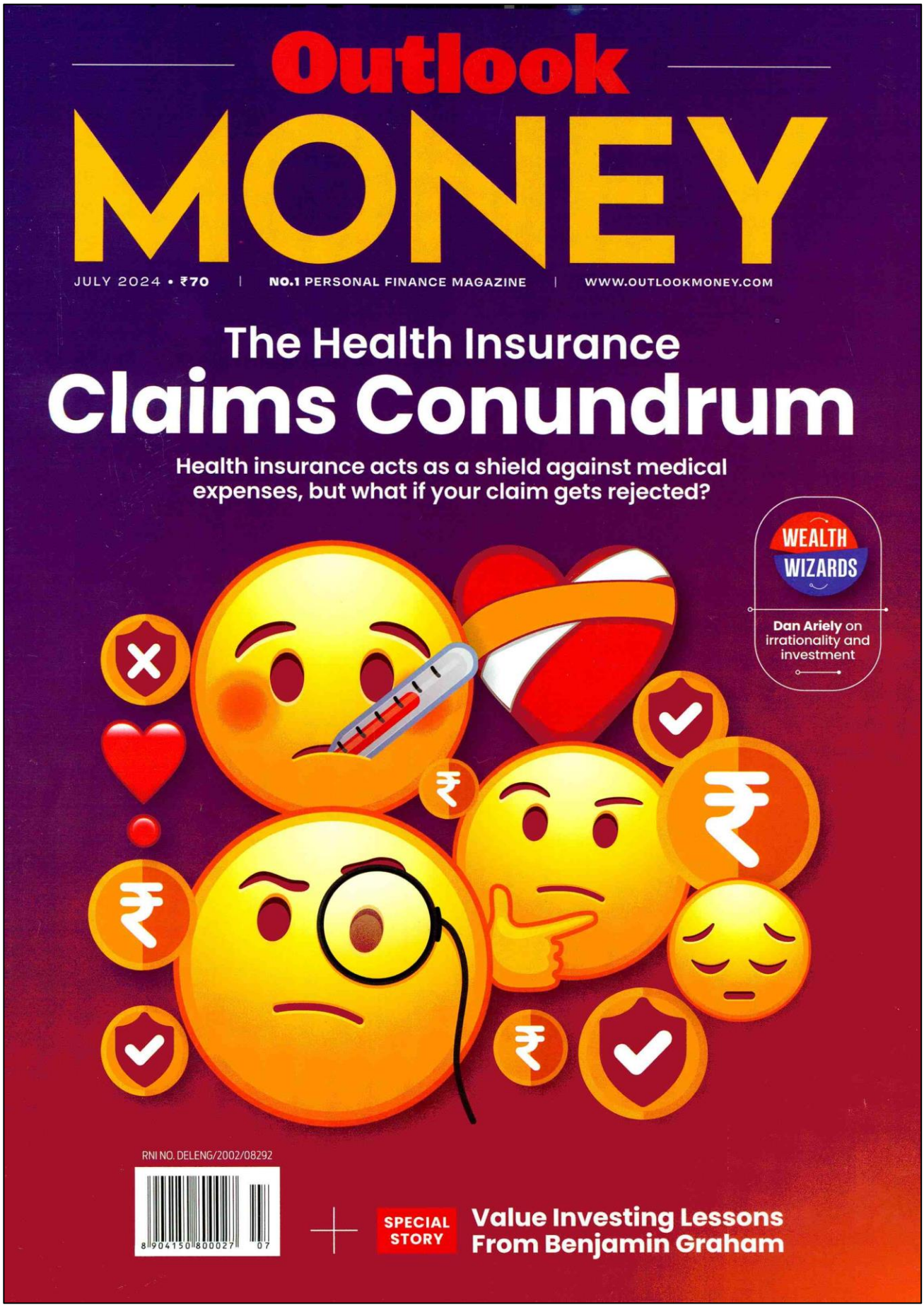
Article Date	Headline / Summary	Publication
31 Jul 2024	Lay Claim On Your Rights	Outlook Money



Lay Claim On Your Rights

Health insurance claims may often be rejected on legitimate grounds, but there are cases in which claims have been denied when policyholders are not at fault. We tell you why claims are usually rejected, how you can minimise the chances of rejection and what's the recourse in case of a logjam

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COLUMN

3 PILLARS OF SUPPORT ON CLAIMS

In the last 6-8 months, Irdai has introduced a set of regulatory changes that promise to resolve issues that previously often led to poor outcomes on health insurance claims

Illustration: Anjan Das

Cover Design: **ANJAN DAS**

Lay Claim On Your Rights

Health insurance claims may often be rejected on legitimate grounds, such as the customer hiding key details on medical history or existing ailments, but there are cases in which claims have been denied even when policyholders are not at fault. Though the road is long-winding, there are redressal mechanisms in place to protect the policyholders. In short, there's nowhere to hide that Pinocchio nose either for the policyholders or insurers when it comes to claim settlement

By **Meghna Maiti** and **Anuradha Mishra**

Illustration: **Anjan Das**

There is a buzz around rejection of health insurance claims. The Insurance Regulatory and Development Authority of India (Irdai) has come out with a flurry of announcements and proposals aimed at reducing customer complaints. At the same time, the percentage of such complaints has seen a sharp increase after Covid, from 0.80 per cent of total complaints in 2020-21 to above 18 per cent in 2022-23.

No wonder complaints of rejection of health insurance claims abound—a simple search on the social media will throw up numerous such cases.

The problem is that such cases have the potential to wreak financial havoc in the lives of people who may need to undergo expensive treatment for certain illnesses, and also erode the newly-earned trust in health insurance after Covid-19.

Data backs anecdotal experiences. A survey by LocalCircles released in May 2024, a community social media platform, says that 43 per cent of health insurance policyholders surveyed struggled with getting their health insurance claims processed in the last three years. It surveyed 39,000 respondents from across 302 districts of India and was conducted to understand how people buy general insurance, the kind of policies they buy, and where they face the most issues.

According to the Irdai annual report 2022-23, a total of 45,082 health insurance claims were reported during the year, out of which 8,158 or above 18 per cent were repudiated or rejected.

The data during the Covid period told a different story, perhaps because the government and insurers were proactive then. In 2020-21, there were 21,836 claims due to the Covid-19 pandemic, out of which 21,304 were settled, 175 were repudiated, and 357 were outstanding. The rejection rate was only about 0.80 per cent. In 2021-22, however, out of 2,996,801 Covid-19 health insurance claims, 2,654,001 were approved, 7,223 claims were disallowed, 311,952 were repudiated and 30,848 were outstanding. The rejection rate shot up to more than 10 per cent during this period.

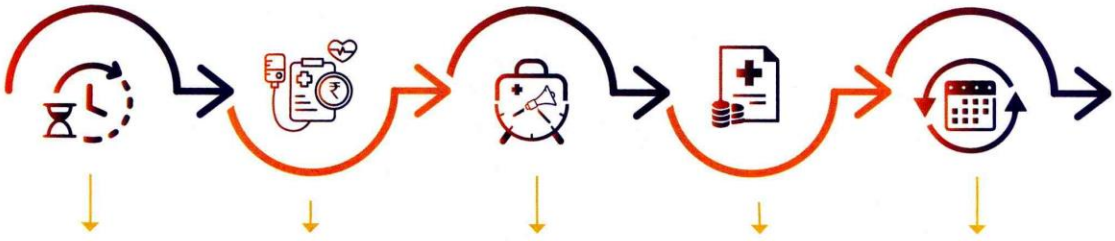
It is important to note here that the numbers include a large portion of claims rejected because of the insured person's fault as well.

While the above data doesn't clearly specify the number of rejections and repudiations for all the years, it is important to understand the difference between the two terms. Claims rejected refers to claims that cannot be settled because they do not fully meet the policy terms and conditions, such as the waiting period, sub-limits, exclusions, lack of proper documentation, and so on. In the case of claim repudiation, the insurer studies the claims and discovers fraudulent documentation or submission of wrong data.

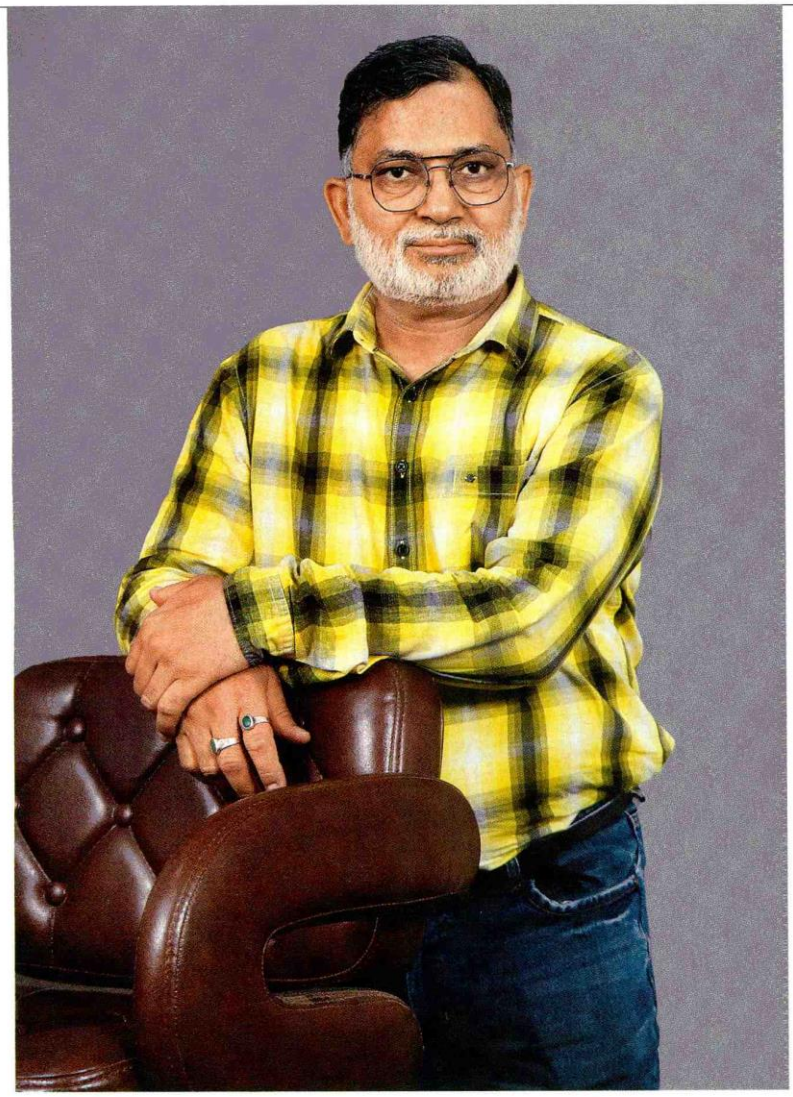
That's the theoretical difference. The practical difference can affect the final outcome of your claim dispute. When your claim is rejected, you have a chance to rectify any errors made during the submission and resubmit your claim. But when your claim is repudiated, you cannot resubmit the claim, and the only recourse is to take the legal route.

So what are the reasons for

How To Ensure A Smooth Claims Journey



Understand the policy features, coverage, exclusions, and waiting periods, (if any).	Provide complete and correct information about your medical history, both at the time of purchase as well as during the claims process.	Inform the insurer about the medical event within the stipulated time frame.	Keep a copy of your medical treatment, doctor's prescription and medical bills until the claim is processed.	Most health insurance plans require annual renewal, so remember to do that. If the policy expires, claims may not be settled.



such rejections, what can you do to minimise the chances of rejection, and what is the recourse if you become a victim, even if unwittingly? We try to answer all these questions to ensure you have a smooth health insurance claim experience.

Why Are Claims Rejected?

Though in some cases, lack of awareness on the part of customers in understanding the terms and conditions of the policy get highlighted, that's not always the case.

Customers often become victims for no fault of theirs. *Outlook Money* ran an extensive search on social media to study the complaints and spoke to at least four people, and most of them became victims unwittingly.

RAVINDER PRASAD SAHI UNIYAL
Age 59
Bhiwadi, Rajasthan

He faced trouble with his corporate health policy on the grounds that he had opted for non-standard treatment.

There are cases of rejections due to online technical errors, overcharging by the hospitals, which is labelled as fraud by the insurers, and even for opting for a non-standard treatment for an illness that is not even excluded in the policy. It is common to opt for non-standard treatment for serious and life threatening illnesses, such as cancer.

Apart from rejection and repudiation, customers may also face the problem of getting only a part of the claim settled. "Issues faced by health insurance clients include outright rejection of claims and unwarranted deductions from hospital bills, including that from network hospitals," says R. Balasundaram, secretary general, Insurance Brokers Association of India (IBAI).

Non-disclosure: This is among the most common reasons for claim rejection, and in this case, the responsibility often lies with the complainant. This includes non-disclosure of pre-existing conditions or providing incorrect or incomplete information at the time of buying the insurance policy.

Says Parthanil Ghosh, director and chief business officer, HDFC ERGO General Insurance: "The customer should provide complete and correct information regarding their medical history, both at the time of purchase as well as during the claims process. Non-disclosure of pre-existing conditions or any misrepresentation can lead to the rejection of the claim."

In such cases, it is sometimes the customers who may willingly hide information, such as the family's medical history or the frequency of smoking consuming or alcohol, or other substance abuse, or, the seller may not ask the right questions at the time of filling the health insurance proposal at the time of buying,

leading to a discrepancy created unintentionally.

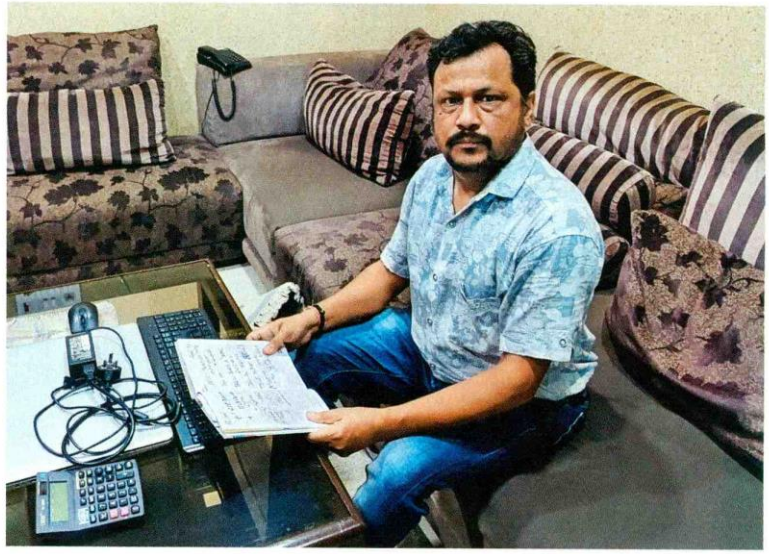
Lack Of Awareness: Claims can also get rejected because a customer may not be fully aware of, or misunderstand the policy's terms and conditions. These are often hidden in fine print. Says Suvigya Awasthy, partner, PSL Advocates & Solicitors, a Delhi-based law firm: "Insurance policies are often complex documents that are drafted with utmost precision to avoid frivolous claims. The provisions of any insurance policy are strict and narrow which ought to be read meticulously by the policyholder before agreeing to the same."

Lack of awareness about termination of a policy due to non-compliance of some term, or the claim amount you are eligible for, or the services or treatment not offered by the policy as per the fine print, among others, can also lead to claim rejection.

The family of Bihar's west Champaran district-based Kunal Pratap Singh, 44, faced problems because they were misinformed regarding the period within which claims had to be filed after the discharge under their family floater plan. Kunal claims he was informed through the insurer's call centre in September 2023 that multiple claims could be individually filed within the policy year.

However, he got a financial setback because there were five hospitalisations in his family that year and claims for only two were settled.

In August 2023, Kunal's daughter was hospitalised in Kota, Rajasthan for high fever and symptoms of dengue. However, dengue was not confirmed in the final report in September. A month later, while in Noida, his wife needed an urgent ear surgery. Then, in October, his daughter was hospitalised due to high fever again. It so happened that in November, both Kunal and his wife were hospitalised for dengue and allergies, respectively, at the same hospital.



B. PRIYESH KUMAR BRIJBHOVANDAS
Age: 47
Varanasi

His reimbursement claim was rejected on the grounds that the doctor consulted by him wasn't credible. It was later partially settled.

He filed all the four claims, separately, in April 2024. Though Kunal's claims regarding hospitalisation of himself and his wife were approved, his earlier claims for hospitalisations in August, September and October were rejected in May this year due to "late submission". His one-year family floater policy with a sum insured of ₹5 lakh expired in June 2024.

Kunal feels that being misinformed is not his fault because several details are hidden in the fine print. Irdai has now directed all health insurance companies to provide a customer information sheet (CIS) to policyholders highlighting all key policy details in simple terms. This new CIS format has been made effective starting January 1, 2024, by which time Kunal's policy was ongoing.

Kunal says, "An insurer can't expect its customers to be thorough with the terms and conditions of the policy documents. They should know that many policyholders depend on customer care calls. They should at least maintain the credibility of passing on the right information." However, it is advisable for new policyholders to know the terms and conditions.

Documentation Issues: It's important to remember that making an insurance claim does involve paperwork, though it gets minimised in cashless policies. The "cashless everywhere" initiative introduced by the General Insurance Council (GIC) recently, gives policyholders the freedom to seek cashless treatment at any hospital, irrespective of its network status. Thanks to this,

policyholders can now get admitted to a hospital without paying any money, and the insurance company will pay the bill upon discharge. In a way, this reduces paperwork on the part of the policyholders, simplifies the claims process, while also mitigating fraud.

However, in the case of reimbursement policies, if you do not do the documentation properly, there are chances that your claim will get rejected.

In some cases, a technical glitch can also create problems for you. That's what happened in the case of a 60-year-old resident of Kota in Rajasthan, who was suffering from cancer and did not want to be identified. His daughter has been following up to get the claim for a surgery he underwent in April 2024, but has been unsuccessful till date. The surgery was done to remove a cancerous ulcer. He was hospitalised in a network hospital for five days and the cost added to ₹2,69,657, including pre- and post-hospitalisation bills. The claim is not even 50 per cent of the policy's sum insured of ₹10 lakh for which they pay an annual premium of ₹16,331.

When his daughter filed for a claim on his behalf later in April this year, it was just the beginning of a tiresome ride. She tried submitting an online claim multiple times, but repeatedly faced technical glitches while uploading the documents. She has kept a video as proof that shows that even after all the documents were uploaded, she still received requests for uploading documents.

She reported the problem to the insurer's customer care, including how the website did not allow seeing the details of the claim after it was submitted. However, she received no active support for the technical glitches.

She finally emailed all the claims documents to the insurer. Her ordeal continued with another 10 rounds of communication via email with the insurance company. During this phase, she was asked to submit the documents multiple times, and received a request for a house visit to provide further documentation, which was not previously mentioned in the email communications, and so on. *Outlook Money* has reviewed the documents and the communications between the claimant and the insurer.

"I am trying to settle the claim on behalf of my father, but imagine if someone of his age were to go through the process themselves. How would they handle such anxiety and harassment?" she asks.

According to Shilpa Arora, co-founder and chief operating officer, Insurance Samadhan, an insurance-complaint redressal platform: "Irdai has issued specific guidelines on insurance claim settlement timelines. As per the regulation, insurance providers are mandated to settle health insurance claims within 30 days of the receipts of the last 'necessary' document."

Allegations Of Fraud: A lot of times, when hospitals overcharge or prescribe tests or treatments that are not required for the medical condition of the claimant, it can lead the insurer to label the claim as fraudulent.

"The rejection can be on the ground that a claim is genuine but exaggerated by hospitals by way of unwarranted procedures, tests, or inflated bills," says Balasundaram.

It is important to note here that when a claim is rejected, the onus is not always on the insured person. "While fraudulent claims are prevalent, it would be wrong on the part of the insurers to look at every claim with a jaundiced eye. As for exaggerated claims, the insured can do little about it, if hospitals milk them," says Balasundaram.

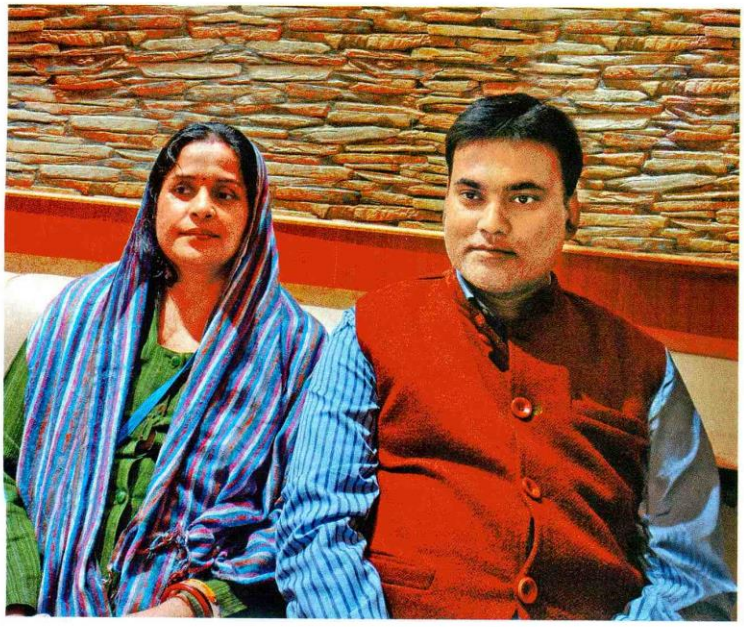
Something similar happened with Varanasi-based Babu Priyesh Kumar Brijbhovandas. His health insurance claim of ₹1,94,734 was rejected after being labelled fraudulent in May 2024, two months after he filed for it. It was a reimbursement-based claim because the hospital was not in the insurer's network. The 47-year-old was admitted to a hospital for observation and tests for around 12 days in March and had raised the claim after a few weeks of recovery.

"I had been feeling lethargic for a few days and felt feverish. I went to the hospital when the fever spiked and was hospitalised," he says. Doctors suspected that he had intestine tuberculosis germs, for which he underwent biopsy and colonoscopy tests during his hospitalisation.

Two months after Priyesh filed the claim, the insurer's third-party administrator (TPA) came for the claim investigation and checked the necessary documents and bills. In the coming weeks, Priyesh's claim was rejected as "fraud", backed by the TPA report, which cited that the doctor consulted by him was not credible and Priyesh was physically fit.

He rues the fact that the TPA investigation took place two months after his hospitalisation. "If you come to me almost two months later for investigation, would you still expect to find me on bed?" he asks.

Non-Standard Treatment: The inclusion of non-standard treatment



for any illness in the coverage also depends on the policy wordings. In India, usually, Ayush treatments were considered non-standard, but earlier this year, Irdai brought these under health insurance, subject to certain conditions.

The regulator allows modern treatments as well, but insurers have the elbow room to fix the terms and conditions. Says Gurpal Singh Dhingra, joint managing director, Prudent Insurance Brokers, "Irdai has instructed insurance companies to cover modern treatments, but has allowed them to incorporate internal ceilings on such products. Customers should know that there are no standard sub-limits; they vary depending on the insurer and the product. Variants include sub-limits on the sum insured, co-payment, or, covering only up to the cost of conventional treatment."

Ravinder Prasad Sahi Uniyal, 59, a corporate employee based out of Bhiwadi, Rajasthan, faced trouble with his corporate health insurance policy with a sum insured of ₹4.5 lakh on the grounds that he opted for non-standard treatment. Ravinder has had blood cancer since 2007. Until July 2013, all the bills he submitted were approved, but after August 2023, all the bills were consistently rejected on the ground that the line of treatment was "experimental".

The insurer wrote to him stating that as per a clause of his insurance policy, experimental, unproven, or non-standard treatment that is not consistent with or incidental to the usual diagnosis and the treatment of any illness or injury leads to permanent exclusion.

Sahi told *Outlook Money* that during one of the instances, he was stuck at the hospital because of the rejection. In fact, once the insurer pushed him to opt for a usual surgery which was not advised by his doctor due to certain co-morbidities that didn't allow it to happen, he claims. *Outlook Money* could not verify this claim independently.

KUNAL PRATAP SINGH, 44, WITH WIFE AMITA, 36
Bettiah

He faced problems due to misinformation regarding the period within which claims had to be filed after discharge. He says he was informed through the insurer's call centre that multiple claims could be filed within the policy year, however only two of his claims were settled out of the four he had submitted in the year

Minimise The Damage

Provide Accurate And Complete Information:
Ensure that all the documents are correctly filled out, and all necessary information is provided to the insurer, treating doctor, and hospital authorities. "Missing or providing incorrect documents are a common reason for claim rejection. Generally, a list of the required documents is mentioned on the claim form. Also, ensure that the claim form is completed accurately with all the required details. Incorrect or incomplete information can lead to delays in claim approval," says Bhaskar Nerurkar, head of health administration team, Bajaj Allianz General Insurance.

Fill The Proposal Form Yourself:
It's crucial to disclose any pre-existing ailments or conditions during the application process, such as high blood pressure, diabetic conditions, cardiovascular issues, or past surgeries. Sometimes, when the distributor fills it on your behalf, key

information may get ignored.

"Additionally, any new medical conditions acquired during the policy term should be disclosed at the time of renewal. Failure to disclose such information could result in claim rejections. Utmost care should also be taken by providing such declarations during the sum insured enhancement process," says Nerurkar.

Check The Waiting Period: Health insurance policies often include a waiting period, during which claims cannot be raised for specific ailments or conditions. This waiting period begins with the inception of the policy and varies depending on the insurer and the ailment.

Meet Hospitalisation Criteria: A minimum of 24 hours of hospitalisation is typically required for raising a claim. Daycare procedures or treatments are covered, depending on the policy.

Understand Your Policy: Be well-informed about your policy's details, including inclusions, exclusions, and terms. This knowledge helps in reducing confusion when filing a claim. "For instance, if you raise a claim for an ailment which specifically comes under exclusions, then the claim will be rejected," says Nerurkar.

Adhere To Filing Deadlines: For reimbursement claims, it is advisable to file the claim within 30 days from the day of discharge, which is the usual time for filing claims. For cashless claims, it is advisable to notify the insurer within 24 hours in case of an emergency, and 24-48

hours before a planned admission.

Use Cashless Facility: Since a cashless facility is available for all, one should remember to opt for it. Says Nerurkar: "This will help them access the cashless facility even in non-network hospitals. Additionally, if the hospital is blacklisted, the insured will be informed of other possible preferred hospitals for a seamless customer experience."

Keep Documentation In Place: To streamline the process, verify all the details in medical bills to avoid discrepancies. Also, save them as proof during the claim settlement process. Adds Arora: "When submitting the reimbursement form and policy bond to one's insurance provider, policyholders must submit the stamped and signed original hospital bills, cash memos, medical reports, diagnostic tests, prescriptions, hospital admission slips, and discharge summaries. In case of an accidental claim, they must submit an FIR copy along with the rest of the documents. Notably, individuals must give a serial number to all the bills along with an explanation note stating which one requires an early reimbursement."

Some insurers may require individuals to submit their identity details, such as Aadhaar, the doctor's recommendation for hospitalisation in writing, and other supporting documents justifying hospitalisation.

Says Ghosh: "It's a good practice for policyholders to maintain records of their medical history, treatments, and communications with the insurers to resolve any issues quickly and to substantiate their claims."

Road To Redressal

If you are not satisfied with the claim resolution, the first step you should take is to reach out to the grievance team of the insurance company. You will find the details on every insurance company's website.

If you are not happy with the resolution that the company provides, you have the option to approach the regulator. "The customer can also approach Irdai in case he or she finds the insurer's response unsatisfactory, or if the response is delayed beyond 15 days. For such cases, Irdai facilitates re-examination of the complaint and offers resolution by the insurance company," says Ghosh.

You can register a complaint on Irdai's Bima Bharosa System or make use of the insurance ombudsman.

Bima Bharosa, also known as the Integrated Grievance Management System (IGMS), is an online consumer complaint portal where anyone can register a complaint.

The effectiveness of this platform is, however, questionable, according to some experts.

Says Balasundaram: "If a complaint is made to Bima Bharosa, it gets forwarded to the insurer who usually reiterates its decision. Now, Irdai has made it mandatory that an internal product committee should be formed by the insurers and no claim can be declined, without reference to this committee. How this will play out in practice remains to be seen. The problem of unwarranted and customary deductions from claims would continue as there are no solutions or suggestions yet."

Priyesh sought the help of Insurance Samadhan after multiple emails to the insurer elicited no response. He also registered complaints on Irdai's Bima Bharosa System and went to the insurance ombudsman as well. After several rounds of communication, sent by Samadhan on his behalf, the insurer settled his claim only partly and paid him ₹69,960. He pays an annual premium of around ₹13,000 for a sum insured of ₹5 lakh.

Priyesh, however, is not satisfied with this resolution and plans to approach the consumer forum.

"Even though I have been a policyholder since 2011, this is the first time I applied for a claim. Initially, my sum insured was ₹5 lakh, which was upgraded due to the no-claim bonus on the policy over the years. When I bought it, I was paying an annual premium of ₹6,500, which has gradually increased to approximately ₹13,000," he told *Outlook Money*.

An aggrieved can also approach the office of the insurance ombudsman if the insurer has failed to solve the complaint within a 30-day time period, or has not resolved it to the customer's satisfaction.

"The insurance ombudsman scheme was created by the Government of India for individual policyholders to have their complaints settled out of the court's system in a cost-effective, efficient, and impartial way," says Singh.

The ombudsman acts as a mediator and provides a recommendation. "If the consumer accepts this as the full and final settlement, the ombudsman will inform the company which should comply with the terms within 30 days," says Singh.

"Failing this, a penalty of ₹5,000 per day shall be payable to the complainant, as prescribed by Irdai. In addition, penal interest is also levied and payable to the policyholder," says Ankur Mahindro, managing partner, Kred-Jure, boutique law firm.

It is important to note that a policyholder has the option to pursue multiple avenues either sequentially or in conjunction, depending on the specifics of the grievance and the desired outcome.

The last resort is seeking legal recourse. "Legal recourse can be taken if the processing of the claim is being unduly delayed by the insurer (say beyond four months) or action can be taken upon the receipt of the claim repudiation letter or partial settlement of the claim (partly paid, partly rejected)," says Jehangir Gai, a Mumbai-based consumer activist.

A policyholder aggrieved by the services provided by the insurance company can also seek compensation and other reliefs before the consumer courts/forum under the Consumer Protection Act, 2019 upon grounds of deficiency of service by the insurance company.

"The costs would be around ₹5,000 to ₹7,000 if one appears in person at the level of the district commission; else legal fees could go up to ₹1 lakh," says Gai.

The claim may be filed before the district, state, or national commission depending on the value of the claim/compensation sought.

Says Mahindro: "The policyholder may also seek adjudication before the commercial court which recognises 'insurance and reinsurance' claims as a commercial dispute under Section 2(c)(xx) of the Commercial Courts Act, 2015."

The commissions have ruled in the favour of the insured in several cases. "For instance, the National Consumer Disputes Redressal Commission in Life Insurance Corporation of India v. Brijendra Kumar Tyagi, F.A. No. 888 of 2021 has held that insurance policies should be interpreted broadly, keeping in mind the interests of the policyholder and the beneficiaries," says Shri Venkatesh, managing partner, SKV Law Offices.

However, Gai warns that the wheels of justice grind slow, and a consumer must have the tenacity to continue with the litigation for several years to get justice. The best solution, therefore, is to do your due diligence at the time of buying the policy, in choosing the doctor and the hospital, and at the time of filing the claim. ▸OM

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How And When To Register A Complaint

With Irdai

On Irdai's Bima Bharosa Portal, https://bimabharosa.irdai.gov.in/

By sending an email to complaints@irdai.gov.in

By calling toll-free numbers 155255/1800-4254-732

By sending a physical complaint to: General Manager, Insurance Regulatory and Development Authority of India (IRDAI), Policyholder's Protection & Grievance Redressal Department – Grievance Redressal Cell. Sy.No.115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad – 500 032.

When you are not satisfied by the insurer's resolution, you can write to the Insurance Ombudsman.

With Insurance Ombudsman

Submit a written complaint using the ombudsman's form, either in person, by letter, or by email (with a paper copy). The details will be available on the policy document.

Approach when your complaint to the insurer is rejected or you do not receive a response within 30 days, or when you are not satisfied by the insurer's response; or when your complaint involves claims up to ₹20 lakh.

Complaints must be filed within a year of the insurer's rejection and should not be under consideration by a court or consumer forum.

By **ABHISHEK BONDIA,** Co-founder, SecureNow

3 Pillars Of Support On Claims

In the last 6-8 months, Irdai has introduced a set of regulatory changes that promise to resolve issues that previously often led to poor outcomes on health insurance claims

Recently, a senior executive of a health insurance company was lamenting about the fast pace of regulatory changes that they need to catch up with. While he complained about the increased work, he could not help but compliment the Insurance Regulatory and Development Authority of India (Irdai) for keeping the policyholder's interest at the heart of these changes. Ultimately in the long-term, the satisfaction of policyholders will drive the industry development, he said.

I totally agree. Health insurance is a complex service-oriented product with multiple layers. At the time of signing up, policyholders buy into a promise of future time-bound help. They count on the policy for support, when they are adversely affected financially as well as health-wise.

Both finance and health are sensitive areas. Nobody appreciates a surprise at the time of making a claim. At times, an adverse or delayed claim decision can impact the future line of treatment. With a solid appreciation of these factors, the regulator has taken cognisance of areas that typically cause service-level dissonance.

The country already has a solid set of product regulations, such as life-time renewability, portability, and standardisation of exclusions. On top of that, a set of regulatory changes have been introduced in the last 6-8 months. These guidelines are specific, and targeted towards grassroot issues that lead to poor outcomes for the policyholder.

Each of the recent changes carry a powerful impact on a standalone basis. I see three large themes behind these new regulations—empowerment, standardisation, and pre-mitigation.

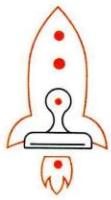
Empowerment

The regulator has taken several measures under the first theme of empowerment. On top of the list is increasing the free-look period to 30 days. This allows policyholders to cancel the policy within 30 days of getting the policy copy, without giving any reasons. The free-look period helps to minimise mis-selling, as policyholders can cancel the policy if it is not in line with their expectations. Increasing the free-look period gives the policyholder more time to review the document.

Each of the recent changes carry a powerful impact that benefits the policyholders in the long term

Also, policyholders can now cancel the contract during the policy term without having to explain themselves, as well as get a pro-rata refund. Earlier, cancellation was cost-prohibitive for the policyholders, as they would get a refund on the short-period scale. This was a non-linear method of calculation of refund. Based on the time lapsed in the policy, policyholders would bear a penalty up to 25 per cent of the premium. This pushed them to continue with the policy, even if the insurer delivered poor service.

Further, the regulations require the insurer to publish a simplified Customer Information Sheet (CIS), carrying all the major policy clauses, including the claim process, in a simplified language. This has been done to make the insurance contract more transparent and accessible to a layman, who may otherwise find the legal language of policy wordings rather daunting to understand.



10 Regulatory Changes You Should Know About

The changes mentioned below have been proposed in the last 6-8 months

1 Increasing the free-look period to 30 days. Free-look allows policyholders to cancel the policy within 30 days of purchase.

2 Policyholders can cancel the contract during the policy term and get a pro-rata refund.

3 Insurers need to publish a simplified Customer Information Sheet (CIS) that carries all major policy clauses, including the claim process, in simplified language.

4 Cashless services are available everywhere and not just in network hospitals. Policyholders can take treatment through the cashless route in any registered hospital.

5 The cashless service is now time-bound. Insurers are expected to provide the initial approval for treatment within an hour.

6 Insurers have been encouraged to move towards 100 per cent cashless treatment.

7 The process of claim rejection is also defined. To reject a claim, insurers must get an approval from the Claim Review Committee.

6 Moratorium period has been reduced from 96 to 60 months. So, insurers cannot question claims due to non-disclosure after five years of continuous policy renewal.

9 The maximum waiting period for pre-existing conditions has been reduced from 48 to 36 months.

10 Definition of pre-existing conditions has been revised. Now, only conditions for which treatment was recommended or taken within 36 months before policy inception, would be classified as pre-existing.

Standardisation

The second theme of standardisation focuses on service delivery. I anticipate that the changes in this category will push a few insurers to substantially improve their servicing capabilities.

Here, the big move has been about providing cashless services everywhere. The strength of hospital network varies substantially across insurers. Historically, policyholders were bound by the insurer's network and would have to resort to reimbursement of a claim, if their preferred hospital was not part of the network. Reimbursement requires upfront payment of cash and can cause financial strain. Now, policyholders can take the cashless route in any registered hospital. Moreover, the regulations define a time-bound approach to deliver the cashless service. Insurers are expected to provide the initial approval for treatment within an hour. On top of it, insurers are encouraged to move towards 100 per cent cashless treatment and resort to reimbursement of claims only in exceptional circumstances.

The other big move has been to define the process of claim rejection. To reject a claim, insurers must get an approval from its Claim Review Committee (CRC). CRC is a sub-committee of the insurer's product management committee, which generally comprises senior executives of the insurer. Thus, any claim rejection would be thoroughly reviewed and have clear accountability. The scope of oversight, and overreach has been curtailed substantially.

Pre-Mitigation

The emphasis of the pre-mitigation theme is to prevent disputes.

Empirically, many health insurance claims have revolved around alleged non-disclosure at the time of purchase, and rejection attributed to pre-existing conditions. Though well-defined rules already exist to prevent disputes on these areas, recent regulations have taken them a step further.

For instance, the moratorium period has been reduced from 96 to 60 months. This means that the insurer cannot question the claims due to non-disclosure after five years of continuous policy renewal.

Regarding pre-existing conditions, the maximum waiting period has been reduced from 48 to 36 months. This is a substantial improvement.

Further, the definition of pre-existing conditions has been revised. Only conditions that were diagnosed, or for which treatment was recommended or taken within 36 months prior to policy inception, would be classified as pre-existing. Undiagnosed ailments remain outside the scope. Both these changes put the burden on the insurer to do thorough underwriting before policy inception, rather than initiate an investigation after a claim is reported.

The above measures are giant strides to make health products inclusive and policyholder-friendly, and reduce several elements of surprise. The regulator, in its recent circular, has also outlined a move toward "zero grievances". The above steps are in the right direction to achieve this goal. ▸OM