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Impact of Guidelines on Standardization of Exclusions in Health Insurance – Considerations for Insurers

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Agenda

- Introduction - current challenges of health insurance market in India
- Key highlights of the regulation
- What it means for various stakeholders?
  - Consumers
  - Insurers
  - Providers
  - Regulator and policymaker
- Considerations for the insurers

Complex products and fragmented market impacting health insurance value proposition.

PRODUCT CHALLENGES

- Complexity of health insurance products.
- Low persistency rates in initial years.
- Low uptake rate for new and innovative products.
- New product development issues due to lack of experience data, inadequate clinical coding and industry research.

DEMAND CHALLENGES

- Fragmented market dynamics:
  - Multiple segments (income levels, geography, literacy, supply etc.).
  - Diverse customer needs.
  - Low awareness.
- Government focus is on poor; low insurer penetration to “unorganised” middle and low income groups.
- Value proposition – health insurance is still considered expensive by potential customers.

Fast changing regulatory environment and lack of standardization of key operational processes resulting in higher operational costs for insurers.

REGULATORY CHALLENGES

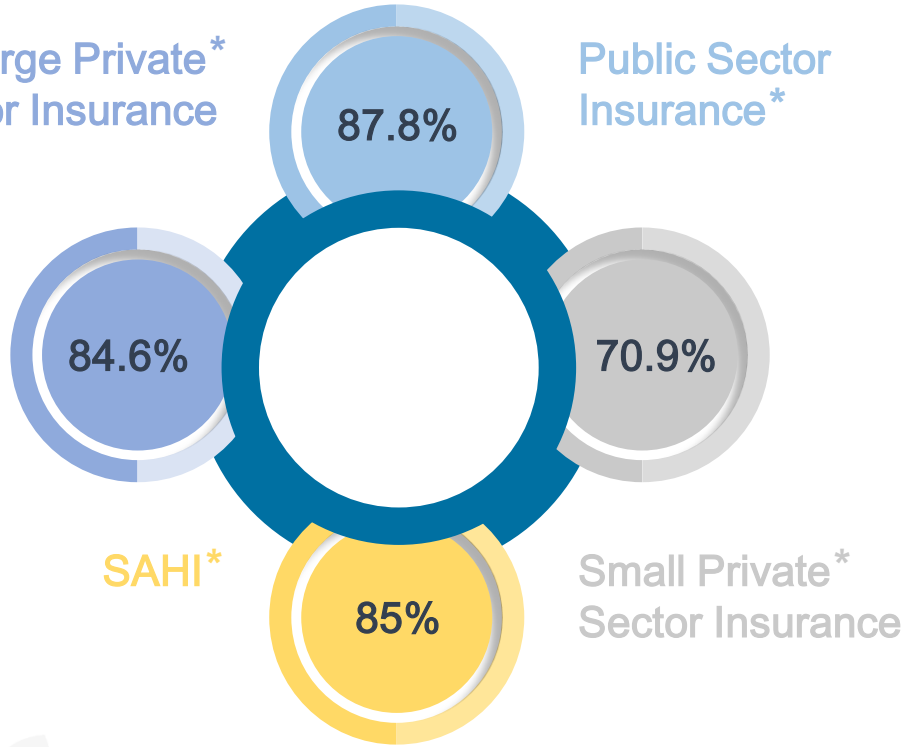
- Proposed introduction of IFRS17 (INDAS117) and RBC regimes by 2020 and 2021 respectively posing new challenges in terms of capital requirements, operations, IT systems and accounting.
- New court rulings (for example inclusion of genetic disorder and congenital diseases) pose abrupt challenges in strategic planning, pricing and operations.

OPERATIONAL CHALLENGES

- Underwriting:
  - Lack of standardization and uniformity in approach.
  - Limited innovation.
- Claims:
  - Manual operations.
  - TPA incentives not aligned to provider management.
- Availability of skilled manpower.

Is lack of customer awareness about the policy terms and conditions, a primary reason for claim rejection?

As per IBAI, the claim settlement ratios** of health insurance of various sectors for the year ending March 31st, 2019 are:



The claim settlement ratio ranges between 70%-90% for different type of insurers. The small private insurance companies have the lowest ratio in the market.

Higher the claim settlement ratio and lower the claims turn around time, implies better customers satisfaction.

* Please refer to the appendices for the details data source of numbers and list of insurance companies in the 4 categories used in the diagram above.

** Claims Settlement Ratio = Total number of claims settled during the period / Total number of claims available for processing during the period.

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Guidelines on Standardization of Exclusions in Health Insurance Contracts

Key Highlights

Standardization of exclusions in health insurance contracts to ensure uniformity across industry – key components

List of Exclusions that will not be allowed in Health Insurance Policies.

Standard Wordings for some of the exclusions in Health Insurance Policies.

Standard list of diseases allowed to be permanently excluded.

Framework for inclusion of Modern Treatment Methods and Advancement in Technologies.

List of exclusions that will now be covered in health Insurance Policies

- Diseases contracted after taking the health insurance policy.
- Injury or illness associated with hazardous activities. However, treatment necessitated due to participation in adventure or hazardous sports is permitted as an exclusion.
- Impairment of Persons' intellectual faculties by usage of prescription drugs prescribed by a medical practitioner.
- Artificial life maintenance, including life support machine use, unless in a vegetative state as certified by the treating medical practitioner.
- Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
- Disorder arising due to aging or age related physiological changes in body. For example Puberty and Menopause related Disorders, Age Related Macular Degeneration etc.
- Behavioural and Neuro developmental Disorders:
  - Personality disorders including gender related problems.
  - Disorders of speech and language including stammering, dyslexia.
- Expenses related to any admission primarily for enteral feedings and other nutritional and electrolyte supplements.
- Internal congenital diseases, genetic diseases or disorders.
- If specified aetiology for the medical condition is not known.
- Failure to seek or follow medical advice or failure to follow treatment.

Standard wordings for specific exclusions

Differences in the interpretation across insurers due to lack of standard definitions.

- Pre-Existing Diseases
- 30-day waiting period
- Investigation & Evaluation
- Rest Cure, rehabilitation and respite care
- Obesity / Weight Control
- Change-of-gender treatments
- Cosmetic or plastic Surgery

- Hazardous or Adventure sports
- Breach of law
- Excluded Providers
- Refractive Error
- Unproven Treatments
- Birth control ,Sterility and Infertility
- Maternity

Diseases allowed to be permanently excluded

- Only applicable for 17 medical disclosures at the time of inception.
- Published specific ICD level details for which permanent exclusion is applicable.

- Sarcoidosis
- Malignant Neoplasms
- Epilepsy
- Heart Ailment Congenital heart disease and valvular heart disease
- Cerebrovascular disease
- Inflammatory Bowel Diseases
- Chronic Liver diseases
- Pancreatic diseases
- Chronic Kidney disease
- Hepatitis B
- Alzheimer's Disease, Parkinson's Disease –
- Demyelinating disease
- HIV & AIDS
- Loss of Hearing
- Any Physical Disability
- Papulosquamous disorder of the skin
- Avascular necrosis (osteonecrosis)

Modern treatment methods and advancement in technologies

To ensure that the policyholders are not denied availability of health insurance coverage to Modern Treatment Methods Insurers shall ensure that the following treatment procedures must be included in the health insurance policy contracts.

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain stimulation
- Oral chemotherapy
- Immunotherapy-Monoclonal Antibody to be given as injection
- Intra vitreal injections
- Robotic surgeries
- Stereotactic radio surgeries
- Bronchical Thermoplasty
- Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
- IONM - (Intra Operative Neuro Monitoring)
- Stem cell therapy

Other guidelines related to exclusions (1/2)

Specific Disease:

Insurers are allowed to impose a waiting period of up to 4 years.

Insurers can impose limits and sub-limits in benefits in terms of amount or number of days of treatment or hospitalisation allowed in the policy.

Insurers have three options to handle the cases of Non-declaration / Misrepresentation of material facts

CASES	OPTIONS
1. Non-disclosed condition is from the list of permanent Exclusions.	1. Policyholder's consent will lead to the permanent exclusion of the existing disease and continue with the policy.
2. Non-disclosed condition is not in the list of Permanent Exclusion	2. Additional waiting period of maximum 4 years from the date of detection of the disease.
3. Non-disclosed condition under option-3, condition is not in the list of permanent exclusions.	3. The company will continue the coverage by levying extra premium.

Other guidelines related to exclusions (2/2)

After completion of 8 years of continuous coverage (moratorium period) in a policy, the company cannot reject any claim except for fraud and permanent exclusions. The policy would however be subject to the limits and sub-limits, co-payments and deductibles as per the policy conditions.

Waiting period for lifestyle conditions such as Hypertension, Diabetes, Cardiac conditions is allowed for a maximum of Ninety days except if these diseases are pre-existing and disclosed at the time of underwriting.

The wordings of the exclusions or waiting periods: should be specific and unambiguous.

Oral Chemo Therapy and Peritoneal Dialysis claims should be covered if chemotherapy and dialysis is allowed respectively subject to the product design.

Pre and Post Hospitalization cover under Domiciliary Treatment benefit shall not be excluded where the product covers pre and post hospitalisation expenses in case of in-patient hospitalisation and the underlying product covers domiciliary hospitalisation as well.

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What it means for various stakeholders?

Standardisation of guidelines is expected to have a major impact on key stakeholders

Consumer expected to benefit from standard and less ambiguous policy terms and conditions resulting in quick buying decision and ease of claim settlement.

- Easy to understand and less variation in policy wordings.
- Expanded coverage:
  - To include some diseases excluded earlier such as mental illness or congenital illness etc.
  - To include the pre-existing diseases after a pre-mentioned waiting time period.
  - To include coverage after 8 years of continuous cover.
- Claim settlement ratios expected to rise due to increase in benefits included as well as transparency and standardization of exclusions increasing customer awareness.
- Coverage of advanced medical treatments which will provide wider options to the patients.
- Potentially lead to increase in premiums but may prove worth the added benefits and transparency of coverage - increased value proposition.

Level playing field to drive product innovation and higher penetration. Increased investments by providers in modern technologies

- Reduced policy and claims-related grievances.
- Drive further product innovation among insurers to achieve competitive edge as compared to peers.
- Drive higher HI penetration.

- Increased investment in modern technological equipment thoug this will drive costs upwards and hence pricing.
- Employment of professionals well versed with the modern treatment technologies.

Benefit for insurers from increased customer satisfaction. Changes in current pricing strategy and more efficient claims and underwriting operations.

- Improved customer trust and satisfaction as there will be reduced claim denial.
- Need to reprice to take the extended coverage into account.
- Need to re-strategize the marketing strategy for the revised products.
- Easier claims settlement process.
- Need to research the availability and cost of advanced medical treatments listed in the regulation.
- Robust underwriting process needs to be developed.

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Key considerations for insurers

- Product benefits and pricing
- Underwriting
- Claims

Considerable product benefits and pricing impact – scientific evaluation of expected pricing impact will be key to remain competitive.

Revised products will have additional benefit coverage such as:

- Treatment of mental illness, stress or psychological disorders, congenital illness, advance modern treatments etc.
- Medical necessity and guidelines for use of modern treatment methods still need to be formalized.

Pricing is required to account for the impact of these additional benefits, for covering pre-existing diseases after pre-specified waiting periods and for the moratorium period of 8 years.	Inclusion of modern treatment methods needs clear understanding of various therapies and impact of current availability on prices along with impact of increased investments on medical inflation to estimate the expected increase in claims cost.	Estimating the premium in respect of these changes will involve various assumptions including the expected frequency and severity for the new inclusions due to lack of any experience.
Administrative and underwriting costs are likely to increase initially due to these changes and should be taken into account while pricing.	New prices should be competitive in the market. Premiums expected to increase initially but with more actual experience, insurers may be able to rationalize the price increases.	Needs to strategize product marketing as there will change in premiums, increase in product comparability and transparency and better understanding of benefits for customers.

Underwriting becomes more and more important as insurers would like to understand as much as possible about the health status of proposer and predict future impact on claims with more certainty.

Underwriting will become critical and will be required at a much more detailed level primarily because of inclusion of some illnesses which were excluded earlier, pre-existing diseases will be covered after a certain waiting period and, a moratorium period of 8 years will be introduced.

Processes and procedures needs to be developed to monitor underwritten population, to formally review performance at regular intervals to evaluate / test assumptions against actual experience. This would help swiftly review the UW cycle and updated information-driven decision making.

Extensive detailed questionnaire will be required for screening and medical history, current ongoing illnesses and drugs consumed.

This would potentially increase underwriting cost for the company.

Revision of minimum required set of medical tests under “pre policy checks” (PPC) along with medical examination report (MER) should be considered.

Rule-driven claims processing can help reduce the overall claims management expenses. With reduced grievances and subjectivity, claims process will potentially become more efficient.

System-driven checks performed by network providers to check member eligibility for a given condition (ICD 10 code).

Set up standard claim forms and templates for data entry to enable system driven claims management.

Develop mobile application based pre-authorization and checks prior to services availed by the member.

Rules driven system automated checks to flag inappropriate billing, non coverage or benefit or utilisation checks.

Implement technology assisted clinical coding, for auto adjudication and real time checking of provider on inappropriate billing.

Set up robust rules and process for denial management comprising of clinical denials and technical or administrative denial.

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Appendices

• Appendix (1/2)

DATA SOURCES:

SOURCE OF CLAIM SETTLEMENT RATIO DATA :
https://blog.securenow.in/wp-content/uploads/2020/01/claim-insights-handbook_013_web-view-1.pdf

SOURCE OF IRDAI REGULATIONS :
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3916&flag=1

Appendix (2/2)

- List of Insurance companies based on the 4 sectors

Public Sector Insurance Companies	Large Private Sector Insurance Companies	Small Private Sector Insurance Companies	Standalone Health Insurance Companies
New India	IFFCO Tokio	Magma HDI	Religare Health
Oriental Insurance	Bajaj Allianz	Acko	Manipal Cigna
National Insurance	Future Generali	DHFL General	Apollo Munich
United India	HDFC ERGO	Go Digit	Max Bupa
	Tata AIG	Liberty General	Star Health
	ICICI Lombard	Edelweiss	Aditya Birla Health
	Bharti AXA	Kotak Mahindra General	
	Royal Sundaram	Universal Sompo	
	Reliance	Cholamandalam	
	SBI General		

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