Business Line

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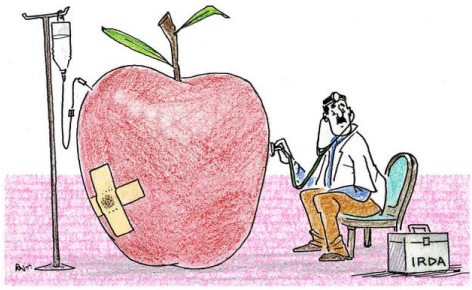
To the Health of Policy Holder!



IRDA's new guidelines usher in landmark changes, making health insurance more customer-friendly.

“I made no claims on my mediclaim policy, taken in 2009, till recently, when my son fell sick. I am now told that my entire accumulated bonus is lost….” This is the lament of an aggrieved policyholder. And this is not an isolated case.

In the first quarter of last fiscal year alone, the Insurance Ombudsman received over 6,000 complaints from holders of health insurance.

Scrapping the entire accrued bonus on the policy at the first instance of a claim, shooing off elderly policyholders on renewal request, changing policy terms without intimating policyholders and increasing renewal premium by as much as 50 per cent after a claim, are some practices of insurance companies that have caused a great deal of inconvenience and monetary loss to policyholders.

But things are set to change thanks to protest from various quarters, including a public interest litigation filed in Bombay High Court by social activist Gaurang Damani.

The Insurance watchdog has released a set of new guidelines that will bring about landmark changes and make health insurance policies more customer-friendly. October 1, 2013, is the deadline for insurers to comply with the new regulations.

On Claims

Your claim on a health insurance policy will be settled within thirty days, from now on.

Unless the insurer suspects a fraud and needs to make further enquiry, he cannot delay claim settlement beyond thirty days from receipt of the last document from the policyholder, says the new regulation.

The Insurance Regulatory and Development Authority (IRDA) has also standardised the claim form and pre-authorisation form (this is the form requesting cashless hospitalisation). Currently, each insurer uses a different format for these forms, causing a lot of confusion at the hospital end as well as for policyholders at the time of filing the claim, says Mahavir Chopra, Head - eBusiness and Personal Lines, Medimanage, a health insurance consulting firm.

Also, the role of third party administrators (TPAs), who liaise between the insurer and the policyholders, is now restricted to claim processing. Claim settlement will now be done by insurers directly.

This will solve a lot of problems for policyholders, says Damani.

“Earlier, TPAs were the ones to issue the cheque to the policyholder. They, in fact, took money from the insurer but didn’t pass it to the policyholders for many months. There was no audit of the amount paid by the insurer to the TPA and the TPA’s settlement with the consumer. The new regulation plugs these holes.”

On bonus

The regulator has also cracked down on the industry’s practice of cancelling the entire accumulated bonus on a policy at the first instance of a claim.

Say, you have a hospitalisation policy of Rs 5 lakh and you have renewed it for three successive years without a claim and have an accumulated bonus of 15 per cent.

This means your sum insured for the current year will be Rs 5,75,000, 15 per cent higher than the original sum insured.

Previously, if you made a claim at this point, you would lose the entire accumulated bonus and the next time you renewed the policy, your sum insured would have reverted to the original Rs 5 lakh.

But, now under the new regulations, you lose only 5 per cent and have a sum insured of Rs 5,50,000. So, the bonus will reduce only in terms of the rate at which it accrued.

On premium

Loading on renewal premiums based on individual claim experience has been barred by the regulator.

So far, insurers penalised policyholders who made claims on their policy by increasing the renewal premium the next year.

The increase here could be as much as 200 per cent in case of a claim that is over 90 per cent of the sum insured, says Meena Nair, Assistant Vice-President of India Insure, an insurance broking company. However, now the regulator has stipulated clearly that insurers shouldn't fiddle with rates of individual policy holders, if need be, they can revise the entire premium structure of the plan.

Also, any increase in premium should be made on an objective criterion and not related to loading because of claim experience with individual policyholders.

The grace period for premium payment has also been extended to 30 days from 15 currently.

On policy terms

Most insurers today don't renew the health insurance contract after the policyholder turns 70-75 years.

Take, for instance, Reliance Life's Care for you plan or ICICI Prudential's Health Saver plan These have an exit age of 75 years.

But now it gets mandatory to offer life-time renewal. Elderly people who earlier entered old age with cover for medical costs now renew it as long as they please.

Insurers have been asked to set up a separate cell too for handling queries of elderly customers. Also, until now, there was no mandate for insurers to give a free look-up period on health policies.

This saw customers who were mis-sold a policy having to stay with it and pay up premium.

Now, it is compulsory to offer a free look-up period of 15 days. The policyholder can look into the terms and conditions in the policy document and return it if not suitable to him.

If you hold more than one medi-claim policy, then the new regulations save you a lot of hassles, says Renuka Kanvinde, AVP, Health Insurance, Bajaj Allianz General.

"Earlier, if you had the hospitalisation plan of two or more insurers, you had to claim on a pro-rata basis, that is, your claim should be in proportion of your sum insured with different insurers. This meant running behind each insurer. Now, it is left to your wish, you can choose to settle your claim with any one insurer, provided the claim amount falls within the limit of sum insured given by that insurer".

The regulator has also put it in ink that any change in the policy terms and conditions or a change in the premium rate has to be communicated to the policyholder three months in advance.

What's in a name?

The IRDA has standardised 46 commonly used terms in health insurance and also defined 11 critical illnesses, ending all ambiguity over the interpretation of these terms.

'Pre-existing disease', for instance, has been defined as any condition or ailment for which one had symptoms and/or were diagnosed and/or received medical advice within 48 months prior to the first policy issued by the insurer. This definition, though not new, buries all misinterpretation.

As a rule, health insurers cover pre-existing illnesses after four continuous policy years.

However, if the policyholder didn't disclose it and the insurer discovers it at the event of a claim, the claim would be rejected.

But, what if the policyholder genuinely didn't know about his medical condition, say, it was a malignant tumour? Sanjay Datta, Chief Underwriter, ICICI Lombard, says, "In such cases, a doctor's report will clearly bring out the facts and policyholders need not worry."

The other crucial point in the case of pre-existing disease is that the '48 months' condition doesn't always stand.

"The prospect needs to declare all conditions for which he is receiving treatment at the time of proposal. For instance, if he has been taking medication for diabetes for the last 10 years, he needs to disclose that, it doesn't matter that the condition was diagnosed 10 years before".

The regulator has also put a stop to fights over 'what is excluded' in a hospitalisation policy by penning them down explicitly.

Now a total of 199 expenses, including baby food, laundry charges, tissue paper, gauze, gown, bed under pad, razor, crepe bandage, etc., need not be paid by the insurer unless he chooses to act otherwise.