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Modern health treatment procedures: How some insurers don't tell policyholders about exclusions and sub-limits

Insurance companies charge hefty premiums for health policies and often revise them upwards to adjust for medical inflation. It comes as a surprise, therefore, if they reject or only partially settle claims linked to modern treatment methods and advanced procedures. After all, innovation in medical treatment is part of medical inflation.

New Delhi-based Rahul Kumar's 67-year-old father was diagnosed with liver cancer that needed an advanced palliative treatment called Transarterial Radioembolization (TARE). Kumar's brother had a corporate policy with a private insurer. However, during pre-authorisation, the company refused to approve the claim, saying, "TARE is an advanced procedure which is not covered under the policy; hence claim not admissible."

Kumar, who studied at the Indian Institute of Management Bangalore, had an alumni group insurance plan from the same insurer which covered his parents. It was a family floater plan with a fixed deductible of ₹5 lakh.

"I approached the insurance company to file a reimbursement. They accepted the documents and settled the claim in two months, probably thanks to some pressure the alumni group exerted on them. The same company had rejected it when my brother filed it under his corporate policy," said Kumar.

Bengaluru-based Parag Jain's mother-in-law was diagnosed with breast cancer in 2023 and was recommended "targeted" therapy. She needed to undergo six chemotherapy sessions followed by a surgery, radiotherapy and 14 post-surgery sessions over 1.5 years. The overall cost came up to ₹40 lakh.

"In my wife's corporate plan and in my personal plan, we had super top-ups. But the insurers told us that modern treatment is not covered in the super top-up plans," said Jain.

Regulatory mandate

To be sure, the insurance company had not shared the correct coverage details with Kumar's brother and Jain. In September 2019, the Insurance Regulatory and Development Authority of India (IRDAI) had mandated that insurance policies must cover 12 modern treatments including balloon sinuplasty, oral chemotherapy, robotic surgery and stereotactic radiosurgery.

However, the regulator left it to the insurance companies to decide sub-limits. That said, not all health insurance policies offer full coverage up to the sum insured for these treatments. Some of them apply sub-limits or caps on the maximum amount for some or all treatments.

Jain followed up with the insurers, citing the IRDAI circular.

"Finally, they covered it but after a lot of back and forth. Many cancer treatments fall under the purview of modern treatment. Policyholders can be taken for a ride if they do not know about IRDAI's circular," said Jain.

Ravi Jakareddy (54) from Pune has a policy from a public insurer. He was told to buy a rider, which cost him an additional ₹20,000, to get modern treatment coverage up to 100% of the sum assured (SA).

“My insurer told me that the base policy does not cover it," he said.

Aayush Dubey, co-founder and head of research at Beshak.org, explains why some insurers tend to reject claims under modern treatment in their first communication.

"When the IRDAI mandated insurers to include 12 modern treatments/procedures in their policy contracts, some of them simply removed them from their permanent exclusion list, without providing any further details on coverage, conditions or limits. Others revised their policy wording and brochures accordingly and specifically added the coverage for them along with the associated conditions and limits. The former set of insurers tends to reject claims," he said.

Regardless of whether or not information on modern treatment is mentioned in a policy document, all insurers have to cover it, as mandated by IRDAI, up to specified sub-limits.

Understanding sub-limits

Ahmedabad-based Sureshchandra Chechani (61) had a mediclaim policy from a public insurance company with a base cover of ₹1 lakh and ₹50,000 bonus. He was diagnosed with prostate cancer and admitted to a hospital in Ahmedabad. The treatment cost came in at about ₹4.65 lakh.

"More than 90% of the claim amount was denied. They gave us only ₹37,500, saying robotic surgery is covered only up to 25% of the sum insured," said Chechani.

Chechani argued that it should have been covered up to the sum insured. However, the public insurer in his case does not offer full coverage. Some public insurers set even lower sub-limits.

For example, New India Assurance Co. covers only 10% of the sum insured in oral chemotherapy up to ₹1 lakh in its floater mediclaim policy. The Oriental Insurance Co. has set similar limits in its family floater plans. Among private insurers, while Niva Bupa covers 11 modern treatments fully, it caps claims against few robotic surgeries at ₹1 lakh per claim in its Reassure 2.0 plan.

"Lower sub-limits defeat the purpose of buying a high sum assured. In some cases, treatments are limited to ₹50,000. This is lower than the cost of traditional treatment for the same ailment. So, insured will have to bear a substantial cost out of pocket," said Abhishek Bondia, co-founder and principal officer at SecureNow Insurance Broker.

According to Dubey of Beshak.org, policies with the lowest sub-limits include IFFCO Tokio Family Health Protector, IFFCO Tokio Individual Health Protector, National Insurance - Mediclaim Plus, National Insurance, Parivar Mediclaim Plus, Royal Sundaram - Lifeline and SBI General - Arogya Supreme.

Porting option

Policyholders should consider porting to a new plan if their existing plans have sub-limits on modern treatments.
"HDFC Ergo Optima Restore and Secure, Niva Bupa Aspire, Bajaj Allianz My Healthcare, Star Health Assure and Comprehensive and Aditya Birla Activ Fit and Activ One are some of products offering 100% coverage up to sum insured for modern treatments," he said.
Parthanil Ghosh, director and chief business officer at HDFC Ergo General Insurance, advises people to be mindful of their coverage and choose treatments accordingly. He said that in the US and western countries, insurance companies, through their panel of doctors, have a right to deny an insurance claim pertaining to a certain treatment or treatment at a particular hospital.

They say if they are the financiers, they should have a say or should be able to recommend the treatment without jeopardizing the patient's health.

"In India, our insurance policies do not have any such restrictions and policyholders are free to get admitted at any hospital based on the advice of their treating doctors. Policyholders need to decide themselves on getting

modern/advance treatments like robotic surgery, depending on their sum insured as a high-cost treatment with a low sum insured policy will exhaust the entire sum insured at one go and may result in substantial out-of-pocket expense for the policyholder," said Ghosh.

What about modern treatment procedures beyond the mandated 12?

"There is no specific list of exclusions. Admissibility is decided based on the claim documents and line of treatment suggested. Any unproven treatment, including drug experimental therapy, which is not based on established standard medical practices or experimental or unapproved, shall be a standard exclusion," said Bhaskar Nerurkar, head of the health administration team at Bajaj Allianz General Insurance.

Dubey said insurance companies typically do not cover popular modern treatments such as gene therapy, CAR-T cell therapy, proton beam therapy, hyperbaric oxygen therapy (HBOT), transcatheter aortic valve replacement (TAVR), and transcranial magnetic stimulation (TMS) in retail insurance policies.

“Some group insurance policies cover these treatments," he said.