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# IS YOUR MEDICAL CLAIM STUCK?

**Find out why you face problems in health insurance claim settlement and what you can do to address these.**


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*By* **Riju Mehta**

When Delhi-based IT professional, Amar Pal, met with an accident in Kanpur in August 2022, he was admitted unconscious to a local hospital. He managed to inform his insurer via mail from the small, non-network hospital that did not have cashless facility. After being discharged, he applied for reimbursement in September, but till January 2023, the insurer's verifying team continued to ask for proof and documents.

After five months of providing what was asked of him, he was told that his claim had been rejected on the grounds of 'serious discrepancies in the event of hospitalisation'. This, after Pal offered counter-proof for the lapses mentioned by the insurer. "I did not have the strength to pursue the case after five months of back and forth with the insurer," says the 36-year-old. His claim amount was ₹1.14 lakh.

Pal isn't the only one nursing a grudge against health insurance companies over claim settlements. As per the Council for Insurance Ombudsmen's annual report 2022-23, of the 51,103 insurance complaints received by it between 1 April 2022 and 31 March 2023, nearly 50.6% or 25,873 complaints were related to health insurance. As high as 93.14% of the total entertainable complaints disposed of were about 'partial and total repudiation of claims by insurer'.

According to a dipstick online survey by *ET Wealth*, nearly 88% of policyholders have faced a problem in claim settlement, with 59% citing issues with claim rejection and partial payments. As many as 69% claimed their grievances were not suitably resolved by the insurer. "Dealing with health claim rejections can be especially tough when you're already grappling with a medical issue, but the insurance industry pays more than 90-95% claims, as the data available in the public domain shows. Some claims are rejected on the basis of just a few parameters," counters Bhaskar Nerurkar, Head, Health Administration Team, Bajaj Allianz General Insurance.

In fact, according to the Insurance Regulatory and Development Authority's (Irdai) annual report 2022-23, standalone health insurers settled a high 99.48% of claims in the first three months of 2022-23, with Care Health Insurance and Niva Bupa Health Insurance scoring a perfect 100%, followed closely by ManipalCigna Health Insurance (99.96%), Star Health and Allied Insurance (99.21%) and Aditya Birla Health Insurance (99.01%).

The high claim settlement ratios of over 90% among health insurers may seem to be at odds with the survey findings, but it's because besides claim rejections, the study included other issues like partial payments and approval delays. "The main grievances of policyholders include rejection of health claims, deduction in claim amounts, delay in claim settlement, cancellation of insurance policy, etc," says Shilpa Arora, Co-Founder and COO, Insurance Samadhan.

"The biggest challenge in health insurance is lack of efficient claim service, delay in discharges, hospitals not able to understand insurer products and protocol, and health insurers not able to talk in hospital language," says Dr S. Prakash, MD and CEO, Galaxy Health and Allied Insurance. All these inefficiencies translate into claim problems for policyholders.

"Be it the public-sector or private insurance companies, they are just looking for excuses to not pay the claim amount," says Ahmedabad-based Manoj Shah, whose claim was rejected in 2022. However, after a relentless pursuit of over nine months, the 54-year-old managed to secure his claim of ₹1.05 lakh from the insurer.

While health insurers can sometimes be blamed for apathy and putting customers through unending hardship in clearing claims, many a times it's the policyholder who is at fault. "While most rejection reasons can be resolved between the treating hospital and health insurer, rejection due to non-disclosure of pre-existing diseases rests with policyholders. Most of the time, policyholders are not aware of their insur

ance policy and processes involved," says Arora.

A lot of these issues can, in fact, be taken care of simply by asking the right questions at the time of buying health insurance, reading the policy details and fine print carefully, and conducting due diligence (see *A question in time..*). Let's consider the main claim-related issues policyholders face and how they can avoid these.

## CLAIM-RELATED ISSUES

### 1. CLAIM REJECTIONS

This is an obvious frontrunner when it comes to claim-related grievances, with many frustrated policyholders raging against rejected claims on what they perceive to be flimsy grounds. Take Mumbai-based Sarvesh Rai.

Last year, his 78-year-old father underwent surgery in a network hospital, but just a few days after his release, he suffered from severe diarrhoea and had to be readmitted to a non-network nursing home in an emergency. When Rai submitted the bills for reimbursement, the insurer refused the claim on the grounds that the illness was not serious enough for hospital admission. "When my aged father is being admitted in an emergency, will I first check with the company if it's a serious illness?" asks a furious Rai.

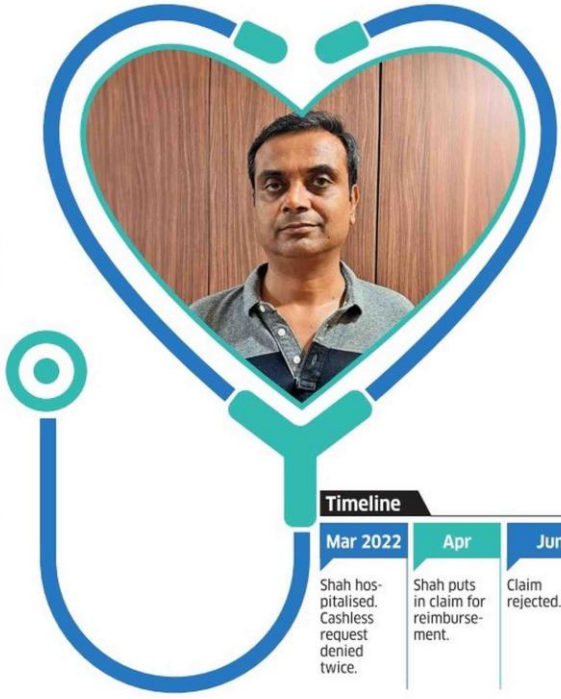
"While the most common cause of claim rejection is the non-disclosure of pre-existing diseases, others include hospitalisation that is not justified, discrepancies in documents, incomplete waiting period, admission for diagnostic purposes, among others," says Arora.

So, what policyholders may consider a vague or flimsy ground could be considered valid justification for denying a claim by the insurer. While there are certain grey areas that are open to debate, here are the main triggers for claim denials.

**Non-disclosure of pre-existing disease:** "Declare any pre-existing conditions before purchasing a policy as your medical history plays a significant role in claim denials," says Nerurkar. Failure to provide details of a pre-existing medical condition or filling incorrect information in the proposal form at the time of buying a policy is one of the biggest reasons for claim rejections. Most people deliberately withhold information on smoking or drinking, or conditions like blood pressure and hypertension, fearing that it will increase the underwriting risk and raise the premium. However, not revealing these conditions can prove more expensive if the claim is rejected. It's best to reveal all—existing and past illnesses, regular medication being taken, allergies, past hospitalisations, genetic disorders, and family history.

**Mismatch in medical records/ incorrect diagnosis:** You need to ensure that the diagnosis and symptoms on your claim form match the medical records that are provided by the hospital. An information mismatch may result in claim rejection.

**Incomplete information & missing documents:** "Claims may be rejected if the submitted documents are incomplete, incorrect,



## Manoj Shah, 54, *Ahmedabad*

**Reason for hospitalisation:** Cardio-vascular stroke

**Issue:** Claim rejection

**Grounds for rejection:** 'Non-disclosure of pre-existing disease'

**Shah's counter:** Thalassemia minor was not related to stroke; it was a genetic disorder that the proposal form did not ask for. BP was related to stroke, but he had no past history, and so did not mention it in the form.

**Resolution:** Insurer offered to settle after escalation to insurance ombudsman.

**Claim raised:** ₹1.08 lakh

**Claim received:** ₹1.05 lakh

### Timeline

| Mar 2022 | Apr | Jun | Jun-Sep | Sep-end | Oct | Dec | Dec-end |
|---|---|---|---|---|---|---|---|
| Shah hospitalised. Cashless request denied twice. | Shah puts in claim for reimbursement. | Claim rejected. | Shah escalates to top level with insurer. Claim rejected. | Shah goes to insurance ombudsman. | Insurer stands by decision. Claim rejected. | Ombudsman sets date of hearing. On the day of hearing, insurer offers to settle. | Claim amount disbursed. |

# A question in time... averts claim issues

Ask these questions while purchasing a health plan or at the time of filling a proposal form.

**Q1 Does the plan have sub-limits?**
This is one of the reasons the entire claim amount is not cleared by the insurer. Sub-limit means that the insurer will not pay more than a certain amount under a specific head, whether it is a percentage of sum assured or fixed amount. For instance, if the insurer has fixed 1% of sum insured for room rent, and you have a cover of ₹5 lakh, it will not pay more than ₹5,000 for the room per day.

**Q2 Will I be covered for a pre-existing disease?**
If you suffer from a medical condition at the time of buying a policy, you will have to typically wait for up to 1-3 years (depends on the insurer) before the illness is covered. It will also result in an increase of premium depending on the insurer's underwriting.

**Q3 What medical information do I need to disclose?**
You need to disclose any existing illness or medical condition for which you have been diagnosed, are taking medication or have been hospitalised for, even those you have recovered from. Some insurers also ask for family's medical history. If you don't, your claim will be rejected due to non-disclosure, and the policy will be invalidated.

**Q4 What's the claim process & claim settlement ratio?**
Ask the insurer for the exact process of filing a claim so that you are prepared for it before hospitalisation. The process should clearly list timelines of submission and approvals, documents required, verifications needed, TPA details, etc. The insurer's claim settlement ratio should ideally be above 95%.

**Q5 What are policy exclusions?**
This is another common reason for claim rejections and partial payments. If you are not familiar with exclusions regarding illnesses, OPD or day-care procedures, specific surgeries, non-medical expenses in billing, or standard exclusions, your claim will either be rejected or you will end up with out-of-pocket expenses at the time of discharge.

**Q6 Is there a co-payment clause?**
If a policy comes with a co-payment clause, usually for senior citizens, you will have to pay a fixed percentage of the claim amount before the insurer covers you. It's important to know this to avoid a nasty surprise of out-of-pocket expenses at the time of settling the claim.

or are missing information such as doctor's prescriptions, diagnostic reports, hospital bills, dates of admission and discharge, and treatment details," says Siddharth Singhal, Business Head, Health Insurance, Policybazaar. Even failure to submit pre-authorisation request for certain treatments can result in denial.

**Claim made during waiting period:** "Claims made within the initial waiting period of the policy, which is typically 30-90 days, are often rejected, except for those related to accident," says Singhal. "Most health plans also cover pre-existing diseases only after a specified waiting period of 2-4 years (maximum waiting period has now been cut to three years). If you seek treatment for a pre-existing condition before this waiting period ends, your claim will be denied," adds Nerurkar.

**Policy exclusions:** It's crucial to go through the policy document for treatments that are not covered by the insurer. If you have a genetic predisposition to certain diseases, it's best not to opt for such a policy. Even specific procedures in some treatments could be excluded. Other standard exclusions include cosmetic surgeries, dental procedures, treatment for alcoholism, drug or substance abuse, self-injury, etc.

**Lapsed policy:** A policy that has lapsed or where the premiums have not been paid will not be entertained. "Keep track of your premium payments and ensure timely payments to keep your coverage active," says Nerurkar. However, as per Irdai, insurers will now have to mandatorily approve claims in the grace period, which can range from 15-30 days.

**Delay in intimation:** If you don't submit the claim within the specified time, it will not be accepted. Make sure you ask the insurer about submission timelines.

**Other reasons:** The *ET Wealth* survey lists 'Other reasons' as the top option for claim denials by 42% of the respondents, with non-disclosure coming a distant second at 23%. There are a lot of grey areas and specific situations under which claims are denied. These are typically settled on an individual basis. A case in point is Shah, who registered high blood pressure during hospitalisation and was considered to be a pre-existing condition that was not disclosed. Strangely, however, Shah had no BP history.

### *How to avoid it?*

The best way to avoid rejections is to ask the right questions at the time of policy purchase and to be careful while filling the proposal form. Ask about claim settlement ratio and preferably opt for one with over 95% ratio. Check the waiting period and policy exclusions, which will reveal the conditions or treatments that are not covered by the plan. "Inquire about waiting periods for specific treatments, pre-existing conditions, and initial waiting period. Also know the steps for filing a claim, including necessary documentation and deadlines," says Singhal. "Verify the list of network hospitals where you can avail of cashless treatment and implications of treatment at non-network hospitals," he adds.

Give correct, complete information in the form and opt for medical tests, if required. Any condition revealed during the check-up will be considered a pre-existing disease and your waiting period will begin immediately. If, however, you avoid a check-up or waive it and a condition is revealed during hospitalisation, it can be considered non-disclosure and the claim can be denied.

### 2. PARTIAL CLAIM PAYMENT

Among the top claim-related grouses is partial payment of the claim amount. "For a claim of ₹57,000, the company deducted ₹20,000, even though I pay a premium of ₹1.34 lakh every year," says Prabir Datta from Kolkata. Datta doesn't realise that premium payment is not related to deductions in claim amount. There are various reasons people like him end up paying a part of the claim from their pockets.

## Will your claim be rejected if...

**...if a new disorder is discovered at the time of hospitalisation, and it is either related to or not related to the condition for hospitalisation?**

"A claim will not be rejected if the new illness is an incidental finding unrelated to the current medical condition, but it will be rejected if it is a pre-existing condition that was not disclosed and is related to the current illness or falls under the waiting period," says Bhaskar Nerurkar, Head, Health Administration Team, Bajaj Allianz General Insurance.

**...if the policyholder acquires a disease a few years after the policy has been issued?**

"For any disease acquired during policy term, there is no separate waiting period. If the waiting period for the particular illness has been surpassed and the disease is detected within the policy period, the claim will not be rejected," says Nerurkar.

**...if the policyholder cannot apply for cashless claim during hospitalisation or within the specified period, and seeks reimbursement only after discharge?**

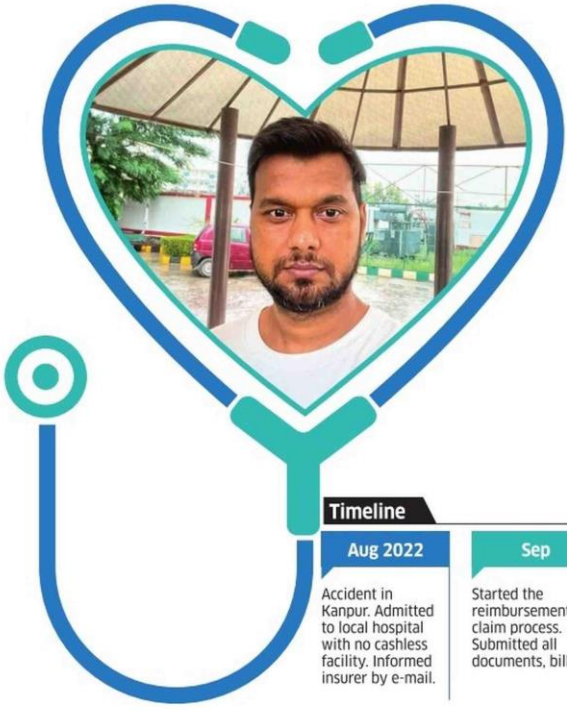
The insurer cannot reject the claim if the insured applies for reimbursement within 30 days of discharge and if the illness has cleared the specified waiting period, standard exclusion, and doesn't violate the non-disclosure clause.


**...if a claim is made after the policy has lapsed but during the grace period?**

As per Irdai's recent changes, the insurer will have to mandatorily offer full coverage during the grace period, which is 15 days for those who have paid monthly premiums, and 30 days if the premiums are quarterly, half-yearly or annual. This means no claim can be rejected during grace period.

**...If the proposal form does not ask for a specific medical condition you have, and is only discovered by insurer at the time of hospitalisation?**

"A claim can be rejected if you didn't disclose a known illness or medical condition that was not asked about in the proposal form or during a telecall," says Syed Meraj Naqvi, CEO & Principal Officer, Riskbirbal Insurance Brokers.



## Amar Pal, 36, *Delhi*

**Reason for hospitalisation:** Road accident

**Issue:** Claim rejection

**Grounds for rejection:** 'Discrepancies in the event of hospitalisation.'

**Pal's counter:** The verifying team cited reasons that were countered with proof by Pal. The insurer brushed aside Pal's proof and persisted with its reasons for refusing claim. After a lot of back and forth over five months, Pal gave up.

**Resolution:** Insurer rejected claim.

**Claim raised:** ₹1.14 lakh
**Claim received:** Nil

### Timeline

| Aug 2022 | Sep | Sep-Dec | Jan 2023 | February |
|---|---|---|---|---|
| Accident in Kanpur. Admitted to local hospital with no cashless facility. Informed insurer by e-mail. | Started the reimbursement claim process. Submitted all documents, bills. | Insurer kept asking for more documents and proof. | Claim rejected by insurer, citing debatable grounds. | Pal gave up. Did not escalate the grievance. |

**Sub-limits:** This means that the insurer will pay only a fixed amount or a percentage of sum insured (SI) under a particular head like room rent, ICU charges, specific diseases, surgeries and treatments, ambulance cover, etc. Room rent sub-limit also means that all the medical costs, services and consultant fees will be proportionately deducted.

Suppose you have a cover of ₹5 lakh with 1% of SI room rent capping, which means the insurer will only pay ₹5,000 per day. However, you choose a room with ₹10,000 per day rent, with the services of a physician (₹10,000), surgeon (₹50,000), and medical tests (₹40,000). After five days of hospitalisation, the insurer will not settle a bill of ₹1.25 lakh {₹25,000 (10,000-5,000 x 5) + ₹10,000 + ₹50,000 + ₹40,000}. The fee for doctors and tests will be proportionately reduced by 50%. So the insurer will settle a claim of only ₹75,000 (₹25,000 + ₹5,000 + ₹25,000 + ₹20,000) and you will have to pay ₹50,000 from your own pocket.

While some premium plans or those with higher covers do not include room rent capping, you will have to pay a higher premium, but it may still be a better choice. Some plans also offer removal of room rent cap as an add-on cover.

**Non-medical expenses:** Even the most comprehensive insurance plans will not cover all the expenses, because Irdai has exempted health insurers from paying certain 'non-medical expenses'. These are deducted by the insurer from the claim and you have to pay from your own pocket.

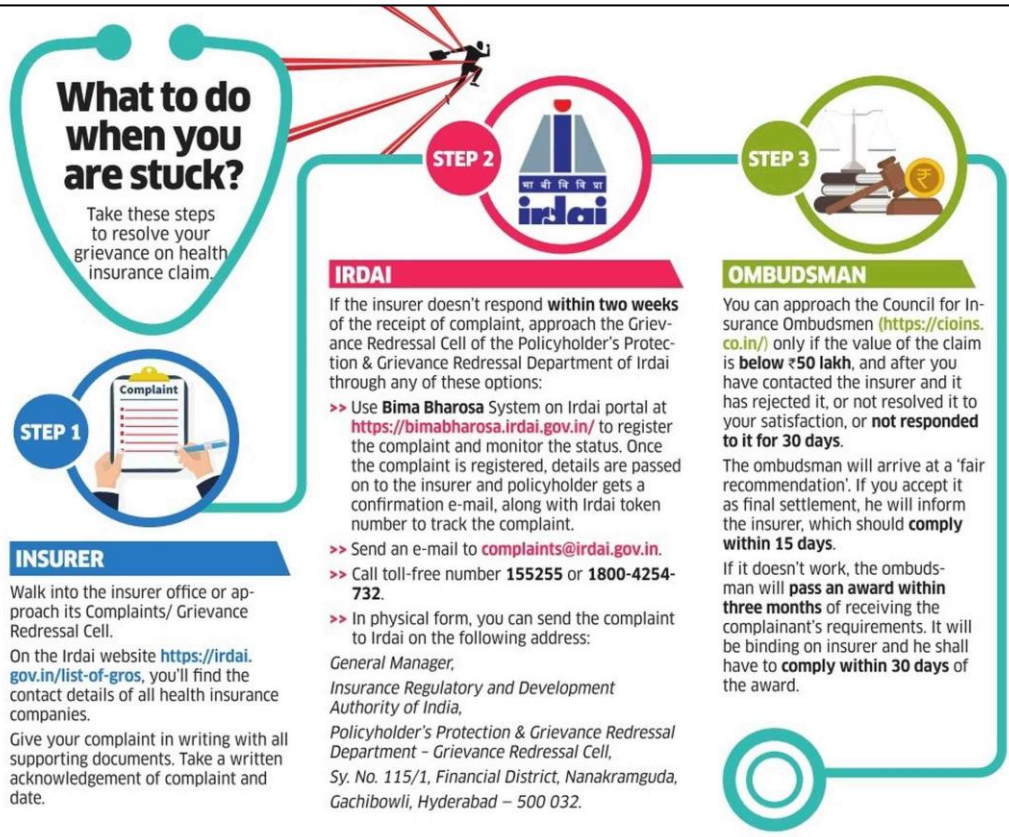
These are listed under categories of 'Room Charges' (gown, hand wash, pulse oximeter, housekeeping, toothbrush, comb, slippers, etc.); 'Treatment Costs' (registration/admission charges, nutritionist/ dietician charges, urine container, vaccination, etc.); 'Procedure Costs' (bandages, cotton, surgical blades, disposable razors, surgical drill, etc.); 'Optional Costs' (thermometer, mineral water, nebuliser kit, braces, etc.); and 'Others' (paper gloves, digestion gels, syringes, needles, etc.).

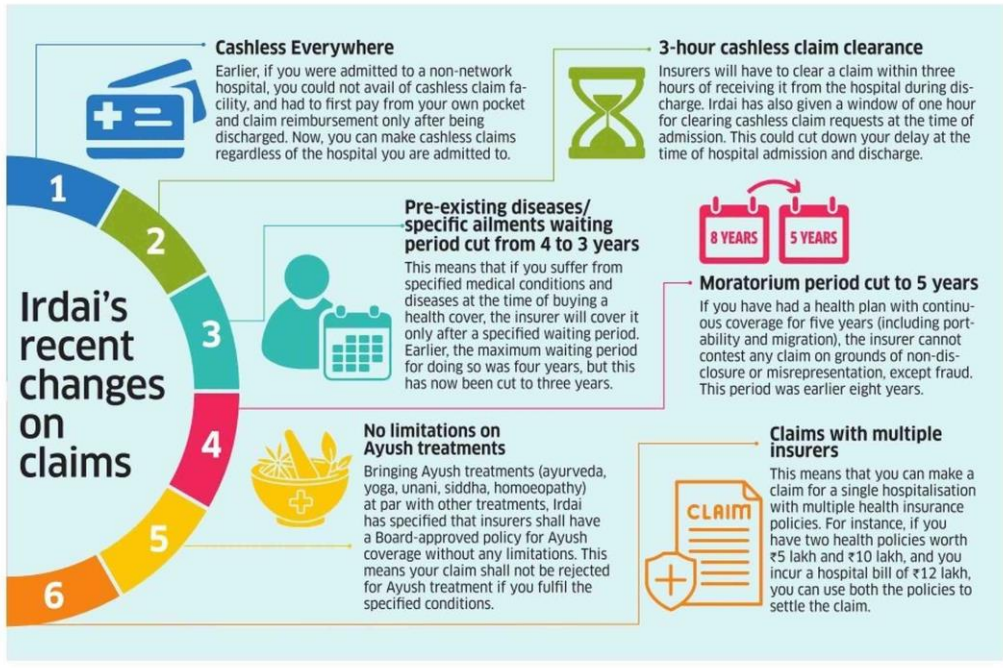
**Policy exclusions:** "If a part of the treatment or procedure falls under policy exclusions, only the eligible part will be paid for," says Arora. This means that the insurer will not pay the full claim amount.

**Co-payment & deductible:** Co-payment means that the policyholder will share a predefined portion of the total claim amount, while deductible means that the insured will pay a certain portion of the claim amount first and the remaining part will be paid by the insurer. Both result in partial payments by the insurer.

So if there's a co-payment clause of 20% and the bill is for ₹20,000, you will pay ₹4,000 and the insurer will pay ₹16,000. Similarly, if you have opted for a ₹8 lakh cover with a deductible of ₹2 lakh and your bill comes to ₹5 lakh, you will first pay ₹2 lakh yourself and the insurer will pay the remaining ₹3 lakh.

**Non-network hospitalisation:** Irdai recently mandated 'Cashless Everywhere' claim settlement, which means you can avail of cashless facility even in non-network hospitals. However, you may still end up paying more from your pocket because the policies may cover a lower percentage of expenses or limit reimbursements if




treatment is at a non-network hospital.

**Documentation & billing:** "If the documents submitted by the insured are incomplete or incorrect, it can lead to partial approval of claim," says Syed Meraj Naqvi, CEO & Principal Officer, Riskbirbal Insurance Brokers. This is also true of non-availability of billing details and unjustified hospitalisation.

### 3. CLAIM SETTLEMENT & DISCHARGE DELAYS

Another main irritant for patients is the inordinately long time, often over 5-6 hours, taken for insurer approvals and hospital clearances during discharge. As per the *ET Wealth* survey, nearly 29% respondents faced problems in claim settlement and discharge delays, with nearly 12% facing delays of over six hours in insurer approval during discharge, and

a little over 16% facing delays of over two months in reimbursement claims. A big issue in the latter is the compilation of documents, including discharge summary, treatment brief, bills, scans, reports, etc.

For delays in cashless claim approvals, both hospitals and insurers are responsible as it can either happen due to the time taken in submitting correct documents or in authentication (see *Claims & discharge: Reasons for delay*). The delay on the part of hospitals can happen due to doctors' approval and signing of documents, manual feeding of information, missing or incorrect information in the documents submitted to insurer, slower response time for insurer queries, and lack of dedicated staff or desk to cater to claims issues. For insurers, the delay is mostly because of manual checking and authentication of claim information.

### How to avoid it?

To overcome the hassle of collecting documents during reimbursements, make sure you ask for these at the time of hospital discharge. Call up the insurer to request the list of documents needed and ask the hospital if anything is missing.

For cashless claims, Irdai has recently taken some steps to curb delays, mandating a three-hour window at the time of discharge and one hour for approving requests at the time of admission. "Many insurance companies have already been adhering to these rules, but those that were not previously following these guidelines will be required to comply," says Nerurkar.

"A lot will depend on the hospitals as well. They should be able to have a process to submit all relevant documents to the insurer at one go," says Arora. Agrees Singhal: "They should streamline documentation to ensure all required papers are complete and accurate. Maintaining effective communication with insurers for quick query resolution and having a dedicated insurance desk to handle claims and assist patients are crucial."

"Maintaining transparency is also crucial; they should offer a clear and detailed medical history of patient, covering diagnosis, treatment plans and progress notes. If the insurer requests additional documents, they should submit promptly," says Nerurkar.

Another big step being taken for a quicker and smoother processing of claims is the setting up of a single portal, National Health Claim Exchange (NHCX), which is set to become operational in a couple of months. The portal will help simplify, speed up and standardise the claim settlement process through seamless exchange of information and documents between hospitals and insurers/TPAs. It will help digitise and automate most of the process.

## Claims & discharge: Reasons for delay

Despite Irdai's mandate on three-hour window for claim clearance by insurers during discharge, here's why it could take a long time for you to leave the hospital.


## GRIEVANCE REDRESSAL

If you feel there has been no procedural breach on your part and the insurer has rejected or reduced your claim amount on flimsy grounds, you can seek redressal. But be prepared for the battle as it can take a long time lasting several months.

To start with, be well-informed and follow a structured redressal process, know all the submission and response deadlines, and the right authority to forward your concern to. A good place to get this information on claim filing process is Irdai's website on consumer education, https://policyholder.gov.in/. As important is ensuring that you have all the documents, details and proof before you start the redressal process. For every reason cited as the cause of rejection, be prepared with concrete documentary evidence.

**STEP 1** "The first step is to reach out directly to the insurance company or service provider that issued the claim. If not resolved, file a formal complaint with the company's customer service," says Naqvi. Explain your issue and provide the necessary details, including policy number and claim reference number.

**STEP 2** "If the issue is not resolved by customer service, escalate it to the insurance company's dedicated grievance cell or officer. You can find their contact details on the insurer's website or in your policy documents," says Nerurkar. File a formal, written complaint with policy details, claim information and grievance details, and keep a copy. You will be given a complaint reference number to help track the status of complaint.

**STEP 3** Every insurer's complaint escalation varies slightly and can involve 2-3 levels. If the online complaint is not responded to or resolved, approach the insurer's grievance redressal officer and he should respond to the complaint within 15 days.

**STEP 4** If the issue is unresolved or you are dissatisfied, approach the insurance regulator, Irdai, through various options—Bima Bharosa System, e-mail, or toll-free number.

**STEP 5** If this too doesn't work, approach any of the 17 insurance ombudsmen, an independent body for out-of-court settlement on claim grievances. Get all the information you need on the Council for Insurance Ombudsmen (CIO) website https://www.cioins.co.in/ and contact details for different cities at https://www.cioins.co.in/Ombudsman.

Please send your feedback to etwealth@timesgroup.com