Commercial Health Insurance in India and the Role of IRDAI as a Supervisor

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Framework of Reference

For the second-most populous country in the world, health expenditure in India is among the lowest, at 3.53%[1] of Gross Domestic Product (GDP). Of this, the share of public expenditure is about 1.3%[2] of GDP, indicating that healthcare spending in India has a greater private orientation. This makes healthcare financing a very important social security measure, one that will not only allow access to healthcare but also create demand for healthcare. However, given that 'out-of-pocket' (OOP) expenses comprise about 62%[3] of total healthcare expenses in India, many households face the risk of slipping into poverty due to a major medical event.

High OOP points to the absence of a robust health-financing system. In the Indian context, the fragmentation of health-financing systems also leads to sub-optimal outcomes. Health financing through risk pooling—buying insurance—ensures risk is spread across the pool instead of concentrated with an individual, thereby mitigating financial shocks and making healthcare affordable. But under-penetration and fragmented risk pools lack scale. This, in turn, results in fragmented health service delivery.

As per a 2019 Niti Aayog report titled 'Health System for a New India'[4], such fragmented risk pools are usually fragile and ineffective. The report recommends consolidating fragmented risk pools to the extent possible, and also to work towards a single set of regulatory and governance rules. In terms of growing the risk pool, the report sees commercial health insurance (private or retail health insurance) having substantial potential for an expansion in the risk pool. The report, however, acknowledges significant market failure in commercial health insurance. Market failures manifest themselves by way of health risk selection (cream skimming), shallow coverage, high administrative costs, low burning ratios (claims ratios) and seemingly high non-operational results. Commercial health insurance in India began in 1986. The sector was privatized in 2000, with the objective of increasing insurance penetration. However, even with over 25 non-life insurance companies that sell health insurance, the penetration of commercial health insurance continues to be abysmally low, at about 12% of population. Under-penetration, coupled with the fact that it finances a sector that's largely unregulated, has led to complicated product constructs laced with caveats to insulate insurers from the vagaries of healthcare providers. Complex products tend to widen information arbitrage. This, in turn, impacts penetration and leads to market failure.

It is against this backdrop that this paper charts out the evolution of retail health financing and assess the role of the Insurance Regulatory and

[1] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=IN
[2] https://www.statista.com/statistics/953163/india-public-expenditure-on-health-as-a-share-of-gdp/
[3] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=IN
[4] https://niti.gov.in/sites/default/files/2019-11/NitiAayogBook_compressed.pdf

Development Authority of India (Irdai) through important lenses of product development, product pricing, public disclosures and grievance redressal. The objective of this paper is to capture challenges in this space that need to be fixed to increase transparency, predictability and comfort. Also, if India has to think of a unified health insurance regulator, it's important to assess the performance of Irdai as a key contender for the position. In writing about key aspects of regulations in health insurance, this paper has relied on several experts from the industry, consultants and regulatory officials who have tracked this space closely. The paper comprises a brief detail about Irdai and five chapters around the key aspects of retail health insurance. Each chapter tries to capture the present construct, challenges and opportunities that lie to improve retail health insurance.

It's also important to note that commercial health insurance in India is partially facilitated by the state through tax deductions. Health insurance premiums paid by individuals qualify for a tax deduction (Figure A: Tax deduction on health insurance premium), which reduces their tax liability. This tax-saving nudge from the government to encourage citizens to buy personal health insurance plans also puts the onus on the government to fix problems and instances of market failure in commercial health insurance. The aim of this paper is to initiate a broader policy dialogue among policymakers to address challenges in commercial health insurance.

OVERVIEW OF THE CHAPTERS

Chapter 1: Product development

Retail health insurance in India largely covers in-patient costs. However, there are several leakages built into the coverage by way of exclusions and other contractual disallowances like a cap on costs. These caveats are embedded to insulate insurers from events of fraud and anti-selection. But, as markets develop, products should improve in favor of consumers.

This chapter traces the evolution of health insurance products in India, and the case to make product coverage more comprehensive. In charting out product evolution in terms of coverage, this

Figure A: Tax deduction on health insurance premium

	Total deduction limit under Section 80D for FY21 (Rs per year)		
Premium paid for	**Self or family**	**Parents**	**Total**
Self	25,000	0	25,000
Self	50,000	0	50,000
Self plus parents	25,000	25,000	50,000
Self plus parents	25,000	50,000	75,000
Self plus parents	50,000	50,000	1,00,000

Note: 1. In Column 1, blue indicates non-senior age group (below 60 years); red indicates senior age group (60 years or more)
Source: incometaxindia.gov.in

chapter also examines Irdai's role in addressing gaps in retail health insurance and developing the segment for end users.

This chapter will focus on:
1. Product construct (coverage, exclusions)
2. Challenges in health insurance coverage
3. Regulatory reforms
4. External influences pushing for reforms

Chapter 2: Product pricing

For health insurance to work in favor of customers for the long term, pricing needs to be affordable, consistent and transparent. However, pricing of retail health insurance in India appears to be falling short on all these parameters. Factors such as high acquisition costs, age band pricing, and the lack of differential pricing and a healthcare inflation index to transparently peg premium hikes sour customer experience.

The low claims ratio seen in the retail segment also suggest there is room to lower health premiums. This chapter unpacks some of the issues plaguing health insurance premiums in India, and the reforms needed to make health insurance affordable and premium hikes more consistent, predictable and less taxing for end users.

Chapter 3: Public disclosure

While products and pricing have a direct impact on consumer purchase decisions and satisfaction, disclosures regarding products in the public domain is important. Comprehensive disclosures enable product understanding and useful comparisons. Elaborate, meaningful disclosures are the hallmark of a mature market as it reduces information asymmetry. This chapter looks at the extent and quality of public disclosures.

Chapter 4: Redressal

Consumer grievance redressal is very important in a regulated market. Data on public grievances helps the regulator understand key problem areas that need to be addressed. Further, a successful grievance redressal system offers quick customer resolution, thereby enhancing customer experience. It's therefore important that a well-regulated market has a robust and effective consumer redressal system. This chapter analyzes complaints data to find out what customers of health insurance struggle with. It also examines the effectiveness of redressal channels.

Chapter 5: Third party administrators

Third party administrators (TPAs) are intermediaries between healthcare providers and insurers that help in cashless settlement of claims. However, insurers are increasingly employing in-house teams to process claims settlement with the objective of controlling and improving customer service. This chapter studies the role envisaged by Irdai for TPAs and how they evolved against this backdrop.

Conclusion and recommendation

While the paper looks at historical evolution and challenges, this chapter summarizes current challenges and gaps in different aspect of health insurance. It also offers some recommendations for policymakers, government bodies and the regulator to work on.

Insurance Regulatory and Development Authority of India: Scope of Work

The genesis of privatization of the insurance sector lies in setting up of the Malhotra Committee in 1993. Chaired by R.N Malhotra, former governor of RBI, the idea of the committee was to look at reforms in the insurance sector and the big wave of reform that was proposed by the committee was to open the sector to private participation.

Subsequently the insurance sector opened in 2000 and the sector got its first regulator in Insurance Regulatory and Development Authority of India (Irdai). Irdai was first set up as an autonomous body and subsequently was incorporated as a statutory body under the Insurance Regulatory and Development Authority Act, 1999. The stated objective of Irdai include promotion of competition to enhance customer satisfaction through increased consumer choice and lower premiums. It is also responsible for the financial security of the insurance market.

Constitution

As per Irdai Act, 1999, Irdai comprises a ten-member team of a chairman, five whole-time members and four part-time members. These appointments are made by the government. The tenure of the chairman as well as the members is for a period of five years.

Currently Subhash C. Khuntia is the Chairman of Irdai. He is an Indian Administrative Services officer. There are five broad divisions within Irdai with one designated member for each. The five divisions are:

1. Life Insurance
2. Non-life Insurance
3. Distribution
4. Actuary
5. Finance and investments

In total Irdai comprises 216 personnel—of which 200 are class I employees-- against a sanctioned staff strength of 280 personnel (FY20).

Role and powers of Irdai

Section 14 of the Irdai Act details the duties, powers and functions of Irdai. The Act states that Irdai shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business. As per Irdai, their mission statement includes

1. To protect the interest of and secure fair treatment to policyholders.

2. To bring about speedy and orderly growth of the insurance industry (including annuity and superannuation payments), for the benefit of the common man, and to provide long term funds for accelerating growth of the economy.

3. To set, promote, monitor and enforce high standards of integrity, financial soundness, fair dealing and competence of those it regulates.

4. To ensure speedy settlement of genuine claims, to prevent insurance frauds and other malpractices and put in place effective grievance redressal machinery.

5. To promote fairness, transparency and orderly conduct in financial markets dealing with insurance and build a reliable management information system to enforce high standards of financial soundness amongst market players.

6. To take action where such standards are inadequate or ineffectively enforced.

7. To bring about optimum amount of self-regulation in day-to-day working of the industry consistent with the requirements of prudential regulation.

The supervisory role of Irdai allows the authority to make regulations and also empowers the authority to penalize insurers and other entities under its purview who are found in violation of the rules and regulations set out by Irdai. To this effect Irdai, under the Insurance Laws Amendment Act, 2015 has been given greater powers. The amended Act increased the quantum of penalty from Rs 5 lakh per incident of violation to Rs 1 lakh per day per incident of violation going up to a maximum of Rs1 crore per incident of violation. However, in order to allow insurers or other regulated entities the option of an appeal the amended Act also allowed the Securities Appellate Tribunal to hear and dispose of appeals against orders passed by the Insurance Regulatory Development Authority of India (IRDAI) under the Insurance Act, 1938, the General Insurance Business (Nationalization) Act, 1972 and the Insurance Regulatory and Development Authority Act, 1999 and the Rules and Regulations framed thereunder.

Remuneration

Salaries and other management expenses of Irdai are met by the Irdai fund that comprises all government grants, fees and charges received by the Authority. Irdai levies a certain licensing fee and annual fee on insurers and other entities under its purview. Irdai details out the fee structure for insurance and various intermediaries in its annual report. For instance an insurance company has to pay Rs 5 lakh as registration fee and subsequently the renewal fee is1/20th of 1% of gross direct premium written in India subject to a minimum of Rs 5 lakh and maximum of Rs 10 crore. It is from this pool of funds that Irdai meets its expenses. For FY20, Irdai registered an income of Rs 166.41. it's excess income over expenses stood at Rs 102.44 crore pointing to a well-funded organization capable of expanding internal capacities.

Irdai's focus on health insurance

The insurance sector now has about seven standalone health insurance companies in addition to the fact that nearly all non-life insurance companies underwrite significant amount of health insurance business. The Insurance Laws (Amendment) Act, 2015 also considers health insurance to be a distinct line of business, yet health insurance comes under the purview of the non-life sector headed by member non-life. This is due to the fact that the Act does not allow for more than five full-time members and the regulatory structure already has its designated members.

However as per Irdai's directory of employees Irdai has a health department which was constituted sometime towards the end of first decade of Irdai with the specific purpose to focus on health insurance. This was largely due to the fact that

after life insurance, health insurance constituted a majority of complaints. The health department comes under member, non-life insurance and comprises 14 officials of which six are on special duty. The health portfolio is also looked after by an executive director at Irdai who is in charge of health along with other portfolios of surveyors, insurance marketing firms and reinsurance. It needs to be noted that the life insurance sector too is allowed to sell health insurance plans, although health insurance forms a very tiny proportion of life business at about 0.15% in terms of premiums. Health plans offered by life companies come under the purview of the life department although the non-life department is also consulted.

Other focus groups

The regulator constituted a health insurance forum in 2012[5] for an effective dialogue between service providers (hospitals), insurers, third party administrators and consumers in general. Since the regulator was already involving external bodies like the Federation of Indian Chambers of Commerce and Industry (FICCI) and Confederation of Indian Industry (CII) to pin point challenges in health insurance and brainstorm ideas, it felt a multi-disciplinary forum would serve the sector well.

The forum was to provide a consultative role in order to enable the evolution of a regulatory structure which would take into account the interest of all stakeholders. Irdai while constituting the forum envisaged it to evolve into a self-regulatory organization with membership extended to all the stakeholders relevant to the health insurance business. The forum had representations from the insurance sector, regulator, government (namely from the ministry of health and family welfare and ministry of labor and employment), private hospitals, government hospitals, third party administrators and National Accreditation Board for Hospitals & Healthcare Providers (NABH).

While the forum was constituted to focus on the health insurance ecosystem, it's not very evident in terms of how often the forum was convened, the discussions and reforms undertaken by the forum. The forum was again reconstituted in 2018 and it also included representation from the National Health Authority (NHA) and Niti Aayog. Given the diverse representation, the forum makes for the perfect platform to look at the larger healthcare ecosystem, but knowledge of working of this forum is extremely limited in the public domain. It's also not known how far along has the forum come to delineate itself and become a self-regulatory body, but in January 2021, the health insurance forum was reconstituted once again and a health insurance advisory was set up comprising of medical professionals to advice the regulator on matters of health insurance. There continues to be very limited public knowledge on the functioning and proceedings of the forum.

Scope of jurisdiction

Health insurance in India is fairly fragmented. While the very poor are taken care of by the government through schemes like the Rashtriya Swasthya Bima Yojana (RSBY) earlier and now the Pradhan Mantri Jan Arogya Yojana (PMJAY), government employees come under the Central Government Health Scheme (CGHS), and Ex-servicemen (retired armed forces personnel) under the ex-servicemen Contributory Health (ECHS) scheme. Even employees drawing wages up to Rs 21,000 come under the Employees' State Insurance Corporation (ESIC) that offers employees medical, sickness and disablement benefits. These schemes do not come under the purview of Irdai. The regulator focusses narrowly on commercial insurance comprising group and retail businesses. The following chapters look at the performance of Irdai in developing commercial insurance through different aspects such as products, pricing and complaints.

[5] https://www.irdai.gov.in/ADMINCMS/cms/frmOrders_Layout.aspx?page=PageNo1608&flag=1

Chapter 1

Product Development

Introduction

The broad spectrum of health financing encompasses not just in-patient or hospitalization costs, but also out-patient (OPD) costs and preventive healthcare. In India, such holistic coverage is in its very early stages, and the focus remains on the in-patient aspect.

In the retail segment, formal health insurance started in the 1980s, with non-life insurance companies owned by the government offering a Mediclaim policy. An indemnity cover, this focused narrowly on reimbursing hospitalization costs to the insured. Since then, health insurance in India has been largely confined to indemnity covers that pay for in-patient hospitalization. Even after the sector opened up to private participation in 2000, and foreign insurers streamed in, this in-patient focus has not changed drastically.

India has travelled nearly two decades with privatization of health insurance, that too with a regulatory body that also has the mandate to develop the insurance sector. Yet, commercial health insurance (retail health insurance) remains poorly penetrated, covering around 12% of the population. The barriers are both supply and demand side. Healthcare being largely unregulated leads to supply-side constraints, with insurers incorporating exclusions, caps and co-payments in policies to avoid adverse selection, moral hazard and also to limit claims outgo. Further, poor penetration points to low demand for health insurance a major cause of which can be attributed to poor customer experience due to large information asymmetry.

Some factors that could increase the penetration of health insurance among households are improving product construct, selling practices, claims experience, pricing and grievance redressal. So, it's important to see how the health insurance sector has evolved through these lenses and the role of the insurance regulator in them.

This chapter focus on product construct, and traces the evolution of health plans in India and the current challenges.

The Early Days

Although health insurance for the retail segment

was introduced in India in the 1980s, in other forms, it pre-dates the nationalization of the non-life sector, which happened in the early-1970s. Commercial health insurance came to India primarily as group insurance products. Multinationals, for whom buying health insurance for employees abroad was a standard practice, started seeking the same for their staff in India. General insurance companies were offering these multinationals other covers like liability risk and fire risk, and they started throwing in health insurance as well.

K S Sankar is, today, Senior Vice President at Alliance Insurers Brokers Pvt. Ltd, an insurance broking firm. Back in 1986, Sankar was a branch manager with the National Insurance Company. He recalls that pre-nationalization policies also covered OPD expenses. "But given the fact that healthcare was largely government-owned, and hence heavily subsidized, and the private sector was largely confined to primary care, these policies were never utilized", he said.

But as private hospitals became popular—Apollo Hospitals was the first corporate set up in 1983—the Government felt the need for a standard retail health insurance product. At the time, the non-life sector was nationalized. General Insurance Corporation, a government-owned entity, managed and controlled four insurers operating in the non-life sector: National Insurance, New India Assurance, Oriental Insurance, and United India Insurance.

Health insurance for retail started in 1986, with a standard Mediclaim Policy that was an indemnity cover catering to in-patient hospitalization expenses. "Earlier, secondary and tertiary healthcare was government-owned. So, when healthcare began opening up, there was an urgent need to have insurance to cater to these expenses," explained Sankar.

Primary care refers to the first point of contact with healthcare, and generally involves out-patient treatment, and general and preventive care. Secondary and tertiary care involve a higher level of medical care, typically needing hospitalization.

Retail Mediclaim provided reimbursement of hospitalisation and domiciliary hospitalisation expenses for illness or injury. It also had exclusions like pre-existing diseases, pregnancy and child birth, and HIV-AIDS, among others. Being an indemnity cover, it reimbursed actual expenses incurred towards hospitalization such as room rent; nursing expenses; fees for doctors, surgeons and specialists; charges for use of surgical appliances and operation theatre; and medicines.

The first version had several sub-limits, as cost heads were segregated and capped. This limited the ability of the insured to be reimbursed all the hospitalization expense incurred. Subsequently, the Mediclaim Policy was revised and sub-limits were removed in 1996[6].

Yet, Mediclaim didn't gain traction as expected. According to Sankar, this was largely due to inadequate awareness, poor claims experience, and shallow understanding of the cover. It also didn't help that health insurance was largely reimbursement-based for individuals: policyholders first paid the bill using their own money and then claimed reimbursement from the insurer.

Greater competition and promoting innovation in the health sector were key driving forces for the government to open it up to private participation. Availability of health financing would also nudge citizens towards private healthcare, and reduce the burden on government healthcare infrastructure. Reiterating this intention, in his budget speech of 1997-98, the then Finance Minister P Chidambaram said penetration of health insurance cover was distressingly low; the General Insurance Corporation had admitted that its Mediclaim policy wasn't a success and that opening up the sector would improve competition and innovation[7].

[6] https://www.IRDAI.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo268&flag=1
[7] https://www.indiabudget.gov.in/budget_archive/ub1997-98/bs/BS18.HTM

Early years

Increasing the penetration of health insurance was, therefore, an important driver that propelled the opening up of the insurance sector as a whole.

The Insurance Regulatory and Development Authority of India (IRDAI), the insurance regulator, was constituted in 1999, and the sector as a whole was opened to private participation in 2000. Privatization saw the entry of foreign players in

Figure 1: List of private non-life insurance companies

} Indicates years where 3 or more non-life insurers started operations

S. No	Name of the company	Date of registration (mm/dd/yyyy format)	Financial year of starting operations
1	Reliance General Insurance Co. Ltd	23/10/00	2000-01
2	Royal Sundram Alliance Insurance Co. Ltd	23/10/00	2000-01
3	Iffco Tokio General Insurance Co. Ltd	04/12/00	2000-01
4	Tata AIG General Insurance Co. Ltd	22/01/01	2000-01
5	Bajaj Allianz General Insurance Company Ltd.	02/05/01	2001-02
6	ICICI Lombard General Insurance Co. Ltd	03/08/01	2001-02
7	Cholamandalam MS General Insurance Company Ltd.	15/07/02	2002-03
8	Star Health & Allied Insurance Company Ltd.	16/03/06	2006-07
9	Future Generali India Insurance Co. Ltd	04/09/07	2007-08
10	Universal Sompo General Insurance Company Ltd.	16/11/07	2007-08
11	Apollo Munich Health Insurance Company Ltd*	03/08/07	2007-08
12	Shriram General Insurance Company Ltd.	08/05/08	2008-09
13	Bharti AXA General Insurance Company Ltd.	27/06/08	2008-09
14	Raheja QBE General Insurance Company Ltd.	11/12/08	2008-09
15	SBI General Insurance Company Ltd.	15/12/09	2009-10
16	Max BUPA Health Insurance Company Ltd.	15/02/10	2009-10
17	HDFC ERGO General Insurance Company Ltd.	09/07/10	2010-11
18	Religare Health Insurance Company Ltd.**	26/04/12	2012-13
19	Liberty General Insurance Ltd.	22/05/12	2012-13
20	Magma HDI General Insurance Company Ltd	22/05/12	2012-13
21	Manipal Cigna	13/11/13	2013-14
22	Kotak Mahindra General insurance Co. Ltd	18/11/15	2015-16
23	Aditya Birla Health Insurance Co. Ltd	11/07/16	2016-17
24	Acko General Insurance	18/09/17	2017-18
25	Navi General Insurance	22/05/17	2017-18
26	Go Digit General Insurance	20/09/17	2017-18
27	Edelweiss General Insurance Co. Ltd.	18/12/17	2017-18

* Since acquired by HDFC Ergo General Insurance, and is now HDFC Ergo Health insurance
** Now Care Health Insurance Co. Ltd.
Source: Irdai and insurers

Figure 1.2: Initial years of health insurance

Financial year	People covered (million)	Premium (Rs Cr)	Per capital premium (Rs)
FY98	2.79	216	773
FY99	3.53	272	768
FY00	4.89	380	777
FY01	5.62	519	923
FY02	7.78	742	953
FY03	8.80	895	994
FY04	11.00	1024	931

Source: Parliamentary report on health insurance FY06

partnership with Indian companies (Figure 1.1: List of private non-life insurance companies).
However, the initial years of privatization continued to be dull for the health insurance segment given the extremely low base of coverage (Figure 1.2: Initial years of health insurance).

Health insurance in the early years remained largely in the form of group covers. In the individual space, defined-benefit health plans—promising a certain corpus for an insured event—made an entry first. Personal accident covers and critical illness plans were among the first health insurance policies to be approved by IRDAI. A critical illness plan lists the critical ailments insured. If the policyholder contracts any of these critical illnesses, the policy pays the entire lumpsum (regardless of actual medical costs), and terminates.

By comparison, in-patient indemnity plans pay for hospitalization costs actually incurred by the policyholder, including pre- and post-hospitalization expenses up to a certain time period. Given that defined-benefit plans were targeted policies and terminated on a claim being made, insurers were more comfortable in pricing such risk, however these plans didn't find much favour in the market.

The first retail health insurance indemnity product approved by IRDAI was in 2004[8]. Policies offered at the time were not much different from the standard Mediclaim offered by government insurers (See Annexure 1 for standard Mediclaim product). What changed with the advent of the private sector was the increase in maximum sum insured: from Rs 3 lakh to Rs 5 lakh.

One of the reasons why, despite the advent of the private sector, insurers drew comfort in replicating the Mediclaim product was the absence of a robust ecosystem for healthcare regulation. According to Girish Rao, a third party administrator (TPA), most global companies were not interested because other pieces of the puzzle were absent. Hospitals were unregulated, there were no coding standards or protocols in place. Data wasn't readily available to effectively underwrite policies. A TPA, or a third-party administrator, is an intermediary that helps insurers in claims processing. Rao has been in this sector since privatization.

In its initial annual reports, IRDAI too noted the lack

[8] Product offered section of IRDAI that lists products approved year wise https://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo1835&mid=27.2.9

Figure 1.3: Growth in health insurance premiums post-privatization and following key events

Financial year	Gross direct premium: health segment (Rs cr)	Year-on-year growth in health premiums (%)	Gross direct premium: Total non-life (Rs cr)	Share of health in non-life (%)	Important event
FY01	519		9,807	5%	Privatization of non-life industry
FY02	742	43%	11,446	6%	
FY03	895	21%	13,898	6%	
FY04	1,024	14%	15,595	7%	
FY06	2,221	NA	20,359	11%	
FY07	3,319	49%	24,905	13%	Launch of 1st SAHI, Industry gets de-tariffed
FY08	4,894	47%	27,824	18%	
FY09	6,088	24%	30,352	20%	
FY10	7,311	20%	34,620	21%	
FY11	9,944	36%	42,576	23%	
FY12	11,809	19%	52,876	22%	
FY13	13,975	18%	62,973	22%	First comprehensive health insurance regulations
FY14	19,634	40%	77,554	25%	
FY15	22,637	15%	84,686	27%	
FY16	27,457	21%	96,379	28%	Second set of regulations aimed at encouraging innovations
FY17	34,527	26%	1,28,128	27%	
FY18	41,981	22%	1,50,662	28%	
FY19	50,834	21%	1,69,449	30%	
FY20	56,865	12%	1,88,917	30%	Guidelines on standardizing exclusions issued

Note: For FY05, health insurance premiums were not available.
Source: Handbook on Indian Insurance Statistics, Irdai, and Parliamentary committee report

of enthusiasm among insurers for health insurance. Till 2004-05, the share of health insurance in the total portfolio of non-life companies by way of premium was less than 10% (Figure 1.3: Growth in health insurance premiums post-privatization and following key events). This lackluster response can also be attributed to the fact that insurers were more focused on other lines of business such as fire insurance, marine insurance and motor insurance as they were tariffed. This meant the pricing was dictated by the regulator, and consequently these portfolios were profitable. De-tarrifing these lines of business would have resulted in lower premiums due to market competition.

Flawed product construct

But it wasn't just the supply side, demand too

continued to be lax. This can be attributed largely to customer experience while buying a policy, understanding it and making a claim. Health insurance was beset by three major product flaws.

1. Continuity: Health insurance cover came with an expiry date. Insurers could decline renewal of a contract in spite of a policyholder paying premiums regularly. This, typically, happened with senior citizens, as insurers were wary of an adverse claims ratio. For customers, this meant paying health insurance premiums through their younger years and not having cover in their older years.

In the early years, policy wording didn't explicitly state for how long the cover was renewable. So, insurers employed different strategies: some insurers stopped renewing after a certain age, while some hiked premiums significantly to make the policy unaffordable. Health plans were designed to cover people typically till about 70 years of age only.

2. Exclusion: In order to avoid adverse selection, insurers considered pre-existing diseases (PEDs) as exclusions—the policy didn't cover them. Some insurers offered to cover PEDs after a waiting period, others refused altogether. It wasn't this confusion alone. The very definition of a PED was open to interpretation and was also a main reason for disputed claims. The definition of a PED was loosely interpreted as any medical condition, ailment or injury that existed before the policy was bought. It didn't matter if the insured was aware of it or not. So, even if an ailment went back many years and the policyholder wasn't overtly aware of it, just a sign or symptom was enough to label it a PED and exclude it from coverage. This led to disputed claims, which affected customer experience.

3. Comprehension: The policy cover itself was difficult to understand, as the list of what could be excluded or the definition was not standardized. A sampling of two product brochures from two insurers in the initial decade of 2010 showed variance in the list of exclusions. In fact even the wordings on similar exclusions were different. (See Annexure 2 for a comparison of exclusions). Further, insurers employing cost control measures like sub-limits and co-payments[9] didn't help an individual comprehend a policy.

Health insurance, therefore, ended up promising neither comprehensive nor lifelong coverage. The biggest burden of this was borne by senior citizens, who were left stumped by the complexity of the products and excluded by its exorbitant premiums.

4. Claims: The claims experience, too, wasn't smooth. According to a health insurance report published by IRDAI[10], about 73% of customer complaints or grievances in 2013-14 pertained to either policy terms and conditions or claims. In 2020 claims complaints still form a bulk at 71% of the total complaints as per the latest Consumer Affairs Booklet (CAB). A bad claims experience points to poor understanding of health insurance by policyholders. But this also means that the industry continues to follow a claims-based underwriting practice, wherein the insurer inspects the policy thoroughly when policyholders raise a claim, rather than when they are on-boarded.

While these practices headlined the initial years of health insurance, there was little by way of regulations to check them. And this can be attributed largely to a lack of focus because other portfolios took precedence. Tariffed products like fire and motor insurance had to be de-tariffed by 2007. This meant their pricing had to move away from rules-based to risk-based. This took a lot of the regulator's time.

The de-tariffing in certain parts of the insurance sector was an important event, with ramifications for the health portfolio too. It meant an end to the cross-subsidization of the health insurance portfolio: in order to capture market share, premiums in the tariffed portfolio fell, and could no

[9] https://www.livemint.com/Money/I7mHqqHfUSXdx4FZnPGUWM/The-sublimit-on-room-rent-in-a-mediclaim-policy.html
[10] https://www.IRDAI.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo2515&flag=1

longer subsidize the health portfolio. This turned the focus on health insurance.

This was also the time when standalone health insurance companies began to set shop. They started making popular features like lifetime renewability, no individual claim-based loading and portability of health insurance. It also helped that some of the contentious practices were brought to the attention of the courts, which nudged IRDAI to review certain provisions like renewability. For example, in a Supreme Court ruling of May 16, 2008, the court ruled that renewal of a Mediclaim policy, subject to just exceptions, should be ordinarily allowed[11].

Initial policy response

The early years of health insurance saw little reforms. In fact, in many cases, regulations stayed a few steps behind. The pattern was to let the industry establish certain trends, which was then followed by regulations, guided sometimes by court intervention or customer complaints. However, initial regulations were not watertight.

For instance, at the behest of the regulator, the General Insurance Council (GIC)—consortium of insurers—in 2008 came out with a uniform definition of pre-existing diseases (PEDs) that capped the 'look-back period' at 48 months. This meant a PED up to four years before buying the policy would be excluded during the waiting period. The waiting period, to include the PED in the cover, could extend for another four years.

The uniform GIC definition of pre-existing diseases, and related exclusion wording, was applicable to policies issued or renewed after June 1, 2008. These read:

> "Pre-existing disease definition: 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 your first policy with us.
> Exclusion wording: Benefits will not be available for any condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy with us."

This basically meant any ailment a policyholder might have had in the past four years from the date of buying the policy would be treated as a PED and would not be covered for the next four years, insurers however are free to reduce the waiting period. From the fifth year onwards, the insurer would cover these ailments. However, this definition was not watertight, as even ailments a policyholder may not have been aware of in the past four years could pass off as a PED. A tighter definition of PEDs would have been only ailments that policyholders are aware of.

Even with regards to abrupt termination of health insurance policies, the regulator clarified[12] that policies should be renewable except on grounds of fraud, misrepresentation and moral hazard. However, the same circular didn't ask insurers to make health insurance renewable for life; it only asked them to explicitly state the age up to which the policy was renewable.

Even to usher in portability (a policyholder changing insurers for a health policy without losing the benefits of continuity), IRDAI, along with GIC, began working on a standard product only in 2008. The idea was that since the product was standard, it would be easier for customers to move across insurers. But for customers, portability was possible only for this standard product, and not a customized one.

In the early years, IRDAI also drew from the product philosophy of standalone health insurance companies. In order to differentiate their offerings,

[11] https://indiankanoon.org/doc/1894467/?type=print
[12] https://www.IRDAI.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo470&flag=1

Figure 1.4: Per capita premium growth of the retail book

Financial year	Individuals covered (million)	Premium (Rs cr)	Per capita premium (Rs)
FY12	20.59	4,896	2,377
FY13	23.65	5,919	2,503
FY14	27.28	7,355	2,696
FY15	25.37	8,772	3,458
FY16	28.65	10,353	3,613
FY17	31.97	12,584	3,936
FY18	33.28	15,291	4,595
FY19	42.06	17,525	4,166
FY20	43.23	19,957	4,617

Premium and number of individuals covered only for the retail portfolio is considered, comprising floater and individual policies.
Source: Handbook on Indian Insurance Statistics, Irdai

and add value, some standalone health insurers began allowing portability to their plans by giving credits against waiting period exclusions and no-claim bonus. This practice was later hardcoded into law, when instead of only standard Mediclaim products, IRDAI allowed portability of similar policies[13]. Other practices of lifetime renewability and stopping claims-based individual loading also made its way to law.

Momentum in health insurance

The first comprehensive guidelines on health insurance came in 2013[14]. By then, health insurance premiums collected had grown from Rs 519 crore in FY01 to Rs 13,975 crore in FY13, and were accounting for about 22% of the entire non-life market. In addition, government schemes in the health domain such as the erstwhile Rashtriya Swasthya Bima Yojana (RSBY) and those of the States had initiated public policy conversations around standardization of treatments and protocols.

IRDAI, too, moved towards standardization of health insurance terms, definition of critical illnesses, list of what constitutes non-payable items and claim forms.[15] It also addressed shortcomings in product construct through its health insurance regulations of 2013. Notable changes were making lifetime renewability of health insurance compulsory, making entry age compulsory till 65 years and also

[13] https://www.IRDAI.gov.in/ADMINCMS/cms/Circulars_Layout.aspx?page=PageNo1061&flag=1
[14] https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo1915&flag=1
[15] https://www.policyholder.gov.in/uploads/CEDocuments/Guidelines%20on%20Standardization%20in%20Health%20Insurance.pdf

prohibiting claims-based individual loading[16].

Customization in the health insurance space

With basic rules in place, and the presence of more standalone health insurers, the industry also saw customization in this space. Instead of a standard Mediclaim product, health insurance started coming with added features like maternity cover, cover for international hospitalization[17] and restore benefit[18] (restoring the sum insured in the event of its exhaustion in the same policy year).

In the defined-benefit space, other than including more critical illnesses, insurers also began offering customizations for ailments like cancer or diabetes. Insurers also experimented with OPD covers, but were unable to price these policies effectively[19].

But at cost....

Health insurance in India was, and remains, largely oriented towards in-patient hospitalization. In its annual report beginning 2012, IRDAI has been breaking down gross premium collections from health insurance under government schemes, group schemes and individual schemes. Between FY12 and FY20, premium growth from the individual segment (excluding government and group segments) grew at a compounded annual rate of 19%. However, the increase in the number of policyholders during this period was 10%. The per capita income grew at a rate of 9%. In comparison to the initial years 98-2004, where number of people grew at a rate of 26% whereas premium per capita grew only at 3%, the growth in the later years came equally from premium hikes. (Figure 1.4: Per capita premium growth of the retail book).

A popular practice adopted by insurers has been to launch new products with additional benefits (at times, while discontinuing older plans), and charge higher premiums. IRDAI is cognizant of this practice and monitors product launches carefully. However, IRDAI has not hard coded this into law, where a policyholder has the choice to stick to the old policy for a lower premium. Re-filing products, and launching new products, also gave insurers the opportunity to reduce their claim outflows by identifying conditions that cause losses and put restrictions or exclusions on those.

A Delhi High Court judgment[20] noticed this practice of insurers unilaterally changing exclusions in the policy contract during annual renewals. This is detrimental to policyholders, who may assume a renewal on similar terms and not read the entire policy again, or may no longer be able to move to another insurer.

In a February 26, 2018, judgment, the Delhi High Court said the insurance industry needed to remove ambiguity from exclusions, and that the buck stopped with IRDAI[21]. While the court ruling was in the context of defining and excluding genetic disorders, the court also raised questions on arbitrary insertion of exclusions at the time of renewal. It also pushed for cleaner policy wordings, and to make contracts transparent and remove any scope of ambiguity and subjectivity.

Writing about this judgment Kapil Mehta, an insurance broker[22], compared the policy wording of a popular health insurance product in 2014 with its wording in 2018. Mehta pointed out that seven permanent exclusion clauses had been added in the policy. The new exclusions included select laser treatments, high-intensity ultrasounds, cyberknife treatments, bio-absorbable stents, Parkinson's Disease and Alzheimer's Disease, even if aggravated by an accident, genetic disorders, stem cell surgeries, taking

[16] https://www.livemint.com/Money/x7s9hSgKzA05SvnQ7xVbBK/Buy-healthier-insurance-plans-now.html
[17] https://www.livemint.com/Money/kWEyNn5iOsEuKhUFE6StUL/Options-for-overseas-medical-treatment.html
[18] https://www.livemint.com/Money/vY9G73kb4TvW5dlHy57iYM/DYK-Some-health-insurance-plans-have-the-recharge-option.html
[19] https://www.livemint.com/Money/FZ4csOyTOV7zI5orERCLBK/OPD-benefits-not-in-sync-with-the-cost.html
[20] https://indiankanoon.org/doc/60279502/
[21] https://www.livemint.com/Money/cQr7GYxxrfWWsSEcKoFOpO/High-Court-pushes-for-clean-health-insurance.html
[22] https://www.livemint.com/Opinion/U6rlqrlZWTokb9fa8UDFgP/Onesided-health-insurance-contracts-and-genetic-disorders.html

> Launching new products allowed health insurance companies to reduce their claim outflows by identifying conditions that cause losses and put restrictions or exclusions on those.

part in military exercises, aviation in professional or semi-professional capacities, oral chemotherapy, use of Remicade or Avastin unless in IPD and accidents due to hazardous activities. These hazardous activities included trekking and martial arts.

This was not the only case where an external institution nudged IRDAI for policy changes. The Mental Healthcare Act, 2017, too asked mental illnesses to be insured, following which IRDAI ruled that insurers could not exclude mental illnesses[23]. However, given that indemnity-based policies only cover hospitalization, only instances of mental health conditions leading to hospitalization are covered.

External factors have played a key role in nudging IRDAI to look at policy reforms. These external factors came from within the industry, by way of customer-friendly features such as lifelong renewability, or were the result of court interventions and customer complaints. It has also helped that the Central government's latest scheme of health financing has been more inclusive and comprehensive.

PMJAY (Pradhan Mantri Jan Arogya Yojana) was launched in 2018 under the umbrella scheme of Ayushman Bharat. It aims to cover about 500 million people at the bottom of the socio-economic pyramid. Like commercial health insurance, PMJAY is an indemnity-based scheme that pays for in-patient treatment. What sets it apart is minimum exclusions. PMJAY covers all pre-existing ailments, and only excludes outpatient care, drug rehabilitation, cosmetic treatments, organ transplants and fertility treatment. PMJAY offers an annual sum insured of up to Rs 5 lakh per household and covers about 1,350 procedures (treatment packages).

By comparison, commercial health insurance comes with a host of exclusions. Retail health insurance comes with five types of exclusions.

1. Initial 30-day period of a policy, when no claims are paid for any illness.

2. Disease-specific exclusion, where certain ailments are excluded for a defined period.

3. Pre-existing ailments, which are excluded for up to four years.

4. Certain medical procedures are permanently excluded from the scope of cover. These include cosmetic surgeries, unless required due to an accident and needing hospitalization; medical expenses on account of alcohol or drug use or birth control; sterility and infertility.

5. Non-payable items that constitute consumables and other non-medical items.

The first three types of exclusions are time bound and the other two permanent. While these are standard exclusions in retail products, group commercial health insurance products come with fewer exclusions.
In retail, these exclusions are inserted typically to

[23] https://www.livemint.com/Money/o0pRqJbfCkMiaiPHRV0TSK/Health-plans-to-cover-mental-illness-too-but-will-that-help.html

avoid adverse selection and for medical treatment that is not the result of accident, illness or emergency but is of a voluntary nature like a weight loss program, cosmetic surgery, aesthetic treatment, self-medication or non-proven treatment. In needs to be noted that it's only in recent times that the list of exclusions has been rationalized. Earlier the list was much bigger as it also included ailments like HIV/AIDS, genetic disorders and Parkinson's Disease simply because earlier insurers didn't know to how to price this risk. Some insurers call it legacy lethargy—where an ailment was excluded in the early years and it continues—and some attribute such exclusions to lack of data or predictability of incidence rate to effectively price these risks. Following the same logic, the product construct also kept technological advancements in medical treatments out of insurance coverage. For instance, in the treatment of cancer, some policies excluded oral chemotherapy, hormonal treatment or even cyber knife treatment.

Given the more comprehensive coverage of PMJAY, and also the nudge from the Delhi High Court order in February 2018 to clean up exclusions, IRDAI constituted a working group that same year to look at exclusions in health insurance more carefully. The terms of reference said:

1. Examine exclusions that are prevalent in health insurance policies.

2. Minimize the number of exclusions to enhance the scope of health insurance coverage.

3. Rationalise exclusions that disallow coverage with respect to new modalities of treatments and technologically-advanced medical treatments.

4. Identify types of exclusions that shall not be allowed.

5. Study wordings/language of exclusions and standardize them in a simple and easily understandable language.
6. Study the scope to allow permanent exclusions that are specific to an individual and/or to an ailment/disease at the time of underwriting so that policyholders are not denied health insurance claims unrelated to exclusions.

What emerged in September 2019 were guidelines that rationalized and standardized exclusions in health insurance[24]. These guidelines are, by far, the most constructive step towards more inclusive health insurance and the adoption of a uniform approach by the industry to spell out exclusions.

To begin with, it stated clearly that ailments contracted after buying a health insurance policy will have to be covered. This meant insurers can no longer permanently exclude ailments like Alzheimer's, Parkinson's and AIDS if they didn't exist at the time of buying the policy. The guidelines also standardized some definitions for permanent exclusions. More importantly, it handled the definition of a PED, where previously even the presence of signs or symptoms could make an ailment pre-existing in nature. The 2019 guidelines clearly state that a pre-existing condition is one that has been diagnosed by a physician or for which medical advice or treatment was received.

In order to encourage insurers to give health insurance to customers with pre-existing conditions, the 2019 guidelines also allowed exclusion of named pre-existing illnesses. That way, these illnesses—some of these are Parkinson's, HIV/AIDS, Alzheimer's, Hepatitis B and stroke—can be excluded from the scope of cover, and the customer can still be insured for other ailments. Previously, individuals with such pre-existing ailments would be excluded from health insurance entirely.

The 2019 guidelines also prohibit insurers from denying claims after 8 years of a policy on grounds other than fraud. Previously, insurers could deny claims for non-disclosure. The guidelines now state that insurers will get a moratorium of eight years of continuous renewal, after which they can't question claims for non-disclosure or mis-representation.

[24] https://www.IRDAI.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3916&flag=1

> It also helped that some of the contentious practices were brought to the attention of the courts, which nudged the insurance regulator to review certain provisions like renewability of policies.

Further, the guidelines prohibit the exclusion of 12 modern treatment methods. The guidelines also prohibit words with an open interpretation and state that wordings should be specific and unambiguous. "No open-ended exclusions like 'indirectly related to' or 'such as' are allowed while incorporating exclusions and waiting periods," the guidelines state.

The new guidelines, which came into effect from October 2020, are a landmark in health insurance reforms. They aim to make health insurance coverage more comprehensive. They also indicate a milestone for IRDAI as the regulator finally captured the pain points of retail health insurance: lack of standardization and arbitrary exclusions.

However, big-picture reforms by IRDAI continue to be reactive. For instance, the previous practice was to exclude oral chemotherapy, due to which there were several customer complaints, as oral chemotherapy became popular. So, finally, regulations allowed for oral chemotherapy. However, this begs the question, why is oral chemotherapy covered but not oral drugs for other serious conditions that could be very expensive as well?

Part of the solution lies in evolving towards 'episode of care'. According to Bhabatosh Mishra, Director of Underwriting, Products and Claims at Max Bupa Health Insurance, care set-up or the route of administration or manner of hospitalization still form the basis of eligibility for insurance claims. If an ailment is insured, coverage should be extended to all treatment modalities for it, irrespective of care set-up or route of administration of drugs etc. However, there needs to be a health committee that can identify indications of right drugs and procedures to enable avoidance of unnecessary lines of treatment or excesses so that insurers can exclude that.

According to Kapil Mehta of SecureNow Insurance Brokers, retail health insurance is still operating in a safe zone. Impaired lives and treatment of diseases with primarily OPD requirements like fractures, burns and mental illnesses are still kept out of the scope of health insurance. The next big shift in retail health financing would be to conversations around insuring 'episode of care'.

Conclusion

Twenty years after insurance was privatized, retail health financing is still largely oriented towards hospitalization and indemnity. As per data from the Insurance Information Bureau (IIB), in 2017-18, indemnity policies accounted for the bulk of policies sold both by number of policies and premium amount. By number of policies, for instance, the share of indemnity policies was 85%. While health insurance continues to operate in an unregulated providers market, its product construct has evolved to make the policy more comprehensive.

The regulatory evolution is largely the result of external nudges. With the latest regulations on standardization and rationalization of exclusions, indemnity policies should look at the next big jump to 'episode of care'. This would mean looking to cover critical illnesses holistically. It should also be kept in mind that a narrow in-patient policy incentivizes

hospitalization even where it's not needed, adding to insurer costs.

The other aspect of retail health financing that needs care and attention is onboarding of customers and underwriting of policies. Recent regulations may have rationalized exclusions, but given that insurers have underwriting freedom, policyholders may not reap the benefits of reforms completely. According to Mahavir Chopra, founder of Beshak, a customer awareness portal on insurance: "Policies have become friendly for existing policyholders who bought health insurance and are renewing their plans. However, for people with diseases that are now covered under the scope of health insurance, like congenital disease or mental illnesses, underwriting is likely to become stringent" Further, while things like mental illness are no longer an exclusion, few insurers have inserted a waiting period clause of 1-2 years before mental illness can be covered."

Health insurance, like the subject it insures, is a dynamic field, and forward movement or reform is likely to be met with some pushback from the industry. It's therefore important that IRDAI be proactive, for which it needs to build more skilled capacities. For example, the health insurance report that looked at rationalization of exclusions had recommended setting up of a health technical committee.

It noted: "...with the dynamic nature of healthcare delivery system focused on newer, shorter treatments, better outcomes and ease will keep on evolving. Health insurers world over must be dynamic and aligned to these developments. The healthcare delivery system is evolving fast with innovations in treatments, new drugs therapies and new medical devices. Health Insurance must adapt, evolve and accommodate for changes in Healthcare delivery. Further it needs to plan how to cover and reimburse these developments in their health policies. Most developed countries have developed Health Technology Assessment (HTA) approach. There are institutions which are authorized to carry this out." However current regulations do not find a mention of setting up of such a committee.

There is also a need for IRDAI to review some of its decisions on product reforms. One such decision is IRDAI's approach to covering the missing middle with a mass product. In order to make available a plain-vanilla, standard and affordable health insurance product, IRDAI mandated all non-life insurers to offer a standard Mediclaim product called Arogya Sanjeevani[25]. Since it's the same product offered by different insurers, the rationale was it would be easily understood by customers. However, underwriting and pricing decisions were left to insurers.

Unlike its government counterpart, PMJAY, Arogya Sanjeevani comes with all exclusions of a regular retail indemnity product. That's not all. Its policy wordings allow insurers to build in sub-limits on room rent and co-payment clauses, ostensibly to control pricing and prevent moral hazard. Moral Hazard arises whenever an individual's behaviour that affects the expected loss is altered by the quantity of insurance he obtains (Pauly 1968). In the health insurance context, moral hazard could occur if the customer becomes careless with preventive care and spends more on treatments just because she has insurance. Capping financial benefits to some extent can tackle the risk of moral hazard, however in a market where there is information asymmetry, these financial barriers may not work given that policyholders become aware of such clauses only while raising a claim. This can lead to sour customer experience.

Furthermore, the more customers end up paying from their own pocket, in spite of having an insurance policy, the greater their dissatisfaction with the experience. In Arogya Sanjeevani, for example, contractual disallowances are high by way of sub-limits on room rents. The policy offers room rent coverage up to 2% of the sum insured, subject to a maximum of Rs 5,000 per day. If the daily room

[25] https://www.IRDAI.gov.in/admincms/cms/uploadedfiles/Guidelines%20on%20Standard%20Individual%20Health%20Insurance%20Product.pdf

Onboarding of customers and underwriting needs attention. Recent regulations may have rationalized exclusions, but insurers have underwriting freedom, and policyholders may not fully reap the benefits of reforms.

rent exceeds Rs 5,000, the proportionate deduction clause applies. Hospitals tend to bill patients for expenses like doctor's fee and nursing charges on the basis of the room the patient chooses. As a result, effectively, the cap on room rent not only applies to room charges alone, but also to other associated costs, which can lead to high contractual disallowance. Further, the policy has a co-payment clause of 5% on all claims.

The aim of Arogya Sanjeevani was to offer a simple standardised product that was also affordable. However, building in numerous disallowances not only make the product complex, but the huge pricing variation defeats the purpose of a standard product. For a Rs 5 lakh cover, the annual premium a 35-year-old male pays can vary from about Rs 3,000 to Rs 7,000.[26] It might be cheaper than customised products by insurers, given the embedded disallowances, but a claim instance also means considerable out-of-pocket payment by the insured. For example, on a Rs 5 lakh claim, the 35-year-old would end up paying Rs 25,000 as out-of-pocket expenses on a co-payment of 5% alone. This defeats the very purpose of designing a product for the missing middle.

It also doesn't help that IRDAI removed the sum insured cap, of Rs 5 lakh, on these policies and allowed insurers to offer a higher cover[27]. Contractual disallowances on low-ticket policies are often placed to avoid misuse. For instance a Rs 3 lakh sum insured would have room rent limits to make sure the patient doesn't end up taking a superior category room and the insurer ends up paying a large part of the claim in room charges alone. However, at a high sum insured, these concerns don't apply, but a standard product means these disallowances will continue to exist.

Commercial health insurance in India has come a long way in the past 20 years. However, it appears the regulator has constantly played catch-up with the industry, wherein the industry established a practice and IRDAI reacted to it.

Yet another example of this approach would be the guidelines on wellness[28]. As a preliminary step towards preventive healthcare, insurers have been offering certain discounts and rewards to policyholders for maintaining good health. Noting the trend, Irdai in wellness guidelines in 2020 put emphasis on transparency by asking insurers to price their wellness program into the product and define what can be passed off as wellness rewards—premium discounts, vouchers, free consultations, reward points, etc. The guidelines have brought clarity on what can be defined as wellness program and the manner in which rewards can be embedded into the product. As per insurers, wellness programs are under-utilized by policyholders for lack of awareness and due to the fact that they were not very well defined in the past.

Preventive healthcare is an important part of the healthcare ecosystem that helps keep healthcare

[26] https://economictimes.indiatimes.com/wealth/insure/health-insurance/will-arogya-sanjeevani-take-care-of-all-your-health-insurance-needs-here-are-its-pros-and-cons/articleshow/75770941.cms?from=mdr
[27] https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4177&flag=1
[28] https://www.IRDAI.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo4236&flag=1

costs in check—and, consequently, insurance premiums. It's therefore important to look at wellness as an integral part of health insurance underwriting, and IRDAI if finally looking at ways to drive conversations to this effect. Other than looking at wellness features offered under health insurance plans, Irdai also appears to be looking at the larger preventive healthcare space, where it can license health maintenance organizations (HMOs) to engage with primary care physicians as the first point of contact for the policyholders thereby bringing primary care under the ambit of insurance as well. It's yet to be seen how this model takes shape in the Indian context.

But it does point to the growing case for IRDAI to increase its internal capacity in health insurance to play a more proactive role. Echoes to this effect go back to 2015[29], when an expert committee on health insurance chaired by former member non-life, M Ramaprasad, recommended creating a separate vertical for health insurance. The report stated: "A focused regulatory oversight and control is necessary as health insurance business is being carried out by all insurers—life, non-life and standalone health insurers. The Committee suggests that the Authority consider forming an exclusive vertical or department for Health insurance and bring all Health insurance issues – pertaining to Life, Non-life Insurance and Health Insurance companies. Only then a level playing field and a consistent approach to regulatory aspects for development of health insurance can be facilitated."

The Insurance Laws(Amendment) Act 2015 recognises health insurance as a separate line of business thereby delineating it from non-life business, yet the regulator capacity lacks a dedicated member for Health. Furthermore the dedicated department of health at Irdai comes under the purview of the non-life department. A consolidated health vertical will enable the regulator to build capacities and take a more holistic view of regulations pertaining to health insurance.

[29] https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo2515&flag=1

Chapter 2

Pricing in Retail Health Insurance

Any kind of insurance is predicated on two basic principles: law of large numbers and pooling of risk. In order to work as an economic proposition, insurance needs a large pool of insured population. A large pool creates economies of scale. It also helps insurers predict risks better, thereby pricing for it more accurately.

Health insurance works on similar principles. However, retail health insurance in India is severely under-penetrated, the impact of which is felt in both product construct (narrow scope of cover) and pricing. Under-penetration causes pricing to remain high. Having said that, the issues in pricing of retail health don't stem from under-penetration alone.

Practice of predatory pricing leads to sharp premium hikes overtime and a high cost of acquisition keeps the pressure on costs. Following from this is the tendency of insurers to revise premiums in blocks of 2-4 years. Such abrupt hikes can lead to selective lapsation, wherein the young and the healthy start to view the cost-benefit of continuing with health insurance less favourably. They lapse their policies, leaving behind an adverse pool, which impacts pricing further.

This chapter unpacks the issues plaguing pricing of retail health insurance in India and how the insurance regulator can address them
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ISSUES

Premium shocks due to age-band pricing

Pricing of retail health insurance is age-sensitive: the older an individual, the higher the premium they pay. But rather than 'age-point pricing', retail health insurance follows 'age-band pricing'. Thus, policyholders in a particular age band—say, 20-

25 years, 26-30 years and so on—pay an identical premium. However, the premium increases sizeably when they move from one age band to another, especially among higher age groups, and this causes the premium hike to appear stark (Figure 2.3: Obese Commissions).

This spike in premiums is compounded by high medical inflation, which causes insurers to revise their premiums usually in a block of 2-4 years, instead of an annual hike. Such premium hikes happen in the range of 15%-35%[30], according to a Milliman paper on Medical Inflation and Health Insurance Products in India. According to the paper, medical inflation along with age band premium hike can inflate premiums by 50% on renewal. This again leads to large risks of selective lapsing.

Age-band pricing and tendency of insurers to revise premiums only in blocks of a few years contribute to premium shocks. Age-point pricing, on the other hand, would lend more predictability and will be gradual. However, as per the Milliman paper, the high cost of conducting an annual pricing exercise, coupled with a slow turnaround time for regulatory approvals, can be counterproductive. Unavailability of granular data, too, restricts insurers from pricing at age points.

The insurance regulator needs to work with the industry to improve data collection and speed up product approvals. Work is also required on a transparent benchmark that captures medical inflation, facilitating regulatory monitoring of pricing, and making price hikes more predictable and transparent.

Predatory pricing

Health insurance pricing comprises two components: morbidity risk (cost of insurance) and operational expenses. Unlike premiums for PMJAY and other federal schemes, which are set by governments, pricing in retail health is determined by insurers.

There is ample anecdotal evidence to suggest the practice of predatory pricing, wherein insurers keep initial premiums low to gain new policyholders. This is a myopic approach for a long-term product like health insurance. As people grow older, their likelihood of using health insurance increases, which impacts the claims ratio.

An ageing book forces insurers to increase premiums sharply. A price correction can potentially lead to selective lapsation: the young and healthy move out, whereas the less healthy stay back, worsening the books and necessitating a further hike. For customers, this vicious spiral can make health insurance expensive and the experience uneven.

Regulatory intervention: While there have been several cases of predatory pricing, among the most prominent ones dates back to nearly a decade. Reliance General Insurance Co. Ltd launched a health insurance policy in 2006, called Health Wise, which was among the cheapest in the market. Five years and an adverse claims ratio later, the insurer hiked premiums in the range of 60%-800%, leaving policyholders in a bind[31].

Such acute premium hikes hurt three sets of policyholders in particular: those who are older, those with pre-existing conditions and those having made a claim. Since porting to another policy is difficult for them, they find themselves trapped. It's therefore imperative for insurers to take a long-term view of pricing. Likewise, for the regulator clearing products.

In order to combat predatory pricing, the Insurance Regulatory and Development Authority of India (Irdai) froze premiums for the first three years of a new policy and allowed for an annual revision

[30] A Milliman white paper on Medical Inflation and Health Insurance products in India places medical inflation in the range of 9%-10% by various definitions and has observed that insurers typically revise their premium by 15%-35% every two to four years to account for medical inflation. https://in.milliman.com/-/media/milliman/pdfs/articles/medical-inflation-and-health-insurance-productsin-india.ashx

[31] https://www.livemint.com/Money/6iGv0paHTOvE1GJWiTBdjK/Why-Reliance-General-raised-premiums.html

thereafter. The 2013 regulations on health insurance thus read: "For a period of three years after a product has been cleared under File and Use Procedure the premiums filed shall ordinarily not be changed. Thereafter the insurer may vary the premium rates depending on the experience, such rate shall not be changed for a period of at least one year from the date of clearance from the Authority."

Has it helped? While the rationale may have been to encourage insurers to price policies with a long-term view, by prohibiting immediate premium changes, the regulation alone may not help. This is because retail policies come with a host of exclusions that are front-ended. This means that the claims ratio (claims-to-premium ratio) is low initially, but as claims pick up, insurers are forced into price corrections. Sharp premium hikes, therefore, can't be eliminated with the 3-year lock-in rule alone. Sharp hikes are prevalent even now, even going up to 100% in certain cases[32].

There are a few common practices insurers follow to overhaul pricing. As has been observed in the previous chapter, some insurers conceal stark premium hikes in product relaunches, where they withdraw an existing product and launch a new product with added benefits and a huge premium revision. Existing customers are then forced to port to new launches on renewal since the older products get discontinued. This offers no choice to the customers to stay with the existing product.

Hidden in this practice is also price signaling, where a certain age group or sum insured category see a steeper hike. Typically, the affected are those who belong to older age groups or who have a low sum insured.

Both instances of product relaunch and selective price signaling can be seen in the case of Ram Reddy, 48, a finance professional, for whom recent premium hikes has rendered health insurance unaffordable. In 2002, the collective premium paid by Reddy and his parents amounted to 2% of their sum insured. In FY2021, it was 11% (Figure 2.1: Price signaling in health insurance: Case study).

Health financing specialist Aloke Gupta sees this an indication of complete market failure. According to Gupta, who has been a member of regulatory committees on health insurance, premium of the erstwhile Mediclaim policy was about 1% of the sum insured. Over the years, this has risen to 10%, defeating the concept of insurance. He reckons that a rate above 2.5% is indicative of market failure, where insurers are unable to increase penetration of health insurance and price the product effectively.

Cost of health insurance should also be seen in the context of India's per capita annual income that is pegged by the Reserve Bank of India at around Rs 1.07 lakh. Further, as per data on income tax returns, nearly 90% of tax returns are filed by individuals with an average gross annual income of less than Rs 10 lakh.

Premium shocks therefore, especially for the older and retired cohort, can adversely impact their ability to retain a health insurance plan. Premium for an insurance cover of Rs 5 lakh for instance can range from Rs 7,000 for someone less than 35 years of age to Rs 54000 for someone in their late 70's. It's evident that health insurance becomes expensive at older ages and any premium shocks therefore can lead to policy lapsation.

High cost of acquisition

The third main problem in retail health insurance is the cost of customer acquisition. Very high cost of acquisition keeps the premiums on the higher side and the same can be assessed by the incurred claims ratio of the health segment of insurance companies. In its annual Handbook of Indian Insurance Statistics, the insurance regulator publishes segment-wise details of incurred claims ratio (claims-to-premium ratio). The retail health book is further segregated by individual health

[32] https://theprint.in/health/health-insurance-premiums-have-nearly-doubled-this-year-but-covid-alone-not-to-blame/544799/

Figure 2.1: Price signaling in health insurance: Case study

Ram Manohar Reddy, a 48-year-old financial professional, bought individual health insurance plans for himself and his parents from a private insurer in 2002. Till FY20, premiums increased as per the age band, and the hike was not steep. However, in FY21, premiums surged 200%.

The insurer, in the premium revision note, said it was withdrawing the existing product as it had become financially unviable. It added it had launched a new product with improved features like no room rent capping, no disease-specific caps and no reduction in no-claim bonus in the event of claims. Reddy's premium hike was lower than what applied to his parents, who are senior citizens. Ram Reddy took to social media to protest the hike. A further slicing of data revealed two ways in which insurers re-price health premiums: by relaunching the product with added benefits and by applying the steepest hike to the cohort most vulnerable.

To make matters worse, the insurer, in a subsequent note (rules mandate insurers to give advance notice of a premium hike), further hiked the premium by 64% to account for rationalization of exclusions mandated by the regulator. However, it should be noted that the regulator had permitted insurers to change the base premium upto +/- 5% of originally approved premium rates in order to comply with the guidelines on standardization of exclusions as a onetime measure for seamless transition of existing products to ensure viability and sustainability. In FY22, the family will have to pay a total premium of Rs1.09 lakh.

According to Reddy, such pricing practices work more like an entrapment of policyholders. In 2002, their collective premium was 2% of their sum insured. In FY21, it was 11%.

Policy details			Age on policy purchase (years)	Sum insured
Year of purchase	2002			
Policy bought	Individual Health Insurance plans	Ram Reddy	30	Rs 1 lakh
		Mother	48	Rs 2 lakh
		Father	57	Rs 3 lakh

Collective premiums paid	
2002	11,520
2019	21,762
2020	66,667
2021	1,09,160

Premium increase	
Between 2002 and 2019 (17 years)	89%
Between 2019 and 2020 (1 year)	206%
Between 2020 and 2021 (1 year)	64%
CAGR over 19 years	13%

PREMIUM HIKE FOR INDIVIDUAL MEMBERS

		Premium (Rs)	Increase	Premium as % sum insured
Ram Reddy (Current age: 48 years; Sum insured: Rs 1 lakh)	2019	2,738		2%
	2020*	7,431	171%	5%
	2021	12,925	74%	8%
Mother (Current age: 66 years; Sum insured: Rs 2 lakh)	2019	6,973		2%
	2020	20,145	189%	6%
	2021	34,877	73%	11%
Father (Current age: 75 years; Sum insured: Rs 3 lakh)	2019	9,964		2%
	2020	39,091	292%	8%
	2021	61,359	57%	13%

*The relaunched product offered a sum insured of Rs 2 lakh for Ram Reddy.
Note: No-claim bonus has not been taken into account given the fact that's it's a free bump-up of the cover in case of a no-claim year.
Source: Provided by Ram Reddy

insurance plans and floater policies; a floater policy considers family members as one unit, and a claim on the policy reduces the coverage available to the entire family by that much amount in the year.

Data between 2013-14 and 2019-20 shows that the incurred claims ratio has ranged between 50% and 74% for the private sector, as well as for standalone health insurers (Figure 2.2: Incurred claims ratio).

Figure 2.2: Incurred claims ratio

The claims ratio (claims paid versus premiums collected) of various categories of insurers shows private insurers to be in a fairly profitable position for their retail book of health insurance. In some markets, this raises consumer protection concerns, as the market seems overpriced.

Up to 75% | 76% to 90% | 91% to 100% | Above 100%

	Incurred claims ratio (%)						
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Government sponsored group schemes							
Private	80	88	82	115	109	93	NC
SAHI	56	49	75	55	98	182	NC
PSU	105	117	117	124	116	86	97
Total	93	108	109	122	115	90	92
Non-government sponsored group schemes							
Private	103	98	93	92	85	91	87
SAHI	91	87	73	76	85	78	86
PSU	114	123	131	138	116	115	106
Total	110	116	120	125	107	105	99
Retail family/floater policies							
Private	62	59	66	65	70	73	74
SAHI	59	61	54	56	56	57	60
PSU	96	93	97	87	87	92	91
Total	73	75	73	73	70	71	71
Retail individual policies							
Private	57	64	57	64	56	54	53
SAHI	64	54	54	51	53	56	56
PSU	96	96	93	101	89	89	92
Total	89	85	80	79	73	73	77
Total							
Private	87	84	81	84	80	84	82
SAHI	67	63	58	58	62	63	66
PSU	106	112	117	122	108	105	102
Total	97	101	102	106	94	91	88

NC: For 2019-20, the ratio for private insurers was 14% and for SAHI was -1,024%. However, this is not comparable to other values due to the fact that details on claims incurred and premiums earned point to fact that earnings in some cases were not there and there was reversal of provisions. SAHI: Stand alone health insurance
Source: Handbook on Indian Insurance Statistics, Irdai

A lower claims ratio is desirable for an insurer's sustainability, as it means it is collecting more as premiums than it is paying out as claims. However, a very low claims ratio raises concerns over consumer protection as it means the product is overpriced. As per a National Institute of Public Finance and Policy (NIPFP) paper, titled Fair Play in India Health Insurance[33], prudential regulations place the sweet spot for incurred claims ratio between 60% and 100%. "The closer the claims ratio is to 100%, lesser is the cost of operating an insurance company, which in turn means that the insurer is efficient. In the international experience, many regulators are agnostic about the claims ratio when it is around 100%," stated the paper.

In the retail bucket, health insurance products, especially from private and standalone health insurance companies, have been in a range that would raise concerns about overpricing. However, the gap between claims paid and premiums collected gets consumed by high expenses of insurance companies. This turns the spotlight on expenses of insurers.

Commissions in health insurance

A high cost of acquisition in health insurance reduces the risk premium (cost of insurance) for insurers, necessitating regular premium hikes. Regulations allow a 15% payout to insurance intermediaries[34]. This is, however, not a one-time payout but a recurring one.

Health insurance plans in India are sold by non-life companies as short-term policies. So, technically, health insurance policies are annual contracts. Every year, when a customer renews the policy, the insurer in effect gets into a fresh contract with the customer. The intermediary thus becomes eligible for an annual payout of 15% commission.

This gets further exacerbated by two aspects:
1. The regulations allow added payment of 30% of the commission as rewards to agents, taking the total effective payout to 19.5%. The Payment of Commission or Remuneration or Reward to Insurance Agents and Insurance Intermediaries Regulations 2016 thus note:

Reward in the general insurance to be calculated separately for health insurance and other than health insurance for insurance agents and insurance intermediaries respectively and not linked to each and every policy solicited by an insurance agent or an insurance intermediary. Reward being not more than 30% of commission or remuneration paid to insurance agents and insurance intermediaries

2. The second aspect is that while health insurance is renewable for life, premiums also increase with age. This, in turn, means the commission to intermediaries is not only regular, but also increases with the age of a policy, even without any change in after-sales service. Figure 2.3 (Obese commissions) illustrates how commission income from health insurance far outweighs commission income from even life insurance policies, where commissions are one of the highest among financial products in India.

Irdai, in its annual report, publishes commission expense ratio (commission to premium earned) for the health insurance segment. For FY20, the commission expense ratio is the highest for standalone health insurance companies at 12.59% whereas for the private sector it's around 8.58% and public sector the ratio is 6.24% (Figure 2.4: Commission Expense Ratio). However the numbers may not give an accurate picture, given the premium bucket comprises direct or non-commission sale as well as other group policies, where commissions can be lower.

Anecdotal evidence, and conversations with insurers

[33] https://macrofinance.nipfp.org.in/PDF/MPSS-Fair_play_in_Indian_health_insurance.pdf
[34] https://www.irdai.gov.in/ADMINCMS/cms/Uploadedfiles/Regulations/Consolidated/IRDAI(Payment%20of%20Commission%20InsAgentsIntermediaries)2016_Consolidated.pdf

Figure 2.3: Obese commission

Regulations allow a 15% commission to intermediaries on health insurance policies, even on renewal. Additionally, regulations also allow rewards up to 30% of commissions. However, this to be calculated on an overall basis. Going by the basic cap of 15%, an agent selling health insurance policies is better off than an agent selling pure life insurance policy on two counts.

One, the 15% commission works as an annuity, given that a health insurance policy is lifelong vis-a-vis term plans that are typically needed till retirement. Two, health premiums are age-sensitive. They increase with age, which means a 15% commission works as an increasing annuity income, as illustrated in the example below. We have taken the premium chart from a random health insurance policy for a single adult till 60 years of age. Simultaneously, we have averaged the premiums accumulated from health for life insurance (pure term) policy. Since life insurance is level premium, the premiums once decided don't increase with age. Also, for a 30-year-old, a premium of around Rs11,000 can buy the customer a decent life insurance cover. Despite a front loaded commission structure, term plans have far less leakage built in by way of commissions.

	Health policy		Term life policy		
Age	Premium for sum insured of Rs5 lakh (Rs)	Commission @15%	Premium (Rs)	Commission (%)	Commission (Rs)
30	7,015	1,052	11,705	40%	4,682
31-35	7,015	1,052	11,705	10%	1,171
36-45	8,075	1,211	11,705	10%	1,171
46-50	13,200	1,980	11,705	10%	1,171
51-55	16,100	2,415	11,705	10%	1,171
56-60	18,700	2,805	11,705	10%	1,171
Total commission		**54,422**			**39,812**

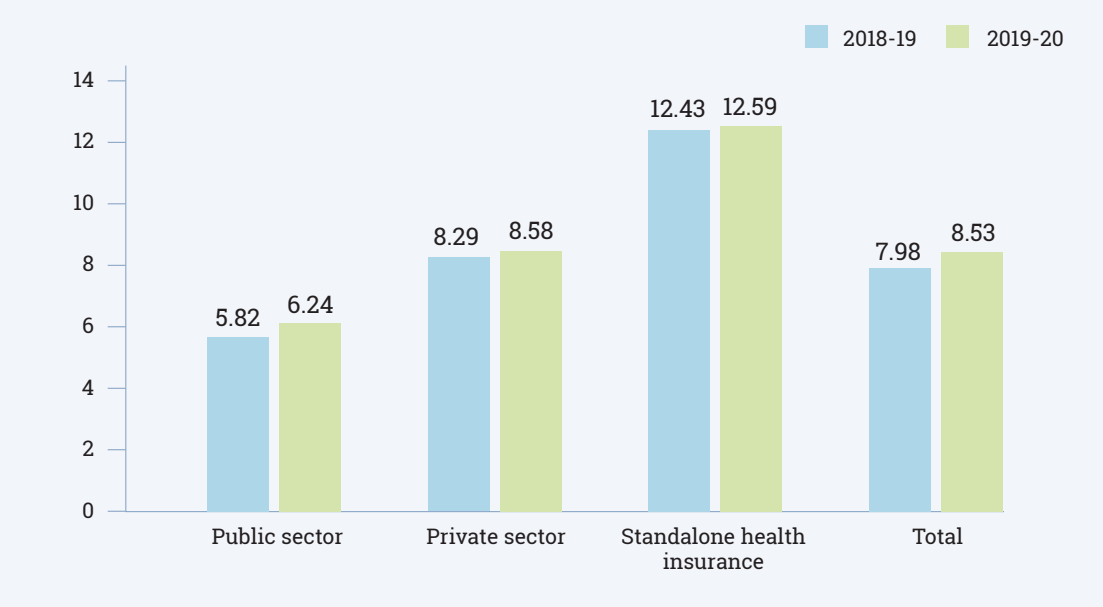
Note: Band hikes in health insurance: 15% at 35 years of age, 63% at 45 years, 22% at 50 years and 16% at 55 years.
Source: The premiums are taken from a health insurance policy of standalone health insurance company and it also illustrates the age band pricing of health insurance that companies typically follow.

and regulatory officials, place the actual payout to intermediaries to be much above 15%. When this happens year on year, it places huge pressure on health insurance pricing. As per Joanne Buckle, Principal and Consulting Actuary, Milliman (London healthcare practice), distribution costs in India are on the higher side. According to her, commissions are structured differently across different economies, but they are typically are in the range of 5%-10%. A 15% year on year commission can put a lot of pressure on cost. It is therefore imperative to review commissions in health insurance.

While a low incurred claims ratio indicates that insurers are getting more premiums compared to claims, the 'combined ratio' indicates high operational expenses for insurers. A combined ratio is made up of the loss ratio (claims ratio) of a company and the expense ratio. A combined ratio of over 100 means insurers are paying out more than they earn by way of premiums (exclusive of any investment return). The gap between the claims ratio and combined ratio, therefore, reflects operational expenses of which commissions comprise a huge portion. While insurers don't report combined ratios by segments, some standalone health insurance companies are operating on a combined ratio of over 100%. For example, for FY20, Max Bupa Health Insurance had a combined ratio of 102%, Aditya Birla Health Insurance 133% and Star Health and Allied Health Insurance 93%.

As per Antony Jacob, chief executive officer of healthcare app Apollo 24/7, reducing renewal

Figure 2.4: Commission expenses ratio (in %)



Source: Irdai annual report 2019-20

commissions will effectively lower expenses. Loss ratios or claims ratio in the first 2 years look good given how health insurance policies come with exclusions in the initial years. So, there is room to absorb higher expenses. But as claims ratio begin to increase and commissions remain high, there is pressure on profitability. Paying a higher commission in the first year and tapering off commissions in subsequent years would make more sense from a sustainability point of view. Also, given how renewals are now actively happening online, the rationale for a 15% renewal commission needs to be reviewed.

Conclusion

Reviewing retail health insurance pricing in India needs a two-pronged approach:

Greater regulatory oversight:

1. A lock-in of premium rates for three years has not been effective in getting the industry to price for health insurance with a long-term view. It, therefore, places greater onus on the regulator to assess pricing at the time of product approval and subsequent revisions. While regulations prohibit cross-subsidization of group and retail portfolios, the segment-wise claims ratio suggests that cross subsidization happens. It's also evident that companies price portfolios to discourage a certain segment of the population by making health insurance unaffordable. Irdai needs to identify such tactics of prohibitive pricing, which compels the most vulnerable to give up health insurance coverage, especially when they have been paying premiums for many years.

2. There needs to be a sharper oversight on product re-launches whereby insurers tend to hide stark premium hikes. While the young and healthy cohort can shop for a cheaper plan in the market, older cohorts or individuals with a pre-existing ailment find it difficult to shop around. They have to port to a policy offered by their existing insurer. Irdai has addressed the problem of tucking premium hikes by way of enhancement of policy features[35], however insurers can still discontinue

[35] https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4397&flag=1

> Some insurers conceal stark premium hikes in product relaunches, where they withdraw an existing product and launch a new product with added benefits and a huge premium revision.

older products to bring in the new with premium revisions.

More actionable reforms:

While greater oversight is important, there are more tangible reforms that Irdai could consider to make health insurance premiums affordable, transparent and predictable.

1. Premium revisions happen due to internal factors, as well as due to external factors like medical inflation. It needs to be noted that in the last 8 years, the per capita hike in health insurance premiums has been in the range of 9% as indicated in the previous chapter (Figure 1.4). A hike of 9% in premiums itself may not be a concern—assuming no lapsation among the older cohorts—given that healthcare inflation is pegged between 9%-10%, the main issue that customers face is the jump in premiums that happen on account of age-band pricing of health insurance.

   As per the paper by Milliman, setting up premiums in age bands also exacerbates the issue of premium shocks. The paper notes: "*Another market practice that exacerbates the issue of premium shocks is setting up premium rates in age bands of three to five years. The premium for any insured remains constant in a particular age band. In normal circumstances, the premium increases from old to new age band are within the expected range. However, when it is combined with the rate revisions, the increase in premium for an insured moving to the next age band on renewal could be as high as 50% compared to the previous policy period. This again leads to large risks of selective lapsing.*"

   Price hikes that are consistent and less abrupt can add to customer retention. In fact in order to address issues of premium jumps, the health insurance committee set up by the regulator to examine the health insurance framework in 2015[36] recommended premium hikes be pegged to an inflation benchmark with Consumer Price Index plus 3% being the cap. This would allow for an automatic increase in premium to take care of medical inflation year on year. Anything beyond this would require Irdai approval.

   While the recommendation did not fructify, there is merit to have a transparent benchmark that captures medical inflation. This not only helps regulatory monitoring of pricing, but also makes price hikes more predictable and transparent. As per Milliman's white paper, a medical inflation index is emerging as a potential best practice to peg premium hikes. "However, no such standardised medical inflation index is currently published in India, although the data exists to do so. Such an index would be extremely useful in providing a solid and robust benchmark and would allow insurers to compare their own experience against the market," noted the report.

2. Irdai needs to work with the industry to improve data gathering for a more accurate pricing of health insurance contracts. This can ultimately

[36] https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo2515&flag=1

lead to differential pricing, where customers who have been with the insurer for long benefit cost-wise. In fact, the report on health insurance in 2015, had recommended entry-based pricing, where loyal policyholders tend to benefit. The report noted:

The age profile of health insurance policies showed that people tend to enter health insurance at an older age when the chances of facing health related issues are higher. Younger population do not take health insurance, knowing fully well that if they take health insurance when they are older, the implied renewability could be used to their advantage.

It has to be ensured that the premium reflects risk at the age of entry into the pool – creating an automatic, structural, incentive to attract the younger population and keep them in the insured pool. This can significantly impact penetration at the market level, and create a structural pull for persistency. (Note: Entry age based pricing also means that a first time entrant which is an older life would be charged more than a similar aged life, which has entered the pool in the past and has stayed insured). Therefore entry-age based pricing is needed. It is recommended that the Authority considers this while approving products under the File and Use guidelines. While Irdai rules allow for entry-based pricing, the industry has not adopted this practice given the lack of data with the insurers.

3. Health insurance commission structure needs to be reviewed. A 15% annual commission structure adds to the operational cost and can be unsustainable in the long run. Also considering that a sizeable chuck of renewals happen online a 15% commission on renewal should be reviewed.

Undertaking reforms in pricing of health insurance is important to complete before India moves from being a young country to a middle-aged country. Irdai will not only have to improve its supervisory role, it will also have to bring in some actionable reforms to control costs.

Chapter 3

Public Disclosures

Retail health insurance is a complex product because in India it doesn't insure all aspects of healthcare, but narrowly focusses on in-patient care. Even in covering in-patient treatment, a retail health insurance policy comes laced with fine-print by way of exclusions, non-payables and other contractual disallowances. Information asymmetry is one of the main reasons why commercial health insurance remains under-penetrated. Furthermore, information asymmetry only compounds market failure as it drives out the incentives for good practices. Buyers of health insurance often have less knowledge of the product purchased than the sellers. The same market peculiarity is observed in the market for physician's services and as per Arrow (1965) the social obligation for best practices is part of the commodity the physician sells, even though it is a part that is not subject to thorough inspection by the buyers. The same principles hold good even in the insurance market where the insurance industry needs to work towards reducing this information asymmetry.

Akerlof (1970) explained market failure and the role of information asymmetry in it by way of sale of used cars. As per Akerlof when sellers of used cars know the quality but buyers don't, only lemons would be traded. Since buyers can't tell the difference between good used cars and lemons, the cars sells at the same price and drives out the owners of good used cars since there is no financial incentive. This leads to market failure and predatory pricing as is being experienced in commercial health insurance.

Reducing information asymmetry therefore needs to be top priority for the regulator and one of the ways that the regulator can enable this is by putting out sharper data in the public domain. In the context of relevant public disclosures for the customers two aspects—on-boarding and claim—are absolutely critical. Data around on-boarding and claims will help customers understand these aspects better which will further help them understand the scope of coverage of retail health insurance. In this context, the chapter will look at the current disclosures and how the data can be sliced further for a meaningful analysis and comparison of health insurers.

What's available?

Insurance sector was privatized in 2000 and the Insurance Regulatory and Development Authority of India (Irdai) was set up in 1999. However, health insurance wasn't a focus area for the regulator initially and the same is evident in the public disclosure documents in the initial years. In the early years, data on non-life business was primarily segregated into fire insurance, marine insurance and miscellaneous insurance with health forming a part of the miscellaneous portfolio. But over the years, data on health has become more pronounced and nuanced.

The annual report put out by the regulator, along with the handbook of statistics have evolved in terms of carrying more industry data including data on the health portfolio. Public disclosure documents put out by insurance companies too are a good source of data however there is scope to slice this data further and also to standardize the manner in which insurers report some of this data.

But before this paper enumerates the kind of data that should be there in the public domain, it's also important to see the data on claims that insurance companies put out in their public disclosure documents. Data on claims in the public disclosure documents is published in form NL24 (ageing of claims segment wise in which health insurance is a separate segment), form NL25 (numbers of claims paid, rejected, closed and outstanding segment wise), and form NL41 (carrying data on complaints including claim complaints on a consolidated basis).

Insurers have documented this data as far back as FY06. While this data helps, but for sharper retail insights into claims settling ability, the numbers needs to get sharper.

On claims

The public disclosure documents that insurance companies put out give out data on claims settlement for health insurance policies without segregating the retail bucket from group. This adulterates the claims settlement data because in case of group policies the number of claims rejected is fewer given the structure of the policy that comes with minimum exclusions like the waiting period on pre-existing ailments and other specified ailments. So a company with a sizeable group insurance portfolio—corporate covers, government insurance schemes—may come across with a better claims settlement record on a consolidated basis.

For retail customers it's important to look at the claims experience of the retail portfolio to assess how the company is settling retail claims. A segregation of claims for group and retail portfolio therefore makes for a more relevant public disclosure. It's interesting to note that Irdai in its annual report mentions death claims of life insurance policies by segregated buckets of group and individual claims. However in the case of health insurance, segregated data on health insurance claims hasn't seen the light of the day. Furthermore as per Aloke Gupta, a health finance expert, health Insurance data also need to be segregated based on age bands. This data should, for each age-band include details like no of persons insured, premium paid and claims.

It's also interesting to note that health insurance consists of two types of plans, indemnity plans that reimburses the cost of hospitalization—what is also known as a regular health insurance policy—and the other is a defined benefit plan that pays the entire insured amount in case the insured even takes place. A critical illness policy is a popular example of a defined benefit policy that commits to pay the sum assured if the policyholder contracts a defined critical illness. Health insurance claims that get reported include claims experience of defined benefit plan as well, however the two experiences can be very different.

Defined benefit plans define the severity of an illness eligible for a claim and therefore the rejection rates tend to be higher because the cover is very specific and customers may not always understand fully the scope of the cover. For example critical illness plans that cover cancer specify the severity of the ailment and usually exclude early stage cancer and

> It's important to standardise the manner in which insurers report data in the public disclosure documents. Inconsistent reporting of data not only clouds transparency but can also distort the true picture.

therefore reject any claim that doesn't meet that severity, however a customer having bought critical illness plan that covers cancer—it's in the fine print that the severity is spelt out—would make a claim even in case of an early stage cancer and find the policy claims to be rejected.

Segregating the data therefore not only makes it sharper but also helps in analysis of customer behaviour and understanding of health insurance products.

Standardization of data reporting

Furthermore it's important to standardise the manner in which insurers report data in the public disclosure documents. For example Form NL41 contains data pertaining to complaints. Annexure 4 highlights three ways in which this data has been reported by three different insurers for FY20. ICICI Lombard General Insurance Co. Ltd for example has reported claims complaints per 10,000 claims registered under line item-7 whereas Star Health and Allied Insurance has reported this number as total claims registered per 10,000 policies. By changing the denominator to number of policies instead of number of complaints the ratio can look much smaller which distorts the picture. Further as per the public disclosure document of Oriental Insurance General Insurance, this data is missing altogether in the NL41 form. It's important to ensure that data reporting follows certain standard norms, because otherwise it can truly distort the true picture.

Within retail indemnity bucket

Data disclosure at the retail level can further be segregated for individual plans which would help understand claims data for various products including the standardized product called Arogya Sanjeevani.

Also while claims settlement data looks at the percentage of claims settled by the insurers, it doesn't really look at the amount being settled. In other words, it doesn't look at leakages for which the customer may have to foot the bill out of pocket.

A health insurance policy doesn't pay for certain items that are listed as non-payable by the insurance policy. These items constitute things like toiletries, cosmetics, telephone costs, laundry charges and internet costs. Even medical items like cost of spectacles, contact lenses and hearing aids may not be paid for by the insurance companies and these are costs that you end up paying out of pocket. Other than this, insurers build in certain exclusions by way of deductibles and co-payment clauses and also reserve the right to not pay for unnecessary treatments, unrelated treatment or for any overcharge by the hospitals. Such expenses become out of pocket for the customers.

Leakages

Other than these, insurance contracts may also have sub-limits like that on the room rent that caps the amount it pays towards the room-rent. But given the fact that other medical costs are linked

> Insurers still enjoy underwriting freedom. Even as recent regulations have rationalised exclusions, insurers can refuse a cover to customers with pre-existing conditions. Data on acceptance rate therefore is important.

to the room rent, a sub-limit on room rent means proportionate deduction on other cost heads as well and hence a much higher out of pocket expense for the customers. In the case of a serious illness that requires expensive treatment the out of pocket therefore could be huge given that proportionate deduction on associated costs.

It's these leakages that the public disclosure can capture by disclosing the amount of claims filed and amount paid. A huge variance however would indicate policies that come with restrictive clauses like sub-limits that customers should watch out for.

Sharper data on claims not only sheds light on the claims settling performance of the insurance company, it's also throws some great insights into the way the policies are sold. If a policy is sold on the back of poor advice and understanding, it's bound to show in the claims experience of the insurers.

On-boarding

But it's not the claims that need focus alone, on-boarding of health insurance too needs focus, a topic which has so far not seen the light in any of the publicly available information. Retail health insurance that covers in-patient costs has come a long way in terms of expanding the scope of coverage. The most recent regulations on rationalizing and standardizing exclusions ensure that insurers don't put in arbitrary exclusions to limit the scope of cover. However, it needs to be remembered that insurers have complete underwriting freedom and therefore while the coverage may have become better the new policyholder may not benefit entirely if the person has pre-existing conditions. According to Mahavir Chopra, founder, Beshak.org the underwriting policies of insurers haven't changed. As per his experience, people with existing conditions that are not covered under health insurance may find it harder to get a policy altogether. That's because insurers have to now mandatorily insure these new ailments if they choose to offer health insurance and so, underwriting is going to get stricter simply because insurers don't seem to have enough data and usually the protocol to deal with the unknown is to refuse cover altogether to people with certain pre-existing ailments. Public disclosures about the number of people who applied for health insurance and number of people that actually got health insurance therefore becomes important and is a good metric to track. While for the regulator, this data can help understand the underwriting practices of the insurance industry, for customers and analysts too this is a powerful dataset to assess how customer friendly an insurance company is.

It's important to capture this data because underwriting freedom has often meant that patients with a pre-existing ailment are left without an insurance cover and worse without a proper reason as to why the insurer couldn't offer a cover. According to Kapil Mehta, co-founder, SecureNow.in, an insurance broker, insurers have this information already. "It is useful to look at acceptance rates because then buyers know where to apply hassle-free. Also, if you are able to get the reason for rejection it is useful - some will not insure diabetics others hypertensives etc. Knowing this acceptance rate is useful for buyers," he said.

A high lapsed rate is also an alarm for customers. Further segregation of this data by age bands will clearly indicate the age groups that tend to lapse their policies more thus requiring deeper regulatory evaluation and action.

Take the case of Abishek Muthian, 34 years old, who bought a health insurance policy some five years back. "I had a knee surgery as a child, and I had declared it to the insurer. I got the policy without much hassle. The sum insured however was just Rs 3 lakh," he said.

About two years back Muthian underwent a spinal surgery and the discharge summary classified him as someone with Achondroplasia (dwarfism). While the insurance policy did come in handy, it also brough home the point that he was inadequately insured and with country in grips of covid-19 he decided to enhance his health insurance cover through a top-up insurance policy. However, all the insurer Muthian approached refused him a policy on grounds of him having undergone a spinal surgery. "The surgery done was to prevent further backpain and is not a lifelong condition. In fact, one of insurers even declared me healthy while rejecting my proposal. Most insurers or their agents upon hearing spinal surgery refused the cover without even bothering to understand the details of it," he said.

For Muthian, changes to the Irdai regulations haven't helped. "The insurers could have permanently excluded my pre-existing condition and could have given me health insurance for other medical emergencies but all the insurers I approached refused me a cover. And it's not clear to me why, because my surgery is neither life threatening nor lifelong. I have not been given a proper reasoning behind rejection," he said. Irdai in its regulations on exclusions has named sixteen pre-existing ailments that can be permanently excluded so that the customer can still have health insurance, however Muthian's surgery—to cure spinal stenosis—is not among the list of ailments that can be permanently excluded. The details of the case can be found here: https://abishekmuthian.com/insurers-are-putting-the-lives-of-sick-and-disabled-at-risk-during-covid-19-pandemic/

New rules haven't helped Muthian and he may not be an aberration. Just by listing ailments that can be excluded, the rules don't make it mandatory for insurers to issue health insurance to a customer. Insurers continue to enjoy underwriting freedom. Giving an example, Chopra of Beshak says: "Epilepsy in a named pre-existing ailment that can be permanently excluded, however practically it's observed that insurers wouldn't issue a policy to people with epilepsy or even with a mental health condition." Data on number of insurance proposals therefore is very important to counter underwriting excesses. It would also help to understand the time taken typically for policy issuance. This data is currently however not in the public domain.

Lapsation

One of the most important metric to track is the rate of lapsation of policies. Lapsation captures the number of people that fall off the bandwagon for a host of reasons. Reasons for lapsing could be as innocuous as buying the policy as a bundled product in the first place and lapsing it upon giving up the main product to more serious concerns like sour claims experience, mis-selling of health insurance plans or steep hike witnessed in premiums making it altogether unaffordable.

A high lapsed rate is also an alarm for customers and can shed some light on industry practices if this data is further segregated by age bands. It will clearly indicate the age groups that tend to lapse their policies more thus requiring deeper regulatory evaluation and action. Data on lapsation is one of the key metric to assess the health of an insurer, however this data is not available in the public domain.

Lack of public disclosures can hamper awareness and can also be counterintuitive to competition. While disclosures have improved, granular disclosures still don't exist and with nearly 7 standalone health insurance companies and health insurance premiums forming nearly 1/3rd of the non-life business it's important to look at health insurance disclosures as a separate segment altogether.

Conclusion

Reducing information asymmetry not only empowers the buyers but also encourages good market practices. While Irdai has taken some consumer centric measures like mandating a consumer information sheet to put out salient features and exclusions of the policy, there is need to put out more data that consumers can use to analyse insurers. Further the manner in which the data is reported needs to get standardised. As per the economic survey 2021, mitigation of information asymmetry would also help lower insurance premiums, enable the offering of better products and help increase the insurance penetration in the country.

Chapter 4

Public Grievance

To assess the extent of market failure and information asymmetry—when the buyer of a product has strikingly less knowledge compared to the seller of the product—it's important to look at customer complaints. Analysis of complaints shouldn't be just limited to the quantum of complaints but also the nature of these complaints.

In the insurance sector, the life insurance portfolio gets the maximum number of complaints followed by the health insurance portfolio. A deeper analysis of complaints suggests that a bulk of complaints in the life sector are related to unfair business practices and policy servicing whereas for the non-life sector—a majority of which comes from the health insurance portfolio—the complaints are largely claims related (Figure 4.1: Complaints by policy type and Figure 4.2: Share of claim complaints in total complaints).

The moment of truth for an insurance product is at the time of making a claim, and any unpleasant surprise at the time not only spoils the customer experience but also brings to light gaps in understanding the product, underwriting practices of the insurers and the product construct.

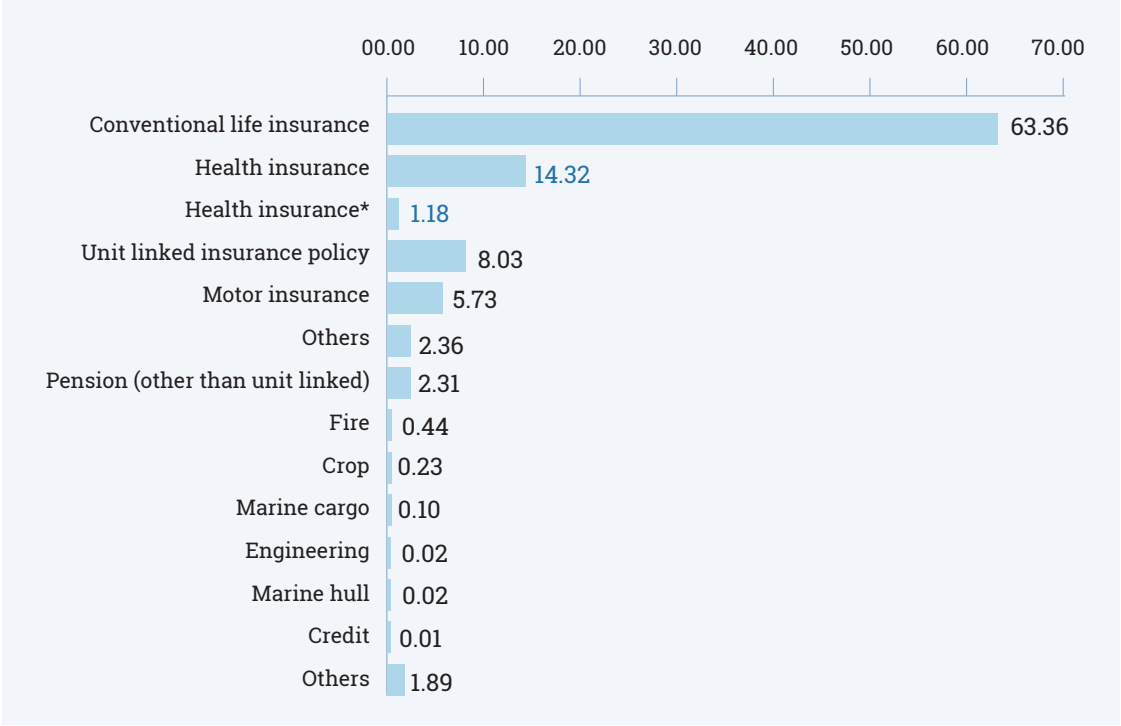
An analysis of complaints and also how efficiently redressal systems work are important to study to understand product experience from the customer standpoint. This chapter therefore will analyse complaints data and will look at if the redressal systems are optimal.

Slicing of complaints

In the non-life segment, majority of complaints come from health insurance as per the latest data available in the Consumers Affairs Booklet (CAB) published by the insurance regulator, Insurance Regulatory and Development Authority of India (IRDAI) for FY20, and this even when in terms of premium size, motor insurance dominated the non-life segment for the same period (Figure 4.3: Complaints comparison of health and motor insurance).

A high number of complaints points to dissatisfaction levels of the customers and worse

Figure 4.1: Complaints by policy type



*Health insurance policies sold by life insurance
Source: Consumer Affairs Booklet FY20, Irdai

Figure 4.2: Share of claim complaints in total complaints

	Claim complaints	Total complaints	Share of claim complaints in total complaints (%)
Non-life insurance segment			
2014-15	26,467	60,688	44
2015-16	26,480	59,083	45
2016-17	27,637	52,104	53
2017-18	25,401	43,995	58
2018-19	26,496	42,761	62
2019-20	32,880	49,988	66
Life insurance segment			
2014-15	31,076	2,78,992	11
2015-16	24,749	2,04,701	12
2016-17	17,383	1,20,847	14
2017-18	21,212	1,54,367	14
2018-19	27,786	1,63,264	17
2019-20	32,921	1,65,217	20

Source: Consumer Affairs Booklet FY 19 and FY20, Irdai

Figure 4.3: Complaints comparison of health and motor insurance (FY20)

Policy Type	Gross premium collected (Rs cr)	No. of Complaints	% of Total number of complaints (49,988)
Health Insurance	56,865	30,825	61.7%
Motor Insurance	68,951	12,328	24.7%

Source: Consumer Affairs Booklet FY20, Irdai, and Irdai annual report FY20

these complaints originate at the most crucial juncture: when the customer makes a claim on her health insurance policy. As per the CAB complaints pertaining to claims have been on the rise. In FY17, claims complaints constituted nearly 54% of the total complaints whereas in FY20 the percentage of claims complaints spiked to 71%. This points to the increasing dissatisfaction emanating at the time of making a claim (Figure 4.4: Breakup of health insurance complaints).

But it's important to understand that health insurance does not operate in isolation. A health insurance policy pays medical costs to the healthcare providers and satisfaction levels at the time of claims is also very much dependent on how healthcare providers function.

Claims complaints originating largely due to mismanagement by healthcare provider

According to Shailesh Kumar, co-founder and insurance head at Insurance Samadhan, customers

Figure 4.4: Breakup of health insurance complaints

	2016-17	2017-18	2018-19	2019-2020
Total complaints	**26,937**	**25,516**	**25,369**	**30,825**
Type (%)				
Claim	53.83	58.67	64.15	70.55
Policy	22.43	18.06	13.95	12.44
Premium	2.58	4.43	3.92	2.57
Refund	2.7	2.69	2.44	1.95
Product	0.48	0.8	0.89	0.72
Proposal	0.68	0.79	0.79	0.42
Coverage	1.43	0.92	0.78	0.67
Others	15.87	13.65	13.08	10.69

Source: Consumer Affairs Booklet FY 19 and FY20, Irdai

Low High

face the brunt of complex products and unregulated healthcare provider space. Unfortunately for the customers, an understanding of health insurance emerges at the time of making a claim. Insurance Samahan is an independent firm--not licensed by Irdai--that helps out (for a fee) mistreated Insurance policyholders whether it's by way of rejection of genuine claims or mis-selling of insurance policies.

"Documentation is a huge problem at the time of making a claim. Usually when a patient gets wheeled into emergency or casualty the patient or family members describe symptoms on the basis of which the insurance helpdesk usually sends the pre-authorization form to the insurers. But at the time of final settlement the discharge summary notes a different diagnosis or a line of treatment it leads to claims getting rejected. It's important therefore that claims processes and treatment protocols are firmly in place because different interpretation too can lead to delays and ultimately rejection of health insurance claims," said Kumar. As per the firms database on health insurance complaints—they receive about 300 complaints a month—the main complaints flow from wrong interpretation of treatment, improper documentation, delay in claim settlement, huge deductions applied to the claim amount and pre-existing diseases.

The CAB too has noted that some of the claims related complaints originate due to poor handling of hospitals. In terms of root causes of claim settlement related complaints non-standardized hospital documents, dependency on receipt of documents from hospitals causing delays and non-utilization of cashless facility by the customer even in case of network adequacy leading to higher requests for reimbursement are main causes of claim delays and rejection and subsequent complaints (Figure 4.5: Root cause of claim settlement-related complaints in health insurance).

Claim complaints originating due to product construct (because of the insurer)

Lack of standardization and protocols in the healthcare sector obviously contributes to customer complaints but complex product structures, narrow scope of coverage, and lack of underwriting rigours—how closely prospects are scrutinised for health information at the time of policy purchase—too leads to customer dissatisfaction.

Figure 4.5: Root cause of claim settlement-related complaints in health insurance

1	Non-utilisation of cashless facility by the customer even in case of network adequacy leading to higher requests for reimbursement
2	Non-standardized hospital documents leading to the need of verification to avoid any abuse scenario
3	Transition from one Third Party Administrator to another
4	Dependency on receipt of documents from hospitals causes delay
5	Non-disclosure of personal medical information at the time of buying of policy (which require verification at claim stage)
6	Verification of pre-existing conditions and/or ailments
7	Lack of previous claims history in case of ported policy
8	Detailed verification is done in case of claims from suspicious hospitals

Source: Consumer Affairs Booklet, Irdai

Figure 4.6: Top 10 reasons for complaints in non-life sector

Complaint description	Complaints type	Share of complaints (%)
Insurer not disposed of the claim	Claim	31.77
Insurer failed to clarify the queries raised by Insured	Others	6.39
Insurer reduced the Quantum of claim for reasons not indicated in the policy	Claim	5.15
Difference between assessed loss and amount settled by Insurer	Claim	6.24
Certificate of Insurance/Policy not received by the Insured	Policy Related	4.53
Insurer repudiated the claim due to alleged breach of policycondition /warranty	Claim	4.25
Details shown in policy or Add-on are incorrect	Policy Related	3.14
Claim repudiated without giving reasons	Claim	3.19
Delay on the part of the TPA to arrange claims reimbursement	Claim	2.05
Insurer failed to make offer of settlement to Insured after receipt of survey report	Claim	2.31

Source: Consumer Affairs Booklet FY20, Irdai

According to Shailesh Kumar from Samadhan partial settlement of claim amount is a huge sore point with retail customers and this ultimately reveals the knowledge gaps and also points to complex product constructs. "A customer buys health insurance policy thinking anything related to hospitalization is covered, but they don't understand the many exclusions and deductions in the policy. In India insured customers end up paying up to 30% of the hospital bill out of pocket which leads to a lot of dissatisfaction," he said.

As per the CAB for FY20 insurers reducing the quantum of claim amount for reasons not indicated in the policy is amongst the top bucket of complaints in the non-life sector (Figure 4.6: Top 10 reasons for complaints in non-life sector). As per the Insurance Ombudsman annual report for FY19 as well inarticulate terms and conditions under health insurance policy is an issue that gives rise to complaints (http://ecoi.co.in/annualreports/AnnualReport2018-19.pdf). Reiterating this point again, the annual report for FY20 too pointed out the fact that in health insurance, complaints occur mainly due to reasonable and customary exclusion clause and that policy terms and conditions need to be sharper for proper interpretation.

But it's not the product construct alone, slicing the data on complaints also sheds light on the selling practices of insurance intermediaries and underwriting practices of the insurance companies. Looking at the same data that explains the root cause of health insurance claims related complaints it's clear that non-disclosure of personal medical information at the time of buying of policy (which require verification at claim stage), verification of pre-existing conditions and lack of previous claims history in case of ported policy are some of the dominant factors for a complaint. The nature of these complaints point to the popular practice of underwriting health insurance at the time of making a claim—in terms of asking and scrutinising all medical details of the insured—rather than at the time of issuing a policy. A lot of these complaints can be nipped in the bud, if Insurers front-end underwriting at the time of selling a policy and not at the time of making a claim.

The same discipline too applies at the time of

porting of policy where the new insurer should ask for all the relevant information of the policyholder from the previous insurance company who is duty bound to share it through a common data repository set up by Irdai, however as reflected from the data from the consumer handbook, lack previous claims history in case of ported policy is one of the root causes for claims related complaints.

Insurance intermediaries too are at fault here who sometime misguide prospects when filling up the proposal form and encourage them to conceal medical information for faster issuance of health insurance policy. The Insurance Ombudsman Annual Report FY19 too has identified:

1. Lack of awareness on the part of distribution channel

2. Completion of proposal forms by agents leading to non-disclosure and misrepresentation

3. Inaction against erring intermediaries

As some of the issues leading to customer dissatisfaction.

In order to offer a smooth on-boarding process, insurers sometime cut corners on underwriting, but are stringent at the time of claims. For customers this can be a double edged sword, because not only will lax underwriting reflect in elevated pricing to account for higher risk the insurer may take but underwriting at the time of claims can lead to a high rejection rate. For customers caught in this difficult spot, things may not help further given they may find it hard to port their policy having made a claim.

This is one of the reasons that India probably has a very high claim rejection rate. As per the data provided by SecureNow Insurance Brokers Pvt Ltd, out of 25 non-life companies for whom the data was collated, only 10 insurers had a claims settlement rate of at least 90% (Figure 4.7: Claims settlement rate by insurers). With a median claims settlement rate of 88% calculated by number of claims, it's evident that health insurance is not working optimally for the customers. "Developed countries have a settlement rate of over 95% and that's largely because the exclusions are limited and waiting periods are not that long. In fact pre-existing conditions are covered immediately in many cases," said Kapil Mehta, co-founder, SecureNow Insurance Brokers Pvt Ltd.

Recourse for the policyholders

Data on complaints exposes gaps in claims management by the provider and the payor and also information arbitrage for the customers, but even in terms of systems put in place for grievance redressal, it appears it's not functioning to optimum levels in favour of the consumers. The industry follows a two pronged approach in terms of grievance redressal. The first is at the level of the insurance company, where the complaints are also monitored by Irdai and subsequently with the Insurance Ombudsman.

Grievance redressal with the insurers

Grievance registration in insurance starts with lodging a complaint with the insurance company. Insurers are mandated to have a grievance redressal policy prominently displayed with details of the grievance redressal officer on their website. Complaints that flow in through the internal grievance management systems of insurers is monitored through the Integrated Grievance Management System (IGMS) of the regulator. Set up in 2011, IGMS is an online consumer complaints registration system maintained by the insurance regulator. IGMS works like a central repository of all consumer complaints received by life insurance and non-life insurance companies.

So when a customer logs a compliant with the insurer it flows into the IGMS system. Customers can also directly approach the IGMS by logging into igms.irda.gov.in or through the toll free numbers 155255 and 1800-4254-732. IGMS was set up by Irdai primarily to monitor turn-around time on complaints and

Figure 4.7: Claims settlement rate by insurer

Insurer	Claims settlement rate 2019-20 (%)
The Oriental Insurance Company	98%
Magma HDI General Insurance Company Ltd.	96%
The New India Assurance Company	96%
National insurance Co. ltd	95%
Reliance General Insurance	93%
Iffco Tokio General	93%
Religare Health Insurance Company Limited	92%
HDFC Ergo Health Insurance	92%
Max Bupa Health Insurance	90%
Future Generali India Insurance Company Ltd.	90%
HDFC Ergo General Insurance Company Limited	89%
Bajaj Allianz General Insurance Company Limited	89%
ICICI Lombard General Insurance Company	88%
United india Insurance Co. Ltd	87%
ManipalCigna Health Insurance Pvt Ltd	87%
Royal Sundaram General Insurance Company	86%
SBI General Insurance Company Ltd.	84%
Liberty General Insurance Company Limited	84%
Star Health Insurance	83%
Tata AIG	79%
Bharti AXA	79%
Kotak Mahindra General Insurance Company Limited	77%
Cholamandalam MS General Insurance Company Limited	77%
Aditya Birla Health Insurance	77%
Universal Sompo GIC Ltd.	75%
Median	**88%**

Note: Claims settlement rate is calculated from public disclosure documents (NL25) and is calculated as a % of total claims on which a decision was taken ie (claims settled/claims settled+claims closed+claims repudiated)
Source: SecureNow Insurance Brokers Pvt LTD

have a repository of data to help Irdai track nature of complaints and timelines. Irdai does not adjudicate on complaints through IGMS, so the efficacy of IGMS depends on Insurers taking complaints very seriously but as per the annual report of insurance ombudsman there have been challenges.

The FY19 Insurance Ombudsman report not only lays down some of the issues that leads to complaints but have also placed on record some of the observations and suggestions. In this regard under general suggestions point number 8 is very telling. It says: "the craze for new business, communication gap between the insurer and the insured, casual approach in filling up proposal forms, non-disclosure of terms and conditions of policy and the indifferent approach in settlement of claims being the genesis of most complaints, the

insurer should take necessary steps to plug these loopholes." The report further observed that the grievance redressal mechanism of the insurers had become ritualistic without properly addressing the grievances raised by their customers. "The insurers are becoming more cautious about their business ranking in the market and least bothered about the ranking in the number of complaints registered against them," said the report.

As per the report even after references to the grieving officer, the companies do not bother to re-examine the cases and treat the complaints as closed (complaint closed is complaint resolved in the IGMS). And so, as per the report, the status of complaints does not get correctly reflected in the Irdai's records. The report further notes that many companies instead of guiding customer to approach their in-house grievance redressal, are directing customers to approach the Ombudsman—which will again send the customer to the insurer first—thus short circuiting the whole system and reducing the effectiveness in a planned manner. The latest annual report of the Ombudsman raises similar concerns as well.

It also has not helped that the regulator has changed the definition of a complaint in its 2017 notification on protection of policyholders' interests. The regulations now define an 'insurance complaint' to be a written expression (even in electronic mode) of dissatisfaction made by the complainant against an entity—such as insurer, agent, broker—about an action or lack of action about the standard of service or deficiency of service. Earlier definition of a complaint also included verbal communication, but that is no longer the case. While this may have made lives easy for insurers in terms of documenting complaints, for the policyholders this provision brings no respite. In fact one of the reason for complaints falling is the fact that many customers may not want to go the extra mile and file written complaints. Furthermore it's important to have some standards in terms of what consists of a complaint and the escalation mechanisms employed by insurers. According to some insurers that were spoken to, complaints don't have a standard definition and therefore what one insurer may register as a complaint, the other may register as service request. Even the grievance redressal mechanism employed by insurers follow different patterns. For example one insurer follows a three step approach where unresolved complaints are escalated to senior officers within the insurance company. Failing this the insurer recommends approaching the insurance ombudsman. Another insurer follows a two-step approach failing which, customers are advised to reach out to the insurance Ombudsman.

Grievance redressal by Insurance Ombudsman

Insurance Ombudsman is a quasi-judicial body created by the government in 1998 with the purpose of quick disposal of the grievances of the insured customers. The offices of ombudsman are typically drawn from the insurance Industry, civil services and judicial services. Currently there are about 17 Ombudsman offices spread across the country.

Insurance Ombudsmen are appointed by the Council for Insurance Ombudsmen of which Irdai is a part and are empowered to entertain complaints against insurance companies and their agents and intermediaries on aspects that include

1. Delay in settlement of claims.
2. Any partial or total repudiation of claims by an insurer.
3. Any dispute over premium paid or payable in terms of the policy.
4. Misrepresentation of policy terms and conditions at any time in the policy document or policy contract.
5. Any dispute on the legal construction of the policies in so far as such disputes relate to claims.
6. Policy servicing related grievances against

> Most complaints originate in the craze for new business, communication gap between the insurer and the insured, casual approach in filling up forms, non-disclosure of terms and an indifferent approach to claims settlement.

insurers and their agents and intermediaries

7. Issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with the proposal form submitted by the proposer.

8. Non-issue of any insurance policy to customers after receipt of premium in life insurance and general insurance including health insurance.

9. Any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned at clauses 1 to 6.

It's important to note that the ombudsman's powers are restricted to insurance contracts of up to Rs 30 lakh. For value above this limit, disputes can be taken to courts or consumer forums.

While the idea of an Ombudsman is to offer quick relief to the customers, data doesn't inspire confidence. As per the latest annual report of the Insurance Ombudsman for FY20, it received a total of 9645 complaints of which it disposed of 75% of the complaints—resolution could have been in favour of insured or insurer. However it was able to dispose of only about 30% of the complaints within three months. The bulk of the complaints took a year or more for resolution.

Even in term of resolution it's observed that there are discrepancies in adjudication of complaints of similar nature by two different offices of Ombudsman. Take for example the case of Rakesh Kohli vs Apollo Munich Health Insurance Co. Ltd (now merged with HDFC Ergo General Insurance Co. ltd) Date of award 30-12-2019. The insurance ombudsman presiding over states of Western Uttar Pradesh and Uttarakhand awarded in favour of the policyholder whose claim was denied on grounds of non-disclosure of pre-existing disease while porting the policy from one insurer to another. The ombudsman argued that it was due to incorrect filing of proposal form by the agent of the new insurer. Also record of previous claims was available with the previous insurer and hence the new insurer should have done the due diligence while porting the policy. The same ombudsman took a similar view in another case (case of Tanmay Sharma vs HDFC ERGO General Insurance Co. Ltd) Date 11-12-2019 where it held the agent responsible for not correctly filling up the form at the time of porting the policy. However in the case of Lallan Ram Maurya vs Max Bupa Health Insurance Co. Ltd, date 02-12-2019 the insurance ombudsman office of Lucknow (a different ombudsman) dismissed the case of repudiation of claim on grounds of non-disclosure of pre-existing ailment. The policyholder in this case admitted to have been a patient of CAD (Coronary Artery Disease) even before the policy was bought and according to the policyholder this was mentioned to the agent at the time of buying the policy. However the claim for acute gastroenteritis was rejected on grounds of non-disclosure of material facts. The statement of the ombudsman thus reads: "Ground of repudiation is non-disclosure of CAD

in the proposal form and this fact is admitted by the complainant himself that he was an old patient of CAD. Although according to the complainant he disclosed this fact to the concerned agent but in the proposal form, this fact has been concealed. Accordingly the claim is rightly repudiated by the respondent insurance company,". The wording of these awards can be found on this link: http://ecoi.co.in/AwardsMonthwise/December2019/IndividualMediclaim_Dec_2019.pdf

On reading some of the awards and dismissal by insurance ombudsman it's also evident that while some Ombudsman are consumer leaning, where there is effort to establish the cause of concealment of information or if treatment and claim was for unrelated ailments, some are pure ritualistic, hence there needs to some sort of common understanding and rules in the process of adjudication.

Conclusion

Data regarding complaints sheds some very important light on what's ailing the health insurance customers and while making health insurance product more comprehensive maybe some distance away given the healthcare provider market, other aspects of policy distribution, issuance, underwriting can be dealt with by Irdai.

The regulator also needs enhance its monitoring capacities over complaints and resolutions and there should be some sort of guiding principles in place for the adjudicating officers at the insurance offices and also the ombudsman offices so that complaints of similar nature can be disposed of in the same fashion.

Chapter 5

Third Party Administrators in Health Insurance

Introduction

Following the formation of the Insurance Regulatory and Development Authority of India (IRDAI), regulations relating to Third Party Administrators (TPA) were among the earliest regulatory pieces in health insurance to be put in place. Announced in 2001[37], the regulations identified TPAs as intermediaries between insurers and insured patients to settle health insurance claims.

Over the years, the vision for TPAs was not just to help insurers in settling claims, but an overarching role that would build the healthcare value chain for insurers and customers alike. It's important, therefore, to track the evolution of TPAs, and also the role of IRDAI, in enabling an environment for TPAs to achieve their stated objectives.

Concept of TPAs

While the 2001 regulations formalized TPAs as an entity involved in claims settlement, their concept is as old as the Mediclaim policy itself. According to Aloke Gupta, a health financing expert, the need for TPAs originated from the inability of insurers to understand health insurance claims due to their medical terminology and practices. Gupta said: "Mediclaim for retail was initially based on cashless settlement of claims, where the insured was handed a list of empaneled hospitals, and the bills would go directly to the insurer. But most underwriting offices of the insurers did not have any understanding of health insurance, hence many hospitals began misusing this tie-up. There were cases where hospitals would get patients to buy health insurance so that the treatment could be billed to the insurer or bills would be

[37] https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo25&flag=1

inflated. Since insurers did not have the know-how in processing medical claims, the claims piled up. Ultimately, this led to hospital tie-ups being annulled policies becoming reimbursement-based, where the insured first paid bills and then claimed reimbursement."

Even for group health insurance, where a company buys health insurance for its employees, claims adjudication was a nightmare. Corporate human resources (HR) was ill-equipped to handle claims. So, when employees submitted medical bills to HR, it was often a hassle, given the lack of expertise in adjudicating claims and, worse, in explaining benefits and exclusions to employees.

It was against this backdrop that TPAs came into existence informally, when the sector wasn't even privatized. The concept of TPAs, therefore, took root in the realization that the health insurance industry needed specialized skills in claims management and administration, given the varied treatment protocols, practices and billing patterns followed by hospitals. Insurers could outsource claims to TPAs, who would then interact with insured patients and hospitals to ensure smooth and fair settlement of health insurance claims.

TPA vision

What was a business opportunity was hard coded in law with the formation of IRDAI. The regulations brought TPAs under the purview of the insurance regulator and defined their function towards claims settlement.

TPAs were required to obtain requisite documents to process claims, and give necessary assistance and advice to claimants in complying with the requirements for settlement of claims. They were also required to watch for any adverse practices by hospitals or the insured that could hamper the insurer's business. While the regulations didn't state so explicitly, TPAs at the time would also adjudicate on claims—they had the power to reject claims.

According to Ajith Mohan Sharan, former Joint Secretary in the Department of Banking and Insurance, who oversaw the opening of the insurance sector and initial reforms, the initial idea of TPAs was to give confidence to insurers in claims settlement. "We looked at TPA as professional entities for intermediation. Even after opening the sector, the industry was primarily confined to group health insurance, and even that was a minor part of their business. Group health insurance was sold as an add-on to other corporate covers such as fire insurance. The idea of TPAs was to provide cashless claims[38] and manage claims for the insurer, which would encourage them to open out to retail eventually," he said.

While initial regulations carved out a special role for TPAs in claims adjudication and settlement, the vision for them didn't stop there. According to Girish Rao, Chairman, Vidal Health Insurance TPA Pvt. Ltd, health insurance operated in a highly unregulated and fragmented environment. So, the regulator was also looking at a third party to build the healthcare value chain from an insurance standpoint, while the insurance company could focus on underwriting and financing. Said Rao: "Third party meant they were neither the payer nor the provider, but a third person who kept everyone's interest in mind—hospitals, insurers and customers. This would allow general insurance companies to stick to underwriting, while adjudication of claims would then lie with the third party. So, the insurer would be competent in underwriting and TPAs would bring an understanding of medicine, deeper clinical competency, better understanding of disease management etc. Accordingly, the regulator hoped that TPAs would negotiate and standardize tariffs with hospitals, bring in-treatment protocols and adjudicate on claims." Outsourcing payment control to third party also addresses an important aspect of moral hazard. Insurance removes the incentive on the part of individuals, patients

[38] https://www.livemint.com/Money/jA4Q1iGywZaOwrUXigSo8J/Did-You-Know--The-difference-between-cashless-and-reimburse.html

> Health insurance operated in a unregulated, fragmented environment. So, Irdai was also looking at a third party to build the healthcare chain from an insurance standpoint, while the insurer focused on underwriting and financing.

and physicians to shop around for better prices for hospitalization and surgical care (Arrow 1963). Third party therefore can bring in value proposition for insured, insurer as well as the healthcare facility.

According to K.C Misra, former director of the National Insurance Academy, while health insurance began in India with in-patient hospitalization, the government was keen to expand the scope to bring in managed care, and TPAs were seen as entities appropriate to marshal this cause. TPAs were to perform a hybrid role, where they would also act as the health guardians of customers. They would not only get into morbidity—through administering health insurance claims—but also managed care by looking at preventive healthcare, recommending and monitoring treatments, and also do referrals.

Given their position of interacting with all stakeholders, TPAs sat at a vantage point: they were a repository of data on insurers, customers and healthcare providers. In its 2001-02 annual report, IRDAI noted the health insurance industry needed credible data to price health premiums scientifically. It could also facilitate other features like policy portability.

In the same annual report, IRDAI also acknowledged the shortcomings of health insurance coverage. It noted: "Due to the limitations of access to data, the covers for insurance that are available are narrow in scope. The insurance coverage of population is scanty, restricted, costly and poorly administered. Those covered have only an omnibus policy, with no element of risk differentiation. There is no reliable basis to measure premium cost in relation to specific risk/occurrences and the policyholders have no choice of cover, specific to their requirement. The insurance companies have hardly any role and no interface with hospital establishments in determining the reasonableness of charges, relative to quality of medical care provided. There are no benchmarks and no standards for billing for these services. The health care delivery is consequently cost-ridden which is passed on to the patient, i.e., the policyholder. Owing to the hidden costs in health care delivery system, without any audit or authentication of their reasonableness, health insurance comes with a big price tag. Additionally, there is no mechanism to check these against established standards, and no benchmarks have been attempted/ established. This scenario greatly inhibits exponential growth of medical care / health insurance business in the country."

Accordingly, IRDAI, in that annual report, noted that TPAs would not only enable insurers to outsource their claims administration and assist in raising service efficiency, but would also assist insurers to design customized products and create a health statistics database.

Stumbling blocks

While the canvas for TPAs was huge, the first set of regulations narrowed the scope of TPAs as intermediaries that would help insurers in claims management. But even that role was performed unsatisfactorily. As per the 2003-04 annual

report of IRDAI, the growth of TPAs was hampered due to multiple complaints related to servicing policyholders. This included delays in claims settlement, lower settlement amounts, refusal to renew policy in case of adverse claims experience, and improper guidance.

All three stakeholders—insurers, regulator and TPAs—were responsible. From a regulatory stand point, the first set of regulations on TPA were loose. According to Gupta, the regulations loosely defined training requirements and quality of people, but a low entry barrier compounded the problem.

The minimum capital requirement for TPAs was Rs 1 crore, against Rs 100 crore for non-life insurers. By the end of 2002, there were 20 TPAs. "A low entry barrier meant non-serious players, who could barely settle claims, came in. Management bandwidth was shallow and customers didn't have a choice to choose their TPA, which curtailed market competition as well," said Rao.

Insurers, too, were left unsatisfied with the TPA experience. According to Sharan, the reason was primarily squeezing profits of TPAs. "Insurers were largely looking at group portfolios and were incurring huge losses in initial years. So, they couldn't remunerate TPAs adequately. For TPAs, this meant an inability to hire and manage specialized skills required for the role," he said. Further according to Sharan TPAs were to take care of the moral hazard implicit in the insurance companies processing their own claims. The TPAs were expected to bring more objectivity and transparency in claim processing. Unfortunately the insurance companies were not too happy with this and many of them took over the claim processing back

Sharan says the regulator did not handhold TPAs adequately. They were left at the mercy of insurers, who didn't remunerate them adequately. "IRDAI should have done proper handholding to build capacities, but that just didn't happen. In fact, TPAs reduced in stature to become a pass-through for claims," he said. According to Sharan, this was largely due to the fact that health insurance wasn't a priority for IRDAI then.

IRDAI'S focus

It wasn't until 2008[39] that IRDAI set up a committee to evaluate the performance of TPAs and recommend rules towards their development. By now, health insurance premiums made up about 20% of non-life premiums.

The report, published in July 2009[40], noted the need to formulate comprehensive regulations to build long-term players, create infrastructure and employ the required skillset. It highlighted the lack of standardization in processes such as billing, information sought by hospitals and discharge procedures. It also recognized the need to develop service standards, turnaround times and an effective redress mechanism.

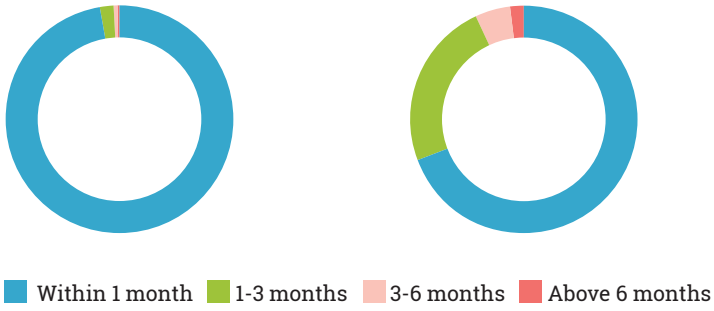
While making all the right noises, much of the recommendations are not hard-coded into law. One of the reasons why is that this needs healthcare providers to play ball as well. What was within the regulator's control was to revisit regulations for TPAs, which it did when it came out with health insurance regulations[41] in 2013. The rules clearly demarcated the role of TPAs as an interface between the insurer and the hospital.

These regulations specified that TPAs did not have the power to deny claims, and also that the insurer should make direct payments to hospitals or policyholders. Till then, TPAs had the power to adjudicate claims, according to Nayan Shah, Managing Director of Paramount Health Services and Insurance TPA. "The model was to take money from insurance companies as deposits and settle hospital bills on behalf of the insured patient," said Shah.

[39] https://www.irdai.gov.in/ADMINCMS/cms/Circulars_Layout.aspx?page=PageNo447&flag=1
[40] https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo1233&flag=1
[41] https://www.irdai.gov.in/ADMINCMS/cms/Circulars_Layout.aspx?page=PageNo2085&flag=1

Figure 5.1: Comparison of claims registered and time to claims settlement by TPAs versus in-house

	In-house	TPAs
Claims handled		
Registered	**6.08 million (31% of total)**	**13.81 million (69% of total)**
Rejected	9%	7%
Outstanding	9%	8%
Duration of settlement		
Claims settled	**4.99 million**	**11.78 million**



Source: Irdai annaul report FY20

However, in light of malpractices, IRDAI took away the power of adjudication from TPAs and instead made insurers responsible for adjudicating claims. There were also complaints of TPAs not settling bills on time and IRDAI further instructed insurers to pay directly to hospitals or policyholders. While the rules may have reduced the scope of TPAs and put more onus on the insurers, enforcement of these rules remains a problem. The annual report of the Insurance Ombudsman for FY20 notes: "TPAs decision on settlement of claims should not be final and the matter should be reviewed by the insurer to arrive at a judicious decision. Most general insurers don't have any established system for review of the complaints rejected by their TPAs. Even when the complainant approaches the grievance cell, after repudiation of claim by the TPA, the insurer seldom examines the claim dispassionately. In some cases, the insurer depends on the TPA to present cases before the Ombudsman."

TPA vs In-house

The subsequent 2015 regulations, which was notified in 2016[42], built on the claims-settling function of TPAs. By then, TPAs were not the only entity in claims settlement. With the advent of standalone health insurance companies, and growth in retail books, many insurers developed in-house claims settlement capabilities to differentiate themselves in handling claims, given this was core competency. TPAs were largely restricted to handling group claims.

Still, in FY20, TPAs processed 69% of claims by volumes (Figure 5.1: Comparison of claims registered and time to claims settlement by TPAs versus in-house). They have a dominant presence in

[42] https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo2801&flag=1

group claims, government schemes and state-run insurers. In other words, while their function may have narrowed in scope, they are still handling a sizeable chunk of claims, and therefore need proper regulatory supervision.

Given that TPAs handle a sizeable portion of group businesses that come with lower exclusions and hence lower probability of rejections, TPAs have understandably done slightly better in terms of claims repudiation and claims outstanding. However, turn-around time for claims settlement places in-house teams far more superior compared to TPAs.

Conclusion

There are about 24 TPAs that look at health insurance claims, against 20 in 2002. According to Shah, this count was 28 till about three years back. But a few merged. It's likely this number will shrink further, he added, as the scope of work for TPAs has narrowed and insurers are more inclined to manage claims as a point of service differentiator.

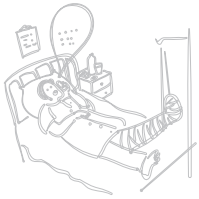
The absence of evolution in Indian health insurance from indemnity-based to managed care has also impacted growth of TPAs. In a managed care system, TPAs could have played an important role in terms of disease management. Even, as data repositories, TPAs have not gained a foothold.

Twenty years into privatization, TPAs have gone from being thought of as game-changers to much-sidelined entities. Much of the responsibility for this lies at the doors of TPAs, as they didn't create a strong value proposition for insurers. There's also the initial neglect by IRDAI in developing TPAs.

Some recent regulations like allowing customers to choose their TPAs is a good step towards creating competition. However, the reforms are late. A proactive start to regulations could have changed the face of health financing in India to a great extent.

How does TPA work in a cashless claim

Step 1 (Customer):
Customer buys policy. Docket contains TPA card along with list of empaneled hospitals.



Step 2 (TPA desk):
On hospitalization, policyholder contacts TPA desk at hospital, which then contacts the TPA.

Step 3 (TPA):
TPA receives insured patient details like ailment, line of treatment and treatment cost. TPA approves treatment cost, as per claims guidelines prescribed by the insurer.

Step 3a (TPA):
In case claims need adjudication, TPA raises matter with insurer. Once approved, TPA informs hospital.

Step 4 (TPA desk):
On discharge, TPA desk in hospital sends the final bill, along with supporting documents such as discharge summary, to TPA.

Step 5 (TPA):
TPA uploads claim details using the insurer's software.

Step 6 (Insurer):
Insurer pays the hospital.

Chapter 6

Conclusion and Recommendations

Under-penetration of commercial health insurance even after two decades of privatization points to the fact that commercial health insurance in India has not taken off as expected. Lack of data, premium shocks experienced by policyholders, nature of complaints registered and manner of redressal all point to market failure.

Retail health insurance in India narrowly focusses on the "in-patient" part of healthcare, where a medical event leading to hospitalization is covered. Within this construct, in order to avoid moral hazard and anti-selection, the product is layered with exclusions that makes health insurance a complicated product to understand by laypersons who buys health insurance with the assumption that it would pay all the hospital costs.

And this leads to a chicken and egg situation. For insurance to be comprehensive, it's important that more people are covered, but for that to happen insurance policies need to be simpler with minimum exclusions. Cracking this problem may not be a simple one given the involvement of a third entity, healthcare providers, who are not controlled by Irdai. However, even within the health insurance ecosystem there lies huge scope for improvement that Irdai can work upon. In fact, some areas of focus have been outlined by the regulator already in the past.

1. The working group for standardization of exclusions in Health Insurance Contracts recommended the formation of Health Technology Assessment Committee. The scope of HTA was to examine and recommend the inclusion of advancements in medical technology as well as new treatments / drugs introduced in the Indian market for coverage under Insurance. The working group constituted representatives from Irdai, National Accreditation Board for Hospitals and Healthcare Providers (NABH), Third Party Administrators

The working group for standardization of exclusions in Health Insurance Contracts recommended the formation of Health Technology Assessment Committee. The scope of HTA was to examine and recommend the inclusion of advancements in medical technology as well as new treatments / drugs introduced in the Indian market for coverage under Insurance. The formation of HTA is still pending.

(TPA), Insurers and industry bodies. While much of the recommendations of the working group has been hardcoded into law, the formation of HTA is pending. Irdai has reconstituted the health insurance forum and has also formed a health insurance advisory committee to advice Irdai on various aspects of health insurance. The advisory group consists of experts and academicians from the healthcare sector. Subsequently Irdai also reconstituted the health insurance forum. Deliberations over a HTA could be delegated to these committees. Most developed countries have developed Health Technology Assessment (HTA) approach and Irdai should embark on this too.

2. Irdai now has a separate health department handled by member-non-life. Periodically Irdai has reached out to industry bodies to brainstorm on issues of health insurance. One such important event was the constitution of the health insurance forum that invites participation from not just the regulator and the insurance industry but also from the government and healthcare providers. While the forum exists and was reconstituted as well, the engagement with the larger audience needs to be there. The forum needs to be more public with its discussions and work. There is also a growing need for the regulator to review and expand capacities for proactive regulations and enforcement.

Pricing

1. Pricing in retail health insurance follows an age-band approach where premium are usually fixed for a number of years—usually 3-5 years—and when the customer jumps from one age band to another the premium sees a revision. This along with other factors like medical inflation can lead to huge premium hikes. Insurers respond to medical inflation by revising premiums usually in blocks of 2-4 years in spite of regulations allowing them an annual revision. One of the reasons cited for this is delay in regulatory approvals. This not only merits increasing regulatory capacities but also designing a healthcare inflation index by which to peg an annual premium revision schedule.

2. As per the report of an expert committee constituted in 2014 to look into health insurance framework, the age profile of health insurance policies showed that people tend to enter health insurance at an older age. The report recommended entry-based pricing when the premiums paid by policyholders reflect risk at the age of entry into the pool. As per the report this can positively impact penetration and create a structural pull for persistency. Irdai regulations since then have allowed for entry-based pricing, the industry has not adopted this practice given the lack of data with the insurers. Work is needed to not only strengthen

data gathering, but the industry would need a proactive push from the regulator.

While these are some of the recommendations that have been deliberated by the regulator itself in the past, following recommendations too need to be looked at for better public disclosures, complaints handling and pricing.

3. Cost of acquisition needs to be reviewed. Currently the rules allow for a 15% commission payment every year upon renewal of the health insurance contract and a reward of 30% on top. This puts a lot of pressure on costs and keeps premiums high.

Public disclosures

Public disclosures are important as they aid competition and also shine light on company's performance vis a vis consumer centric metrics. Currently public disclosures on health insurance portfolio does not give a 360 view and are inconsistent in the manner in which it's reported. There is scope to improve disclosures further and to that effect five things should be done.

1. There needs to be a standard format in which the industry captures and reports data. Currently there are discrepancies in the way insurers report their data in the public disclosure documents. Lack of consistency in the manner of reporting distorts the true picture and clouds transparency.
2. Data on claims needs to be segregated for group and retail portfolio for retail customers to see how insurers are faring in terms of handling retail portfolio. Right now claims data is a consolidated number in the public disclosure documents of the insurers.

3. Data on acceptance rate should be collated and published. While the regulatory authority has reduced and standardized exclusions to a great extent, insurers have underwriting freedom that allows them to accept risks as per their appetite. From a consumer standpoint it's important to identify insurers with a better acceptance rate.

4. An indicator of whether retail health insurance products are actually working in the interest of policyholders can be seen in the disallowance built into the health insurance policy. Capturing the % of out-of-pocket expenses in settling claims therefore is important.

5. Ultimately customer happiness can be measured by looking at lapses in health insurance. A high lapsation rate in health insurance points to customer dissatisfaction which can be a result of many things ranging from unaffordability, to poor understanding of product to a bad claims experience. Rate of lapsation therefore is extremely important to be captured.

Grievance redressal

1. The insurance sector has a layered system for redressal of public grievance where the first point of contact is the insurer, failing which the second point of contact is the insurance ombudsman and ultimately the courts. While the infrastructure is well placed to handle complaints, monitoring of complaints needs enhancement for effecting grievance redressal at the point of insurers only.

2. Definition of a complaint also needs a rethink. What makes a complaint needs to be clearly spelt out and also forcing customers to file a complaint in a written format only is tedious. A step toward consumer protection ideally shouldn't have any such terms and conditions.

3. Also there needs to be some sort of guiding principles in place for the adjudicating officers at the insurance offices and also the ombudsman offices so that complaints of similar nature can be disposed of in the same fashion.

4. There is a growing consensus that health financing alone is not a long-term solution. Preventive care is equally important and insurers too have started to build certain wellness features into policy designs. This may be a good time to review

the role of TPAs and with insurers trying to build claims settling capabilities in-house, TPAs could don a fiduciary role and build managed care.

The post pandemic world has made healthcare a focal point in many economies. In India too healthcare ecosystem has gained centerstage and was recently acknowledged by the Economic Survey, 2021. Given the low level of public expenditure on healthcare, and the considerable under-penetration of commercial health insurance, there is tremendous scope for commercial health insurance to expand. However given the signs of market failure in health insurance it's clear that Irdai needs to work on building capacities to take on the task. Working along with industry bodies and creating focused groups is a good first step. The recommendations of the paper should also help Irdai in increasing the expansion of commercial health insurance.

ANNEXURE 1: Features of Mediclaim as furnished by National Insurance Company Limited for the report on health insurance commissioned by the Ministry of Finance and was laid in the parliament in 2006

Mediclaim Insurance Policy

The policy covers reimbursement of Hospitalisation / Domiciliary Hospitalisation expenses for illness / diseases or injury sustained.

In the event of any claim becoming admissible under this scheme, the Company will pay to the Insured Person the amount of such expenses as would fall under different heads mentioned hereunder and as are reasonable and necessarily incurred by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate in any one period of insurance stated in the policy schedule.

Reimbursement of hospitalisation expenses are allowed for :

1. (a) Room, Boarding Expenses as provided by the Hospital / Nursing Home.

2. (b) Nursing Expenses.

3. (c) Surgeon, Anaesthetist, Medical Practitioner, Consultant, Specialist Fees.

4. (d) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances,

Medicines and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemakers, Artificial limbs and cost of organs and similar expenses.

Pre-hospitalisation expenses incurred during the period upto 30 days prior to hospitalization and post hospitalization expenses Incurred during the period upto 60 days after discharge from the hospital are also covered under the policy.

This Insurance is available to persons between the age of 5 years and 80 years. Children between the age of 03 months and 05 years of age can be covered provided one or both parents are covered concurrently.

The Sum Insured under the Mediclaim Policy varies from Rs. 15,000/- to Rs. 5 Lakh wherein liability of the Company for domiciliary hospitalization are Rs. 3000/- and Rs. 65,000/- respectively.

Premium under Mediclaim policy varies according to the age of the Insured Persons as well as the Sum Insured opted by them. Thus the premium for Sum Insured of Rs. 15000/- upto 35 years age category comes to Rs. 213/- and that for Rs. 5 lakh comes to Rs. 5,151/-. Similarly premium for Rs. 15000/- for 76-80 years age category is Rs. 551/- and that for Rs. 5 lakh comes to Rs. 17,156/-

Family Discount @ 10% of the total premium is allowed under the Individual Mediclaim Policy for covering the family members comprising of Spouse, Dependant Children, and Dependant Parents. In case of Group Mediclaim Policy a maximum limit of 30% depending upon the size of the group is allowed as Group Discount.

Cumulative Bonus @ 5% of the Sum Insured for each claim free year subject to a maximum of 50% of the Sum Insured is admissible under the Individual Policy.

Cost of Health Check-up is also admissible to the Insured Persons once at the end of block of every 4 (four) Underwriting years provided there are no claim reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average Sum Insured during the block of four claim free underwriting years.

Income Tax Benefit is also available under Section 80D of the Income Tax Act.

In addition to the "Individual" and "Group Mediclaim" Policy our Company also issue "Tailor made Group Mediclaim" policy according to the need of the Clients.

Tailor made Group Mediclaim Policy

This is issued when modifications sought by groups based on their individual requirements and is very popular. Tailor-made policies are sold to Corporate groups as also to non corporate groups. A large chunk of mediclaim premium comes from tailor made group policies.

Annexure 2: Comparison of exclusion list by two randomly picked insurers in their brochures from 6-7 years ago

Insurer A: Major Permanent Exclusions

1. Non-allopathic treatment
2. Expenses attributable to self-inflicted Injury (resulting from suicide, attempted suicide)
3. Expenses arising out of or attributable to alcohol or drug use/misuse/abuse
4. Cost of spectacles/contact lenses, dental treatment
5. Medical expenses incurred for treatment of AIDS
6. Treatment arising from or traceable to pregnancy (this exclusion does not apply to ectopic pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner) and childbirth, miscarriage, abortion and its consequences Congenital disease
7. Tests and treatment relating to infertility and invitro fertilization

Insurer B: Permanent Exclusions

1. Intentional self-injury/injury under influence of alcohol, drugs/criminal act.
2. Outside India or robotic or stem cells.
3. War/Nuclear/Chemical/Biological
4. Disease such as HIV or AIDS or STD
5. Disease existing from the time of birth (Congenital diseases)
6. Maternity, Fertility
7. Cost of spectacles, contact lenses and hearing aids
8. Dental treatment or surgery
9. Treatment of mental illness
10. Cosmetic, aesthetic treatment
11. Non-allopathic, diagnostics, self-medication, unproven treatments

Annexure 3: Data reporting in public disclosure documents

Data reporting in public disclosure documents of insurers need to follow a standard format. Lack of protocols will not only distort the true picture but will also hinder comparison and cloud transparency. Case in point: Form NL41 of three insurers in which claim complaints are reported differently.

Insurer 1

PERIODIC DISCLOSURES

FORM NL-41 GRIEVANCE DISPOSAL

Name of the Insurer: ICICI Lombard General Insurance Company Limited

Registration No. 115 dated August 03, 2001
CIN: L67200MH2000PLC129408

S.No	Particulars	Opening Balance as on beginning of Q1, 2019-20	Additions during Q1, 2019-20	Complaints resolved / settled during the year			Complaints pending at the end of Q1, 2019-20
				Fully accepted	Partial Accepted	Rejected	
1	Complaints made by customers						
a)	Proposal related	-	3	3	-	-	-
b)	Claim	33	268	252	-	28	21
c)	Policy related	25	166	187	-	-	4
d)	Premium	-	6	5	-	-	1
e)	Refund	1	6	7	-	-	-
f)	Coverage	1	62	58	-	-	5
g)	Cover note related	-	-	-	-	-	-
h)	Product	-	-	-	-	-	-
i)	Others	11	239	232	-	3	15
	Total number of complaints	**71**	**750**	**744**	**-**	**31**	**46**

2	Total no. of policies during previous year: FY 2018-19	26,484,078
3	Total no. of claims intimated during previous year: FY 2018-19	1,620,705
4	Total no. of policies during Q1 2019-20	5,988,244
5	Total no. of claims intimated during Q1 2019-20	458,356
6	Total no. of policy complaints (Q1 2019-20) per 10,000 policies (Q1 2019-20)	0.80
7	Total No . of Claim Complaints (Q1 2019-20) per 10,000 claims registered (Q1 2019-20)	5.85

8	Duration wise Pending Status	Complaints made by customer	Complaints made by Intermediaries	Total
(a)	Upto 7 days	33	-	33
(b)	7 - 15 days	13	-	13
(c)	15-30 days	-	-	-
(d)	30-90 days	-	-	-
(e)	90 days & Beyond	-	-	-
	Total No. of complaints	**46**	**-**	**46**

Insurer 2

STAR HEALTH AND ALLIED INSURANCE CO LIMITED
Registration No. and Date of Registration with the IRDA : 129 / 16.Mar.2006

FORM NL-41	Grievance Disposal for the period January 2020 to March 2020	Date	31.03.2020
INSURER	Star Health and Allied Insurance Co Ltd		

Sl No.	Particulars	Opening Balance At the beginning of the Quarter	Additions during the Quarter	Complaints Resolved/ settled during the Quarter			Complaints pending at the end of the Quarter	Total Complaints Registered Upto The Quarter During The Financial Year
				Fully Accepted	Partially accepted	Rejected		
1	**Complaints made by Customers**							
a)	Proposals related	0	3	2	0	1	0	10
b)	Claim	215	1784	448	499	964	88	6475
c)	Policy Related	18	222	115	36	88	1	919
d)	Premium	0	3	0	1	2	0	7
e)	Refund	11	55	53	5	7	1	195
f)	coverage	0	1	0	1	0	0	7
g)	cover note relaed	0	0	0	0	0	0	0
h)	Product	0	3	2	1	0	0	16
i)	Others	8	47	25	7	19	4	205
	Total number of Complaints	**252**	**2118**	**645**	**550**	**1081**	**94**	**7834**

2	Total No. of policies during the quarter ended 31st March 2019	15,11,821
3	Total No. of claims during the quarter ended 31st March 2019	2,04,855
4	Total No. of policies during the quarter ended 31st March 2020	16,62,615
5	Total No. of claims during the quarter ended 31st March 2020	2,60,809
6	Total No. of policy complaints (current year) per 10,000 policies(current year)	2.01
7	Total No. of claim complaints (current year) per 10,000 policies(current year)	10.73

8	Duration of Pending Status	Complaints made by customers	Complaints made by intermediaries	Total
a)	up to 7 days	30	0	0
b)	7-15 days	64	0	0
c)	15-30 days	0	0	0
d)	30-90 days	0	0	0
e)	90 days and beyond	0	0	0

Insurer 3

PERIODIC DISCLOSURES
GREIVANCE DISPOSAL
Insurer: The Oriental Insurance Co Ltd.
up to 31-03-2020
GRIEVANCE DISPOSAL

4th Quarter

Sl No.	Particulars	Opening Balance *	Additions	Complaints Resolved			Complaints Pending
				Fully Accepted	Partial Accepted	Rejected	
1	Complaints made by customers						
a)	Sales Related	0	6	3	1	2	0
b)	Policy Administration related	0	635	525	39	71	0
c)	Insurance Policy Coverage related	0	29	6	3	20	0
d)	Claims related	0	1598	568	185	845	0
e)	Others	0	687	442	61	184	0
	Total Number	0	2955	1544	289	1122	0

2	Duration wise Pending Status	Complaints made by customers	Complaints made by intermediaries	Total
a)	Less than 15 days	0	0	0
b)	Greater than 15 days	0	0	0
	Total Number	0	0	0

* Opening balance should tally with the closing balance of the previous financial year.