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Claim Settlement: The Moment of Truth in Health Insurance

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Abstract: ***A customer centric claim settlement system goes a long way in mitigating the anxiety of patients. At the time of buying Health Insurance, a customer is assured that the Health Insurance Company (HIC) will take care of the medical expenses, in case of his hospitalization. But when such an eventuality happens, many times HICs go back on their words based on procedural non-compliance or because of some conditions written in fine prints. Therefore, how HICs respond to the financial needs of the patients during the claim settlement is the real Moment of Truth. Failure on the part of the HICs in honoring their commitment leads to high Out of Pocket (OOP) Expenses and acute financial hardship to the patients. This article is important primarily because a customer always has an apprehension about the claim settlement. Hurdles one faces during claim settlement is a big contributor to the low customer satisfaction (LCS) which in turn contributes to poor Health Insurance penetration. On the other hand, false, ineligible and inflated claims adversely affect the business model of HICs. The article also highlights why the Incurred Claim Ratio (ICR) in Health Insurance is very high in India and why this has become a roadblock towards expansion of Health Insurance Market (HIM).***

Index Terms: HIC, OOP, Claim Settlement, LCS, ICR, HIM.

I. INTRODUCTION

The market penetration of health insurance products in India is low at 33% (IRDAI Annual Report 2016-17.p.50) [1]. One of the reasons why consumers shy away from Health Insurance is the perceived difficulty during claim settlement. While the Insurance companies have a big role to play in alleviating such a negative perception, consumers also have to be open and transparent while enrolling them for health insurance. Insurance business works under the concept of risk pooling and if the risks are not disclosed completely at the time of enrolment, there is a great chance of misunderstanding, conflict and litigations at a later point in time. Due to low acceptance of Health Insurance as the preferred mode of healthcare financing, there is very high incidence of Out of Pocket (OOP) expenses in India and is estimated to be 72% (Cognizant 20-20 Insights, February 2014. p.2) [2].In fact such high OOP expenses (Gupta & Trivedi 2006) [3], [4] pushes many poor people into debt trap as they seek loan from moneylenders and even sell off the little property they possess. The current level of market penetration has been largely contributed by Government sponsored schemes like Employee State Insurance (ESI) [5], Central Government Health Scheme (CGHS) [6] and Rashtriya Swasthya Bima Yojona (RSBY) [7]. The following table shows the growth of health insurance over the last few years (IRDAI Annual Report 2016-17).

Table 1: Persons Covered under Health Insurance under different Class (Figures in lakhs)

Source: Annual Report of IRDAI, 2016-17

Class of Business/ Year	2012-13	2013-14	2014-15	2015-16	2016-17
Govt. sponsored scheme including RSBY	1494 (72%)	1553 (72%)	2143 (74%)	2733 (76%)	3350 (77%)
Group Business (other than Govt. business)	343 (17%)	337 (15%)	483 (17%)	570 (16%)	705 (16%)
Individual Business	236 (11%)	272 (13%)	254 (9%)	287 (8%)	320 (7%)
Grand Total	2073	2162	2880	3590	4375

Ayushman Bharat National Health Protection Mission (AB-NHPM) [8], the latest flagship program of the Government intends to cover 10 (ten) Crore economically backward families. Considering India's population to be approx 130 Crore, inspite of AB-NHPM program, there will still be a big segment of population who will be dependent on Private Health Insurance and therefore we need to find out why this sector is not growing as we like it to be.

II. HEALTH INSURANCE

Insurance is a hedging against the unforeseen eventualities. Health Insurance is one such product which gives one a kind of financial protection, in case the insured falls sick and gets hospitalized. When one gets hospitalized, his immediate family members go through various hardships. Health hazards don't come giving advance notice. It can come anytime.

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Not only accidental health hazards, but also all kinds of illness where hospitalization is necessary, can come anytime. Higher the age of the individual, higher is the chance of health related emergency. In fact, many doctors advise that, people should become careful about their health, once they reach the age of thirty. Further, if the person is suffering some chronic disease like diabetic, hypertension, asthma etc, then the chances of hospitalization increases. In short, no one can really predict when a health-related catastrophe will strike a person. So the wise thing to do is to provision for necessary finance for such an exigency. One of the best modes of financing for healthcare expenses is Health Insurance. As on date, most of the health insurance products cover only the hospitalization expenses. That is, the insurance company or the insurer will bear the financial burden only if the insured is hospitalized. The standard condition is the patient has to be hospitalized for at least 24hours to get the health insurance benefits. But with the advent of better medical technology, many operations can be done very quickly and the patient can be discharged without the need for hospital, stay for 24-hour. So, many insurers are recognizing this issue and are becoming liberal in their conditions of hospital stay also.

III. CLAIM SETTLEMENT

Unlike life insurance, the claim settlement paraphernalia of Health Insurance is complicated. In health insurance risk coverage, there are many grey areas (The Economic Times, October 11, 2017) [9]. That means many conditions decide whether a claim will be honored or not. Besides the self disclosures made by the customer, many times the insurance company conducts a range of medical tests before they enroll someone for their policy. If an insured person conceals some diseases while applying for insurance and then those conditions coming to surface at the time of hospitalization, those may become the reason for the Insurer to decline a claim. Many times the first prescription of the doctor at the hospital becomes the deciding factor if the claim will be honored or not. Therefore, it is prudent to disclose all pre-existing diseases at the time of taking Health Insurance. At the time of applying for health insurance, HICs also ask the applicants to fill up a Health Status questionnaire wherein he has to disclose all pre-existing disease and medical conditions. If the Insured suspects that some information has been suppressed, they may not only decline the claim but also may cancel the policy altogether.

IV. DISCLOSURES

Settlement of claims by HICs is not seamless and hassle free, as one would like it to be. A person who needs hospitalization is in a stressful situation – mentally, physically and financially. Even when he has a Health Insurance in his name, there is a concern if the Insurance Company will act promptly and favorably as they promise during enrolment. There are many ifs and buts in Health Insurance products and hence the uncertainty. The uncertainty that the Insurance Company will not act as per their commitment is a great cause of anxiety. Therefore the time of claim settlement is the 'Moment of Truth' for the insured and his trust on the HIC squarely depends on this experience. While the onus of keeping this promise squarely lies with the Insurer, there are some aspects of the service where the customer also has a role to play. One of key expectation from the customer at the time of enrolment is self declaration of pre-existing illness/diseases so that the Insurer can measure the risk of providing the health insurance and decide on premium and conditions. For example, many Insurance companies don't cover patients who have suffered epileptic stroke in the past. All HICs need pathological data on blood sugar level, blood pressure, past hospitalizations, medications etc to assess current health status. The risk level of a diabetic who takes insulin is considered higher than those who take oral drugs. Similarly smokers and drinkers are considered higher risk category compared to non-smokers and non-drinkers. Therefore all these information must be disclosed completely and truly. The other expectation from the customer is that he should be aware of the claim procedure. If the procedure is followed as per the guideline of the HIC, it becomes easy to settle claims. So claim settlement is a joint responsibility of the Insurer and the Insured.

V. THIRD PARTY ADMINISTRATORS (TPAS)

In the Health Insurance business, TPAs [10] play a very important role in the Health care value chain. Right in the early stages of its development IRDAI has defined the role of TPAs to manage claims and reimbursements (Bhat & Babu, 2004) [11]. Since the Insurers can't have their representatives at all the hospitals, they operate through TPAs who act as their eyes and ears. They ensure that the treatment being provided to the patient is fair in terms of price and the procedures. Similarly, they also check that the Insured is not mis-utilizing the Insurance services or is not indulging in some kind of malpractice. The relationship between the Insured and the Insurance Provider has to be win-win for long terms well being of the patient and also the Insurance company.

VI. HURDLES IN CLAIM SETTLEMENT

One of the moot questions regarding Health Insurance is "Why the HICs are so conservative or careful in insuring and also in claim settlement".

i) Insurance business works on the concept of risk pooling. In the Indian market, since health insurance is not mandatory, most of the young and healthy in the age group of 25-35 don't take health insurance.

ii) Since only the aged and not-so-healthy people take Health Insurance, the insurer exposes itself to a skewed risk. Therefore they undertake a medical examination before enrolment.

iii) Some hospitals in collusion with the insured people, inflate the bill through unnecessary and fake medical procedures. There are examples where, insured have submitted claims without even getting hospitalized. This is a moral hazard in Health Insurance. There has not been any empirical study in India to find out the extent of this malaise, but some studies conducted in Iran (Khorasani, E. 2016) [11] and Malaysia (Kafeli & Jones 2012) [12] reveals that there are broadly two reasons for the malpractice– (1) Economic. (2) Moral-cultural. There are evidences to show that poor and uneducated people are more prone to indulge or yield to such supply side moral hazards. IRDAI has also taken note of this issue in their latest Annual Report (Annual Report. 2016-17.p-47)

iv) Health Insurance covers specific procedures and hospitalization expenses. There are many expenses that they don't bear or exclude from the claim. There is also some capping on different heads of expenses as well. All these make the claim settlement a complex activity.

v) The standardization of different medical procedures and treatments and costs thereof is in a very nascent stage in India (The Times of India, December 17, 2017) [13]. That means, for similar treatment, different hospitals might bill differently. So the insurance company is exposed to a kind of uncertainty of claim.Let's discuss this subject of Claim settlement from the point of view of the insured. It is not as easy as it appears to be till one really gets hospitalized. The claim settlement happens in two modes – cashless and reimbursement. Whether, it will be cashless or reimbursement depends on the hospital where the insured gets hospitalized and also at times the specific treatment that he undergoes. Some of the top private HICs who provide cashless facility are Bajaj Allianz, Apollo Munich, HDFC Ergo, Max Bupa, Cigna, Reliance, Tata AIG, Star and Bharti Axa. All the four PSU General Insurers also offer health plans with cashless reimbursement. Some hospitals enter into an agreement with insurers to offer cashless claims for every hospitalization. Such hospitals are part of the list of network or empanelled hospitals. Those that are not on such a list are called non-network hospitals and claims are processed on a reimbursement basis. That means the insured first pays the bill to the hospital and then submit the claim to the insurance company for reimbursement. Some hospitals have also entered into agreement with insurers for only specific procedures and treatments and not for all kinds of hospitalization. Normally insurance companies take 30 days time, from the date of receipt of last document from the insured, for settling the claim. In case of delay they have to pay interest also. But sometimes if there is a need for investigation and verification of documents/ hospitalization/treatment processes etc, they make take 45 days time. In addition to the net-work hospitals, many insurers also declare a negative list of hospitals. These are the hospitals, if treatment is taken by the insured, the insurance company will not honor the claim. Insurance companies do this negative listing after verifying the credibility of hospitals and checking the malpractices done by the hospital in the past.

A claim may get declined even in a cashless arrangement in a net-work hospital in the following circumstances:

i) If at the time of hospitalization, the concerned doctor doesn't give all the information in the pre-authorization document to help the insurer arrive at a decision. Insurers also have their own retainer/empanelled doctors who advise them about the admissibility of a treatment.
ii) If the ailment is not covered under the policy.
iii) If the request for pre-authorization is not done on time.

However, in case of (i) and (iii), if there is an emergency, the insured can go ahead with the hospitalization and treatment and then submit the bills for reimbursement. In every case of hospitalization, whether planned or emergency, the Insurer should be kept informed. In case of planned one, intimation should be through pre-authorization letter. In case of emergency type, the intimation has to be done within 24-hours. In case of reimbursement kind payment, all necessary documents as stipulated by the insurer should be submitted. Many customers only realize at the time of making a claim that their health insurance policy does not cover certain medical conditions or ailment. Policyholders usually depend on what has been told to them by their insurance agents, who sometimes overstate the coverage. The prospective customers don't really go through and understand the fine prints in the application documents or the policy document. To prevent such cases, the Insurance Regulatory and Development Authority of India (IRDAI) have asked insurers to group together all policy exclusions upfront in the policy document. It is not that the exclusions are not there in the Policy document, but all these information are lost in the maze of so many, other information in the fine print. It is also noticed that the Insurers take their own time to settle the claim. To prevent this IRDAI has introduced interest provision. Further all the Insurers have been asked to mention in their website different service parameters and the turnaround time, as approved by their board.

VII. INCURRED CLAIM RATIO (ICR) AND CLAIM SETTLEMENT RATIO (CSR)

While choosing a health insurance, we need to look at two Ratios – Incurred Claim Ratio (ICR) and Claim Settlement Ratio (CSR). The former is the ratio of claims settled and the premium collected. This basically shows, whether the Insurance company is earning adequate premium for settling the claims. This may not the right ratio for a prospective customer to decide whether to buy the Health Insurance from that company or not. ICR in Indian Health Insurance market has been rising over the years. As per the IRDAI, it has increased from 94% in 2012-13 to 106% in 2016-17 (IRDAI Annual Report. 2016-17. p.51). It is possible that the ICR is high because of high claim or a low premium collection, or both. Any ICR higher than 70% makes HICs business unsustainable.

Table 2: Incurred Claim Ratio Percentage in Different Insurance Companies

Name of the Insurer	ICR (%)
Public Sector Health Insurers	
New India Assurance	98.78
United India Insurance	118.98
National Insurance Company	110.02
Oriental Insurance Company	117.02
Private Sector Health Insurers	
Future Generali	79.94
ICICI Lombard	87.38
Reliance General	107.49
Bajaj Allianz	73.59
Bharati Axa	97.48
Standalone Health Insurers	
Religare	61.13
Apollo Munich	63.03
Max Bupa	55.16
Star Health	63.96

Source: IRDAI Incurred Claim Ratio of Health Insurers in India for 2014-15

On the other hand, buyers look at Claim Settlement Ratio while choosing their HIC. This is the ratio of Number of claims settled and the Number of claims received.

A higher Claim Settlement Ratio can build the confidence in the mind of the buyer that, there is a fairly good chance of his claim getting settled as well, in case there is a claim from his side.

Though Claim Settlement Ratio is a better measure for making a decision, such data are not compiled or published by IRDAI. These data are available at the websites of respective Insurance companies. The CSR of some of the leading Insurance companies for the year 2013 are as follows.

Table 3: Claim Settlement Ratio Percentage in Different Insurance Companies

Name of the Insurer	CSR (%)
Public Sector Health Insurers	
New India Assurance	93
United India Insurance	89
National Insurance Company	78
Oriental Insurance Company	65
Private Sector Health Insurers	
Future Generali	98
ICICI Lombard	89
Reliance General	87
Bajaj Allianz	83
Bharati Axa	78
Standalone Health Insurers	
Religare	78
Apollo Munich	80
Max Bupa	78
Star Health	69

Source: Websites of the Insurers & Policybazar.com [14], [15]

As a thumb rule, an Insurer which has a CSR more than 80% is dependable. Further, one should not only look at this percentage, but the volume of transactions behind this number. Higher the volume, higher is the confidence that that they will settle the claim.

VIII. GRIEVANCE REDRESSAL

In case of Claim related grievance, the first point of contact is the Grievance Cell of the Insurer. As per IRDAI guidelines, grievances must be acknowledged by the HICs in 3 (three) working days and it must be resolved in 15 (fifteen) working days. If there is no response to the letter, you can file a Right to Information (RTI) application with the Grievance Officer. If the matter is not resolved at that level, it can be addressed at following forums:

i) The Insurance Ombudsman scheme was created by the Government of India for individual policyholders to have their complaints settled out of the courts system in a cost-effective, efficient and impartial way.

ii) IRDAI had introduced the Integrated Grievance Management System as an online platform where the policyholders having a grievance or dispute. The action being taken on the matter is updated in the system and it can be tracked by the insured person.

iii) If the complaint has still not been resolved, one can register the same with the consumer court. The consumer court has a separate department to handle health insurance grievances, especially those arising out of Unfair Trade Practice/ malpractice/ service issues.

IX. CONCLUSION

Claim settlement makes or breaks the relationship between the Insured and the Insurer. While the Insured wants the process to be prompt and hassle free, the Insurers are generally very conservative and careful. If they settle claims in haste, there is every chance of making mistakes and losing money. Therefore a kind of balance is needed both from the Insured and the Insurer. They both should act in a manner that is win-win. The Insurer should follow due diligence while enrolling people in their policy and should also settle the claims fast so that the customer gets the service as promised by the Insurer. TPAs should act as the mediator to resolve any issue between the Insured and Insurer. At the end of the day, it is a matter of life for the Insured.

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Mr. Amarendra Ku. Pattnaik, is an Engineer-MBA with twenty years of experience in industry and more than six years of experience in teaching. He is a passionate fiction writer and has two books to his credit - 1. Shades of Life, 2. Quick Whispers.

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