REPORT
OF THE EXPERT COMMITTEE
ON
HEALTH INSURANCE

भारतीय बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND
DEVELOPMENT AUTHORITY OF INDIA

REPORT
OF THE EXPERT COMMITTEE
ON
HEALTH INSURANCE

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA (IRDAI)

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एम. रामप्रसाद
सदस्य (गैर–जीवन)
M. Ramaprasad
Member (Non-Life)

बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

Date: 24.04.2015

Dear Shri. Vijayan,

On behalf of the Expert Committee on Health Insurance, set up vide Chairman's order ref: IRDA/HLT/MISC/ORD/284/12/2014 dated 29th December, 2014, I have great pleasure in placing before you the report of the Committee. I thank you for bearing with the extended time the Committee has had to take as more rounds of interaction than were envisaged became necessary. Coming as it does on the heels of the amendment to the Insurance Act; the report, among others, includes recommendations pertaining to the changes to the insurance framework the Amendment has ushered in, apart from suggesting improvements /revisiting certain aspects of the current framework. While preparing its recommendations, the Committee had certain objectives-- level playing field for life, non-life and stand-alone health insurers, increasing growth and penetration, improving sustainability, improving policyholder servicing and review of Health Insurance Regulations and Policy Holder Protection regulations in the light of various feedback received over time.

The Committee is of the view that a focused regulatory oversight and control is necessary as health insurance business is being carried out by all categories of insurers. The Committee therefore suggests that the Authority considers forming an exclusive vertical or department for Health insurance and bring all Health insurance issues –pertaining to Life, Non-life Insurance and Health Insurance companies onto the same platform. Only then will a level playing field and a consistent approach to regulatory aspects for development of health insurance be facilitated.

I am very thankful to the members of the Committee as well as those coopted to the various sub-groups, for putting in valuable time and energy into crystallizing the recommendations and in the making of this report. I thank the Health Insurance Department of IRDAI for its administrative, logistic and other support for enabling conduct of the meetings and other interactions. Last but not the least, I would like to thank you for giving me the opportunity to take up this exercise and make recommendations on the various aspects of functioning of Health Insurance at this opportune moment, when this fastest growing segment of non-life insurance has been recognized as a class of its own in the recent amendment to the Act and is all set to embark on an exciting journey of further growth and penetration even while seeking to enhance its role as a financing mechanism for healthcare of the people at large.

With regards,

Yours sincerely,

M. Ramaprasad

Shri. T.S.Vijayan
Chairman
IRDAI

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Disclaimer: Views expressed are those of the members in their individual and collective capacity as members of the Committee and do not necessarily reflect that of the organisation or institution they represent.

IRDAI ORDER CONSTITUTING THE EXPERT COMMITTEE

बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

Ref: IRDA/HLT/MISC/ORD/284/12/2014 29th December, 2014

ORDER

Re: Constitution of Expert Committee to examine Health Insurance Framework

Health Insurance has grown by leaps and bounds over the last few years and in the non-life segment, it is today, the fastest growing segment with a premium of nearly Rs.17,500 crores as on 31st March, 2014. The year 2006 saw the establishment of the first stand-alone health insurance company. Today there are five stand-alone health insurance companies in the country. Recognising the unique features of health insurance and realizing the need for a separate framework for the segment, IRDA brought out comprehensive framework for health insurance in the form of the Health Insurance Regulations, 2013 as well as the Guidelines on Standardisation in Health Insurance, in the same year.

Health Insurance business is being given a distinct place in the amendment to the Insurance Act, 1938—it is being recognized as a separate segment, apart from life and non-life insurance. Moreover, both life and non-life companies can carry on health insurance business and are to comply with relevant provisions in this regard in so far as the Act, the Regulations, Guidelines, Circulars etc are concerned. Hence, this is one segment where both life and non-life insurers, apart from stand-alone health insurers, participate.

In the above backdrop, a need has been felt to visit/re-visit various areas in the framework applicable for health insurance to ensure level playing field for the industry as well as rationalize various provisions, wherever required given the nature of business. For this purpose, a committee (hereinafter called the 'Committee') is hereby constituted as follows and with the following Terms of Reference (ToR):

I. **Chairman and Members:**

1. Shri.M.Ramaprasad, Member (Non-Life), IRDA, Chairman
2. Shri.A.V.Girijakumar, General Manager, National Insurance Company Limited, Member
3. Shri.Segar Sampath, General Manager, The New India Assurance Company Limited, Member
4. Shri. H.S. Shashi Kumar, Executive Director (Health), Life Insurance Corporation of India, Member
5. Shri.Bhargav Dasgupta, CEO, ICICI General Insurance Company Limited, Member

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6. Shri.K.S. Gopalakrishnan, CEO, Aegon Religare Life Insurance Company, Member
7. Dr.Prakash, Managing Director, Star and Allied Health Insurance Company, Member
8. Smt.Tania Chakravarthy, Appointed Actuary, Royal Sundaram General Insurance Company Limited, Member
9. Shri.R.Chandrasekaran, Secretary General, General Insurance Council, Member
10. Shri.P.C.James, Chair, Non-life, National Insurance Academy, Member
11. Smt.Yegnapriya Bharath, Joint Director (Health), IRDA, Convener

II. Terms of Reference

The Committee shall examine the existing framework for regulating Health Insurance business on the various relevant areas, including the following:

(i). Health Insurance Products
(ii). Health Insurance Product distribution
(iii). Reinsurance in so far as Health Insurance is concerned
(iv) Protection of policyholders of health insurance
(v). Place of health in rural and social sector obligations
(vi). Place of health in micro insurance
(vii). Mergers and acquisitions in so far as stand-alone health insurers are concerned
(viii). Approaches to solvency and various actuarial matters relating to health insurance
(ix). Investment as well as various financial matters relating to health insurance
(x). Any other area relevant for health insurance from the regulatory perspective, identified by the Chair.

II. Time-frame:

The Committee shall finalise its report containing its recommendations within 8 weeks from the date of this order and submit the same to Chairman, IRDA. The Committee may meet as often as felt necessary to carry out its deliberations.

(T.S.Vijayan)

Chairman

STRUCTURE OF THE EXPERT COMMITTEE

The Expert Committee was split into four sub-groups that were assigned the topics as shown below:

Sub- Group	Members	Nodal Member
Policy Holder protection, Service Providers incl. TPAs, Fraud and Risk management	Shri. P C James Dr.S Prakash Shri. R Chandrasekaran	Dr.S Prakash
Product, Distribution, Rural & Social Sector, Micro-Insurance	Shri. Segar Sampath Shri. BhargavDasgupta Shri. Sashi Kumar Smt. Tania Chakrabarti	Shri. Bhargav Dasgupta
Reinsurance, Solvency, Reserving and other Actuarial matters	Smt. Tania Chakrabarti Shri. K S Gopalakrishnan Shri. A V GirijaKumar	Smt. Tania Chakrabarti
Investment, Capital, Management Expenses, Amalgamations, Mergers, and Other financial matters	Shri. R Chandrasekaran Shri. A V GirijaKumar Shri. Bhargav Dasgupta	Shri. R Chandrasekaran

Modus Operandi

Each of the sub-groups independently reviewed regulations in respect of the areas allocated to them and tabulated a list of key issues. These were presented in the meetings of the sub-groups held on January 13th and January 27th and were refined into specific recommendations for changes in Regulations in the Committee meetings held on Feb 26th, March 5th, March 11th and March 30th 2015.

In addition to the face-to-face meetings, each sub-group co-opted industry experts. The following is the list of industry experts who were co-opted and who contributed to the deliberations:

1) Mr. Shreeraj Deshpande, Head of Health Insurance, Future Generali India Ins. Co Ltd
2) Mr. P R. Ramesh, Chairman, Deloitte Haskins & Sells LLP
3) Ms. Gayle Adams, Appointed Actuary, SBI General Insurance Co Ltd.
4) Ms. Vidya Hariharan, Director, Vidal Healthcare Services Pvt Ltd
5) Mr. Sanjay Dutta, Chief, Underwriting and Claims, ICICI Lombard General Insurance Company Ltd

Frequent interactions via telecons and emails were carried out to firm up the Committee's recommendations. The members representing various stakeholders also had interactions with their peers whenever necessary.

EXECUTIVE SUMMARY

The Committee has made detailed recommendations relating to the various areas identified in the Terms of Reference. While a synopsis of the same is given below, the detailed recommendations and the rationale for the same are given in the relevant Chapters and Annexures.

1. Policyholder Protection, Policyholder Servicing, Fraud Control and Risk Management

(i) Duty of disclosure:

The Principle of **'Utmost Good Faith'** is valid for both the Insurer and the Insured. The obligations on the part of both the parties need to be captured more clearly in the relevant framework and should include certain declarations/confirmation on the part of the Agent/ Intermediary as well as the prospect/policyholder as regards product suitability and understanding of the features. Similarly, greater disclosures are required on the part of service providers – Insurers and TPAs during the currency of the policy as well as when servicing claims.

(ii) Transparency and Clarity:

There should be greater transparency and clarity to enable policyholders to understand the boundaries of coverage in their policy. This will help reduce the asymmetry of information that exists among all the parties concerned – customer, provider, payer etc. Prominent display of what is payable/ not payable, what is covered/not covered etc is necessary at every customer touch point written, digital etc.

(iii) Fraud Management:

Insurers and TPAs should have systems in place to identify, monitor, control and deal with fraud (including hospital abuse) by various agencies including healthcare providers. Regulator should direct Insurers and TPAs to put systems and internal processes in place for detection of fraud and its mitigation. Insurers and TPAs should delineate and disseminate information on fraudulent cases. A central repository of data for the purpose needs to be created. In due course of time, an institutional mechanism such as a Health Insurance Fraud Bureau (HIFB) should be in place for continuous fraud control.

(iv) Technology:

An enabling provision may be incorporated in the Regulations that Service Providers (Insurers and TPAs) must follow guidelines, if any, issued by the Authority or other Government agency/ ies from time to time in the matter of automation and capture of data electronically. Further, KYC (contact information) should be made compulsory for all health insurance policies/ beneficiaries. Online interface with UIDAI should be encouraged by the Regulator. Also, the hospitals in the insurance network would need to comply with such requirements as may be laid down in respect of automation and capture of required data.

(v) Other suggestions:

a) An industry level collaborative effort, through a joint mechanism involving the two Councils, would be required to minimise subjective and varied interpretation of policy terms and conditions, which is the root cause of disputes between the insurer and the policyholder. A uniform and consistent interpretation of policy terms and conditions (coverage and exclusions) would go a long way in increasing customer confidence.

b) The Regulator is requested to consider removing the section on excluded items --Annexure 4-- from the Standardization Guidelines as such a provision would stifle the design of products. For instance, coverage of physically handicapped people, mental and psychiatric ailments etc.

c) The Regulations must require Exclusions in the prolicy to be categorized as Primary (which cannot be carved back), Secondary (which can be carved back by paying additional Premium) and Supplementary (Risks which are covered by other policies).

2. Product, Distribution, Rural, Social Sector and Micro-insurance

(i) Categorisation of products and level playing field:

There should be a level playing field for Life insurance, Non-life and Health insurance companies when it comes to the tenure of the product and this must be done immediately. All insurers must be allowed to offer all types of products and tenure. The various types of products that insurers may offer would include Indemnity, Benefit as well Health Savings products.

(ii) Pilot [Innovative] products (for excluded or otherwise generally not covered in products already offered):

Insurers may have a category of close ended products (termed Pilot Products) running for a period of 5 years from the date of launch of the product covering risks that are otherwise generally declined or excluded today, where they have the option to renew or not to renew after a period of 5 years. This is to encourage new and innovative products. However, after 5 years they have to confirm it as a regular product that would be subject to the various provisions of implied renewability as provided for in the Regulations, should they decide to continue with the product.

(iii) Entry-age based pricing:

Sub-group 2 members pointed out that the age profile of health insurance policies showed that people tend to enter health insurance at an older age when the chances of facing health related issues are higher. Younger population do not take health insurance, knowing fully well that if they take health insurance when they are older, the implied renewability could be used to their advantage.

It has to be ensured that the premium reflects risk at the age of entry into the pool – creating an automatic, structural, incentive to attract the younger population and keep them in the insured pool. This can significantly impact penetration at the market level, and create a structural pull for persistency. (Note: Entry age based pricing also means that a first time entrant which is an older life would be charged more than a similar aged life, which has entered the pool in the past and has stayed insured). Therefore entry-age based pricing is needed. It is recommended that the Authority considers this while approving products under the File and Use guidelines.

(iv) Use and File approach for Group Health Insurance products:

Group products may be given only up to one year except those linked to credit, which may be extended up to the period of the credit. As far as Government Schemes are concerned, the earlier guidelines under IRDAI circular ref. IRDA/Chm/Misc/Cir/029/02/2011 dated 10/02/2011 should be restored.

For Group products, a **Use and File approach** has been recommended, details of which are covered in Chapter III.

(v) Enabling environment for Health Savings Products:

It is recommended that the Regulations enable all health insurers to offer Health Savings products which allow customers to build up a fund to pay for long term health expenses. Tax incentives should be extended to encourage insureds to buy such savings linked health products to provide for health care costs for long term. Introduction of comprehensive covers including OPD would also be necessary.

Therefore, there is an urgent need for an enabling provision to permit products that are a mix of Savings and Indemnity/Benefit Health Insurance. However, Unit Linked Insurance may be discouraged for Health Savings product so that policyholders are not exposed to market volatilities.

(vi) Wellness and Preventive healthcare incentives (discounts in premium):

Use of premium discount structures as a risk management tool to incentivize customers through wellness and preventive care mechanisms to actively manage health may be permitted. This is specifically recommended because not only does it lead to people being healthy but also reduces the claim cost in the long run for health insurers.

(vii) Price revisions:

The pricing aspects in the Regulations may be revisited to include an inflation benchmark (CPI+3%) that allows an automatic increase in premium to take care of medical inflation year on year. This is a cap and insurer can increase up to this limit. Any higher increase would require the Authority's approval.

(viii) Rider premium limits (Life insurance):

It is necessary to create a level playing field by removing restrictions on rider premiums for health insurance contracts, which currently exists in the IRDAI Regulations for Protection of Policyholders.

(ix) Health Insurance Distribution:

(a) Commission structures:

An overall expense ratio cap (including commission and management expenses) may be set, with forbearance for operations during the first 8 (eight) years of operations of the insurer.

The structure of commission (e.g. FY v/s renewal commission) may be set by each insurer within the overall cap. Regulatory focus is recommended on key metrics – expense ratio, combined ratio and solvency margin.

In view of high First Year commission being paid by life insurance companies, it was suggested by the member representing LIC that the benefit of amortisation of Commission paid by life insurance companies be given for five years for every year of sale. This benefit may be extended to other classes of insurers, if required.

(b) Agency Force:

(x) Conflict of interest arising out of sale of products of stand-alone health insurers and those of life and/or general insurers can be taken care of in the Code of Conduct for Agents. The Committee noted that IRDAI had already issued guidelines on these lines.

Any insurer, if he prefers, may restrict [in his contract of appointment] any agent appointed by him or while renewing his appointment, from acting as agent for any other insurance company.

(xi) Change in wordings for Disclaimer on insurance advertising:

Currently IRDAI requires the following -- "Insurance is a subject matter of solicitation" to be mandatorily mentioned in each and every advertisement. The word 'solicitation' creates customer disconnect. This needs to be reworded.

The Committee recommends the following: **"Before buying, know the conditions and exclusions, to make a well-informed decision".**

(xii) Micro-insurance:

The Micro-insurance regulations must reflect a level playing field for Life, Non-life and Stand-alone Health insurers. Currently it mentions only Life and Non-life. It must recognise Health as a separate class. Commission structure too needs to be reflected separately for health insurance.

(xiii) CSC guidelines:

CSC guidelines should deal with health insurance separately as it is a separate class now.

(xiv) Rural and Social Sector Obligations:

Within the Rural as well as Social Sector targets, a separate target for health insurance may be prescribed. For Stand-alone Health Insurers the target could be 50% of the prescribed targets applicable to general insurers. There should be an enabling provision that gives IRDAI the authority to modify or waive certain requirements depending on certain contingencies

3. Reinsurance, Reserving and Solvency

(i) Reinsurance:

Uniformity in approach for health insurance business is recommended. Quota share reinsurance may be allowed for all insurers in respect of specific portfolios/products subject to appropriate controls.

(ii) Reserving (other than for Health Savings Account products):

It was felt that if an implied life-long guarantee of renewability is being provided (as in the Health Insurance Regulations), such a guarantee has a cost and must be adequately reserved for. All options and guarantees have a cost and must be priced and reserved for.

(iii) Reserving for long term products:

Some of the Committee members felt that health insurance portfolio of many insurers is highly skewed towards older people, as the younger population do not take health insurance cover in their prime. As the premium rates get revised upwards, the younger population

perceives that they are subsidizing the claim costs from policies of older age insureds. This skews the portfolio towards older age people. Life-long renewability (guaranteed renewals) has given ample scope among the persons seeking health insurance covers for anti-selection against insurers. It is in this context some members strongly felt that the reserving regulations should provide for additional reserving for any product which has got guaranteed (or implied) renewability - both for limited tenure product as well as life-long renewable products.

Some other members of the Committee, however, felt that as the insurers have the right to re-price the product every year, there is no compelling reason to change the reserving practices as currently defined in the Regulations.

(iv) Reserving methodology for Health Savings Account products:

In view of the recommendation to allow Health Saving Account products to be designed and marketed by all insurers, the Committee recommends a uniform reserving methodology as follows:

The reserves are recommended to be the summation of:

Reserves calculated from a cash flow discounting method taking into account future expected health incidence rates, difference between future expected expenses and the charges under the product. 3% of mathematical reserves is recommended towards the Required Solvency Margin.

(v) Solvency:

a. Factor A and Factor B for RSM 1 and RSM 2 computation for health insurance business can be replaced by 'actual retentions'.

b. UPR for one year policy term product to be calculated on 1/365 basis.

c. UPR for more than one year policy term to be calculated on basis of actuarial formula factoring in risk across the policy term. [exact formula to be specified by professional guidance notes].

d. The Committee recommends that the Authority sets up a Working Group as soon as possible to study the reports of Insurers available with IRDAI on Economic Capital assessments and suggest the various steps to be taken with a definite timeframe towards implementation of Risk Based Capital adequacy norms (given that the insurance companies are already familiar with the concept of economic capital).

4. Capital, Accounts, Expenses of Management, Investment, and Mergers and Acquisitions

(i) Capital:

Regulations may provide as follows: "Provided that no issuance and allotment of capital by an insurance company shall be in any form other than as fully paid up equity shares and such other form of capital as may be specified by IRDAI regulations." The rationale is that the new 6A (1) amendment in Insurance Act provides for issue of other capital instruments other than equity, to be specified by IRDAI.

(ii) Additional forms of capital:

A. Noting that the Insurance Laws (Amendment) Act, 2015 has maintained Rs. 100 crores as the minimum capital for Health Insurers, whether there are any special situations in

health insurance that require additional short term capital was debated. Some members felt that such short term needs would be necessary for other classes of non-life insurance business as well.

B. Further, it was debated whether we can assist / incentivize health insurance business needs by providing additional capital forms and whether the health insurance sector can be declared as a preferred sector with a view to tapping the huge potential.

C. With a view to providing the flexibility needed for raising capital to facilitate growth and penetration as well as to meet solvency shortfall for Health Insurance Companies, preference share capital of duration not less than 5 years and not more than 10 years, with no voting rights is recommended. As per the Companies Act, redemption has to be out of profits by a transfer to Capital Redemption Reserve or proceeds of a fresh issue (ref. Section 55 of the Companies Act, 2013).

Since Preference Shares, are in substance, debt instruments it is preferable that they do not exceed 50% of equity capital. The Authority could consider, to begin with, between 25% and 33% and under extreme conditions upto 50% of total capital needs.The Committee recommends that such additional capital instruments can be made applicable to all classes of insurers.

(iii) Separation of Accounts and Funds:

IRDAI may consider issuing a waiver urgently as per Section 114A for non-life insurance companies (including stand-alone health insurance companies) as there is no apparent benefit from segregation of receipts and payment at the LOB level as the shortfall in overall policyholders' liabilities are to be met by shareholders in case of solvency margin deficiency.

(iv) Expenses of Management:

a) Level playing fields for commission structure is a must for all three players in health segment – Life, Non-life and Stand-alone Health companies;

b) Expenses of Management for health insurance portfolio are quite steep in the initial years. IRDAI may look to waive limits of expenses for initial 8 years to enable any start up Life, Non -life, as well as Health insurance companies to settle down.

c) Benefits of RI Commission, if any, may be allowed to be set off with EOM, as these are a part of expenditure defrayed.

d) A single limit for expenses and commission put together be prescribed.

e) Base for calculation for limits of EOM should be on Gross Written Premiums instead of Gross Direct Premiums.

(v) Mergers and Acquisitions:

In the light of Health Insurance being recognised as a separate category, there is a need to examine the need for Merger or Demerger provisions. Certain modifications have been suggested and are covered in Chapter III of this report.

(vi) Investments:

Existing investment norms can take care of liquidity requirements.

When the three categories of insurance companies are allowed to market all the three types of products, namely, Indemnity, Benefit and Savings Linked Long Term, there would be a clear need for Asset-Liability matching. Hence, Investment Regulations relating to health insurance may need a review.

(vii) Registration of Indian Insurance Companies (Regulations) 2000:

This Regulation requires changes arising out of the Insurance Laws (Amendment) Act, 2015 – details of which are given in Chapter V of the Report.

5. Health Insurance Regulations 2013

The Committee examined the extant Health Insurance Regulations with a view to bring in changes to reflect the various suggestions as above. It also discussed the need to amend or modify the Regulations to shift some of the operational details in the Regulations to Guidelines and bring in clarity arising out of feedback / complaints/ court cases with respect to the following:

i. Change in the definition of 'Health Insurance Business' in keeping with the Amendment to the Insurance Act;

ii. Inclusion of new definitions—Pilot Product; AYUSH; Health Savings Account Product;

iii. For Health plus Life Combi—the Term cover only restriction needs to be removed for Life products;

iv. "File and Use" needs to be replaced by "Product Clearance" as it would subsume Use and File (for Group Products) ;

v. Assignment needs to be restricted to only benefit policies—PA and Critical Illness;

vi. Clause 12(d) of the Regulations needs to be modified to reflect that while a TPA cannot reject or repudiate a claim, settlement of claims may be made by TPAs subject to following detailed guidelines issued by the insurers for the various products;

vii. The Regulations should enable prescription of standards, protocols and benchmarks for providers in the network;

6. Policy holder Protection Regulations

Sec. 7.2, 3 and 4 of the draft Policy holder Protection Regulation shall also apply to Health Insurance. With regard to benefit policy the stipulations as applicable to life insurance shall apply.

The Committee recommends that a separate section on Health Insurance be included. The details are given in the chapter on the subject.

CHAPTER I
INTRODUCTION

Health insurance focuses on the concept of risk in health which people face. Illness, more often than not, is an unpredictable phenomenon. The ability to shift the risks of illness to others is a benefit for which many are found willing to pay. The risk of illness can not only disable persons and create financial distress through loss of income/wages, but also compound the loss with unpredictable and volatile medical costs. The characteristics of health risk needs to be financed, and it is best done through concepts in line with the standard insurance practices. Despite many attempts to offer health financing models that look at paying for illnesses without focus on the underlying risks and costs, risk-based insurance of health is gaining in importance as the unpredictability of illness or injury makes it difficult to plan for losses, and the growing size of health care costs makes managing of healthcare quite futile whether for Governments, employers or individuals.

However, some of the characteristics of illnesses show that health incidents are not always ideal insurable risks. Certain types of health costs easily meet the insurability criteria such as emergency care and most hospitalisations, but many other types of care are either predictable, frequent and/or of low cost. Hence, though health insurance may not dovetail to the rigours of standard property insurance paradigms, insurers have focused on health insurance through various prisms. Health insurance can be provided by life, non-life and standalone health insurance companies. A wide variety of indemnities and benefits are made available in the form of reimbursements, pre-authorisation and cashless service, managed care, health savings accounts, and many others.

Insurance based health financing offers unique advantages in the risk sense, where insurers design products and benefits such that there is a persistent bias in favour of reducing risks across all those who take insurance, which aids in preserving societal wealth and also in reducing risk costs. Commercial insurance structurally pushes for reduction of risks through pooling uncorrelated risks and improving other insurability factors, which reduces the cumulative magnitude of loss and offers predictive accuracy. Further, insurers make risk classifications based on risk magnitude; they put risks into separate pools and charge premiums based on actuarial principles, keeping the frequency and severity of losses in mind as analysed on the basis of exposure and experience. This helps insureds to effect changes for betterment in the risk sense and makes insurance attractive by incentivizing people to lower their risk, thereby benefitting society through risk reduction and transfer. Insurers also try to remove adverse selection which helps to prevent those with low risks from leaving the pool and also attempt to reduce moral hazard by the careful design of benefits and by the use of tools such as deductibles, coinsurance and exclusions to push those in high risk into lowering their risks, and the uninsurable to insurable levels.

Health insurance, world over, is very complex with divergent understanding of the subject and a range of expectations. Thus, people expect medical coverage from birth to death and for all health needs starting from doctor visits, to catastrophic incidents as also long term care. Some feel that health risks cannot be managed and only transfer of income can take place and this should be not only from the healthy to the sick, but also from the rich to the poor and from the young to the old. All these expectations may take the solidarity concept to unsustainable heights. In the area of health risks, while genetic risks are a given, the risks from behaviour and lifestyles are sharply increasing and unless they are managed and controlled, not only financing systems but also social

welfare will be affected. Similarly, insurance coverage of the predictable, the routine outpatient type, the chronic, the long term care and the end-of-life, need much more active management, if at all, they are to be covered. Commercial insurance in a competitive setting has the capability to work on these in the context of Government stewardship and regulation.

In standard insurance settings, as the numbers grow, owing to chronic high cost treatments, insurers will need to say no to an increasing number of uninsurable individuals, who will have to be moved to a high risk pool where the public would look to the Government to finance the care. Such targeted spending could be the agenda for future Government consideration apart from the subsidy to the poor, as models in other countries indicate.

Any health insurance regulation must therefore focus on core insurance values which are contained in standard policy wordings such as 'expenses reasonably and necessarily incurred' for treatment of 'disease and injury'. In this context, the insurers need to draw boundaries using insurance techniques and as the boundaries are more transparently and fairly set, for which regulation is required, public good is enhanced and contract certainty outcomes are more assured. Health risk is dynamic, subjective; prone to insurance problems of adverse selection, moral hazard, fraud and inflation. Hence, there are obligations that all stakeholders need to abide by to ensure that health insurance is made affordable and health risks are made containable and care is made accessible to all.

As the Executive Summary indicates, this report has dealt with the subject of health insurance and its regulatory framework from four perspectives –policyholder servicing; product design and related matters; solvency, reserving and reinsurance, and various financial aspects including capital, investment, accounts etc. The latter two buckets reflect the approach envisaged in those areas and though they do not dwell on very many details, they do give a good idea of the thinking of the Committee on those subjects. Revisiting the Health Insurance Regulations as well as the Policyholder Protection Regulations has become necessary not only because the Amendment triggers some changes, but also because the two years of functioning within the Health Insurance Regulations, which were enunciated for the first time in 2013 has given the necessary experience to understand where to improve and in what direction, given the important objectives of growth, penetration, sustainability, better policyholder servicing and bringing in greater transparency and clarity, to name a few.

CHAPTER II
POLICY HOLDER PROTECTION, SERVICE PROVIDERS INCL. TPAS, FRAUD AND RISK MANAGEMENT

Two perspectives have been covered here – that of the industry and the policyholder. The key impact areas for each stakeholder are summarized below:

Insurers	Policy holders
1. Growth	1. Penetration
2. Level playing field	2. Policy holder protection
3. Transparency	3. Duty of disclosure
4. Sustainability	4. Deter fraud

1. Disclosures by Insured

Issue description:

The Principle of 'Utmost Good Faith' is valid for both the Insurer and the Insured. The insureds need to be alerted about filling up a proposal form fully and truthfully and not sign on a blank form.

How framework can enable:

Duty of disclosure of material information by the insured / policyholder should be brought into the Policyholders' Protection Regulations. This can be done by:

- Requiring incorporation of a declaration in the proposal form to be signed by the Agent / Intermediary that information as well as advice given to the client, i.e. policyholder, is based on product suitability as far as the prospect is concerned and that the prospect has been informed of all the choices available.
- Obtaining a declaration from the prospect that he/ she has been explained about the Policy terms and has fully understood the same.
- Requiring the prospect to declare that all material and relevant information including contact details asked for in the proposal form have been submitted correctly and truthfully by the prospect.
- Where a product is sold online, the insurer should put up appropriate disclosures on the website.

2. Disclosures by Service Providers

Issue description:

Same as 1 above

How framework can enable:

a. Insurers and TPAs must abide by timelines which should be clearly shown in public disclosures on websites or disclosed by call centres.

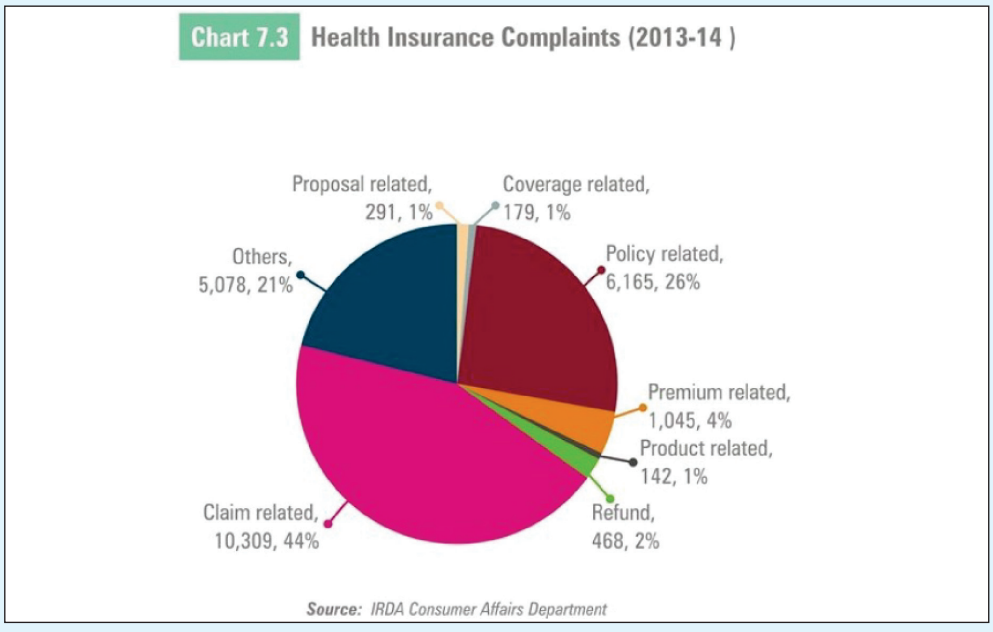
b. Cashless Services should be clearly explained in policy, at hospitals, on website etc.

c. Delay which is unavoidable or owing to customer or hospital fault should be communicated.

3. Transparency and Clarity

Issue description:

There needs to be transparency and clarity to enable policyholders to understand the boundaries of coverage in their policy



An analysis of Customer complaints for the year 2013-14 reveals that more than 75% of the customer complaints or grievances pertain to either policy terms and conditions or claims - which again would lead to issues relating to policy coverage, limitations and exclusions. In the case of Health Insurance, it is seen that 73% of the complaints relate to these two aspects.

Hence , it is necessary to introduce clarity in all Product publicity material - **written or digital media** - even the Policy schedule for individual / family floater can be standardized so that the when each insured / provider / TPA looks at the retail insurance policies of various companies, they are clear as to what are the benefits and what are the limitations.

How framework can enable:

1. Reduces asymmetry of information among all parties concerned viz., Customer, Hospital Front Desk, Insurer, Treating Doctor etc

2. Improves synchronisation between Payer and Provider

It is important to ensure that there is more clarity as regards coverage and exclusions.

The prospect needs to understand the boundaries of the cover. Towards this end, the Customer Information Sheet provided for in the Regulations and the Standardization Guidelines may be modified .The recommended template is at **Annexure I** of this report.

This will be uniform to all health insurance products and is to be mandatory displayed in all the marketing materials, digital presentations, print formats, policy documents – example: What we Pay; What we Don't, Deductible, Sub-limits etc.

Further, the Regulations must require Exclusions in the policy to be categorized as Primary (which cannot be carved back), Secondary (which can be carved back by paying additional Premium) and Supplementary (Risks which are covered by other policies).

Agents and Intermediaries should be mandated to use the standardized benefits template while dealing with prospects.

4. Fraud Alerts, Monitoring and Control

Issue description:

Insurance fraud usually includes inflated bills, treatments that are not prescribed, not so relevant diagnostic tests and resorting to exotic instead of essential treatment.

While any fraud committed by officials of the Insurance Company, Intermediary, TPA, Policyholder and their Nominees are included, the most important areas to be covered are hospitals, practitioners, diagnostic centers etc. Most of the frauds viz. inflated bills; unethical clinical practices are committed by health care providers, sometimes without the knowledge of the policyholders. Fraud detection processes and mitigation procedures are therefore vital.

What Health Insurance Framework Can Enable:

Insurers should be required to put in place the following:

Prospectus and other literature to highlight policyholders against hospital abuse and frauds

Analyses of suspicious claims through a Fraud Detection Cell by:

a. Identification of trigger points for investigation of fraudulent claims

b. Investigation of close proximity claims/claims for chronic diseases in the first year

c. Identification of suspicious and fraudulent hospitals

d. Identification of agents indicted in suspicious activities

e. Identification of customers indulging in fraudulent transaction/ claims

f. IT automation to indicate suspicious hospitals while processing claims

g. Analysis of GMP clients where hospitalization is concentrated in a single hospital with probable nexus resulting in excessive billing

Field Visit System:

a. Assurance to customer regarding coverage

b. Check for impersonation

c. In addition they check the hospital records, interact with patients about the nature and duration of illness and previous treatment taken

d. Clarifies to the customer regarding any lack of understanding of the communication sent by Insurer if any

e. Scrutiny of drugs prescribed and administered. Original vs. Generic

Industry Forum (Life and General Insurance Councils):

I. De-empanelment of Providers - Hospitals:

Standardization guidelines have prescribed step by step process to be adopted by each insurer for de-empanelment of health care providers by following the various steps given. But there is a need for co-ordination amongst the Life and Non-Life insurance companies including stand-alone Health Insurance Companies to make this an industry process rather than an individual company activity.

II. Sharing of information on Health Insurance Frauds:

Setting up a process whereby both Life and General Insurance Councils enable a mechanism for sharing of information on health insurance frauds. Unified action to be followed by the health insurers in isolating all such entities against whom there has been evidence of malpractice to make benefit out of Health Insurance after following due process of sending notices, etc.

III. Formation of Health Insurance Fraud Bureau:

Action should be initiated soon for setting up an institutional mechanism which will monitor and Implement Fraud Control measures as well as has the desired data bank.

5. Technology

Issue description:

Use of technology is a must for faster and better servicing, cutting down costs and bringing in greater transparency.

How framework can enable:

IT enabled real time information would need to be passed on to the insured by the insurer in matters of claim, cashless approval, medical advice etc., as may be needed in customer interest (without prejudice)

KYC should be made compulsory for all policies. Creating an online interface with UIDAI should be enabled and use of **Aadhaar Card** should be encouraged.

In a nutshell, interfacing between the various stakeholders Insurer-TPA-Hospital-Customer is necessary.

There could be an enabling provision to require the Insurers and TPAs to streamline technological interfaces between the various stakeholders in so far as they come within the insurance purview.

6. Other Suggestions

Issue description:

Product improvement and Other suggestions

How framework can enable:

From the perspective of ensuring availability of products for various strata of society and in a bid to encourage product innovation, the Regulator may encourage the design of products which include:

a. Covers for the physically handicapped people, psychiatric ailments etc.,

b. In the standardization guidelines, the list of excluded items should not be mandated as being part of the policy – this should be left to the insurer. Even having an indicative list of exclusions could mean that insurers may stay away from offering products for the exclusions indicated in the list.

CHAPTER III
PRODUCT, DISTRIBUTION, RURAL, SOCIAL SECTOR & MICRO-INSURANCE

1. Categorisation of products and level playing field

Issue description:

Currently, Non-life insurers and Stand-alone health insurers are allowed to design and sell Individual products of falling under the short term category, i.e., term up to 3 years only and life insurers can do long term. This does not offer a level playing field. Since the Amendment places Health Insurance Business in a separate class, it is necessary to have a level playing field for all insurers carrying on health insurance business.

How framework can enable:

There should be a level playing field for Life, Non-life and Health insurance companies when it comes to the tenure of the product. **All insurers must be allowed to offer all types of products and tenure.** The various types of products that insurers could offer include Indemnity, Benefit as well Health Savings products. However, products beyond 3 years term need to follow the framework enunciated for the long term products be it pricing, reserving etc.

While the Committee recommends this, a couple of other Members of the Committee felt that a level playing field for Health insurance should achieved in the long term and that extant segregation in the Health Insurance Regulations may remain for some more time. The Regulator can take a view on the period up to which the segregation may be maintained and at the opportune time allow all insurers to design and sell all types of products.

2. Pilot [Innovative] products (for excluded or otherwise not covered in products already offered)

Issue description:

There is a need for innovative products that will cover risks that are not generally covered. However, the current framework involving implied lifelong renewability discourages this. Hence, it is recommended that there be a category of products called 'Pilot Products' that could go up to a term of five years after which either the product needs to be regularized (wherein it would have to comply with all the clauses of the Health Insurance Regulations, without exception) or can be withdrawn by the insurer. However, such products should have adequate disclosures by insurers.

How framework can enable:

Insurers may have a category of close-ended products (termed Pilot Products) running for a period of 5 years from the date of launch of the product covering risks that are otherwise declined or excluded today, where they have the option to renew or not to renew after a period of 5 years. This is to encourage new and innovative products. However, after 5 years they have to confirm it as a regular product that would be subject to the various provisions of implied renewability as provided for in the Regulations unless they decide to discontinue it.

Hence, Pilot products could be innovative products with a tenure of 5 years or less, with limited guaranteed renewability and annually reviewable premium rates.

3. Entry-age based pricing needed

Issue description:

Sub-group 2 members pointed out that the age profile of health insurance policies showed that people tend to enter health insurance at an older age when the chances to face health related issues are higher. Younger population do not take health insurance knowing fully well that if they take health insurance when they are older, the implied renewability could be used to their advantage.

How framework can enable:

It should therefore be ensured that premium reflects risk at the age of entry into the pool – creating an automatic, structural, incentive to attract the younger population and keep them in the insured pool. This can significantly impact penetration at the market level, and create a structural pull for persistency. Entry age based pricing also means that a first time entrant which is an older life, would be charged more than a similar aged life, who has entered the pool in the past and has stayed insured. Some others felt whether this is a design issue and the Regulator can consider this when approving the products.

4. Group Products: Use and File approach

(a). Issue description:

Tenure of group health insurance products

How framework can enable:

Group products may be given for a term of only up to one year except those linked to credit, which may be extended up to the period of the credit. As far as Government Schemes are concerned, the earlier circular bearing ref. IRDA/Chm/Misc/Cir/029/02/2011 dated 10/02/2011 can be rolled back.

It is suggested that for Group products a **'Use and File'** approach be introduced as against the current File and Use procedure.

Every insurer would need to set up a Board led, Product Management Committee (PMC) as a self-regulatory mechanism, which will internally approve all 'Use and File' products and minor changes to existing products (where there are no financial implications on the customer).

(b). Issue description:

Currently, insurers are required to file group insurance rates with the regulator. While this inhibits flexibility it does not also address the structural issue of lack of sustainability of group insurance – at the market level.

How framework can enable:

The regulatory authority needs to adopt a 'portfolio' management approach to group health insurance sustainability. This would mean standardizing the inputs to group health pricing and underwriting, on the one hand, and using capital management (i.e. solvency ratios) to signal to the market, the need to course correct towards sustainability, on the other.

- An enabling provision requiring standardization of data formats used to gather exposure and past claims experience data for pricing.
- Product Management Committee would be the custodian of risk appetite for Group Insurance.
- The Pricing and Underwriting approach to be approved by the Board of the Insurer.
- Create greater transparency of intermediary commissions by requiring that they be included in policy schedules.
- Prescribe segment-wise PDR.

5. Enabling Environment for Health Savings Products

Issue description:

The main customer need with reference to health insurance is to create a 'fund' to pay for long term healthcare expenses. This involves a mix of savings and indemnity health insurance. Currently, savings benefits are written by life insurers and indemnity products are (largely) written by general insurers and stand-alone health insurers.

Existing regulations for 'Combi' products mandate the use of risk products for life insurance (i.e. term insurance) with indemnity or benefit products for health.

Increasing gap between customers underlying need and the product profile of the industry.

How framework can enable:

It is recommended that the Regulations may enable all health insurers to offer Health Savings Products which allow customers to build up a fund to pay for long term health expenses. Tax incentives should be extended to encourage insureds buy such Savings linked Health products to provide for Health care costs for long term. Introduction of comprehensive covers including OPD would also be necessary.

There needs to be an enabling provision to permit products that are a mix of Savings and Indemnity/Benefit Health Insurance. However, Unit Linked Insurance may be discouraged for Health Savings product so that policyholders are not exposed to market volatilities.

6. Price revisions - Retail Insurance

Issue description:

Currently, all rate revisions for retail products follow the 'File and Use' structure – they have to be filed and approved.

Life insurers provide 3 year rate guarantees, while Non-life and Stand-alone Health insurance companies provide 1 year rate guarantees. While rates are annually reviewable, in practice, the current File and Use guidelines do not permit rate revisions for up to 3 years. When Non-life insurers review rates, they are 'pricing to catch up' – which creates customer disconnect. Life insurers are required to price with a 3 year rate guarantee, which renders them uncompetitive in the market.

How framework can enable:

The pricing aspects in the Regulations may be revisited to include an inflation benchmark (CPI+3%) as a cap, that allows an automatic increase in premium to take care of medical inflation year on year. Anything beyond this would require IRDAI approval.

Allow a 'normal' range for annual increase / decrease for retail indemnity products, linked to an inflation benchmark (e.g. a maximum increase or decrease of CPI + 3%) – for all insurance companies. For annual price increases within this range, a 'Use and File' structure would apply and the Product Management Committee would be responsible for sustainability.

Rate increases / decreases beyond this benchmark would require specific approval from the IRDAI. This would bring life insurers on par with non-life insurers for health insurance products. All classes of insurers would provide rates which are reviewable annually.

7. Wellness and Prevention based incentives for health insurance products

Issue description:

Innovation in payment mechanisms includes allowing premium discount structures, which incentivize customers to actively manage their health.

How framework can enable:

Use of premium discount structures as a risk management tool to incentivize customers through wellness and preventive care mechanisms to actively manage health may be permitted. This is specifically recommended because not only does it lead to people being healthy but also reduces the claim cost in the long run for health insurers.

8. Rider premium limits

Issue description:

Current policy holder protection regulations mandate rider premium limits for life insurance products – rider premiums cannot be more than 30% of the base product premium for a life insurance contract, and also CI and all health premiums should not be more than 100% of the premium of the base policy for term and group life products. Life insurers are limited in the range of products they can 'manufacture'.

How framework can enable:

Create a level playing field by removing restrictions on rider premiums for health insurance contracts.

The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to health associated or critical illness riders, in case of term or group products shall exceed 100% of premium under the basic product. All other riders put together shall be subject to a ceiling of 30% of the premium of the basic product. Any benefit arising under each of the riders shall not exceed the sum assured under the basic product.

The allowable rider or riders on the product shall be clearly spelt out with regard to their scope and benefits.

9. Health Insurance Distribution

(a). Commission Structures

Issue description:

Currently, life and non-life insurers pay commissions on health insurance which are structurally different – which impacts their ability to create high retail penetration.

How framework can enable:

For indemnity and long term health products, commission rates need to be similar to those of other long term retail insurance products. Insurers also need the freedom to manage the pattern of commission pay outs – subject to the overall cap of management expenses.

An overall expense ratio cap (including commission and management expenses) may be set with relaxation for operations during the first eight years as a company.

Structure of commission (e.g. FY v/s renewal commission) to be set by each insurer subject to overall cap. Regulatory focus on key metrics – expense ratio, combined ratio and solvency margin - as with other markets.

In view of high First Year commission being paid by Life Insurance companies, it was suggested by the member representing LIC that the benefit of amortisation of Commission paid by life insurance companies be given for five years for every year of sale. This benefit may be extended to other classes of insurers, if required.

(b). Agency force

Issue description:

Currently, stand-alone health insurers are permitted to empanel health insurance agents of other segments – i.e. life and non-life insurance companies.

The overall pool of agents in the market is stagnant / decreasing as the stand alone companies have not so far made any significant investments in agency force training or development. The initial dispensation was meant to support the stand alone companies; however that dispensation is now eight years old.

How framework can enable:

Conflict of interest arising out of sale of products of stand-alone health insurers and those of life and/or non-life insurers can be taken care of in the Code of Conduct for Agents. Any insurer, if he prefers, may restrict [in his contract of appointment] any agent appointed by him, or while renewing his appointment, not to act as agent for any other insurance company.

10. Change in wordings for Disclaimer on insurance advertising

Issue description:

Current wording which states that "insurance is a subject matter of solicitation" – the word, 'solicitation' creates customer disconnect.

How framework can enable:

Recommend changes in the wording used for insurance advertising. Recommended wording: "Before buying, know the conditions and exclusions, to make a well-informed decision".

11. Micro-insurance

Issue description:

The IRDA Micro-insurance Regulations (2005) and the amendment revised micro-insurance regulations (2014) provide specific definitions of health micro-insurance products. Currently, these regulations distinguish between life and non-life companies in terms of the health micro-insurance products that can be sold.

How framework can enable:

Creating a level playing field within health insurance for life, non-life and stand-alone health insurance companies would mean aligning the nature of the micro-insurance health product to the underlying risk (i.e. short term vs long term).

(a) Commission structures - Micro-insurance

Issue description:

Commission rates for life and non-life companies for micro-insurance – need to be applied to health micro-insurance products as well.

How framework can enable:

Current micro-insurance regulations (IRDA Micro-insurance Regulations 2005) specify commission rates for non-life and life insurance companies but do not explicitly specify health micro-insurance commission rates. While section 2b of the IRDA micro-insurance regulations 2005, defines 'general micro-insurance' products to include health insurance, the Insurance Laws (Amendment) Act, 2015, has introduced explicit sections (section 3 iii of the Act) around Health insurance as a separate class of business. Consistency must be created for health micro-insurance products.

12. CSC Guidelines

Issue description:

CSC Guidelines not issued specifically for 'Health Insurance Business'

How framework can enable:

CSC Guidelines have to be issued separately for Health Insurance Business, on the lines they have been issued for Life products (IRDA / Life / CIR / GDL / 044/ 01/2014).

13. Rural /Social Micro-insurance obligations for Health

Issue description:

With Health Insurance becoming a separate class of business under the Insurance Laws (Amendment) Act, 2015, the Rural, Social Micro-insurance obligations need to be reviewed. Of these, Social Sector obligations have, in the past been generally complied with due to insurance companies writing social insurance schemes such as RSBY.

How framework can enable:

It is recommended that Govt. Schemes be not reckoned for the Rural and Social Sector obligations. The RSBY scheme would probably no longer be available for fulfilment of social sector targets. This would create a situation where the industry would need time to build up the social sector portfolio. During this period of transition, the industry would require a temporary forbearance in the form of amended social sector targets.

Within the Rural as well as Social sector targets, a separate target for health insurance may be prescribed.

CHAPTER IV
REINSURANCE, SOLVENCY, RESERVING & OTHER ACTUARIAL MATTERS

Reserving, Reinsurance and Solvency are related to the risks being written by the insurers. The Committee agreed that the product design would impact the reserving approach. The following premise is borne in mind while examining the Reserving and Solvency issues

- Group health insurance products will be one year renewable products except for credit linked policies which may go up to the loan period.
- Individual health insurance products could be of different policy terms.
- Premium guarantees will be for a maximum of three policy years.

The Committee felt that it is not relevant as to who are the providers of the products amongst the three classes of insurers and there has to be uniformity of approach as regards Reinsurance, Solvency, Reserving and related Actuarial matters.

1. Reinsurance

Issue description:

It is well established that reinsurers offers a variety of expertise such as product design, risk management, underwriting support and claims management. Reinsurance is a vehicle for better risk management and also provides capital relief. An insurer should be allowed to use appropriate forms of reinsurance, as deemed fit by the insurer, within the overall requirements of meeting counterparty risk, limits on credits that can be availed for meeting solvency norms and the insurer's Board approved reinsurance policy.

At present IRDA (Life Reinsurance) Regulations prescribe prior approval of Authority for programme of reinsurance based on original premium basis. This would mean a restriction on quota share type of reinsurance programme.

In view of compulsory cessions to Indian Reinsurer under Section 101A of the Act, reinsurance regulations for Stand-alone Health and Non-Life Insurance companies do not explicitly specify any restriction on quota share reinsurance. However, the Authority has been consistent in granting permission for a limited period for start-up non-life and stand- alone health insurance companies for a period not exceeding two years of commencement of business. From the third year onwards the Authority is generally not permitting quota share reinsurance other than compulsory cessions for health portfolio of stand-alone health and non-life insurance companies.

How framework can enable:

Irrespective of which category of insurer is writing health insurance, we recommend uniformity in approach. For instance, Quota Share reinsurance may be uniformly allowed for all insurers— Life, Non-life and Stand-alone.

Risks pertaining to Health insurance are same irrespective of who is providing the health insurance; uniformity in reinsurance regulations will provide a level playing field for the providers of health insurance.

2. Reserving

Issue description:

The objective behind holding a reserve for future liabilities is to target an adequate amount being held in the books of the insurer on a prudent basis. This typically involves estimating future estimated policy benefits, future expenses and future expected premium income, discounting to a present value. A simplified approach will suffice where premium guarantees are for short duration and the liability is short tailed.

For products where the premium is guaranteed for one year, the current practice for Non-Life insurers and stand-alone health insurers is that the reserve be based on the current approach of UPR, URR, PDR and IBNR as specifically applicable to health insurance business. Reference IRDAI Circular IRDA/F&I/CIR/015/02/2011 (creation of reserve for unexpired risk (URR) by Non-Life Insurance Companies for Health Segment; Circular No. 11/IRDA/ACTL/IBNR/2005-06.

For life insurers, the method of projecting claims, expenses and premiums, and discounting to a present value is recommended for products where the premium is guaranteed for more than one year – as given in the IRDA (Assets, Liabilities, and Solvency Margin for insurers) Regulation 2000.

How framework can enable :

For products where the premium is guaranteed for one year, we recommend that the reserve be based on the current approach of UPR, URR, PDR and IBNR as specifically applicable to health insurance business.

UPR (Unexpired Premium Reserve)

UPR for one year policy term product to be calculated on 1/365 basis

UPR for more than one year policy term to be calculated on basis of actuarial formula factoring in risk across the policy term.

PDR (Premium Deficiency Reserve)

PDR to be calculated separately for Health business. Within health, in case there is a need for sub-class wise PDRs, these would be left to professional guidance notes.

IBNR

To follow the current practice with reference to IRDAI Circular No. 11/IRDA/ACTL/IBNR/2005-06

Reserving for products with premium guarantees beyond one year

The method of projecting claims, expenses and premiums, and discounting to a present value is recommended for products where the premium is guaranteed for more than one year. For these products, a simpler approach as mentioned above is acceptable if the insurer can demonstrate that the reserves thus estimated will not be lower than the projection method.

Guaranteed Renewability Options

The Health Insurance Regulations 2013 give the policyholders the right of guaranteed renewability with the same insurer or another insurer. Any such guarantees and options at the hands of the policyholders carry a cost to the insurer and must be provided for in the pricing and reserving. This is particularly so if the insurer does not have the right to re-price every cohort of lives reflecting the emerging claims experience or where such a right exists but is not exercised by the insurer in a manner that it addresses this risk. It is recommended that the Institute of Actuaries of India be asked to look into this and issue appropriate professional guidance to the Appointed Actuaries.

The Committee, in the next section of this Report, is recommending a move towards a risk based capital framework. There is a need to harmonize the reserving and solvency requirements within the health insurance business written by stand -alone health insurers and general insurers; also, there is a need to align the reserving and solvency requirements between all writers of the health insurance products (life, non-life and stand- alone health).

3. Solvency

Issue description:

At an overall level, there is a link between pricing, reserving and solvency. Normally, pricing assumptions are on best estimate basis (say, targets 50th percentile), reserving assumptions are on a prudent basis (say, targets 70th percentile) and solvency requirements target towards the tail risk (say, targets 99th percentile). Thus, solvency requirements should take into consideration the reserving requirements so that the balance sheet of an insurer has the adequate financial strength expected by the regulator.

A formula based approach to capital adequacy and solvency, as is currently followed, involves calculating capital requirement based on static accounting results and hence is limited in scope with respect to the overall risks that the insurance company is exposed to.

Though the factors are simple to apply, easy to administer and understand, they are formula based and do not consider the risks explicitly thereby lacking the capability to cope with increase in market complexity and rising customer protection needs.

The Solvency norms state that the technical provisions should be adequate in respect of the entire business of the insurance company and is that they have typically included margins for prudence. In the factor based system, a strengthening of reserving basis leads to an increase in mathematical reserve and hence a direct increase in required solvency margin. Hence prudence does not work towards the advantage of the insurance company.

Currently, the Solvency Margin for the insurance industry in India is guided by Assets, Liabilities and Solvency Margin of Insurers Regulation 2000.

IRDAI has stipulated that all insurers should have available solvency margin of at least 150% of the RSM.

The current solvency factors:

- Products where reserve is based on UPR/URR/IBNR, the required RSM factors are 20% of net premiums or 30% of net incurred claims, whichever is higher.
- Products where a discounting approach is used for reserving the required solvency margin is 3% of reserves.

The reserves and RSM, as described above, typically capture insurance risks (example—sickness incidence rates) but do not capture other risks (example—operational risks, management quality). It is perhaps for these reasons that the regulator stipulated an additional solvency margin, expressed as 50% of the RSM.

How framework can enable:

In the Insurance Laws(Amendment) Act, 2015 it is said that

"83(3) The Authority shall by way of regulation made for the purpose, specify a level of solvency margin known as control level of solvency on the breach of which the Authority shall act in accordance with the provisions of sub section (4) without prejudice to taking any other remedial measures as deemed fit."

It is recommended that the Authority proactively moves towards a risk based solvency system while defining the control level solvency.

A risk based solvency assessment involves considering the risks that the company is exposed to and factoring these risks while addressing the capital needs.

It is acknowledged that there is a felt need for downward revision from the current level of Solvency Margin (150%) for Health business transacted by all the three classes of insurers namely Life Insurance companies, Non-life insurance companies and Stand Alone Health Insurance companies. Technical reasons and justifications especially from actuarial point of view and the trend of loss ratios in the market could not be adduced in this regard. Solvency is to be judged from a company level perspective, hence it will be reasonable to move towards a Risk Based Solvency model without resorting to short term changes in the existing formula based solvency regime. As mentioned at the start of this section, solvency and reserving needs to be viewed together and a Risk Based approach will address both of these elements of financial strength of an insurer.

The first step towards risk based capital assessment has already been initiated by the Authority through circular on Economic Capital for Non-life insurance companies dated 25th May, 2011 (ref no IRDA/ACT/CIR/MIS/111/05/2011) and IRDA/ACT/CIR/LIF/049/3/2010 (for life insurance).

The Committee recommends that the Authority sets up the Working Group as soon as possible. The said working group would study the reports of insurers available with IRDA to assess the possible impact of transition to RBC based Solvency, and formulate the structure, steps and recommend a timeframe towards RBC implementation (given that the insurance companies are already familiar with the concept of economic capital).

Pending such an exercise, the Committee recommends continuance with current practice as reviewing only one or few of the elements of the current reserving / solvency norms will only result in a sub-optimal situation.

a. Factor A and factor B for RSM 1 and RSM 2 computation for health insurance business can be replaced by 'actual retentions'.

b. UPR for one year policy term product to be calculated on 1/365 basis

c. UPR for more than one year policy term to be calculated on basis of actuarial formula factoring in risk across the policy term. [exact formula to be specified by professional guidance notes]

d. The Committee recommends that the Authority sets up a Working Group at the earliest, to study the reports of Insurers available with IRDAI on Economic Capital assessments and suggest the various steps to be taken with a definite timeframe towards implementation of Risk Based Capital adequacy norms (given that the insurance companies are already familiar with the concept of economic capital).

4. Health Savings Account

Issue description:

It is expected that IRDAI will allow all classes of insurers permitted to offer health insurance products to offer savings-cum-health insurance products to individuals. Such a product could be a health insurance plan that provides an account to the policyholder where they can put money to save for future medical expenses. The premium paid by the policyholder will be divided into three components. The first towards the risk charges toward health insurance, the second towards expenses including commissions, and the rest towards to its savings account.

The health insurance component shall have a guaranteed renewability for life but the risk charges could vary each year with age, with the insurers having the right to review risk premium rates annually. The charges for expenses and commission shall be guaranteed for the term of the policy subject to IRDAI approval.

How framework can enable:

Recommended Reserving

The mathematical reserves is recommended to be the summation of:

- Reserves calculated from a cash flow discounting method taking into account future expected health incidence rates, difference between future expected expenses and the charges under the product.

- Account value of the savings component.

Required Solvency margin: 3% of mathematical reserves otherwise

CHAPTER V
INVESTMENT, CAPITAL & OTHER FINANCIAL MATTERS

The Committee suggests the following changes to the relevant regulations:

1. Capital

Issue description:

The existing provision in the Issuance of Capital by General Insurance Companies – Regulations, 2013 states as follows:

Provided that no issuance and allotment of capital by an insurance company shall be in any form other than as fully paid up equity shares. This makes it restrictive.

How framework can enable:

Regulations may provide as follows: "Provided that no issuance and allotment of capital by an insurance company shall be in any form other than as fully paid up equity shares and such other form of capital as may be specified by IRDAI regulations." The rationale is that the new 6A (1) amendment in Insurance Act provides for issue of other capital instruments other than equity, to be specified by IRDAI.

2. Additional forms of Capital

Issue description:

Additional capital requirements for health insurance companies

How framework can enable:

A. Noting that the Insurance Laws (Amendment) Act, 2015 has maintained Rs. 100 crores as the minimum capital for Health, whether there are any special situations in health insurance that require additional short term capital was debated. Some members felt that such short term needs would be necessary for other classes of non-life insurance business as well.

B. Further, it was debated whether we can assist / incentivize health insurance business needs by providing additional capital forms and whether the health insurance sector can be declared as a preferred sector with a view to tapping the huge potential?

C. With a view to providing the flexibility needed for raising capital to facilitate growth and penetration as well as to meet solvency shortfall for Health Insurance Companies, preference share capital of duration not less than 5 years and not more than 10 years,

with no voting rights is recommended. As per the Companies Act, redemption has to be out of profits by a transfer to Capital Redemption Reserve or proceeds of a fresh issue (ref. Section 55 of the Companies Act, 2013).

Since Preference Shares are in substance debt instruments it is preferable that they do not exceed 50% of equity capital. The Authority could consider, to begin with, between 25% and 33% and under extreme conditions upto 50% of total capital needs.

3. Treatment of dues from Government

Issue description:

Treating dues from Government business as allowed assets as outstanding premium from Government business for more than 30 days is being disallowed for solvency purpose.

How framework can enable:

The Insurance Laws (amendment) Act, 2015 has substituted earlier Sec. 64 V and 64 VA by a new section 64 V. As per this substitution, assets shall be valued at value not exceeding their market or realizable value and certain assets may be excluded by the Authority in the manner as may be specified by the regulations made in this behalf.

In view of this, it is for Authority's consideration and review whether all outstanding premiums from Government business should be disallowed for the purpose of valuation of assets. The rationale is that dues from Central or State Government outstanding premium is a sovereign asset for an insurance company. With the new substituted section 64 V (1), the Authority is requested to consider not disallowing this part of the assets for solvency purpose.

4. Separation of Accounts and Funds

Issue description:

Section 10 of the Insurance Act requires all receipts due in respect of each sub-clause of such insurance business shall be carried to and shall form a separate fund.

New clause (ea) of Section 114 of the Insurance Act 7provides for separation of accounts of all receipts and payments in respect of each classes and sub classes of insurance business as required under sub section (1) and sub section (2A) of Section 10. Both under Section 10 and Sec 114 A (v) (ea), the Authority has been given power to waive the requirement.

For a Non-life insurance as well as Health Insurance Company, maintaining separate receipts and payment for each line of business is practically difficult due to large volume of small policies as well as offices spread across the country. It is not practicable to allocate the

investment portfolio between various lines of businesses leave alone shareholder funds and policyholder funds as most of the Non-life insurance policies are annual contracts.

Also, even in the current form in terms of cash flow, cross subsidization of Motor TP segment to other segment is necessary due to inadequate pricing, though IRDAI administers premium rates based on increasing TP liability claims costs. There is no apparent benefit from segregation of receipts and payment at the LOB level as the shortfall in overall policy holder's liabilities are to be met by shareholders in case of solvency margin deficiency.

Taking into account the practical aspects of issues in maintaining separate accounts, IRDAI has already provided a relief under Investment Regulation as under:

Para 10 of Annexure II of Investment Regulations, 2008 states as follows:

Segregation of shareholders & policyholders funds

Taking note of representations of general insurance companies, as a measure of practical application, the provisions of Section 11(1B) would be deemed to have been complied with, in the case of General Insurance Company, if Investments are 'allocated' to the policyholders' funds to the extent of the Technical reserves in respect of general insurance business and the specific liabilities of general insurance business and the balance shown as Shareholders' funds.

The rationale of bringing out the above amendment in the said annexure II is still relevant today.

How framework can enable:

IRDAI may consider issuing a "waiver" as per Section 10 as well as Sec. 114A for Non-life Insurance companies (including health insurance companies) urgently.

5. Expenses of Management

Issue description:

Expenses of Management

Rule 17E read with Section 40C of the Insurance Act, 1938:

How framework can enable:

Level playing fields for commission structure must for all three players in health segment – life, non-life and stand-alone health companies;

Expenses of Management of stand-alone companies are quite steep in initial years. IRDAI may look to waive limits of expenses for initial 8 years to enable any start up non life, as well as Health insurance companies to settle down.

Benefits of RI Commission, if any may be allowed to be set off with EOM, as these are a part of expenditure defrayed.

Proposed regulations under Amended Section 40C of the Act may allow

a single limit for expenses and commission put together;

Base for calculation for limits of EOM should be on Gross Written Premiums instead of Gross Direct Premiums

6. Mergers & Acquisitions

(a) Issue description:

Under the Scheme of Amalgamation and Transfer of General Insurance Business Regulations, 2011

1. Authority (IRDAI)'s approval was mandatory before any scheme of merger and acquisition can be completed.
2. The applicant's track record of dividend payment to shareholders was not required to be factored for merger/demerger proposals.

How framework can enable:

In the light of Health insurance being recognised as a separate category, there is a need to examine the need for Merger or Demerger provisions.

(b) Issue description:

Scheme of Amalgamation and Transfer of General Insurance Business Regulations, 2011

Scheme under Sections 391-394 of the act needs court approval

How framework can enable:

Court approval not required under section 232 of Companies Act, 2013

Tribunal/Court clearance not mandatory as per new Act;

(c) Issue description:

Scheme of Amalgamation and Transfer of General Insurance Business Regulations, 2011

Current regulations only envisage merger/amalgamation of two insurance entities. As a whole

"Scheme" definition needs improvement and clarifications.

How framework can enable:

In the light of Health insurance being recognised as a separate category, there is a need to examine the need for Merger or Demerger provisions. It is not clear whether Hiving off a segment of general insurance or life insurance business would amount to a scheme. There could be cases of hiving off "health segments" into a new stand-alone company or merger with another company.

7. Investments

Issue description:

Whether Health Insurance requires separate norms for Investments

Health insurance may require more liquid funds to settle claims. As technology and cashless approvals form the basis for claim settlements the time available for settlement of claims would be minimum, and as such, there should be some minimum prescription for Liquid Assets. It is also necessary that the value of Assets should not be susceptible to change, such as in Bank Deposits.

When all the three types of products, namely, Indemnity, Benefit and Savings Linked Long Term would be offered by all the three categories of insurance companies, there would be a clear need for Asset-Liability matching. Hence, Investment Regulations relating to health insurance may need a review.

How framework can enable:

Existing investment norms can take care of liquidity requirements.

When all the three categories of insurance companies are allowed to market all the three types of products, namely, Indemnity, Benefit and Savings Linked Long Term would be offered by, there would be a clear need for Asset-Liability matching. Hence, Investment Regulations relating to health insurance may need a review.

8. Registration of Indian Insurance Companies

Issue description:

With the recognition of Health insurance as a separate category, the Registration of Indian Insurance Companies (Regulations) 2000 need amendments as follows:

How framework can enable:

- Act means the Insurance Act, 1938; (Section 2 (a)) to be replaced by “Act, means the Insurance amendment Act, 2014”
- Section 4 (2) – classes of insurance for which requisition for registration application to be modified to include: Health insurance business;
- Clause 2(a) of Section 10 under Chapter III i.e. Documentary proof evidencing the making of deposit required under Section 7 of Insurance Act may be deleted
- Clause 2(b) regarding evidence of having Rs. 100 Cr. as capital, in case the application is for grant of certificate is for life or general insurance. “Health” needs to be included here.

- Para 11 – showing manner of calculation of twenty six percent equity capital held by a foreign company. The figure “twenty-six” to be replaced by “ forty-nine”. Also to be aligned to the new capital regulation rules notified recently.

  Para 15 – manner of payment of fee for registration – (Bank draft)

- Should include NEFT/RTGS etc

- Para 16 – Grant of certificate of registration – Link to Section 32 (clause e) may be deleted

- Chapter VII – provisions applicable to existing insurers. May be deleted as these are infructuous.

CHAPTER VI
HEALTH INSURANCE REGULATIONS

The Committee is of the view that the Health Insurance Regulations need to be revisited not only in the light of various recommendations that have been made by it but also a few modifications are warranted on their own merit.

1. Issue description:

Clause 2 relating to Definitions--Certain definitions need modification and certain new definitions need to be added.

How framework can enable:

Clause 2 (f). "File and Use procedure"

Current wording:

"File and Use procedure" means a procedure to be followed for health insurance product approval by the insurers in accordance with guidelines/circular issued by the Authority.

Suggested wording:

Replace definition title as "Product clearance procedure" and define thus:

"Product clearance procedure means the procedure laid down by the Authority to be followed by insures for clearance of a product either under the File and Use Guidelines or the Use and File Guidelines as may be the case.

Clause 2 (g) "Health Insurance Business"

Current wording:

"Health Insurance business" or "health cover" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

Suggested wording:

"Health Insurance business" means the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether inpatient or out-patient, travel cover and personal accident cover

Clause 2 (h)."Health Services by TPA"

Current wording:

"Health Services by TPA" means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

Suggested wording:

"Health Services by TPA" means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business in the matter of either pre-authorization of cashless treatment and/or settlement of reimbursement claims purely within the framework of the detailed guidelines for settlement of claims provided to the TPA by the insurer for each and every product as may be agreed upon. It does not include the rejection of claims nor the soliciting, either directly or indirectly, of health insurance business.

Clause 2 (i)."Health plus Life Combi Products"

Current wording:

"Health plus Life Combi Products" mean products which offer the combination of a Life Insurance cover of a life insurance company and a Health insurance cover offered by non-life and/or standalone health insurance companies.

Suggested wording:

"Health plus Life Combi Products" means products which offer the combination of a life insurance cover of a life insurance company and a Health Insurance cover offered by non-life and/or standalone health insurance company.

New definitions proposed—

Pilot Product:

Suggested wording:

Pilot products are short term innovative constructs, which enable insurers to gauge market reaction to new ideas and innovation.

Health Savings Account:

Suggested wording:

Health Savings Account is a long term, retail health insurance product which enables policyholders to create a contingency fund to be used to pay for future health expenses.

2. Issue description:

Clause 3 relating to Registration and Scope of health business needs modification.

How framework can enable:

Clause 3(b):

Current wording:

Life Insurance Companies may offer long term health products but the premium for such products shall remain unchanged for at least a block of every three years, thereafter the premium may be reviewed and modified as necessary.

Suggestion: To be deleted

Clause 3(d):

Current wording:

Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts. However, the non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.

Suggested wording:

Group Health Insurance policies may be offered by any insurance company, provided that all such products shall be only short term products (up to 5 years term).

3. Issue description:

Clause relating to File and Use Procedure for health insurance products needs to be revisited.

How framework can enable:

Clause 4 title to be changed to "Product Clearance Procedure".

Group Insurance products to be brought under the Use and File procedure. Details of the File and Use and Use and File to be brought under the Standardization Guidelines.

Clause 4 (a)

Current wording:

a. No health insurance product shall be marketed by any insurer unless it has the prior clearance of the Authority accorded as per the File and Use procedure.

Suggested wording:

No health insurance product shall be marketed by any insurer unless it has the clearance of the product by IRDAI, as provided for in the Guidelines laid down for the purpose.

Guidelines need to be provided separately for File and Use and Use and File procedure.

Clause 4 (b)

Current wording:

b. Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.

(i). Any revision or modification in a policy which is approved by the Authority shall be notified to each policyholder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, and in particular mention the reason for the increase in premium and the quantum of such increase.

Suggestion:

To be moved to Standardization Guidelines

Clause 4 (d): Withdrawal of Health Insurance Product

Current wording:

(i). To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing policyholders.

(ii). The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.

(iii). If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.

(iv). The withdrawn product shall not be offered to prospective customers.

Suggestion: To be shifted to Standardization Guidelines

Clause 4 (e):

Current wording:

All particulars of any product shall, after introduction, be reviewed by the Appointed Actuary at least once a year. If the product is found to be financially unviable, or is deficient in any particular the Appointed Actuary may revise the product appropriately and apply for revision under the File and Use procedure.

Suggested wording:

All particulars of any product shall, after introduction, be reviewed by the Appointed Actuary at least once a year. If the product is found to be financially unviable, or is deficient in any particular, the Appointed Actuary may revise the product appropriately and apply for revision under the Product Clearance Procedure.

Clause 4 (f):

Current wording:

Five years after a product has been accorded File and Use approval, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

Suggested wording:

Five years after a product has been cleared under the Product Clearance procedure and launched on the market, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

4. Issue description:

The clauses in respect of General Provisions relating to Health Policies need modification.

How framework can enable:

Clause 5(a):

Current wording:

Health Insurance product may be designed to offer various covers:

(i). To specified age or gender groups; (ii) To different age groups; (iii). To treatment in all hospitals throughout the country, provided the definition of hospital is met (iv). To treatment in specified hospitals only, provided the morbidity rates uses are representative (v). To specified geographies only, provided the morbidity rates used are representative etc., provided such specifications are disclosed upfront and clearly in the product prospectus, documents and sales process.

Suggested wording:

In order to facilitate offering of innovative covers by insurers, 'pilot products' may be designed and on being cleared by IRDA under the File and Use guidelines be launched for a period not exceeding 5 years. After 5 years, the product needs to get converted into a regular product which shall not give the insurer an option to deny. In the alternative, the product, if not found successful may be withdrawn subject to the insured being given an option to migrate to another product subject to portability conditions.

Clause 5 (d) : Nomination and Assignment

Current wording:

No assignment of health insurance policies shall be allowed irrespective of whether the coverage provided under such policies are indemnity based or benefit based. Provided that in Life-Health-Combi products, assignment may be allowed only for the life insurance component of the product in accordance with Section 38 of the Insurance Act, 1938.

Suggested wording:

Assignment of health insurance policies would be permitted for benefit products such as Personal Accident, Critical Illness and Hospital Cash. It shall not be allowed for indemnity products.

Clause 5 (f) Renewal of Policies

Current wording:

An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the previous or earlier years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy, like the critical illness policy following payment of the critical illness benefit, the policy terminates.

Suggested wording:

The wording may be retained but the clause needs renumbering.

Clause (g): Free Look Period

Current wording:

(i). All Health Insurance Policies shall have a free look period. The free look period shall be applicable at the inception of the policy and:

1. The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

2. If the insured has not made any claim during the free look period, the insured shall be entitled to (a).A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or (b). Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or; (c). Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period; (d). In respect of unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units as on the date of the return of the policy.

Suggested wording:

(i). All new individual health insurance policies except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy and

1. The insured will be allowed a period of at least 15 days from the date of receipt of the policy, to review the terms and conditions of the policy and to return the same if not acceptable.

2. If the insured has not made any claim during the free look period, the insured shall be entitled to—(a) A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or ;(b) where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or; (c).Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period; (d). in respect of unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units as on the date of the return of the policy.

Clause 5 (m): Disclosures/Declarations:

Current wording:

(contains the standard declaration wordings in a proposal form)

Suggestion:

To be shifted to the Standardization Guidelines. Micro matters such as declaration wordings should be in the Guidelines rather than in the Regulations.

Clause 5 (p): List of excluded items

The Regulator would do best not to lay down prescriptions by getting into actual design aspects such as what needs to be excluded etc.

Current wording:

Hospitalization indemnity policies shall generally exclude from cover the standard list of excluded items as may be stipulated by the Authority from time to time.

Suggested wording:

Hospitalization indemnity policies that exclude certain standard items must ensure that this list is part of the product filing and when cleared as per procedure, should not only be appended to the policy document without fail but also find a mention in the prospectus even if the entire list is not appended to the prospectus.

5. Issue description:

Clause 6 relating to Underwriting needs to be revisited.

How framework can enable:

Current wording:

Insurers may devise mechanisms of incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use.

Suggested wording:

Insurers may devise mechanisms of incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, and following the product clearance procedure.

6. Issue description:

Clause 7 relating to Principles of pricing of Health Insurance Products needs modification.

Group products, as recommended, need to have a different approach.

How framework can enable:

Clause 7 (a):

Current wording:

The premium for a health insurance policy shall be based on:

(i). For individual policies, the completed age of the prospect on the date of inception of the policy or on the date of its renewal.

Suggested wording:

The premium for a health insurance policy shall be based on the completed age of the prospect on the date of inception of the policy or on the date of its renewal.

To add Clause 7 (b): Add "Pricing approach for group products"

Suggested wording:

Group products shall follow the Use and File procedure as suggested in Chapter III of this report.

Clause (b) [as existing earlier]

Current wording:

The policy premiums shall be unchanged

(i). For all group products and travel insurance products, for the entire period of cover

(ii). For all individual and family floater products, other than travel insurance products, for at least:

1. a period of one year in case of one year renewable policies and

2. for the period of the tenure as stipulated in Regulations 3(b) and 3(c) herein in case of multiple year policies

Clause 7(c):

Clause relating to pricing approach for group products should now include Use and File as well.

Current wording:

For a period of three years after a product has been cleared under File and Use procedure the premiums filed shall ordinarily not be changed for a period of at least one year from the date of clearance from the Authority.

Suggested wording:

For a period of three years after a product has been cleared under the File and Use procedure the premiums filed shall ordinarily not be changed for a period of at least one year from the date of clearance.

Clause 7 (h)(i): Loadings and Renewals

Current wording:

The loadings on renewal shall be in terms of increase or decrease in premiums offered for the entire portfolio and shall not be based on any individual policy claim experience.

Suggested wording:

For Group Insurance this shall not apply. Group insurance will be guided by separate recommendations given elsewhere in this report.

Current wording:

The discounts and loadings offered shall:

1. not be at the discretion of the insurer
2. be based on the objective criteria
3. be disclosed upfront in the prospectus and policy document along with the objective criteria, and shall be as approved under File and Use for individual policies.

7. Issue description:

A clause covering Fraud related aspects needs to be incorporated in the Regulations

How framework can enable:

Suggested wording:

Insurers and TPAs should have systems in place to identify and monitor fraud

8. Issue description:

Clause 7(h) needs to be deleted because the requirement relating to group pricing is to be revisited.

How framework can enable:

Use & file approach suggested.

9. Issue Descrption:

It is unfair that this clause benefits those insureds whose treatment falls just before a policy is due for renewal and the cost for this actually gets borne by other policyholders too.

How framework can enable:

Clause 8 (d) (iv).

Current wording:

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

Suggested wording:

To delete

10. Issue description:

Some revisiting is required when it comes to the clause relating to the obligations of the prospect.

How framework can enable:

Suggestion:

A declaration to be incorporated in the proposal form to be signed by Agent/Intermediary that information as well as advice given to the prospect is as per the requirement of the prospect and follows due diligence. A declaration from the proposer that he/she has been explained fully about the policy terms and has understood the same is also to be included.

On the part of service providers, including TPAs

Suggested wordings:

Insurers and TPAs to publish timelines as public disclosures on websites, details to be provided physically wherever required and provided through call centres; explain the process to be followed for cashless; give access to network list; delay which is owing to requirements from customer should be communicated.

11. Issue description:

A few changes and additions are required in the clause dealing with agreements between Insurers, Network Providers and TPAs.

How framework can enable:

Clause 10.Agreement between Insurers, Network Providers & TPAs

Standards, Benchmarks and Protocols for Providers

Suggested wording:

The Authority may prescribe certain standards, benchmarks and protocols for Network Providers from time to time and Insurers and TPAs shall ensure that only those Providers who meet with such laid down standards, benchmarks and protocols are enrolled in the network.

Clause 10 (b). The services offered by a TPA should not include

Current wording:

(i). Claim settlements and rejections with respect to the Health Insurance policies. However, TPA may handle claims admissions and recommend to the insurer for the payment of the claim settlement, provided a detailed guideline is prescribed by the insurer to the TPA for claims assessments and admissions in terms of capacity requirements, internal control requirements, claim assessment and admissions procedure requirements etc under the agreement.

(ii). Any services directly to the policyholder or insured or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the insurer.

Suggested wording:

(i) Claim settlements and rejections with respect to Health Insurance policies: TPAs may pre-authorize cashless claims in line with the detailed claims guidelines issued by the insurer/s

for the various products. Similarly, TPAs may settle reimbursement claims on behalf of insurers in line with the detailed guidelines. However, TPAs cannot repudiate claims. Repudiation of claims can only be done by the insurer/s concerned.

Clause 10(d). Settlement and Denial of Claims:

Current wording:

(i) All documents submitted to TPA shall be electronically collected and shall be forwarded to the insurers for taking a decision on the claim settlements or claim rejections.

(ii) TPA shall, in the correspondence to the policyholder with respect to settlement/denial of the claims, state clearly the following:

"As per the instructions of the insurer (name of the insurer) the claim being settled/denied for Rs. (amount) on account of (specifics of treatment/grounds of denial). For any further clarifications, you may directly contact the insurer."

(iii). The above statement shall form the mandatory part of the communication to be sent to the policyholder in every case of settlement or denial of the claims.

(iv). The insurer and the TPA shall be responsible for the proper and prompt service to the policyholders at all times.

Suggested wording:

Needs to be changed in line with what has been suggested above.

Clause 10 (c).

Current wording:

A copy of the agreement entered into between the TPA and the Insurance Company or any modification thereof, shall be filed, within 15 days of its execution or modification, as the case may be, with the Authority.

Suggested wording:

The Agreements can be inspected by IRDAI whenever it wants. They need not be filed.

12. Issue description:

Clause 15.Data and related issues need to be reflected separately.

How framework can enable:

Suggested wording:

Insurers and TPAs shall follow guidelines relating to technology requirements from time to time to facilitate better policyholder servicing.

13. Issue description:

17.Transitory provisions:

Suggestion:

These may be deleted now as they have served their purpose.

CHAPTER VII

POLICYHOLDERS' PROTECTION REGULATIONS

The draft amended regulations for protection of policyholders' regulations may take into consideration, the following recommendations of the Committee.

1. Matters to be stated in a Health Insurance Policy

A health insurance policy shall clearly state:

1. The name of the policyholder and the names of each covered beneficiary
2. Date of birth of the insured and corresponding age in completed years
3. The address of the insured for correspondence
4. The email id and mobile phone no of the insured
5. The name of the intermediary with code and mobile no.
6. The period of insurance and the first date of the first policy where insurance is without break
7. The Sum Insured
8. The sub-limits, if any, in the Sum Insured, with cross-reference to the concerned policy section
9. The pre-existing disease (PED) waiting period, if applicable
10. Specific waiting periods as applicable
11. Deductible as applicable – general and specific if any
12. No claim bonus Sum Insured
13. Free health check-up, when applicable, if any
14. The premium paid
15. Policy period
16. Policy terms, conditions, exclusions, warranties
17. Action to be taken on the occurrence of a claim for cashless and reimbursement options separately
18. Details of TPA, their local and national address, their toll free number, website details
19. Grievance contact nos. of both insurer and TPA
20. Obligations of the Insured in proper disclosure and timely intimations
21. Free look period facility and portability conditions
22. Policy migration facility and conditions where applicable
23. Renewability conditions
24. Premium revision and/or loading conditions
25. Provision for cancellation of the policy as per the Health Regulation

26. Proforma for communication to insurer/TPA

27. Address of policy issuing office, Head Office and grievance department with email ids, website address of the insurer and links to guidance sites therein.

28. Ombudsman service details with address and contact nos. of local Ombudsman

Sec. 7.2, 3 and 4 of the draft Policy holder Protection Regulation shall also apply to Health Insurance. With regard to benefit policy, the stipulations as applicable to life insurance shall apply.

2. Claim Procedure in respect of a Health Insurance

1. A health claim coming in the purview of the policy is to be intimated to the insurer/TPA directly or through the hospital immediately. Insurer however needs to specify in the policy a reasonable time for intimation. However no claim late intimated will be repudiated or otherwise treated as non-standard merely on the basis of delay in intimation, if proper explanation is given for the delay. If the reasons given for the delay are in the area of proven non-disclosure, misrepresentation or fraud the insurers can to turn down the claim.

2. In cashless claims the TPA/insurer should respond to the hospital and the insured with a clear decision within a maximum period of 24 hours. The insured should be informed of what the policy will pay and what it will not pay for the treatment prescribed. All later formalities will be between the TPA and the hospital concerned for the admitted treatments/amounts as allowed in the policy. The insured will be kept in the know and no unnecessary or extra charge other than what has been agreed will be paid by the insured in the normal course of treatment.

3. In respect of reimbursement claims the insured will send all 'necessary' papers as defined in the Health Regulation to the TPA and/or insurer as the case may, as laid down in the policy and the claim should be settled or disclaimed within 15 days of submission of documents.

4. Insurers should ensure that all information on claims sent by the customer is preserved with confidentiality.

5. Repudiation of a claim must be transparent and reasons for the repudiation should be spelt out and the insured may be advised to take up the matter with the grievance department and ombudsman thereafter for resolution of any grievance.

6. Where there is reduction of amounts indicated in the treatment costs/bills submitted, reasons for reduction must be clearly indicated.

7. In case of delay of seven days or more in payment of claim after the acceptance by the insured, the insurer will be liable to pay interest on the claim amount at a rate which is 2% above the bank rate for the period of delay.

CHAPTER VIII
CONCLUSION

The Committee members have made a number of recommendations towards the following objectives:

1. To increase Health insurance penetration and tap the potential for growth
2. Level playing field amongst all the insurers
3. Categorisation and Innovation of products
4. Improve the standardization guidelines
5. Regulator to prescribe Protocols and processes for Hospitals
6. Reserving and Solvency reforms to strengthen insurers offering Health insurance products
7. Additional capital instruments (apart from Equity) to meet medium term and short term capital needs

Some of the key recommendations are summarized below:

The Committee members were unanimous in their view that Level playing field for Life, Non-life and Health insurers in respect of Health insurance products is crucial to enable the industry tap the vast potential that exist for Health insurance.

Health insurance regulations 2013 and Protection of policy holders Regulations were examined in depth. The Committee has suggested a number of changes arising out of feed backs to make the Health Insurance Regulations as a pure Regulatory prescription and move certain parts of the existing Regulations into Standardisation guidelines to give the Regulator the flexibility to continuously remove the information asymmetry between all the stake holders – Policy holders, Insurers and Hospitals. In a sense, it would be necessary for the Regulator to provide Protocols and systems to be adopted by Network Hospitals who treat patients possessing Health insurance policies.

Both Indemnity as well as Benefit based products play a complementary role to each other in meeting the Health care needs of policy holders. There is also no need to segregate the tenure of the products between Life and non life insurers. Freedom of product design, along with pricing flexibility, is strongly recommended as the Long term goal to be achieved to improve the health insurance penetration.

The Committee members came to the conclusion that certain pilot products and innovation in terms of entry age based pricing as well as premium discounts and incentives to encourage wellness behaviour are necessary to attract younger population into Health insurance portfolio.

Uniform claim reserving methodology prescription would pave way for freedom of products and tenure, which in turn will give good choice to the insuring public.

The Committee was unanimous in their view that the Regulator should lay down a time bound action plan to move towards Risk Based Capital Adequacy norms (Solvency norms). Additional capital instruments to meet short to medium term needs of Health insurance portfolio has been recommended.

Finally, a focussed regulatory oversight and control is necessary as health insurance business is being carried out by all insurers—life, non-life and stand-alone health insurers. The Committee suggests that the Authority consider forming an exclusive vertical or department for Health insurance and bring all Health insurance issues -pertaining to Life, Non-life Insurance and Health Insurance companies. Only then a level playing field and a consistent approach to regulatory aspects for development of health insurance can be facilitated.

Annexure I

CUSTOMER INFORMATION SHEET TEMPLATE

Product name	:	**Family Health Optima Insurance**
Policy No.	:	X/99999/99/99999/99999
Previous Policy No.	:	X/99999/99/99999/99999
Name of Proposer	:	Shri. R.Chandrasekaran
Address and contact details	:	203 – 204 Celebration etc.,
Mobile	:	
E-mail	:	
Period of Insurance	:	09 March 2014 - Mid night of 08 March 2015
Policy issuing office	:	Fort Branch Office
Address:	:	19 A , 1st Floor, Rohit Chambers ……

Details of Insured persons:

Coverage		**Exclusions and Limitations**	
Basic Sum Insured (Amount) :	1. Rs. 3 lakhs annual limit	What is not covered (major exclusions) 1) absolute health based exclusions 2) exclusions which can be covered by paying additional premium 3) general insurance exclusions Distinguish between Primary Exclusions (that cannot be carved back) and Secondary Exclusions (that can be carved back on payment of additional premium) here.	a) Non allopathic medicines b) Substance abuse, self inflicted injuries, HIV/ AIDS
Individual/ Floater:	Family floater 2 Adults and 2 Children	Waiting period :	. xx days for …….
Cumulative Bonus SI	Rs. 1.05,000 […% age for)	Pre-Existing Disease	**Diabetes** would be covered after ……. months / not covered
What is covered	a. Surgical , b. Hospitalisation [incl. Pre and post c. Only IP and Day care	Major Exclusions : Hazardous sports War, Terrorism, Civil War, Breach of Law	
Renewability	……. upto … age [subject to ….]		
Whether SI can be increased, if so how			

Cost Sharing / deductibles / co-pay/ sub limits			
Sub limits [Room rent, Boarding and Nursing home expenses, Daily cash, Dental, Maternity etc.,	Room rent limited to 2% of SI subject to maximum of Rs. 5000 per day	Room rent limited to 1% of SI subject to maximum of Rs. 3000 per day	Room rent limited to 1% of SI subject to maximum of Rs. 2000 per day
Diagnostics:	Not to exceed 10% of the overall claim		
Daily Cash / Dental / Maternity etc.,			
Deductibles / co-pay (Amount / %)	Deductible each and every claim 10% (Rs.5000)		
Others restrictions			
Other benefits – e.g. medical check up			

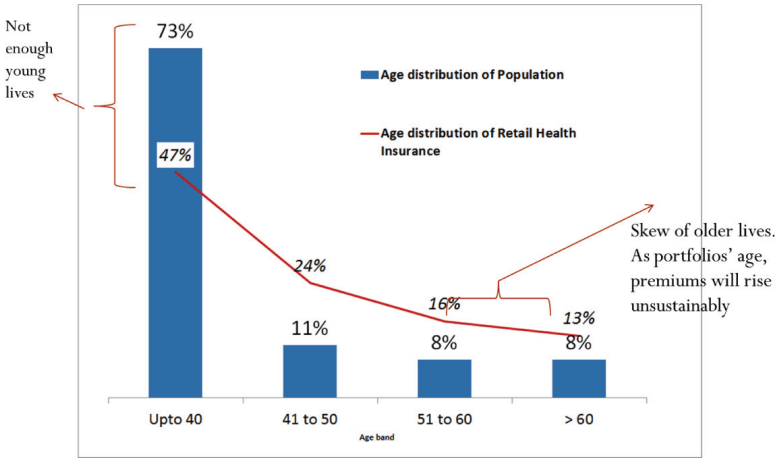
Claims	
Pay out basis:	Cashless / reimbursement
Claim process	Details
Hospital net work / Provider details	List and details
Intermediary (Agent / Broker /TPA details)	Name and other contact details
Policy servicing / Grievances / Complaints	
Company officials	Contact details :
	Toll free number:
	Email
	Fax Number
IRDAI (IGMS / Call centre) 155 255	Procedure
Ombudsman	Details

Insured Rights		Insured Obligations /Duties
Renewal	Company would not deny renewal	1. Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.
Increase SI (during policy term	Please contact	2. Disclosure of Material information during the policy period – such as : detection of any critical conditions or Change of occupation
Migration and Portability	Please contact [email id and name of person	
Free look :	up to 15 April 2015	
Grace period	grace period of not later than 5th of April 2015 for renewal	
Turn Around time (TAT)		
Cashless :	Pre – authorization within 24 hours of intimation	
Reimbursement :	Within 15 days of submission	

Annexure II

CONCEPT OF ENTRY-AGE PRICING

The figure below shows the enrolment rate for retail health insurance, across 3 health insurance portfolios including a PSU company in India.



The retail health insurance market is not able to attract younger lives because of the current approach to pricing which uses a 'financial' year approach to pricing.

For individual customers, the underlying risk of illness is life long – i.e. the nature of health risk is long term – therefore pricing approaches need to mirror the same. Lifetime renewability of the product ensures that customers have access to cover through their lifetime, but the current, short-term, burning cost approach to pricing, does not ensure optimum pricing for age-based risk. The current practice creates an automatic cross subsidization structure, with younger lives subsidizing the older lives, which lowers rate of enrolment among younger lives[1]. For the younger lives which do enroll, the 'value-for-money' equation in the customer's mind is eroded when they do not claim in the initial years – in turn, this puts pressure on persistency for the industry.

General insurance companies use the burning cost approach because reserving requirements are annual. Since general insurers are market-share leaders in health, life insurers find that their products, priced using the traditional 'age at entry' approach of life insurance – are not competitive, unless bundled with a savings benefit.

Therefore entry-age based pricing is needed. This is to ensure that the premium reflects risk at the age of entry into the pool – creating an automatic, structural, incentive to attract the younger population and keep them in the insured pool. This can significantly impact penetration at the market level, and create a structural pull for persistency. (Note; Entry age based pricing also means that a first time entrant which is an older life, would be charged more than a similar aged life, who has entered the pool in the past and has **stayed** insured).

From a risk management perspective, entry age pricing has to be matched with long term reserving.

The current regulations do not prohibit entry age based pricing, but reserving norms for health insurance, are annual in nature.

The reserving regulations need to be amended to establish, at a product level, whether the intention is to write long term or short term risk.

[1] *See Graph above*

Annexure III

USE AND FILE GUIDELINES FOR GROUP INSURANCE PRODUCTS

A **Use and File** system is prescribed for Commercial Group Health Insurance products (Commercial products which are sold to Corporate entities), for Group Retail (affinity group) contracts and for pilot products. A Use & File System is where the Insurer is permitted to market the product without prior filing / approval with IRDA.

To administer the "Use and File" system, each insurance company would set up an internal committee, called the Product Management Committee (PMC). The PMC would be a board led committee. It may be headed by any board member who does not have executive responsibilities and will include CEO, Appointed Actuary and Chief Underwriter, at the minimum. The PMC will be responsible for the product management cycle of all 'use and file' products, including framing guidelines for product withdrawal.

All products under Use and File will be approved by Product Management Committee, and filed with the IRDA within 7 working days of approvals. Such products may be sold by the insurance company upon obtaining approval from the PMC. The documents to be filed to the Authority may be prescribed by the Authority in its communication to industry.

Use and file approvals would be valid for a period of 5 years – after which fresh approval would be sought from the PMC.

Minor Modifications in Products

Many a time insurers want to make minor modifications. As an illustration some minor modifications are given below but this is not an exhaustive list of all possible modifications:

- Change in proposal/claims form to either capture more information or remove some information
- Change in the prospectus/customer information sheet/brochure to bring more clarity about the product
- Change in policy schedule to capture more/less details

It is recommended that all such modifications may be approved by PMC subject to the company's Appointed Actuary confirming that:

- The changes in no way have any financial implications either for customer or for insurer
- The changes will not mislead the customer in believing something that the product does not offer

Pricing of Group Products

Price of group products may be different than that arrived from the retail price on account of lower expenses of management, lower commissions and/or different experience than the retail product. However, any such deviation in price shall be done only on the basis of deviations allowed by Appointed Actuary of the company and being noted by PMC.

Product Management Committee

All products either under File and Use or Use and File will have to be approved by Product Management Committee.

Products under File and Use will have to be sent to IRDAI after Product Management Committee's approval.

Products under Use and File may be sold by insurer after Product Management Committee's approval under information to IRDAI – i.e. they will have to be filed within 7 days of approval from the PMC.

It is expected that IRDAI would revert with its observations on the products under File and Use within 30 days of receipt of product filing, failing which insurers may be free to sell the product.

Under the existing File and Use system, any product approval is valid till eternity. This is proposed to be changed and it is recommended that products once approved under any of the approval systems will remain valid for 5 years after which they will have to be filed again

Constitution of the PMC

Each insurance company may set up an internal Product Management Committee to review and approve all the products that are being / will be sold by the insurer. The Product Management Committee may be formed as a Board level Committee. The Committee can create a Product Management Policy (an expanded Underwriting Policy) and may delegate powers to the management of the company for day to day operations and put in place mechanisms to ratify decisions.

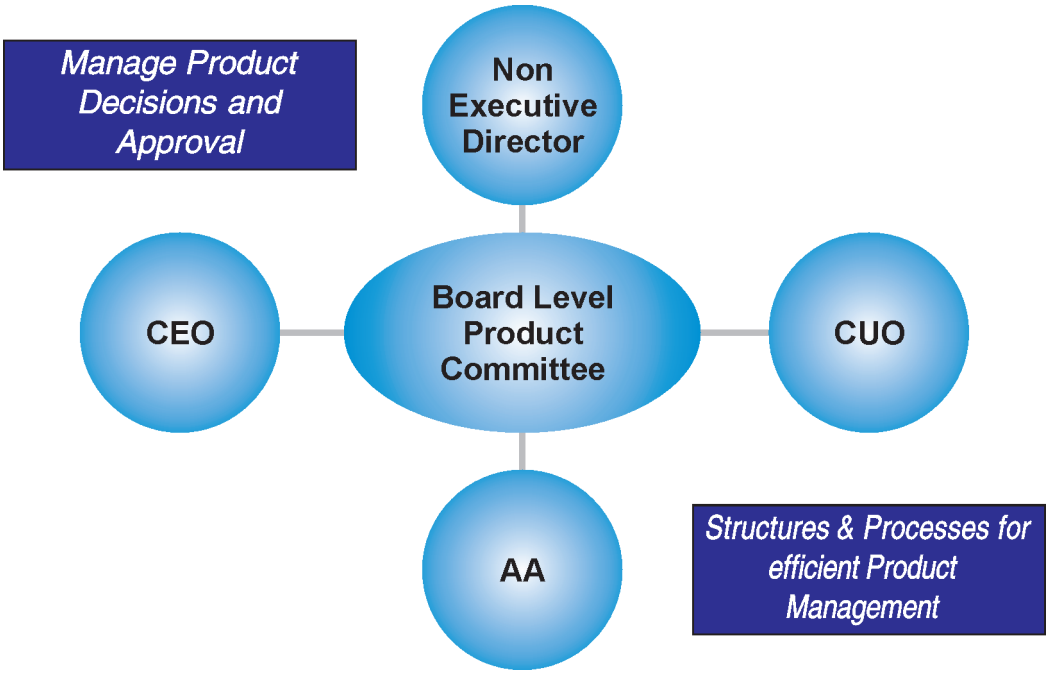
PMC will report to the board (not to any committee or subcommittee of the board) and will assist the board in effective control over the risks posed, in particular, by insurance products being sold by the insurer. In order to meet its obligations towards the board, the PMC will carry out a due diligence process and record its concurrence/sign off on various product related risks for all product filings before any insurance product is sent to IRDAI for approval. The Board may however delegate the day-to-day responsibility to the Appointed Actuary and Principal Officer of the Company with due ratification process in place during its next meeting.

The due diligence process through internal PMC will apply to all products whether these fall in Use & File or File & Use category or any other product category that IRDAI may introduce from time to time.

The committee will hold its meetings as and when required but not less than once a year. However, if the committee has delegated some of its responsibilities to the Appointed Actuary and Principal Officer of the Company, it MUST hold the meeting at least once a quarter to ratify the decisions taken by AA & Principal Officer during the intervening period.

The companies may wish to consider including other persons in the PMC if they believe that the inclusion of any such person will add value to the due diligence process. The company may also create internal work groups to suitably support the PMC (which may include the CMO / CFO and the CRO, Compliance Officer, Head for reinsurance etc.).

The designations used here (Chief Underwriting Officer, Chief Marketing Officer etc.) are only indicative. In case a company does not use these designations, the principal officer of the company may propose the name of the officer who performs functions closest to these designations.



Role of PMC

The role of the PMC will include the following, inter-alia

- To create appropriate structures and processes for effectively managing the operations in the entire product life cycle
- To ratify any product related decisions by the management if delegated
- To assist the board in effective management of risks associated with the products being sold by the company
- To present to the board the product performance report, as presented by AA, at least once in a year.
- To apprise the board of the residual risks and its impact on company's capital for the products on which it has done its due diligence during the period intervening two board meetings.
- To ensure that the underwriting policy covers all the aspects of business as required and that it is relevant in the context of evolving regulations and market complexities
- To ensure that all the necessary data and/or assumptions have been provided to the AA for the purpose of pricing of the product
- To ensure that the IT systems are in place before the product is sold and the systems are capable of capturing the necessary policy and claims data to enable the company in general and AA and underwriters in particular, to analyze the emerging experience of the product and whether it is in line with the assumptions.
- To ensure that the claims settlement process is in place for the product and all claims handlers have been trained in the claims settlement process

The roles and responsibilities of some members of the committee have been laid down in some regulation/s or regulatory guidelines/circulars. However, many a time, these roles and responsibilities, though equally important from the product perspective, may be more indicative in nature than specific. Therefore, in order to bring absolute clarity in the role of each member from the product perspective and even at the cost of repetition, the roles of members have been defined herein. However, these guidelines do not define any particular role for Principal Officer and Directors and they are assumed to have an overall responsibility for ensuring that a robust due diligence process is in place to mitigate risks of new and current products.

Role of Appointed Actuary

- To ensure that due diligence has been carried out on the product development process and pricing in accordance with Appointed Actuary regulations, 2000, Appointed Actuary Regulations, 2013 and all other regulatory guidelines, circulars and directions in force.
- To document all the assumptions used in product pricing and the basis of those assumptions
- To analyze the financial implications of risks covered in the product and build these into the rating of product on sound and prudent actuarial basis
- To confirm that the margins built into rates are consistent with the experience of the insurer in respect of commission, management expenses, contingencies and profit
- Analyze the impact of product on the capital and solvency margin of insurer and inform the management and board of additional capital requirement, if any, to maintain solvency margin
- Determine and inform the PMC about the data and system requirements, both at the time of underwriting and claims, to enable the company analyze the emerging experience of the product on a regular basis
- To advise the PMC about the basis on which URR, PDR should be calculated for the product
- To present product performance report to PMC along with recommendations

Role of Chief Underwriting Officer

- To check and confirm that similar wordings have been used for describing the same cover or the same requirement across all the products in the company.
- To check and confirm that the product is in conformity to the board approved Underwriting policy of the company and that the Underwriting policy is relevant in the context of evolving regulations and market complexities
- To check and confirm that the product and its features satisfy all the Basic principles of insurance
- To check and confirm that the product is customer need based, the contingencies covered are clear and provide transparent cover which is of value to policyholder. The terms and conditions of cover are fair between the insurer and the insured.
- To check and confirm that the product is a genuine insurance product of an insurable risk with a real risk transfer.

- To check and confirm that all the literature relating to the product is in simple language and easily understandable to the public at large

Role of Chief Financial Officer

- To check and confirm that the commissions built in the product are in line with regulatory guidelines and actual commissions paid will not exceed those allowed under regulations
- To confirm that the accounting for the product premium and claims shall be done in accordance with Indian GAAP/regulatory guidelines
- To apprise the PMC about the tax implications of the product, if any
- To coordinate with AA in identifying the additional capital requirements that the product may pose

Role of Chief Marketing Officer

- To identify the target segments to which the product would be sold
- To indicate the volume of business that the company plans to achieve over future three years after the product approval
- To confirm that the product would be sold only by IRDAI authorized intermediaries
- To confirm that all the distributors and company sales staff would be appropriately trained in the product and sales process
- To confirm that appropriate systems would be set up to avoid and minimize sale of the product mismatching customer need
- To present to PMC periodic report on cancellations due to product sales not matching with customer need and action plan to reduce the cancellations.

Role of Chief Risk Officer

- Integrate the risks arising of the proposed product into the company's risk management framework
- Coordinate with Appointed Actuary, Chief Underwriter and other product stakeholders in the company to
    - identify and assess non insurance risks
    - quantify these risks
    - recommend an effective mechanism to minimize these risks to the PMC
    - quantify the residual risk and recommend providing for these in the company's financial statements

Role of Head Reinsurance

- To assess the reinsurance requirement for the product from risk perspective and arrange suitable reinsurance that reduces overall risk arising from the product
- To ensure that reinsurance cessions, If any, for the proposed product follow Reinsurance Regulations and any other Guideline/Circular/Directions of IRDAI
- To identify if there are risks that are not likely to be covered by reinsurance and the company will retain these risks on its books. Analyze and apprise the PMC of the financial implication of such risks.

Role of Compliance Officer

- To ensure that the product development process, including reporting requirements to IRDAI are followed by the company in letter and spirit
- To ensure that the product does not breach any of the laws, regulations and extant guidelines, circulars and directions of IRDAI

Technical Audit - the role of the PMC

IRDAI will have monitoring and oversight authority over PMC. The following wording is recommended.

These roles are indicative in nature and the company's board may expand these roles or more clearly define them. While many of these roles may state the obvious, they have still been reproduced here in an attempt to avoid any interpretational gaps. In case a company wishes to include other persons in the PMC, it must define their roles of each member of the committee. In order to fulfil its responsibilities, PMC may ask any officer of insurer to confirm on the due diligence done by him/her in respect of the product presented for approval.

Annexure IV

GROUP INSURANCE GUIDELINES

The following guidelines are recommended for Group Insurance:

1. Group insurance should be allowed only for groups of persons who assemble together with a commonality of purpose other than for the purpose of taking insurance or are working together under an employer. Members of non employer-employee groups such as welfare associations, holders of credit cards of banks, borrowers or deposit holders of banks, members of established clubs etc. can take insurance covers as an add on benefit and such coverage will be treated as group insurance provided the group organiser has authority from the majority of the members to arrange insurance on their behalf.

2. No group should be formed for the main purpose of taking insurance. Groups should have relationships and services for purposes other than insurance. No insurer or intermediary should allow any person or group to negotiate 'group rates' and then canvass or enrol members.

3. There should be a minimum number of persons to form a group. Underwriters of the insurer will decide the ideal number.

4. Entry or exit from the group should be tightly regulated so that there is no scope for adverse selection, moral hazard or fraud.

5. Persons, who join a group insurance, on retirement or leaving the group as per group rules, will have an option to migrate to a suitable policy at a premium as applicable to an individual insurance, but with all benefits of portability. It should be facilitated both by the group organiser and the insurer concerned.

6. All policies will be sold or marketed only through a licensed intermediary or directly by the insurer. No commission or any other charge for administration or any other expenses for whatever reason will be payable to the group.

7. A master policy will be issued to the group, which should be available for verification and guidance for the members. All members should be given a certificate of insurance giving the main details of the cover given and the important conditions and exclusions.

8. Any amount charged as 'premium' by the group should be paid in full to the insurer and no part of this should be appropriated by the group. No other amount should be collected in the name of insurance cost/charges and the insurer will have to monitor this.

9. All group discounts shall be passed on to the beneficiary, unless the premium in part or full is paid by the group in which case the group may be allowed to keep the proportionate discount. Method of collection of premium should be clearly spelt out by the group and verified by the insurer.

10. All discounts should be based on valid underwriting considerations, keeping in mind the loss experience of the group, the expenses including commission that may be incurred/payable. Insurers must justify the rates and terms given to any group to the Authority, if called on to do so.

11. All insurers wishing to do group insurance should have a Board approved group insurance underwriting policy which should be filed with IRDAI. The policy should spell out the manner in which its risk and costs are analyzed and factored in the premium cost. All risk factors per units of coverage such as individual, family, group floater, etc., should be separately analyzed and priced. Past experience and future exposures should also be critically analyzed at a controlling office level for large groups.

12. Tailor-made policies can be made for large groups, subject to the guidelines of the Authority, if any.

13. All past insurers and intermediaries concerned must provide to the insurer quoting for a new group, approaching them for the previous claim experience of the group for the last five years. The General Insurance Council and the Broker Association may issue suitable instructions in this regard.

14. Rating for group insurance can on individual morbidity, group morbidity or subgroup (children, adults, senior citizens) morbidity based experience and so on. Innovative covers should be priced prudentially.

15. All health insurance policies should be having named beneficiaries and ID cards should be issued to them to obtain cashless service and in other cases e.g. personal accident, unnamed policies can be issued provided the group has non-tamperable registers or records which should be kept open by the insurer for inspection at any time.

16. All claims will be payable only to the insured member or the beneficiary or registered nominee, in case of death of member/beneficiary. For employer-employee groups claims may be paid to employer, if employer has paid the premium and reimbursed the claim.

17. The beneficiary/insured member will have the right directly to raise grievances with the insurer and take up matters also with the Ombudsman as applicable.

18. The group's role as facilitator in offering a group cover and facilitating insurance services including claims from a central point needs to be clearly spelt out between the group and insurer through an MOU. If the group wants to charge for the services, how the same is collected and how it is made aware to the members as a non-insurance charge is to be made clear in the MOU with the insurer. The insurer should keep a provision for surprise inspection so that the interests of the beneficiary policyholder are duly protected.

19. The insurer and the broker, if any, who is intermediary will be held responsible, for any malpractice that is detrimental to the beneficiary members or potential consumers or to the public at large and for violation of any regulation or guidelines of the Authority relating to the insurance transaction with groups.

Annexure V

HEALTH SAVINGS PRODUCT: AN ILLUSTRATIVE PRODUCT CONSTRUCT

- Health Savings Products are long term in nature and creates a contingency fund (corpus) dedicated to health needs for the future
- The product seeks investments during the early life of an individual when he is earning, young and healthy to build the corpus for withdrawal when old, retired and medically infirm.
- The product's Out of Pocket section comprehensively seeks to address medical needs hitherto typically kept out of health insurance space
- Given its savings orientation coupled with comprehensive coverage and robust use of tax incentives this product is likely to attract the currently uninsured segments, namely the young and healthy as well as the not so young and wealthy.
- This product is likely to increase penetration and therefore bring more healthy people into the health insurance space. This should lead to reduction in load on the existing insured population, bringing down premiums, and making health insurance more viable
- The product construct should bring down moral hazard of the policyholder by building positive financial incentives over the long term
- The product should increase financial strength of the insurance companies over the long term. The product does not offer any unsustainable guarantees over the long term and therefore does not pose any systemic financial risk to the sector as a whole

Based on the key considerations of product design mentioned above, the following product construct is recommended:

Component	**Recommended Treatment**
Market participants	**All insurance companies (General, Life and Stand-alone companies)**
Product description	**Comprehensive health insurance policy incorporating indemnity and out of pocket expense covers. Envisages a package of covers including-** **Lead product-** High deductible indemnity based health insurance product **Alternative lead product-** Benefit based products like critical illness **Out of Pocket expense product-** OPD benefit, waiver of premium, cover for deductible and co-pay payment etc.
Coverage	• Indemnification of expenses in relation to hospitalization, domiciliary care and day care treatments undergone by insured (or alternative benefit based covers like Major Medical Illness cover)

	• Indemnification of out of pocket expenses incurred by the insured in relation to- • Approved outpatient expenses • Preventive care expenses • Out of pocket expense in relation to contingencies covered in part A. on account of application of any deductible, co-pay, but excluding repudiation, or contribution clause • Waiver of premium- Payment of due insurance premiums on behalf of the insured for cover A.
Tenure of policy	**Whole life; as per the existing definition under IRDAI Health Insurance Regulations 2013**
Premium payment	**Annual premium payment subject to Premium Payment Term** **Minimum Premium Payment Term- 5 years**
Sum insured benefit	**For cover A. :** Sum insured as evidenced on the policy **For cover B.:** At the inception of the policy will be determined by premium paid and choice of cover under A. **Provision of Bonus Sum Insured :** **For cover A. :** As per the bonus/malus scheme, depending on the claims experience of the policyholder **For cover B.:** Bonus sum insured @ 4% per annum of the cover B. Sum Insured at the beginning of the year. This guaranteed addition will be reviewed by the company every three years and the prospective rate of addition will be reset, if necessary. **Limits will be reduced by the amount of claim incurred for both cover A. & B.** Cover A. limit will be reinstated automatically to the policy Sum Insured upon renewal of policy, subject to prevailing policy features as per the provisions of Health Insurance Regulation of IRDAI Cover B. limit will accrue over time based on bonus sum insured, and payment of successive annual premiums and will be carried forward across successive policy periods
Premium	**Rs. 25,000 per annum is prescribed as a minimum. It is intended to match the section 80D tax exemption limits. Additional contribution would be permitted and would be applied towards enhancing the covers. Employers could contribute medical reimbursement into this scheme instead of paying it directly to employees.**

Commission scale	**Maximum of:** **Year 1: 15%** **Year 2: 10%** **Year 3-5: 5%** **Trailing commission: 2% thereafter**
Deductible/Co-pay	**Will apply to cover A. offered at the discretion of individual company and as selected by the policyholder** Fixed rupee value deductible per policy year Choice of Deductible will be at the discretion of the insured. It is however envisaged that the deductible will increase in value over time as the sum insured in cover B. increases
Cancellation scale	**Premium refund scales:** Policy year 1-3: 0% Policy year 4 onwards: 90% of SI under cover B. (net of any claims).
Portability	The policy will be cancelled and refund value paid to the policyholder. However the insured will be able to carry forward his continuity benefit to another insurance company as per the stipulations of Health Insurance Regulations of IRDAI
Tax benefits	**As available under the relevant statutes, as amended from time to time**
Tax treatment	**As per the currently prevailing procedures for health insurance policies**
Death of the insured	**The insurance policy will cease and cancellation refund amount will accrue to the nominee on the policy**
Waiver of Premium benefit	**Upon payment of 5 consecutive premiums, in the event premium is not paid in any subsequent year and the insured requests the company for premium waiver benefit then the claim will be paid from cover B) to fund the premium of cover A) and the policy will continue uninterrupted, till 90% of cover B) is used up**

Report of the Expert Committee on Health Insurance

1.	Shri M. Ramaprasad (Member-NL, IRDAI), Chairman	
2.	Shri A.V. Girijakumar (GM, United India Ins. Co. Ltd), Member	30/3/
3.	Shri Bhargav Dasgupta (CEO, ICICI Lombard Gen. Ins. Co. Ltd.), Member	31/3/15
4.	Shri H.S. Shashi Kumar (ED, LIC of India), Member	30/3
5.	Shri K.S. Gopalalakrishnan (CEO, Aegon Religar Life Ins. Co. Ltd.), Member	
6.	Shri P.C. James (Chair Professor, NL, National Ins. Academy),Member	30/3/15
7.	Shri R. Chandrasekaran (Secretary General, General Ins. Council), Member	R. Chandra 30/3/2015
8.	Shri Segar Sampath (GM, The New India Assurance Co. Ltd.), Member	31-03-2015
9.	Dr. S. Prakash (MD, Star Health and Allied Ins. Co. Ltd.), Member	30/03/2015
10.	Smt. Tania Chakravarthy (AA,Royal sundaram Gen. Insl. Co. Ltd.), Member	Chakravarti 30/03/2015
11.	Smt. Yegna Priya Bharat (JD, (Health, IRDAI), Convenor	Priya 30/3/15

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