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President

6th July, 2012

Submission to IRDA

Submission to IRDA on the exposure draft IRDA (HEALTH INSURANCE) REGULATIONS, 2012_draft for comments

This submission provides the comments based on the input provided by the Advisory Group on Health Care Insurance of the Institute of Actuaries of India and does not constitute views of the Council of the Institute.

Background:

The IRDA circulated an exposure draft of Health Insurance Regulations 2012.
The Health Insurance Advisory Group to IAI welcomes the effort from IRDA to consolidate the various circulars and regulations under one Health Insurance Regulations which will create more clarity and transparency to all involved stakeholders.

We have bifurcated our observations into two categories:

a) points which do not appear easily understandable and hence could be clarified in the final regulation and more importantly.
b) points which could –as per our opinion- affect the industry and/or the customers in a negative way. For these points we suggest some changes which would reduce these concerns.

a) Suggestions to clarify:

- Related to 1.1 i) definition of "Provider Network":

  It should be clarified if also provider with terminated or expired agreements do fall under this definition.
- Related to 1.1 k) definition of "Senior Citizen":

  Life Insurer and General Insurer do have generally a different understanding on the term "commencement date". Hence we suggest to sharpen the definition by using the following words " .. who is sixty or more years of age as of the commencement data/or renewal date of the insurance policy"
- Related to 3.2.1 "Term of Health Insurance Policies"

  It is not quite clear if the term of the policy needs to necessarily go along with guarantee of premiums. Since longer term guarantees in health insurance are usually very expensive we would suggest not to enforce longer term premium guarantees but keep it to the consumers to decide if they want to pay more for guaranteed premiums or lesser for protection with adjustable rates.
- Related to 3.3.1 "Assignment":

  The meaning if the term is not quite clear and should be described a bit more in detail. What does it mean to group polices sold to employers or non-employer groups?
- Related to 3.8.4 "General Provisions – information sharing"

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It should be made clear that any such mechanism for information sharing should be in compliance with applicable rules, laws and regulation regarding data confidentiality and protection of personal data.

- Related to 3.12.2 "Pricing Health Insurance Products"

  Life Insurer and General Insurer do have generally a different understanding on the term "commencement date" – hence we would suggest to use the term "commencement/renewal date" which we assume is the meaning of this paragraph.
- Related to 3.12.6 "Pricing Health Insurance Products"

  We assume that this rule is applicable for new business only. It would be furthermore, helpful to clarify if premiums can be reduced even within less the a one year period.
- Related to 3.14.1 "Pricing Health Insurance Products"

The description in this clause seem to contradict clause 3.2.1 as it suggests that non-life companies can offer health insurance policies with a duration of more than 3 years.

- Related to 4.4 b) "Renewability of Health Insurance Polices"

  This contradicts 3.1.2. It may be noted that there are health products –covering only certain niches – where it makes sense to limit the age – since above this age incident rates of 60 % or higher are expected and hence it would not be insurance any longer or because the product benefits are by definition for the working population. For instance short term disability products (suitable for working population), Health Saving Account products or CI coverage where the high SI is for changing the live style of the insured with immediate effect, etc. It should be also kept in m ind that CI riders are also sold on top of life term polices – also this case would create a problem to enforce this paragraph.
- Related to 8.5.2 "Identity Cards issued to policyholder to avail cashless facility"

It sounds technically challenging to restrict the validity of the card to the term of the policy but not to issue a fresh card in case of renewal of the policy – since the validity date of the expiring policy may have been shown on the card.

- Related to 10.7 "Contracts between Insurers and Hospitals"

This rule may bring new type of liabilities to the health insurers since a network provider of Insurer A will need to somehow directly or indirectly accept cashless requests from Insurer B. In case of problematic cases the liability may fall back to Insurer A since this is the party with contractual relationship to the provider. Also Insurer A may charge for the costs to maintain the network and other additional administration costs as well as and for the increased liabilities. Hence, Insurer B should be not obliged to necessarily enter into such an agreement for any price or condition.

From consumer point of view this could be perceived as the right to access any network provider in the country which could be misleading and hence this paragraph should be made more clear to insurers and customers.

b) Concerns and suggestions to change

- Related to 1.1. d) "Definition of Break in Policy"

The majority of health insurance claims are planned which makes generally health insurance open to anti-selection. From a technical point of view the group of insured's paying insurance premium delayed is generally performing worse than the group of insured's paying premium timely. Due to this and also

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due to the reduced interest income the insurer should be allowed to charge additional late premium payment fees to get compensated for the increased risk, higher administration costs and reduced interest income. This should be made clear in the regulation.

- Related to 3.2.1 “Term of Health Insurance Policies”

While it is understandable that non-life insurers (in which category the stand alone health insurers (SAHIs) currently fall) may not have the required infrastructure to service long term products, it may not be reasonable to close this option for Stand Alone Health Insurers. In countries where Health Insurance is defined as a separate business segment (Australia, USA, Germany, Singapore), SAHIs sell long term or whole of life term health insurance policies such as Health Savings Accounts, or level premium calculated health products.

Therefore, we would like to suggest that the term of the products should not be restricted in this regulation and it should be reviewed by IRDA on a case to case basis during product approval in order to allow product innovations in the interest of both consumers and the industry. Removal of this restriction would also allow a level paying field between various insurers and type of insures which should be in the interest of the consumers and the industry as a whole.

- Related to 3.4 “Pan India Access”

In some cases –for instance certain Government schemes - , the healthcare access may be limited to only the particular state which would be contradicting to the regulation.

In other markets we see HMO type of membership insurance product options (for individuals and groups) which restricts treatment in a certain group of hospitals. Such products may be beneficial for all parties: the insurer (due to better discounts), the policyholder/customer (due to lower premium and proximity to the hospitals).

Whereas it is understood that emergency situations are to be covered pan India in any licensed and not black listed hospital, the insurer should have the right to develop products for group and individuals with clear network restrictions since this is a well established measure to control medical costs and quality of services to the benefits of the consumers. Therefore, we suggest that this clause is liberalized as described above.

- Related to 3.7.1 “Cumulative Bonus”

Products within Asia do have a very wide range of Cumulative Bonuses or in more general terms claim free bonuses in form if increased benefits (increase limits, additional benefits, reduced premium, etc). We would strongly recommend not to explicitly state of how such a bonus has to be applied to sub benefits and sub limits since it will limit product innovations.

However, it is understood that such benefits should not mislead the customer and therefore, we suggest that the regulation emphasizes more the aspect that the claim free benefit must be made transparent to the customer and misleading policy gimmicks must be avoided.

- Related to 3.7.2 “Cumulative Bonus”

See also the comment under 3.7.1. However, to give the insured generally the option if he wants to pay more premium to keep his SI on the higher level or accept the reduction of the premiums is from an actuarial point of view extremely exposed to anti-selective behavior of the insured against the insurer (e.g. if the insured is prepared to pay the higher premium, he may more likely claim in the following

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year as compared to the group of insured's which do accept the reduced SI). In general for a medical reimbursement product the pro rate premium would be not the adequate premium portion to cover the costs of the higher SI.

In order not to overburden the insured's which did not claim and hence subsidize those with claims – we strongly recommend not to enforce option a) and b) for the insured's – since this is not in the interest of the rest of the portfolio.

From a technical point of view whenever the insured increases on his request benefits – the insurer should have the right to underwrite at least the portion of increase benefit.

- Related to 3.9.2 "Underwriting", 3.11.1 "Special Provisions for Insured Persons who are Senior Citizens", 3.12.1 "Pricing of Health Insurance Products"

The word "fair" is a highly subjective term and will likely lead to ambiguity. Health Insurance is about solidarity between the health and the sick and from a health insured's point of view the underwriting decision made may look not fair (when accepting chronically sick person with a loading) whereas the decision may look acceptable to the concerned chronically sick person.

Hence, it is suggested to remove the word "fair".

- Related to 3.13.1 "Loading on Renewal"

  This regulation weakens the need for underwriting at the first place and makes the premium development for insured's unpredictable. The rule may also not be perceived as fair –since one single very high claim may not trigger the malus whereas three smaller claims in total lower than the large single claim could trigger the malus.
  Generally, the products for individuals should be risk class rated but not based on individual claims experiences since this clearly will create issues with elderly and chronically sick population. Hence, we would suggest not to encourage insurer to implement such features at the first place and hence we suggest to remove this paragraph.
  See also our point related to 3.7.2.
- Related to 3.16.3 "Multiple Polices"

This is good from the point of view of customer's convenience. However, the insurance company should be given a right to claim the proportionate claim amount from other insurers with whom the insured had a policy and the other insurer should oblige. Otherwise, Insures with knowingly good quality service may be preferred by the policyholder but should not get punished by carrying the higher claim load.

Furthermore, the clause as proposed could encourages anti-selective behavior of insured's in the following way: The insured may opt to chose two 1 lac policies from different insures rather than purchasing one two lac policy because he can carry on collecting cumulative bonus under one policy even if he claims every year under the other policy.

Therefore, we propose that the insurers shall have the right to claim for contribution from each other and this may also effect the claim free bonus. Otherwise it would be of disadvantage of the those insured population which does not claim or purchase polices only from one insurer.

- Related to 4.4 "Renewability of Health Insurance Polices"

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As far as point a) “coverage and estimated premium for the future renewals of policy” is concerned we wanted to highlight that future premium adjustments due are not quantifiable at the time the policy is sold. Reason for that is that neither medical inflation due to general price increase nor due to medical advanced technology, new diseases or changing utilization behavior of the remaining insured portfolio (after first year lapses) is not predictable.

Hence, we strongly recommend that clause a) only refers to premium adjustments –which were planed at the inception of the policy. Premium adjustments due to deteriorating portfolio claims experience – which are to be approved by IRDA- cannot be estimated in future and hence cannot be shown under a).

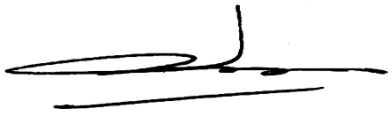
- Related to 10.6 “Contracts between Insurer and Hospital“

Creating a provider network and link such a network to a product allows Health Insurers to manage costs and quality. It is very common that high end and expensive products are linked to different networks providers than medium and low end products (see for instance product environment in middle east or US).

We would suggest to allow insures to develop and tailor networks related to certain products. Currently clause 10.6 allows the insurer only to maintain one single network only which restricts product innovation and cost control especially for the lower end products to the disadvantage of the consumers. In this context it would be essential that the insurer can remove the provider from one particular product related provider network in case the provider does not qualify any longer for this product - for instance because he has increased his fee’s and falls now under another provider category or he did not fulfill the service standards for the particular product, etc.

Always ready to assist IRDA so as to serve the cause of public interest.

Regards,



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