that a series of steps are to be followed in case of both Cashless or Reimbursement claims. Some of the initial steps were explained in the previous chapters. Now, let us understand the remaining steps which needs to be followed during a process of claim management.



Notes

12.2.1 Arriving at the Final Claim Payable

The next step after Adjudication of Claim is to decide the health insurance claim amount payable. The factors for deciding the final claim payable are as follows:

- i. **Availability of Sum Insured under health insurance policy-** In some policies the health insurance policy is issued on family floater basis where the sum insured is floating and is available on all family members within the time period. In family floater all family members collectively or individually can claim under one sum insured. In individual health insurance policies given to the family there is an individual sum insured given to the each family members. In this format if sum insured of one family member is exhausted he/she cannot take the sum insured of other family member. So the claims team sees the sum insured in the policy before arriving at final amount payable.
- ii. **Sum insured left under the policy-** The claims manager will see the sum insured left in the policy for the member after checking any claim availed earlier. It's really important to see the sum insured left within the policy period if any claim is availed under the policy within the policy period. Previously the claim department use to refer the hard copies stored at claim department offices. But due to digitalization these days the copy of policy, proposal form submitted and sum insured left in the policy can be ascertained within fraction of time.
- iii. **Sub Limits-** In many policies there is room rent limitation as per the terms and condition of the policy. The sub limit can be in form of percentage of sum insured or there is limit per day in room rent. Similar kind of limits can be in ICU, ambulance charges etc. The claims department will see this sublimit (if any) and deduct the amount if it exceed in that criteria. The rationale behind putting this was to check the high claim ratio and moral hazard in health insurance. But these days there are many health insurance products without sub limits.
- iv. **Illness based specific limits-** Policy features can mention specific amount for benefits like maternity cover or disease specific limit. The claims department will check any other capping in the policy like room rent and nursing charges.
- v. **Cumulative Bonus-** Many companies' offers addition sum insured or enhanced sum insured by some percentage for every claim free year. The claims department will also check no claim bonus or cumulative bonus in case where the claim exceeds the available sum insured and there is enhanced sum insured in the policy due to claim free year. For example- For every claim free year health insurance company can enhance the sum insured by 20% at the time of renewal.



Notes

- vi. **Other expenses covered with limitation-** The claims department will check other limits like AYUSH benefits where there is limits up to specified percentage of sum insured before arriving at final claims amount payable. There is also limit to health checkup costs of a certain limits after 4 year of the policy, hospital daily cash payment with a limit per day.
- vii. **Co Payment under health insurance policy-** The copayment means that some percentage of claim amount is to be paid by insured and left amount by insurer. It is done at the final claim amount stage. The copayment is general applicable with senior citizen policies. Deduction of non-payable items is also done at this stage. Non payable items are now standardized according to IRDAI health insurance standardization guidelines. Previously TPA or insurance companies used to send its own non payable items lists to policy holders.

Non-payable items in a health claim

There are two types of expenses incurred in treating of illness. They are:

- Expenses related to cure and
- Expenses related to care.

The expenses related to all medical costs are covered and it comes under the category of expenses for cure. Generally health insurance policy covers expenses for curing an illness.

Earlier every TPA/insurance company used to have its own list of non-payable items but now the non-payable items has been standardized under IRDAI Health Insurance Standardization Guidelines. IRDAI have prescribed the standardized list which has about 199 items that are generally excluded from a health insurance policy. Items on this list range from consumables, non-medical items including toiletries, cosmetics, personal comfort or convenience items. telephone, laundry or internet costs are not payable. Even medical items such as spectacles, contact lenses, hearing aids, adhesive bandage, crepe bandage, and gauze are not payable. In room-related costs, expenses on television, air conditioning, housekeeping and attendant costs are not payable if they are billed separately and are not part of the room costs. Administrative costs like the admission kits, discharge procedure, entrance passes or visitor passes, and patient identification bands or name tags are not payable by your policy.



Notes

Steps for final claim payable arrival are:

Step 1	All bills and receipts to be listed under various heading like room rent, doctor fees etc.
Step 2	The non-payable items to be deducted from the claimed amount under each head.
Step 3	Any other limit applicable for each expense head.
Step 4	Arriving at final amount payable and verify that the final amount payable is within overall sum insured.
Step 5	At last deduct any copayment and non-payable items charges for net claim payable amount.

Payment of claim

After the finalization of claim amount payable, it is directly send to the network hospital in cashless claim settlement and in reimbursement cases send to policy holder. The final approved claims amount is send to Accounts or Finance department. The customer receives claim amount payment either through cheque or transferred directly through NEFT in customer account. The necessary tax is deducted (if any) from claim amount and then the payment is send to the concerned hospital. TPA payment process may vary from insurer to insurer. The details of payment paid is also shared with the policy holder through call center or sms service. The claim is treated as settled when the claim payment is made. Reports to management, intermediaries, customer and IRDA are provided on settled claims.

12.2.2 Submission of remainning documents or additional information required

Scrutiny of key documents is necessary for the processing of claims. These are patient discharge summary, supporting diagnostic reports, and break up of final consolidated bill, prescriptions and medicine bills, receipts of payment, claim form and customer authentication. Many a times there is deficiency of required documents. The customer is advised to submit the necessary documents not submitted and adequate time is given to submit required documents for claim settlement process. When the important information required is overlooked and policy holder does not respond to the queries raised in such cases policy holder is send gentle reminders regarding necessary information required for processing the claim.

Additional information may be required at the time of claim processing. This may be because of:

- a) When diagnosis details and history of disease is not properly mentioned or discharge summary of patient is not provided according to prescribed format of IRDAI.
- b) The full detail of prescribed treatment details is not described in a document which requires further clarifications.
- c) As per the discharge summary the treatment and medicine prescribed are not in line with the diagnosis of illness.
- d) Required breakup of the bill is not provided.
- e) The two documents of insured patient having mismatch of age.
- f) Due to difference of date of admission or date of discharge in the final bill and discharge summary.
- g) The full indoor case papers (ICP) are required for detail scrutiny of hospitalization under claim settlement.

For additional information or document requirement policy holder is intimated in writing or through mail. These days the agent and policy holder are intimated about these requirement through various means like Sms, e-mail etc. If these requirement are asked during hospitalization then network hospital will also be intimated for the same by TPA/ Insurance Company. The required document will be provided by policy holder and network hospital. If policy holder does not provide required document or information then TPA will remind him for the same. These types of information are required for claim processing. The claim settlement is subject to the information provided by policy holder.

Example

The ICP papers are required by TPA/ Insurance Company for in depth study and if the treatment protocol or procedure is not according to terms and condition of the policy then insurance company may require further information. And if these information or documents are not provided within stipulated time then insurer may deny the claim. If insurer requires additional information or documents it should not be assumed that the insurer has accepted the claim.

Management of missing or additional documentation, explanation and information is main challenge in health insurance claim management. For claim settlement process



Notes

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required information or documents are needed but at the same time we cannot ask repeated requests for more and more documents or information. This will lead to dissatisfaction and inconvenience among policy holders. For this we can ask for additional information or documents as consolidated list of all documents or information in one go.

12.2.3 Denial Claims

The health insurance claims experience shows that 10-15 % of the claims does not fall in the preview of the health insurance policy. This could be due to various reasons.

Some of them are as follows:

- i. Admission date of patient not within policy time period
- ii. The patient admitted and whom the claim has come is not covered under the health insurance policy.
- iii. Pre-existing disease or illness (Generally covered after some years).
- iv. Delay in submission of claim without any valid reasons. (Specially in reimbursement claim)
- v. Patient admitted for investigations purpose only not for any disease/ illness treatment.
- vi. Patient admitted for excluded illness or disease like HIV, dental treatment etc.
- vii. The reason for admission is due to abuse of alcohol or drugs
- viii. Hospitalization less than 24 hours. (which is general condition except day care procedures)
- ix. Fraudulent claim

Repudiation or denial of health insurance claim (whatever the reason may be) need to be informed to policy holder in writing citing the reason for denial of claim. It should be supported by citing the policy terms and condition as reason for claim denial.

Denial of insurance claim should be done by the authorized person of Insurance Company. The denial of the claim should be fully justified because that reason for denial is important in case the policy holder take any legal remedy.

The policy holder has various options under grievance redressal mechanism in case of denial of claim. Firstly policy holder should give representation to concerned insurance

company and if he is not satisfied with the reply of insurer or insurance company have not replied within the turnaround time (TAT), policy holder can approach following:

- Integrated Grievance Redressal Mechanism (IGMS of IRDAI)
- Insurance Ombudsman or
- The consumer forums or
- Courts of Law.



Notes

12.2.4 Suspect claims for more detailed Investigation

Health insurance industry is bleeding due to high claim ratio. It is very important to focus on eliminating or reducing health insurance fraudulent claims. Fraud in health insurance is a big challenge for the insurers. All insurance companies are facing the problem of frauds in all line of business. Around 15 to 20% of total health insurance claims are fraudulent claim according to various estimates.

Some examples of triggers for health insurance fraud are as follows:

- **Impersonation-** An act where the person admitted in hospital is different from the insured
- **Fabricated documents-** to avail the health insurance claim without being admitted in hospital.
- **Inflated medical expenses-** Generally hospital inflate the bill to make profit out of claim. Sometimes insured is also with hospital in this type of fraud. Treatment expenses are generally higher as compared to etiology.
- **Outpatient Treatment (OPD) converted to in- patient / hospitalization (IPD)-** Sometimes insured patient want to undergo diagnostic tests only for this he will be admitted to hospital even if it is not required.
- **Different treatment-** Hospital in liaison with insured patient give treatment for the excluded disease/illness which is otherwise not covered in health insurance policy. But in ICP have shown some other disease which is covered under policy.
- Unnecessary expensive diagnostic tests conducted
- Diagnosis of the illness and diagnostic test reports are not related to each other
- Length of stay in hospital is more than expected

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- Post surgery reports are not available (in surgical cases)
- Claim settlement related documents in perfect order
- There is higher number of reimbursement cases from certain hospitals
- When there is pattern where the insurance agents, type of illness and treating doctor are similar in many health insurance claims
- All medicine bills are in serial order
- The hospital, chemist address, policy holder residence are not in same geographical location

A group involving policy holders, insurance agents, doctors, hospital making series of false claim is known as fraud rings. Health insurance industry has come across with different type of frauds on daily basis. It is very important for TPA/ Insurance Company to monitor the case very diligently and monitor the cases on ground. These days TPA/ Insurance Company have their own in-house investigation unit or they take the help of external agency for investigation. Insurer should come up with strategy or mechanism to control frauds.

There are two methods for claim investigations:

- Routine claims and
- Triggered claims

A specified percentage of health insurance claim would be physically verified by Third Party Administrators or Insurance company to check frauds. This specified percentage could be defined by TPA/Insurer for cashless and reimbursement claims.

Random sampling method is used by TPA for claim verification methods. Some insurers may specify that all health insurance claim above certain amount would be investigated and claim below the specified amount be verified.

In another method the insurer/TPA each insurance claim goes through specified checkpoints. There are triggers for health insurance frauds leading to investigation. Some of them are as follows:

- i. When a majority portion of final claim bill consists of diagnostic tests or medicines
- ii. When policy holder is in hurry to settle the claim and putting pressure on TPA/ Insurer to do the same.
- iii. Over writing or cutting or whitener used in bills. The claim is investigated if it is suspected to be non-genuine even if it is of small amount.

**INTEXT QUESTIONS 12.1**

1. _____ is an act where the person admitted in hospital is different from the insured
 - a) Impersonation
 - b) Insured
 - c) TPA
 - d) None of the above
2. A group involving policy holders, insurance agents, doctors, hospital making series of false claim is known as
 - a) Fraud Rings
 - b) False claim
 - c) Impersonation
 - d) None of the above
3. The methods for claim investigations is/are:
 - a) Routine claims and
 - b) Triggered claims
 - c) Both a) and b)
 - d) None of the above
4. The policy holder options under grievance redressal mechanism in case of denial of claim is/are
 - a) Integrated Grievance Redressal Mechanism (IGMS of IRDAI)
 - b) Insurance Ombudsman
 - c) The consumer forums
 - d) All of the above
5. Policy holder should report first in case of denial of claim grievance:
 - a) Insurance Company
 - b) IGMS
 - c) Consumer Forum
 - d) Insurance Ombudsman
6. Which of the following are the triggers for health insurance frauds:
 - a) Higher length of stay in hospital for given illness
 - b) Unnecessary expensive diagnostic tests conducted
 - c) Diagnosis of the illness and diagnostic test reports are not related to each other
 - d) All of the above

**Notes**

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7. To make the health insurance viable, there is a need to focus on:
 - a) Reducing fraudulent claims
 - b) Identifying fraudulent claims
 - c) Classifying fraudulent claims
 - d) Encouraging fraudulent claims

12.2.5 Cashless settlement process by TPA

How does the cashless system operate? An agreement between the TPA, the insurer, and the hospital forms the basis of this. Other medical care providers may also be included in the agreements.

In this part, we'll examine the procedure for offering a cashless facility:

CASHLESS' CLAIMS

Cashless is a service provided by an insurer wherein your hospitalisation expenses are directly settled by the insurance company.

AVAILING CASHLESS FACILITY FROM NETWORK HOSPITALS



**Step 1**

When a customer with health insurance becomes ill or hurts themselves, they are urged to check into a hospital. He or she (or someone acting on their behalf) goes to the hospital's insurance desk with the necessary information, such as the name of the TPA, his membership number, and the name of the insurer, among other things.

Step 2

The hospital gathers the essential data, including the following:

- i. Illness diagnosis.
- ii. Treatment.
- iii. Name of Treating Physician.
- iv. Proposed Hospitalisation Days; and
- v. Estimated Cost.

The format used to present this is known as the cashless authorization form.

Step 3

The information on the cashless authorization form is examined by the TPA. It determines whether cashless authorisation could be given and, if so, for what amount. It does this by comparing the information with the insurance conditions and, if applicable, the agreed-upon tariff with the hospital.

To make a decision, the TPA may request more details. The hospital is immediately informed of the decision once it has been made.

The IRDAI Health Insurance Standardisation Guidelines have now resulted in the standardisation of both forms.

Step 4

The hospital treats the patient while maintaining the money the TPA authorised as credit in the patient's account. The policy may demand for the member to pay a deposit payment to cover the non-treatment costs and any co-pays.

Step 5

The hospital compares the credit amount in the patient's account that was approved by the TPA to the actual treatment costs that were paid for by insurance when the patient is ready to be discharged.

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In the event that the credit is less, the hospital asks for further credit permission for the cashless procedure. The increased amount is approved after analysis by TPA.

Step 6

The patient pays the inadmissible charges and is released. He will be required to sign both the bill and the claim form to finish the required documents.

Step 7

The hospital compiles all the documents and provides the following to the TPA for the bill's processing:

- i. Claim form
- ii. Discharge summary / admission notes
- iii. Patient / proposer identification card issued by the TPA and photo ID proof.
- iv. Final consolidated bill
- v. Detailed bill
- vi. Investigation reports
- vii. Prescription and pharmacy bills
- viii. Approval letters sent by the TPA

Step 8

After checking certain information, such as the following, TPA will process the claim and suggest payment to the hospital.

- i. The patient who is being treated is the same one for whom permission was granted.
- ii. Handled the patient's condition for which it had asked for approval.
- iii. The bill does not include any costs associated with the treatment of an excluded illness.
- iv. All restrictions that were made known to the hospital have been followed.

Calculate the net payment amount after ensuring that the tariff rates agreed upon with the hospital have been followed.

The customer must also understand how to utilise the facility to its maximum benefit. The things to remember are:

- i. The customer must make sure that he or she has their insurance information on hand. His TPA card, policy copy, terms and conditions of coverage, etc. are included in this.

If this is not available, he can get more information by getting in touch with the TPA (through a 24-hour helpline).

- ii. The customer must confirm that the hospital recommended by his or her consulting physician is included in the TPA's network. If not, he should ask the TPA about choices where a cashless service for such treatment is offered.
- iii. He or she must ensure that the pre-authorization paperwork is filled out correctly. According to the 2013 Guidelines on Standardisation in Health Insurance, this form has been standardised by IRDAI. The TPA may refuse the cashless facility or raise a question if the matter is not obvious.
- iv. He or she must make sure that hospital fees adhere to restrictions like room rent or caps on particular treatments like cataract surgery.

It is preferable to know in advance what would be his or her share of expenses in the event that he or she wants to spend more than what is permitted by the policy.

- v. Prior to discharge, the patient must notify the TPA and ask the hospital to send the TPA any additional approvals that may be necessary. By doing this, the patient won't have to wait around the hospital unnecessarily.

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.



INTEXT QUESTIONS 12.2

1. Reimbursement claim facility can be availed in
 - a) Non Network hospital
 - b) Any Hospital



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- c) Network Hospital
 - d) None of the above
2. An insurance company settles claim through its own claim processing department (in house) or ties up with a _____ which undertakes to do this on behalf of the insurance company.
- a) IRDAI
 - b) Network Hospital
 - c) Ombudsman
 - d) Third Party Administrator (TPA)
3. A hospital which has an agreement with a TPA/Insurer for providing cashless treatment, is referred to as a _____
- a) IRDAI
 - b) Network Hospital
 - c) Ombudsman
 - d) Third Party Administrator (TPA)
4. _____ are those which do not have tie up with the tpa and any policy holder seeking treatment in these hospitals would have to pay for the treatment and later claim as per the reimbursement procedure.
- a) Non Network hospitals
 - b) Cashless hospitals
 - c) Network Hospital
 - d) Main hospitals
5. Choose the correct statement:
- a) Cashless facility is not provided at the network hospitals
 - b) Cashless facility is provided in all hospitals
 - c) Cashless facility is provided only at the network hospitals
 - d) None of the above



WHAT YOU HAVE LEARNT

There are different factors which helps in deciding the final claim payable. One needs to check the availability of sum insured under health insurance policy along with how much Sum insured is left under the policy in case or previous claims. Other important factors which will determine the amount on final claims are sub limits, illness based specific limits, cumulative bonus, expenses covered with limitation, co payment under health insurance policy.

Health insurance policy covers expenses related with the curing of illness. IRDAI have prescribed the standardized list which has about 199 items that are generally excluded from a health insurance policy. Items of consumables, non-medical items including toiletries, cosmetics, personal comfort or convenience items. telephone, laundry or internet costs are generally not payable. After the finalization of claim amount payable, it is directly send to the network hospital in cashless claim settlement and in reimbursement cases send to policy holder.

These are some important documents which are required at the time of claim settlement like patient discharge summary, supporting diagnostic reports, and break up of final consolidated bill, prescriptions and medicine bills, receipts of payment, claim form and customer authentication. Additional information may be required at the time of claim processing.

There are certain reasons which may lead to denial of a claim. There are some examples which can help you in triggering health insurance frauds and may include the cases of Impersonation, Fabricated documents, inflated medical expenses, Outpatient treatment (OPD) converted to in-patient / hospitalization (IPD), Different treatment given to patient among many others.

There is an agreement between the TPA, Insurer and Hospitals where TPA assists and insured for availing a cashless facility during hospitalization.s



TERMINAL QUESTIONS

1. Explain how the health insurance claim amount is calculated? What are the factors that may affect the final amount of claim payable?
2. Write a note on Non-payable items in a health claim.
3. Why some of the claims are denied during the health insurance claim settlement? Give examples to support your answer.



Notes



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4. Write a note on triggers that can help you in identifying health insurance frauds?
5. Explain the cashless settlement process by a TPA using examples.



ANSWERS TO INTEXT QUESTIONS

12.1

1. (a) Impersonation
2. (a) Fraud Rings
3. (c) Both a) and b)
4. (d) All of the above
5. (a) Insurance Company
6. (d) All of the above
7. (a) Reducing fraudulent claims

12.2

1. (a) Non Network hospital
2. (d) Third Party Administrator (TPA)
3. (b) Network Hospital
4. (a) Non Network hospitals
5. (c) Cashless facility is provided only at the network hospitals



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To explain different terms used in health insurance claim settlement process to the client and the cashless claim procedure to the client during hospitalization.

**13**

CLAIM DOCUMENTATION AND ROLE OF TPA IN HEALTH INSURANCE

13.0 INTRODUCTION

You have already studied that many documents are required in Insurance at the time of taking an insurance policy or during claims. These documents help different parties in getting necessary information about the subject matter of insurance and other related aspects. In case of health insurance claims, some specific documents are required which are different from the documents required in case of life insurance or other categories of insurance. The purposes of these documents are to assess whether the claim is genuine and payable; and if payable, how much amount is to be paid. This chapter will help you understand about these documents and also aims to explain the role of Third Party Administrators (TPAs) in the claim management.



13.1 OBJECTIVES

After reading this lesson, you will be able to:

- Explain the documentation required at the time of Health Insurance Claims
- Describe the concept of Claims reserving
- Explain the Role of Third Party Administrators

13.2 DOCUMENTATION OF HEALTH INSURANCE CLAIMS

Different types of documents are required for processing of health insurance claims. Every document is required with an aim to answer two main questions - regarding the admissibility (Is the claim payable?) and regarding the amount of claim (how much amount is to be paid?).



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Some of the major documents which are required to be submitted by the customers at the time of health insurance claims are explained below:

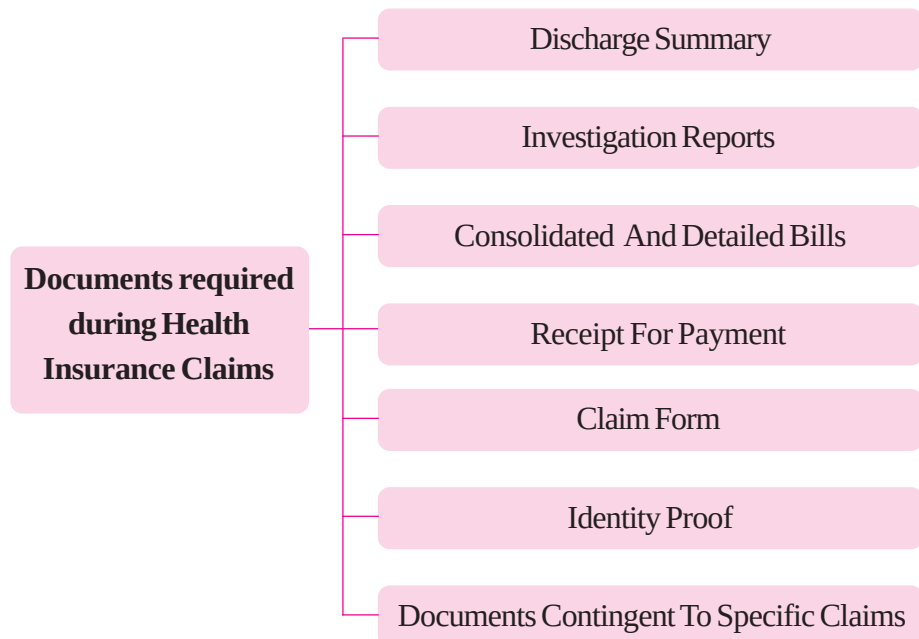


Figure 13.1: Documents required during Health Insurance Claims

13.2.1 Discharge Summary

Discharge summary as the name suggests is a clinical report prepared by health professionals at the conclusion of a hospital stay or series of treatments. It is required for processing health insurance claims and is assumed to be very important document. It contains the information regarding line of treatment and condition of the insured patient at the time of taking a discharge from the hospital. As per IRDAI Standardization Guidelines, the contents of a standard Discharge Summary are as follows:

1. Patient's Name- The patient's name shall be the official name as appearing in the insurance policy document
2. Telephone No. / Mobile No. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.
3. IPD (In Patients Department) No.
4. Admission No.
5. Treating Consultant/s Name, contact numbers and Department / Specialty
6. Patient's admission date with time
7. Date of Discharge with Time



8. Medico legal case (MLC) Number / First Information Report (FIR) Number- Where applicable, copy of MLC/FIR needs to be attached
9. Provisional Diagnosis of disease/illness at the time of Admission
10. Final Diagnosis of insured patient at the time of Discharge
11. ICD-10 code(s) or any other codes, as recommended by the IRDAI, for Final diagnosis
12. Presenting Complaints with Duration and Reason for Admission
13. Summary of Presenting Illness
14. Key findings on physical examination at the time of admission
15. History of alcoholism, tobacco or substance abuse, if any
16. Significant Past Medical and Surgical History, if any
17. Family History if significant/relevant to diagnosis or treatment
18. Summary of key investigations during Hospitalization
19. Course in the Hospital including complications if any
20. Advice on Discharge
21. Name & Signature of treating Consultant/ Authorized Team Doctor
22. Name & Signature of Patient / Attendant

A well written discharge summary plays a vital role in fast claim settlement process as it helps the claim team to ascertain the disease/injury and line of treatment. If the insured patient dies in the hospital then discharge summary is termed as death summary in majority of hospitals. The discharge summary document is always required in original.

13.2.2 Investigation Reports

Investigation reports helps the doctor in ascertaining final diagnosis and accordingly line of treatment is decided to cure the insured patient. This also helps in monitoring the progress of the patient. The medical examination should be conducted on the advice of registered medical practitioner only and these medical examination conducted should be related to the diagnosis.



Notes

Investigation reports usually consist of:

- a) Blood test reports
- b) X-ray reports;
- c) Scan reports and
- d) Biopsy reports

The insurer may return the original films like X ray, CT scan and Ultrasound films to insured on specific request. Generally all medical or investigation reports need to be submitted to insurer in original.

13.2.3 Consolidated and Detailed Bills

The insurance company / TPA pays the claim amount based on consolidated and detailed bills. While the consolidated bill offers the big picture, the detailed version breaks it down with reference codes. Non-payable expenses are scrutinised using the detailed bill, where non-admissible expenses are rounded off and deducted under the expense head to which they correspond. There were a lot of problems because different companies use to have their own billing format which sometimes delays the claim settlement. But now, IRDAI have prescribed the standardized format for the bill as per the IRDAI Standardization Guidelines. According to these guidelines:

1. The Provider shall submit original invoices directly to insurer or its representative TPA and such invoices shall contain, at the minimum, following information:
 - a) the insured's full name and date of birth;
 - b) the policy number;
 - c) the insured's address;
 - d) the admitting consultant;
 - e) the date of admission and discharge;
 - f) the procedure performed and procedure code according to ICD-10 PCS or any other code as specified by the IRDAI from time to time;
 - g) the diagnosis at the time treatment and diagnosis code according to ICD-10 or any other code as specified by the IRDAI from time to time;
 - h) whether this is an interim or final bill/account;
 - i) the description of each Service performed, together with associated Charges,

- j) the agreed standard billing codes associated with each Service performed and dates on which items of Service were provide; and.
- k) the insured's signature (in original).

13.2.4 Receipt for Payment

The formal receipt of amount paid by the insured to the hospital is also required under reimbursement of health insurance claim as it is a contract of indemnity. Many health care providers or hospitals provide discount or concession on payable amount. In these types of cases, insurance companies pay only the amount actually paid on behalf of insured patient. The payment receipt should be submitted in original, numbered and/or stamped.

13.2.5 Claim Form

Claim form is the formal official document that is used for processing the claim. The claim form is submitted in original by the insured and is signed by the insured/ customer.

The claim form has now been standardized by IRDAI and broadly consists of:

- a) Details of the patient, person who is primary insured and the policy number under which the claim is made.
- b) Details of the insurance history
- c) Details of the hospitalization such as hospital, room category, date and time of admission and discharge, system of medicine, etc.
- d) Whether reported to police in case of accident
- e) Details of the claim for which the hospitalization was done including breakdown of the costs, pre and post-hospitalization period, details of lump-sum/cash benefit claimed, etc.
- f) Details of bills enclosed
- g) Details of bank account of primary insured for remittance of sanctioned claim
- h) Declaration from the insured.

The policy holder's declaration on claim form is very important legal document. In claim process, principle of utmost good faith is applied through declaration forms and any breach of which attracts the misrepresentation clause under the policy.



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13.2.6 Identity Proof

The insured have to submit the valid identity proof document at the time of claims. The main purpose of identity proof is to prevent impersonation (pretending to be another person for the purpose of fraud). It is to ascertain whether the insured person and the person taking treatment are same.

Generally identity proof document which is sought could be:

- a) Voters identity card,
- b) Driving license,
- c) PAN card,
- d) Aadhaar card
- e) Passport etc.

The insistence on identity confirmation has led in a large drop in impersonation cases in cashless claims because the identity proof is sought before hospitalisation, making it the hospital's responsibility to verify and deliver the same to the insurer or TPA. In reimbursement claims, the identity proof serves a lesser purpose.

13.2.7 Documents Contingent to Specific Claims

Some additional documents are required in certain types of health insurance claims. These are:

- a) In the event of an accident, a FIR or a Medico-legal certificate given by the hospital to the registered police station may be necessary. In the instance of a traffic accident, it describes the reason of the accident as well as whether or not the person was under the influence of alcohol.
- b) Indoor papers in the case of complex or high-value claims. Indoor case paper or case sheet is a document kept at the hospital end that details all treatments offered to patients on a daily basis for the course of their hospitalisation.
- c) Dialysis / Chemotherapy / Physiotherapy charts, as required.
- d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked.

For processing of health insurance claims, claims department uses certain internal formats for documents. These are:

- i. Document verification checklists,
- ii. Scrutiny/ settlement sheet,
- iii. Quality checks / control format.

These formats are not uniform across the insurers, Let us examine the purpose of the documents with a sample of their usual contents.

1. Document verification sheet	Document verification sheet is a simple document containing the checklist of the documents received from the customer. Some insurers may provide a copy of this as an acknowledgement to the customer.
2. Scrutiny/process sheet	It is usually a single sheet where the entire processing notes are captured. a) Name of the customer and id number b) Claim number, date of receipt of the claim papers c) Policy overview, Section 64VB compliance d) Sum insured and utilization of sum insured e) Date of hospitalization and discharge f) Diagnosis and treatment g) Claim admissibility / processing comments with reason thereof h) Computation of claim amount i) Movement of the claim with dates and names of people who processed the claim.
3. Quality checks / control format	Final check or quality control format is used for checking of claim by a person other than claim handler. Besides check list and claim scrutiny questionnaire, the quality control/audit format shall also include information relating to: a) Settlement of claim, b) Rejection of claim or c) Requesting for additional information.



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13.3 CLAIMS RESERVING

This refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims. While this looks very simple, the process of reserving requires enormous care - any mistake in reserving affects the insurer's profits and solvency margin calculation.

Processing systems today have built in capability to compute the reserves as at any point of time.



INTEXT QUESTIONS 13.1

1. The documents collected during the health insurance claims helps in _____
 - a) Assessing the admissibility (Is the claim payable?)
 - b) Assessing the extent of claim (how much amount is to be paid?)
 - c) Both of the above
 - d) None of the above
2. _____ details the complete information about the condition of the patient and the line of treatment.
 - a) Discharge summary
 - b) Investigation reports
 - c) Claim Form
 - d) Consolidated Bills
3. Which of the following is not the example of Investigation reports?
 - a) Blood test reports;
 - b) X-ray reports;
 - c) Scan reports
 - d) None of the above



4. _____ is the formal and legal request for processing the claim and is submitted in original signed by the customer.
- a) Discharge summary
 - b) Investigation reports
 - c) Claim Form
 - d) Consolidated Bills
5. Which of the following document is maintained at the hospital detailing all treatment done to an in-patient?
- a) Investigation report
 - b) Settlement sheet
 - c) Case paper
 - d) Hospital registration certificate
6. The amount of provision made for all claims in the books of the insurer based on the status of the claims is known as _____.
- a) Pooling
 - b) Provisioning
 - c) Reserving
 - d) Investing

13.4 ROLE OF THIRD PARTY ADMINISTRATORS (TPAS)

13.4.1 Introduction of TPAs in INDIA

In 2000, the insurance sector was opened for private players. With this, lot of health insurance products were launched and demand for health care products also increased substantially. There was a need for an insurance intermediary for post-sale services who can service the health insurance policy holders which give rise to formation of Third Party Administrators (TPAs).

Seeing this, the Insurance Regulatory and Development Authority of India allowed TPAs to be introduced into the market under license from IRDAI, provided they complied with The IRDAI (Third Party Administrators - Health

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Insurance) Regulations, 2001 notified on 17th Sept 2001. After this, new regulations regarding TPA came into existence known as Insurance Regulatory and Development Authority of India (Third Party Administrators - Health Services) Regulations, 2016. Recently there were amendments in previous TPA regulations in 2019. Subsequently Insurance Regulatory and Development Authority of India (Third Party Administrators - Health Services) (Amendment) Regulations, 2019 were implemented.

Definitions:

"Third Party Administrator (TPA)" means a company registered with the IRDAI, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under these regulations."

"Health Services by TPA," 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 health insurance policies. TPA can also extend this service for life insurance policies.
- d) health services matters of foreign travel policies and health policies issued by Indian insurers covering medical treatment or hospitalization outside India.
- e) servicing of health services matters of travel or health or medical insurance policies issued by foreign insurers for policyholders who are travelling to India.
- f) TPAs may also render such other health Services to be offered under healthcare schemes promoted, sponsored or approved by Central or State Government as may be specified by the Authority from time to time.
- g) any other services as may be mentioned by the IRDAI".

The TPA services start after the sale and once the policy is issued. Some insurance companies do not take the services of TPA. In that case, they perform the services by the in-house team.

13.4.2 Post Sale Service of TPAs in Health Insurance

- a) The health insurance commences once the proposal and premium is accepted.
- b) The health insurance company passes the policy and insured details to the TPA chosen for servicing health insurance policy holders.
- c) TPA after enrolling the insured members, issue a TPA card or member identification card to policy holder in a physical or electronic form.
- d) The allotted TPA helps the policy holders to avail the cashless and reimbursement facility as well as process the claim. They also provide support to insured members regarding hospitalization and documentation.
- e) The TPA within the turnaround time (TAT) processes the claim and provides the service to the policy holder.

**Notes****13.4.3 Objectives of Third Party Administration**

The concept of Third Party Administration in health insurance was developed with the following objectives:

- a) To assist a health insurance customer in whatever way feasible during a time of need.
- b) Arrange for cashless care at network hospitals for insured patients.
- c) To offer clients with fair and timely claim settlements based on the claim papers submitted and in accordance with the insurance company's procedures and requirements.
- d) Develop functional competence in the processing of health insurance claims and related services.
- e) Responding to customers in a timely and appropriate manner.
- f) To create an environment in which an insured individual can obtain quality healthcare at a reasonable cost; and
- g) To assist in the generation/collection of important data pertaining to morbidity, costs, procedures, length of stay, and so on.



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13.4.4 Relationship between Insurer and TPA

Generally health insurance companies avail the services of TPA for post-sale services of health insurance policies. But life insurance companies also avail the services of TPA for arranging pre policy medical check-up. This helps the medical underwriter to assess the risk of proposer.

There is a contractual relationship between TPA and Insurer where process and arrangement are built into the contract. IRDAI Health Insurance Standardization guidelines, now lays down the guidelines and provide a set of suggested standard clauses for contract between TPA and insurance company.

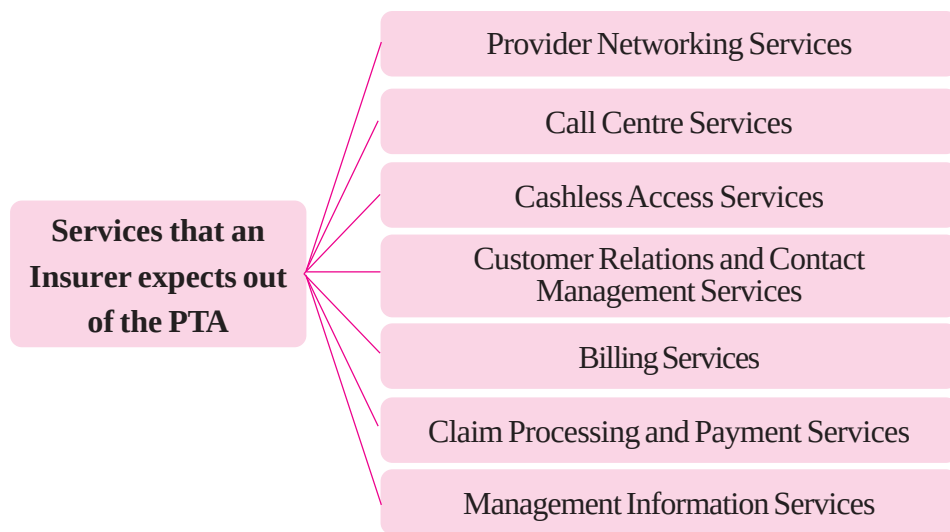


Figure 13.2: Services of TPA

The services that an insurer expects out of the TPA are as follows:

A. Provider Networking Services

"**Network Provider** means hospital enlisted by an insurer, a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility."

TPA is expected to build the relationship with network of hospitals by signing MOU with them for providing cashless claim for insured patients. The recent guidelines by IRDAI require the relationship to be tri-partite including the insurer and not just between the TPA and the provider.

TPA also negotiate on scheduled rates for various hospitalization procedures and can enter into package system for medical procedures with network hospitals which reduce the cost for insured and insurance companies. They can enter into the contact with network hospital as preferred provider network (PPN).



B. Call Centre Services

The TPA is often expected to operate a call centre with toll-free lines that is accessible 24 hours a day, seven days a week.

The TPA's call centre will provide information on:

- a) the coverage and benefits provided under the policy.
- b) Health-care-related processes and procedures.
- c) Assistance with services and cashless hospitalisation.
- d) Data on network hospitals.
- e) Information on the policy's available balance sum insured.
- f) Claim status information.
- g) Assistance with missing documents in the event of a claim.

The call centre should be accessible via a national toll-free number, and customer care representatives should be fluent in the major languages commonly spoken by customers. The contract between the insurers and their TPAs governs these specifics.

C. Access to Cashless Services

"Cashless facility" refers to a facility provided by the insurer to the insured in which payments for treatment costs incurred by the insured in line with the policy terms and conditions are made directly to the network provider by the insurer, according to the amount of pre-authorization allowed.

The contract requires the insurer to meet the following standards in order to provide this service:

- a) All policy-related information must be provided to the TPA. It is the insurer's responsibility to deliver this to the TPA.
- b) Data of policy members should be available and accessible, with no errors or deficiencies.
- c) Insured individuals must carry an Identity Card that identifies them with the policy and the TPA. The TPA must provide this Identity Card in an agreed-upon format, it must reach the member within a reasonable time frame, and it must be valid during the policy duration.



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- d) Based on the information supplied for seeking the cashless facility, the TPA must issue a pre-authorization or a Letter of Guarantee to the hospital. It could request additional information to better understand the nature of the condition, proposed treatments, and associated costs.
- e) If the information is unclear or unavailable, the TPA may reject the cashless request, emphasising that rejection of the cashless option does not imply refusal of treatment. The member may also pay and file a claim later, which will be evaluated on its own merits.
- f) In emergency instances, notification should be sent within 24 hours of admission, and the cashless decision should be communicated.

D. Customer Relationship and Contact Management Services

The TPA must provide a way for clients to express their complaints. It is common for health insurance claims to be scrutinised and verified. It should also be highlighted that a small number of health insurance claims are denied because they fall beyond the scope of the policy terms and conditions.

Furthermore, practically all health insurance claims are subject to a reduction of some amount. These deductions irritate customers, especially when the reason for the deduction or denial is not properly explained to them.

The insurer needs the TPA to have an efficient grievance management system in place to ensure that such grievances are resolved as fast as feasible.

E. Billing Services

Under the billing services, the insurer or an insurance company expects the TPA to provide three major services:

- a) A standardized billing pattern from the TPA which can help the insurer in analysing the use of coverage under various heads. The same would help in decide the pricing under different heads.
- b) Confirmation from the TPA regarding the authenticity of the claim amount mentioning that the amount charged in the bills are as per the actual treatment required for curing the illness.
- c) In order to standardized the data across all TPAs according to different National and International Standards, diagnosis and procedure codes are to be carefully captured.

Trained and skilled manpower in the TPA is required for properly coding the procedures and diagnosis, verifying the traffic applicable and standardizing the structure of the bills.

F. Claim Processing and Payment Services

Claim Processing and Payment Services is the most critical service offered by the TPAs. It includes services which starts from the registration and includes services like intimation, processing, recommendation, seeking approvals and making payments for the settlement of claims. The insurer has to pay the claim amount to the TPA in the form of advance money after taking necessary approvals or may be settled directly by the insurer through its bank to the customer or to the hospital. In case of cashless treatment, the payment is directly made to the TPA or the hospital.

The TPA is expected to record the details of payments by the insurer and should periodically reconcile the same with the insurers. The money received from the insurer can only be used for making payments of the approved claims and not for any other purpose.

G. Management Information Services

A single TPA can be empanelled with many hospitals and may provide services to the insurers for large number of claims in a particular state, region or country. Series of payments may be involved in the settlement of a single claim. Thus, it is expected from a TPA to maintain these records in a system so that it can be provided to the insurance company as and when required. A strong Management Information system for capturing data and its management is required at the end of a TPA. This will help in providing information to both TPA as well as the insurance company.

Thus, the scope of a TPA services can include end-to-end service of the health insurance policies issued by the insurers or it could be restricted to few activities, depending on the requirements and MOU with the particular insurance company.

13.4.5 TPA Remuneration

The insurer pays the TPA a fee for the services it provides. The fee is based on one of the following:

- a) A percentage of the customer's premium (not including service tax), b) A set amount for each member the TPA takes care of for a certain amount of time, or
- c)



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CLAIM DOCUMENTATION AND ROLE OF TPA IN HEALTH INSURANCE

- b) A fixed amount for each time the TPA performs a service, such as when a member card is given or when a claim is made.

So, TPA gives insurance companies access to:

- i. Cashless services
- ii. Putting together and analysing data
- iii. A call line and help for customers that are open 24 hours a day.
- iv. A network of hospitals and other medical facilities.
- v. Help for the largest group of customers.
- vi. Making it easy for the customer to file a claim.
- vii. Talking with doctors about fees and prices for procedures.
- viii. Services made easier by technology to help with customer service
- ix. Verification and investigation of suspicious cases
- x. Analysis of claim patterns across companies and important information on prices, new methods of treatment, emerging trends, and stopping frauds
- xi. Services that reach more people quickly



INTEXT QUESTIONS 13.2

1. Third Party Administrators (TPAs) is a channel which provides services majorly at the time of
 - a) Before the Sale
 - b) At the time of Sale
 - c) After the sale
 - d) All of the above
2. Which of the following are the objectives of the Third Party Administrators (TPAs)?
 - a) To organise cashless treatment for the insured patient at network hospitals.
 - b) To provide fair and fast settlement of claims to the customers based on the claim documents submitted and as per procedure and guidelines of the insurance company.
 - c) To help generate/collate relevant data pertaining to morbidity, costs, procedures, length of stay etc.

- d) All of the above
3. The call centre of the TPA will not provide information relating to:
- Coverage and benefits available under the policy
 - Processes and procedures related to health claims
 - Guidance related to the line of treatment during hospitalization
 - Guidance relating to the services and cashless hospitalization



WHAT YOU HAVE LEARNT

Health insurance claims require a range of documents for processing. Each document is expected to assist in answering the two key questions - admissibility (Is the claim payable?) and extent of claim (how much amount is to be paid?).

Discharge summary is the most important document that is required to process a health insurance claim which details the complete information about the condition of the patient and the line of treatment. Investigation reports help in providing the necessary information to understand the exact condition that prompted the treatment and the progress made during the hospitalization. Consolidated and detailed bills help in deciding what needs to be paid under the insurance policy. Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer. There are certain types of claims that require additional documents in some specific claims.

The claims team uses certain internal document formats for processing a claim like i. Checklists for document verification, ii. Scrutiny/ settlement sheet, iii. Quality checks / control format. Claim reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

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. Many insurers utilize the services of the TPA for post-sale service of health insurance policies while few insurers, especially from the life insurance sector also seek assistance of a TPA for arranging pre-policy medical check-up service.

There are Services that an Insurer expects out of the TPA like Provider networking services; Call Centre Services; Cashless Access Services; Customer Relations and Contact Management Services; Billing Services; Claim Processing and Payment Services; and Management Information Services.



Notes



Notes



TERMINAL QUESTIONS

1. List the documents required at the time of Health Insurance Claims. Explain the need and importance of collecting these documents.
2. Explain why a discharge summary is termed as the most important document that is required to process a health insurance claim. What are the contents of a standard Discharge Summary?
3. What are the contents of the Claim form?
4. What do you understand by 'Claims Reserving'? Explain its purpose.
5. Write a detailed note on the 'Role of Third Party Administrators (TPAs)'.
6. What are the objectives of the Third Party Administration?
7. What are those Services that an Insurer expects out of the TPA?



ANSWERS TO INTEXT QUESTIONS

13.1

1. (c) Both of the above
2. (a) Discharge summary
3. (d) None of the above
4. (c) Claim Form
5. (c) Case paper
6. (c) Reserving

13.2

1. (c) After the sale
2. (d) All of the above
3. (c) Guidance related to the line of treatment during hospitalization



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To assist the client in completing the documentation at the time of Health Insurance Claims and examine the role of Third Party Administrators in Health Insurance.



Notes

14

CLAIMS MANAGEMENT IN PERSONAL ACCIDENT AND OVERSEAS TRAVEL INSURANCE

14.0 INTRODUCTION

Imagine you are having a vacation in some foreign country and suddenly you fall ill or are met with an accident. You are neither familiar with the area nor much familiar with the language. What will you do next? To whom you will contact? Who will pay for your medical expenses? All these may be the concern of most of the travellers travelling abroad. Overseas Travel Insurance can help you reducing your tension as it covers variety of risks and provides you the assistance required with the help of the service providers known as Assistance company. Similarly, there are risks involved in your life when you met with an accident. Personal Accident Insurance covers accidental death or disablement of the policyholder. You will first learn about Personal Accident Insurance in this chapter and then the Overseas travel insurance will be explained. You will also learn about the claims management process in case of Personal Accident and Overseas Travel Insurance.



14.1 OBJECTIVES

After reading this lesson, you will be able to:

- Describe the Claims management process in case of Personal Accident and Overseas Travel Insurance
- Explain the role of Assistance company in Overseas Travel Insurance



Notes

14.2 CLAIMS MANAGEMENT - PERSONAL ACCIDENT

14.2.1 Meaning of Personal Accident Policy

Personal Accident (PA) Insurance is an insurance policy which covers accidental death or disablement of the policy holder, arising out of unforeseen accident. Your Personal Accident Policy may have add-on coverage which might cover the medical expenses related to an accident, funeral expenses in case of a death of an insured, or some educational expenses, etc. In case of a death or disablement arising out of an accident, fixed compensation is paid to the legal heirs or the insured.

The peril covered under the Personal Accident policy is "Accident". Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means".

Types of disability covered- The different types of disability covered under the PA policy are as follows:

- i. Permanent total disability (PTD)
- ii. Permanent partial disability (PPD)
- iii. Temporary total disability (TTD)

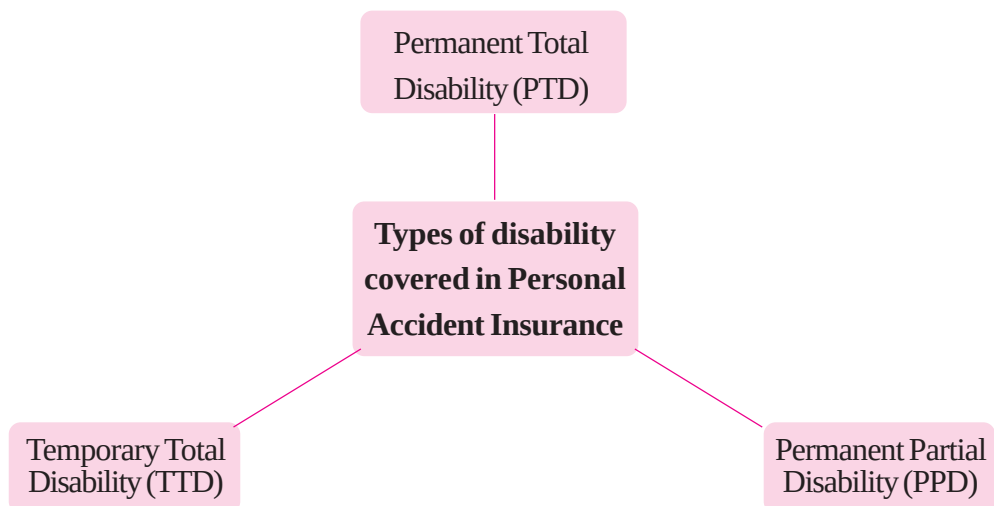


Figure 14.1: Disabilities covered in Personal Accident Insurance

14.2.2 Claim Procedure in Personal Accident Insurance

In case of any accident or injury, the you have to give a notice to the call centre of the insurer immediately. The insured shall also intimate in writing about the accident to the policy issuing office. In case of death, nominee or the family members shall inform the



insurance company on immediate basis. In case of Death, written notice of Death also must be given immediately before internment/ cremation and in any case, within 30 days after the death. In the event of loss of sight or amputation of limbs, written notice must also be given immediately within 30 days of such loss of sight or amputation. All certificates, evidences and necessary information required by the company should be provided by the insured or the family members in case of the death of the insured.

Claims manager should be cautious while checking some areas on receiving the intimation about the claim:

- a) Details of the patient whether covered under the policy.
- b) Validity of the insurance policy and whether premium is received
- c) Loss under the claim is covered under the policy period
- d) Loss occurred due to "accident" and not because of illness.
- e) Check for the possibility of fraud and, if necessary, hire an investigator.
- f) Register the claim and create a reserve for it.
- g) Maintain the turnaround time and Keep informing the customer about the developments

14.2.3 Claims Investigation

Once the claim is intimated to the insurance company by the insured or the nominee of insured, the insurance company can assign an investigator to check the details of the case. In the case of the death of the insured, post mortem report is required. Any authorised representative of the insurance company is allowed to examine the insured by visiting the hospital in the case of any injury or disablement.

If any trigger to fraud or red alerts comes during claim settlement process, then the professional investigator may be assigned to the case for conducting detailed verification. There are certain cases which may trigger fraud or gives a red alert to the investigation team in case of personal accident policy. The purpose of appointing investigator is to stop the frauds. Some of the events which may trigger fraud are:

- ◆ Claim coming after a short time of buying an insurance policy (Close proximity claims)
- ◆ longer period of disability where the weekly benefit amount is high
- ◆ Discrepancy in claim documentation

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Notes

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- ❖ Repetitive claims by the same insured
- ❖ Multiple claims through same insurance agents
- ❖ Maximum claims coming from same geographical location or place or hospital
- ❖ Indication of alcohol
- ❖ Suspected suicide
- ❖ Late night Road Traffic Accident while vehicle was being driven by insured
- ❖ Snake bite
- ❖ Drowning
- ❖ Fall from height
- ❖ Suspected sickness related cases
- ❖ Poisoning
- ❖ Murder
- ❖ Bullet injury
- ❖ Frost bite disappearance
- ❖ Homicide "an act of one human killing another. A homicide requires only a volitional act by another person that results in death, and thus a homicide may result from accidental, reckless, or negligent acts even if there is no intent to cause harm. etc."

The main objectives of the investigation are to verify the real facts about the case in order:

- a) To know the exact cause of loss (peril).
- b) To find out how much and what kind of damage was done.
- c) To gather information and proof.
- d) To find out if there are signs of fraud or if the claim amount has been inflated.

In case of any fraudulent claims or if any fraudulent means are used by the Insured or by any other person on behalf of the Insured for obtaining benefits under the Policy, all benefits shall be forfeited and the policy shall be treated as void. The insurance company will not be liable for making any payment for the claims.

Important information to be recorded in case of Road Traffic Accident:

**Road traffic accident**

- i. Exact time, date and location of the accident
- ii. Whether the insured was driving a vehicle or was a pillion rider of the vehicle involved in the accident or a pedestrian
- iii. Brief description of the accident
- iv. Was the policy holder under the influence of alcohol at the time of accident?
- v. In case of death, what was the exact time and date of death, treatment provided before death, at which hospital, etc.?

The possible reason for the accident

There may be different reasons which may result in an accident:

- The accident may happen due to the Mechanical failure (steering, brake failure etc.) of the insured's or opponent vehicle
- It may be due to any medical problem like heart attack, seizure etc. which a driver of the vehicle may have
- It may be due to the influence of alcohol, or because of any other factors like bad road condition, weather condition, speed of the vehicle, etc.

Some examples of possible fraud and leakage in personal accident claims

- i. Temporary Total Disability (TTD) being extended for a longer period
- ii. Illness can be passed off as an accident. For example, a backache caused by a disease could be turned into a PA claim after a "fall/slip" at home.
- iii. Accidents that happened before are said to be new by making up papers. A natural death is presented as an accident or a pre-existing illness that caused death after an accident.
- iv. Suicidal deaths posed as accidental deaths. The discharge voucher and the post-mortem report are both important pieces of proof that are used to settle personal accident claims, especially those that involve a death. It's also important to get information about the nominee at the time of the proposal, and that information should be included in the policy paper.

14.2.4 Claim Documentation



Death Claim	a) Duly filled up Claim Form b) Attested copy of FIR / Panchnama c) Original Death Certificate d) Original / attested Post Mortem / Coroners Report e) Attested copy of AML documents (Anti-money laundering)- for name verification (passport / PAN card / Voter's ID / Driving license/ Aadhar card) 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) Affidavit from the legal heirs of the deceased (in case nomination has not been filed by deceased)
Permanent Total Disability (PTD) and Permanent Partial Disability (PPD) Claim	a) Duly filled up claims form b) Original/ copy of First Information Report (FIR), if applicable c) Original Certificate from Doctor of Govt. Hospital stating the degree of disability d) Investigation reports and discharge summary document in case of hospitalization. e) Termination letter for claim under "Loss of Employment"
Temporary Total Disability (TTD) Claim	a) Duly filled up Personal Accident claim form signed by the claimant b) Original/ copy of First Information Report (FIR), if applicable. c) Medical certificate from treating doctor mentioning the type of disability and disability period. d) Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer.

The above list is just for a guideline. Depending on the facts of the case, especially if fraud is suspected, you may need to provide other papers, such as photos of scars or the accident site



INTEXT QUESTIONS 14.1

1. Which of the following is covered in a Personal Accident policy?
 - a) Accidental death
 - b) Permanent / Partial accidental disability
 - c) Temporary total disability
 - d) All of the above
2. If a red alert is generated regarding the fraud after the intimation of the claim, claim may be
 - a) Immediately denied
 - b) Assigned to a professional investigator for verification
 - c) Shall be reported to the police
 - d) None of the above
3. The main objective(s) of investigation is/are _____
 - a) To examine the cause of loss
 - b) To ascertain the extent and nature of loss
 - c) Collection of evidence and information
 - d) All of the above
4. Which of the following statement is true in case of any fraudulent claims?
 - a) Total amount of the claim will be paid
 - b) All benefit under this Policy shall be forfeited and the policy shall be treated as void
 - c) Some deductions will be made from the claim amount
 - d) Insured will be given a warning from the Insurer



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Module - 4

Health Insurance



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CLAIM DOCUMENTATION AND ROLE OF TPA IN HEALTH INSURANCE

5. Which of the following documents are not required to be submitted for Permanent Total Disability claim?
- a) Duly filled up claims form
 - b) Attested copy of FIR / Panchnama
 - c) Original Certificate from Doctor of Govt. Hospital stating the degree of disability
 - d) Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties

14.3 CLAIMS MANAGEMENT - OVERSEAS TRAVEL INSURANCE

14.3.1 Overseas Travel Insurance Policy

Travel insurance provides coverage for the expenses and damage associated with travelling in India and abroad. It covers financial loss due to many unforeseen events like theft, death, medical emergencies, loss of luggage, flight delay, etc. that one usually tends to overlook while planning the vacation or a trip.

Even though the Overseas Travel Insurance policy has many parts that cover many non-medical benefits, its underwriting and claims handling were part of the health insurance portfolio because medical and sickness benefit was among the major risks which was covered by these policies.

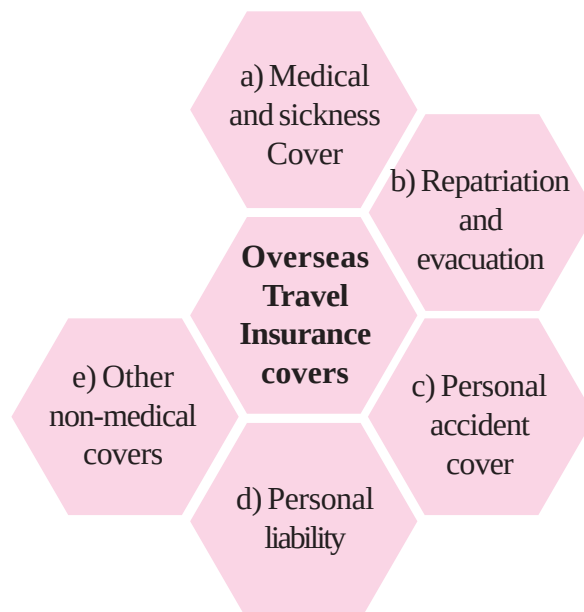


Figure 14.2: Coverage under Overseas Travel Insurance

The covers under the policy can be broadly divided into following sections. A specific product may cover all or few of the below mentioned benefits:

- a) Medical and sickness section
- 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

This policy is taken by persons who travel abroad for some purpose. The specified loss which occurs outside India is serviced by insurer as and when reported by insured. The claim services or assistance in this policy is provided by Third Party service provider (Assistance Company) who provides necessary support at the time of claim and have very good established network worldwide.

**Notes**



Notes

Claims services generally include

- a) Taking down the claim notification on a 24*7 basis;
- b) Sending the claim form and information about the claim procedure;
- c) Telling the customer what to do instantly after a loss;
- d) Offering cashless services for medical and sickness claims;
- e) Making arrangements for return and evacuation, emergency cash advances, etc.

14.3.2 Assistance Companies – Role in Overseas Claims

The insurance company from which you have bought the overseas travel insurance may not be present in the country where you are planning to visit. To provide assistance in those countries, insurance companies take the help of organisation or companies known as 'Assistance Company'.

Assistance companies have their own offices and work with other companies that do the same thing all over the world. These companies help insurance customers if something bad happens that is covered by their policy.

A reputable assistance company generally have worldwide, multilingual representatives who are available 24x7x365 to assist you in different situations which you may face during your travel.

Here are some of the services which an assistance company may offer during your travel as per the period of policy coverage:

- a) Medical assistance services:
 - i. Help you in locating the medical service provider / hospital
 - ii. Update your family, employer and home physician on your medical condition, if required
 - iii. Arrangement of hospital admission
 - iv. Arrangement of Emergency Medical Evacuation
 - v. Arrangement of Emergency Medical Repatriation
 - vi. Mortal remains repatriation
 - vii. Compassionate visit arrangements
 - viii. Minor children assistance/escort



- b) Checking on a patient's health during and after stay
- c) Delivery of essential medicines
- d) Guarantee of medical costs Charges made during a medical stay are subject to the policy's terms and conditions and the approval of the insurance company.
- e) Information services before a trip and other services:
 - i. Visas and inoculation regulations
 - ii. Embassy referral services
 - iii. Services to help with a lost passport or lost bags
 - iv. Services that send out emergency messages
 - v. Bail bond Arrangement
 - vi. Financial Emergency Assistance
- f) Interpreter Referral
- g) Legal Referral
- h) Appointment with a lawyer
- i) Transfer of funds, if your cash is lost or stolen

Documents Required to Process Claims

Different situations would need different sets of documents. Some of the essential documents which need to be submitted to the insurance company to process claims are:

- Original ticket or boarding pass
- Copy of the passport indicating travel dates
- Claim form
- Original bills, receipts and vouchers
- For medical claims - medical practitioner's consultation notes, original admission/discharge card, bills with prescriptions
- Emergency travel certificate and new passport copy (in case of loss of passport)
- Details of compensation provided by Airlines, if any (in case of loss of checked baggage)



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- Letter from policyholder citing the reason for the cancellation of trip
- Copy of cancelled cheque

Note: This is not an exhaustive list and insurance company might ask for additional documents.

14.4 CLAIMS MANAGEMENT FOR CASHLESS MEDICAL CASES

Claim settlement procedure for medical cashless, medical reimbursement and other non-medical cases are different. The cashless medical claim is different in USA as compared to other countries.

The steps involved in the process are as follows:

a) Claim notification

First step is to intimate the insurance company regarding hospital admission. The insured should present the details of the overseas travel insurance at the counter of the hospital. The representative of the hospital then may contact the Assistance Company for confirming the details of the policy and intimating them about the case. The insured must also intimate the Assistance company about the admission in the hospital. You can also call Service Provider Help Line Number for intimating the claim. The service provider will verify the identity of the caller and assist you further with the claim procedure.

b) Case management steps

Steps followed by the insurers may vary as per their tie-ups with assistance companies and as per the countries. Some of the common steps are as follows:

- The manager/representative of the Assistance Company verifies the details of your insurance policy including its benefits, coverage, sum insured, policy period, name of the policy holder, etc.
- The appointed person / representative of the assistance company then connects with the hospital to get an update on the patient's medical condition. They generally ask for medical reports, billing information and an estimate of treatment. This information regarding the clinical notes and estimate of cost of the medical treatment is shared with the Insurer.



Figure 14.3: Claims Management Process for Cashless Medical Cases

- iii. The assistance company then sends a payment letter guarantee to the healthcare provider/hospital after taking the approval from the insurance company.
- iv. In case of any query, a query letter may be sent to the insured and the healthcare provider asking for some more information. After receiving the information, payment letter guarantee is released after due diligence.
- v. In case any investigation is required, it is carried out in a similar process which is followed in personal accident claims. The investigator in the overseas location is selected generally with the help of the Assistance company or the insurance company
- vi. The appointed person from the Assistance Company provides you the necessary support and provide necessary information related with the treatment, cost of treatment, etc. with the Insurer for obtaining necessary approvals for the cost of treatment.
- vii. Once the patient is discharged, the assistance company settles the bills directly with the healthcare provider/hospital.
- viii. The Assistance Company checks and audits the bills in the right way. If a mistake is found, it is reported to the hospital's billing department so that it can be fixed.
- ix. The final bill is then re-priced according to the rates decided upon between the provider and Assistance Company or its associate reprising agent. The faster the hospital knows that they will get paid, the better discount they can get through repricing.



Notes



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Re-pricing is a common part of healthcare in the US, but it doesn't work for cases outside of the US. This is a big difference between US and non-US cashless medical cases.

c) Claims processing Steps:

- i. The Assistance company submits the bill with the Insurer. The claims department or the claim assessor receives and verifies the original bill and ensures that the coverage was as per the dates of service and charges are in line with the treatment provided to the insured. The discount is re-confirmed and the bill is processed.
- ii. The bill is then sent to the Insurer for making a payment to the Assistance company. These bills are accompanied by re-pricing notification sheet and Explanation of Benefits (EoB).
- iii. Insurance company pays the Assistance company once the bills are received.

d) Payment process steps

- i. Assistance Company pays directly to the medical service provider or a hospital on receiving the authorization from the Insurer
- ii. The finance department releases the payment

e) Hospitalization procedures

- i. In case of any medical emergency or hospitalization, you have to approach the medical service provider/hospital abroad and show your Travel Insurance policy to avail the cash less treatment.
- ii. You shall also intimate your assistance company with the help of a Help Line Number available on your policy document shared by the Insurer. The service provider will verify the identity of the caller and assist you further with the claim procedure.
- iii. Information regarding the network hospitals is provided by the services providers/assistance companies.
- iv. Most hospitals, especially in the US and Europe, accept Guarantee of Payments from all foreign insurance companies as long as the insured person has a valid health or overseas travel insurance policy.
- v. Hospitals normally call the insurance company or assistance company using the call centre numbers to make sure the policy is still valid and that it covers everything.



Notes

- vi. After verifying the details of the policy of the insured, the Assistance company then places the guarantee letter with the medical service provider/hospital as per the policy coverage.
- vii. Once the policy details are confirmed by the hospital, the insured would undergo treatment in the hospital on a cashless basis.
- viii. In most countries, treatment is not delayed on account of delay in receiving confirmation of insurance coverage or cash deposit. It gives very large savings. Most of the time, re-pricing agencies arrange with hospitals for discounts if hospital bills are paid early.
- ix. Some basic information that the insurer or help provider needs to know to decide if someone is eligible are:
 - 1. Details of the illness
 - 2. If the person has a medical 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, a copy of Passport and release of medical information form.
 - ◆ 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

f) **Reimbursement of medical expenses and other non-medical claims**

Reimbursement claims are normally filed by insured after they return to India, but it is always advisable for an insured to file a claim as soon as any incident occurs with the help of the helpline numbers details of which is mentioned in the policy document.

Reimbursement of all claims (except claims under Financial Emergency Assistance) will be made in the Indian Rupees once you return back to India at the exchange rate specified by the Reserve Bank of India. You should notify the Service Provider and obtain a Claim Form for completion. The claim form is generally available on the website of the service provider or may be mailed on



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specific requests through emails. The claim form shall be return to the Service Provider along with supporting invoices with any other documentation or information that might be required or requested by the Service Provider. Then the payment is made through cheque or electronic transfer.

- i. The process of Personal accident claims in overseas travel insurance is similar to the process you have studied in personal accident claims section.
- ii. Claims under Financial Emergency Assistance shall be settled directly to you, when you are in abroad by the Service Provider.
- iii. Claims repudiation of untenable claims follows the same process as for all other claims.

g) Claim documentation for Medical Accident and Sickness Expenses

- i. Claim form
- ii. Doctor's report/Medical Practitioner's Consultation notes
- 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
- vii. The original ticket/ boarding pass

The above list only indicates the majority of documents which are required during the claim. Insurance company may ask for additional information or documents, depending upon the requirements of the specific cases, which may vary according to the insurers.



INTEXT QUESTIONS 14.2

1. Travel insurance provides coverage for the expenses and damage associated with travelling in _____
 - a) Only India
 - b) Only abroad
 - c) Both India and Abroad
 - d) None of the above
2. Which of the following is not covered under overseas travel insurance policy?
 - a) Personal accident and Medical sickness during travel



- b) Delay and Loss of Checked Baggage
 - c) Trip Delay and cancellation
 - d) None of the above
3. Which of the following is covered under Overseas Travel Insurance?
- a) Personal liability
 - b) Loss of Checked Baggage
 - c) Hijack cover
 - d) All of the above
4. In case of overseas travel insurance, the services to insured are generally provided by a Third Party service provider known as_____
- a) Third Party Administrators (TPAs)
 - b) Assistance Company
 - c) Investigator
 - d) None of the above
5. A reputable assistance company would have worldwide, multilingual representatives available_____
- a) On the weekdays
 - b) On the working hours of all days in a week
 - c) 24 x7x365
 - d) None of the above
6. The assistance company sends a_____to the healthcare provider/hospital on the admission of the insured after taking the approval from the insurance company.
- a) Cash
 - b) Cheque
 - c) Payment letter guarantee
 - d) All of the above
7. Reimbursement of all claims (except claims under Financial Emergency Assistance) will be made by the Service Provider in_____.
- a) Indian Rupees
 - b) Foreign Currency
 - c) Indian rupee or foreign currency as per the wish of the insured



Notes

CLAIM DOCUMENTATION AND ROLE OF TPA IN HEALTH INSURANCE

- d) Indian rupee or foreign currency as per the wish of the insurer



WHAT YOU HAVE LEARNT

Personal Accident (PA) Insurance is an insurance policy which covers accidental death or disablement of the policy holder, arising out of unforeseen accident. There are different types of disability which are covered under the PA policy like Permanent Total Disability (PTD), Permanent Partial Disability (PPD) and Temporary Total Disability (TTD).

There is a claim procedure which one shall follow in case of making a claim under personal accident policy. Certain documents are to be submitted to the insurance company during the filing of claims. If the insurance company is not sure about the genuineness of the claim, it may appoint an investigator for having a detailed investigation.

In case of any fraudulent claims or if any fraudulent means are used by the Insured or by any other person on behalf of the Insured for obtaining benefits under the Policy, all benefits shall be forfeited and the policy shall be treated as void. The insurance company will not be liable for making any payment for the claims.

Overseas travel insurance is important for those who are planning for a travel abroad or in India as it covers many risks related to both medical and non-medical. The claim services or assistance in the overseas travel insurance policy is provided by Third Party service provider (Assistance Company) who provides necessary support at the time of claim and have very good established network worldwide. A reputable assistance company generally have worldwide, multilingual representatives who are available 24x7x365 to assist you in different situations which you may face during your travel.

The process of Cashless medical claims and reimbursement in case of overseas travel insurance is different. In both the cases, there are certain documents which must be submitted by the insured to the insurance company along with the claim form.



TERMINAL QUESTIONS

1. Write a detailed note on the documents required at the time of claim in Personal Accident Policy in case of:
 - a) Death Claim
 - b) Permanent Total Disability (PTD) and Permanent Partial Disability (PPD) Claim

- c) Temporary Total Disability (TTD) Claim
2. Write a detailed note on the coverage of Overseas travel insurance policy.
3. Explain the role of Assistance Companies in case of overseas claims.



ANSWERS TO INTEXT QUESTIONS

14.1

1. (d) All of the above
2. (b) Assigned to a professional investigator for verification
3. (d) All of the above
4. (b) All benefit under this Policy shall be forfeited and the policy shall be treated as void
5. (d) Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties

14.2

1. (c) Both India and Abroad
2. (d) None of the above
3. (d) All of the above
4. (b) Assistance Company
5. (c) 24 × 7 × 365
6. (c) Payment letter guarantee
7. (a) Indian Rupees



LEARNING OUTCOMES

After reading this chapter, students will be able:

- To demonstrate skills in assisting the client in selecting important covers while buying personal accident and overseas travel insurance policies



Notes



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