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Cashless claims to be cleared in 3 hours

Irdai has also mandated the insurer to decide on the cashless authorisation within one hour of receipt of the request.

by **Riju Mehta**

In yet another customer-centric decision, the Insurance Regulatory and Development Authority of India (Irdai) has mandated that all cashless claims be processed within three hours of the receipt of discharge authorisation request from the hospital. If there is any delay over three hours, the additional amount, if any, that is charged by the hospital shall be borne by the insurer from the shareholder's fund.

Additionally, the insurer shall have to decide on the request for cashless authorisation within one hour of the receipt of the request. In case of death of the insured, the claim settlement request needs to be processed and the mortal remains released from the hospital immediately.

The regulator has set a deadline of 31 July 2024 for insurers to put the necessary procedures and systems in place in order to ensure compliance with the notification.

"In no case, the policyholder shall be made to wait to be discharged from the hospital....Insurers may arrange for dedicated help desks in physical mode at the hospital to deal and assist with the cashless requests. They shall also provide pre-authorisation to the policyholder through digital mode," stated the notification by the insurance regulator issued via a master circular on 29 May 2024. This circular has repealed 55 circulars issued earlier.

"This is a positive step in the right direction because sometimes the patient has to wait long hours for discharge. To be realistic, however, there are two sides to the story. For instance, if there is a time lag in the file being forwarded from the hospital to the insurer, it will still impact the patient. So, both

need to go hand in hand for a seamless experience. Still, it's probably the first of many steps to ensure that the claim experience is streamlined for the policyholder," says Siddharth Singhal, Business Head of Health Insurance at *Policybazaar.com*.

This notification seems set to dovetail with the launch of the digital platform, National Health Claim Exchange, which has been designed to help cut down claim processing time drastically by automating much of the process. However, till this happens, will the insurers be able to meet the deadline when many policyholders regularly experience delays of over six hours?

"Our average turnaround time for pre-authorisation approval is 47 minutes and about one hour for discharge. Even during the pandemic, there were clearcut instructions that claims should be cleared within 30 minutes and the companies had done it. So it is possible to do it," says Bhaskar Nerurkar, Head, Health Administration Team, Bajaj Allianz General Insurance

"The actual problem is that after hospital sends the final bill, there are negotiations between insurers and hospitals on the agreed tariffs, which typically take time. Say, the agreed tariff for a room is ₹10,000 per day and the hospital charges ₹12,000, then we point it out and the hospital corrects it and sends again. This to and fro takes time, but we will have to find a way to work around these," says Nerurkar.

Among other notifications, Irdai has imposed a penalty of ₹5,000 a day on insurers, payable to the complainant, if they fail to comply with the award of the insurance ombudsman within 30 days of the receipt of award. This is in addition to the penal interest to be paid by the insurer.

The insurer will also have to mandatorily offer coverage and retain all the credits during grace period if the premium is paid in instalments. Currently, it's up to the insurer to decide whether they offer cover or not.

If a policyholder decides to cancel his indemnity plan during the term, the insurer will have to refund the premium for unexpired policy period, if the term is up to a year and there is no claim, and for terms more than one year if the risk coverage has not begun.

Reasons for delay in claim processing

Cumbersome process
The fact that the claim information is fed manually by the hospital staff and then sent to the respective insurer's portal, where it is digitised before being validated and adjudicated manually, takes a lot of time. This is a big reason for extended delays.

Doctor's signature
In many cases, doctors sign the claim files to be sent by the hospital to the insurer only after they have completed their daily rounds in the hospital, which can cause inordinate delays.

Differences on tariffs
If the charges forwarded by the hospital differ from the tariffs agreed upon with the insurer, there can be a lot of back and forth between the two, causing delays.

Misrepresentation, frauds
The manual authentication with outdated fraud analytics can take a lot of time in case of misinformation, misrepresentation or fraudulent claims made by the policyholder.

Incomplete information
Any incomplete information or manual errors in filling up details can entail a long process of the files being sent back and forth between the insurer and hospital, taking long hours.

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