

INSTITUTE OF ACTUARIES OF INDIA

EXAMINATIONS

November 2025

SA1 - Health and Care

Time allowed: 3 Hours 15 Minutes

Total Marks: 100

Q.1) You are working as a senior actuary in a large health insurance company in India. Grievance officer has reviewed the complaints lodged by the customers in the last 18 months and identified five recurring complaint themes that are adversely impacting customer experience and operational efficiency.

Five sample out of these complaints have been referred to your department for analysis and resolution. Using the **Actuarial Control Cycle**, prepare a report with your recommendations to address these customer complaints effectively.

Complaint 1: Claims Deduction Without Explanation

"I was shocked to see that my health insurance claim was partially settled, with nearly ₹25,000 deducted without any clear reason. I had submitted all the required documents, and the hospital bill was legitimate. When I contacted customer service, they gave vague responses and couldn't explain the deductions. I feel cheated—what's the point of paying high premiums if the insurer arbitrarily cuts down the claim amount? There should be transparency and a proper breakdown of deductions. I trusted this company to support me during medical emergencies, but this experience has left me deeply disappointed."

Complaint 2: Delay in Claims Payment

"My father was hospitalized last month, and we submitted the claim immediately after discharge. Despite repeated follow-ups, the insurer took over three weeks to process the reimbursement. Every time I called, they said the claim was 'under process'. We had to borrow money to pay the hospital upfront, expecting timely reimbursement. This delay caused unnecessary financial stress during a critical time. Health insurance is supposed to ease the burden, not add to it. I expected better service from a reputed company. If this is how claims are handled, I'm reconsidering renewing my policy."

Complaint 3: Delay in Hospital Discharge Due to Authorization

"After my surgery, I was ready to be discharged, but the hospital said they were waiting for the insurer's authorization letter. I ended up staying an extra 12 hours, incurring additional room charges and discomfort. The insurer's delay in issuing the approval was frustrating. Despite having a cashless policy, the process was anything but smooth. Why can't the insurer coordinate faster with hospitals? It's unfair to make patients wait when they're already vulnerable. This kind of inefficiency defeats the purpose of having health insurance and reflects poorly on the company's service standards."

Complaint 4: Annual Premium Increase Without Justification

"I've been a loyal customer for five years, but my health insurance premium keeps increasing every year—even though I haven't made a single claim. This year, the hike was nearly 20%, and there was no explanation provided. When I asked, they vaguely mentioned 'medical inflation.' I understand costs rise, but shouldn't no-claim customers be rewarded instead of penalized? It feels like I'm being punished for staying healthy. There's no transparency in how premiums are calculated, and I'm starting to feel that loyalty doesn't matter. I'm seriously considering switching to a more customer-friendly insurer."

Complaint 5: Poor Communication and Lack of Transparency

"Dealing with my insurer has been a nightmare. Their website is confusing, customer service is unresponsive, and I never get clear answers. During my recent claim, I had to call multiple times just to understand the status. Emails go unanswered, and the app doesn't show real-time updates. I feel like I'm in the dark throughout the process. Health insurance is a serious matter, and customers deserve timely, transparent communication. If the company can't even provide basic updates, how can we trust them during emergencies? This lack of professionalism is unacceptable."

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Q. 2) You are a qualified actuary employed by a leading health insurance company in India. The company offers a portfolio of private medical insurance (PMI) products that indemnify individual customers for medical treatment received in private healthcare facilities across the country.

Historically, the company has performed well in terms of profitability and growth. However, in recent years, both the volume of in-force business and overall profitability have declined significantly. The Product Management Committee has expressed concern regarding this downward trend and has requested a strategic review of the PMI portfolio.

One of the committee members has observed that several smaller competitors have entered the market, offering comparable PMI products at lower prices and successfully gaining market share. Additionally, there has been a deterioration in the division's solvency position and a notable increase in technical provisions.

In response to these challenges, the product department has proposed two initiatives aimed at improving performance:

- Introducing premium discounts for individual customers based on loyalty, potentially linked to their claims history.
- Launching online sales of PMI products, which are currently distributed through direct sales agents, brokers, and telephone channels.

You are required to prepare a report for the Product Management Committee.

Your report should address the following:

- a) Identify and discuss the potential causes of the recent poor performance of the PMI portfolio. Include your assessment of the likelihood that these issues will persist. (25)
- b) Critically evaluate the proposed initiatives and provide your recommendations for improvement. (10)
- c) Suggest additional strategic actions that could be taken to address the challenges facing the PMI portfolio. (15)

Note: You may assume that reinsurance arrangements and changes in legislation are not relevant to this analysis.

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