Institute of Actuaries of India

Subject SA1 – Health and Care Insurance

November 2012 Examinations

INDICATIVE SOLUTIONS

Solution 1 :

(A)

- The size of the insurer
- Its experience in the marketplace
- Its available free assets
- The size of its portfolio (credibility factor), and
- The degree to which it is felt that the business outcome is predictable within bounds.

[1/2 marks each upto max 2 marks]

(B) **<u>Financial Uses of Reinsurance:</u>**

- Increase Financial Capacity **[1]**
  - Allows ceding company to write more policies with higher limits due to increased spread of risk
  - Allows small companies to compete with larger companies
- Stabilize Earnings **[1]**
  - Maximum loss per life
  - Maximum loss in aggregate
  - Manage mix of business
  - Increase spread of risk
- Spur New Business Growth **[1]**
  - Reinsurer expertise can help in designing and pricing new products
  - Can share the risk with reinsurer
- Improve Balance Sheet Position **[1]**
  - Reinsurance may help reduce taxes
  - If ceded allowance is less than actual expenses, then ceding company may realize additional profits
- Catastrophic Protection **[1]**
  - Controls risk exposure
- Reinsurer will act as guarantor if the ceding company becomes insolvent **[1/2]**

<u>Non-Financial Uses of Reinsurance:</u>

- Increase Intellectual Capacity **[1]**
  - Reinsurer expertise may help small companies or companies entering new product lines
  - Value added services provided by reinsurer
  - Market research/Competitive research
  - Underwriting/Pricing/Product design support
- Joint Ventures **[1]**
  - Direct writer is fronting for reinsurer
  - The ceding company has a main product focus, but offers other products to accommodate sales situations

- There is a mutual interest from both the direct writer and the reinsurer and may structure coinsurance or quota share agreement
- Acquisitions and mergers through assumption reinsurance **[1/2]**

(C)

- What are the goals of the reinsurance program?
- What is the financial condition of the reinsurer? Do they have the financial capacity to absorb adverse claim experience?
- What are the rates and terms being offered?
  - Beware of rates that are too low and may result in high renewal increases or non-renewal of coverage.
- What costs are associated with administering reinsurance?
  - The ceding company will incur additional expenses for managing the reinsurance program.
- What degree of management involvement is required?
  - Reinsurance expertise should limit the amount of management time needed.
- How much profits are lost to the reinsurer?
  - Insurer should determine how much to cede in order to maximize profits and minimize claim volatility
- Flexibility in terms of the agreement
- Reinsurer experience, ability, and expertise
  - It is important for the reinsurer to make a profit because ceding company's results could mirror reinsurer's results.
- What reinsurer services are provided? Do they meet the ceding company's needs?
- Business relationship
  - A good working relationship is important, especially when unforeseen circumstances arise.
- Does reinsurer perform own underwriting? Reinsurer may outsource underwriting functions.

[1/2 marks for each bullet point upto max 5 marks]

(D) **<u>Figures in lakhs –</u>**

Quote1	**Before Reinsurance**	**Reinsurance**	**After Reinsurance**
Premiums	1,000	450	550
Claims	800	400	400
Profit	200	50	150
Regulatory Capital	100		55

(1 marks each for Premiums, Claims, Profit and Regulatory Capital, max 4 marks)

Figures in lakhs –

Quote 2	Before Reinsurance	Reinsurance	After Reinsurance
Premiums	1,000	250	750
Claims	800	204	596
Profit	200	46	154
Regulatory Capital	100		75

(1 marks each Claims and Regulatory Capital, max 2 marks)

(E) **Quote 1 # –**

- Reduces the absolute profit by 50 crores. **[1/2]**
- Does not have any impact on claims volatility as all claims are shared in equal proportion. **[1/2]**
- Significantly improves the return on regulatory capital and improves the solvency margin ratio. **[1/2]**

Quote 2 # –

- Reduces the absolute profit by 46 crores. **[1/2]**
- Removes the claims volatility of very large claims. **[1/2]**
- Improves the return on regulatory capital and the solvency margin ratio slightly. **[1/2]**

Both the quotes roughly reduces the same absolute profit, **however:**

Quote 1 # improves return on regulatory capital significantly, and improves required solvency margin ratio and would be useful for a company looking for a capital relief. **[1/2]**

Quote 2 # removes the claims volatility on very large claims and would be useful for a company looking for relief against volatility in profits. **[1/2]**

[Total Marks – 25]

Solution 2 :

(A)

- Development or lag method—uses history to project future runouts. **[1/2]**

- Loss Ratio or Projection method—uses loss ratio or other projection to estimate incurred claims. Generally used when other data is limited such as for new policies or for recent months of incurred claims on existing policies. **[1/2]**

[1/2 marks may be awarded for any other reasonable method]

(B)

Development Factors –

	Apr	May	Jun	Jul	Aug	Avg*	Cum**	Cum Factors***
1	1.909	1.556	3.571	1.313	1.389	1.947	2.434	0.411****
2	1.095	1.107	1.200	1.190		1.148	1.250	0.800
3	1.043	1.032	1.067			1.047	1.088	0.919
4	1.021	1.016				1.018	1.039	0.962
5	1.020					1.020	1.020	0.980
6	1.000					1.000	1.000	1.000

[1/2 marks may be awarded for any other reasonable method]

Working Notes: -

Calculation of Development Factor (Apr – 1) –

Month of incurred claims (May) = 2,100 = 1.909
Month of incurred claims (April) 1,100

Calculation of Development Factor (May – 1) –

Month of incurred claims (Jun) = 2,800 = 1.556
Month of incurred claims (May) 1,800

and so on……

Other Calculations –

* Avg (1) => (1.909 + 1.556 + 3.571 + 1.313 + 1.389) / 5 = 1.947

** Cum (1) => (1.947 * 1.148 * 1.047 * 1.018 * 1.020 * 1.000) = 2.434

*** Cum Factors (2) => Avg (1) / Cum (1) = 1.947 / 2.434 = 0.800

**** Cum Factors (1) => Avg (0) / Cum (0) = 1.790 / 4.355 = 0.411

Whereas Avg (0) => (1.909 + 1.556 + 3.571 + 1.313 + 1.389 + 1.000) / 6 = 1.790 and
Cum (0) => (1.790 * 1.947 * 1.148 * 1.047 * 1.018 * 1.020 * 1.000) = 4.355

(C) Reserve equals ultimate incurred less cumulative paid where ultimate incurred is cumulative paid divided by completion factor for each month. Total reserve is the sum of each month.

	Cumm Paid	CF	Ultimate Incurred Claims	Reserve
Apr	2,500	1.000	2,500	-
May	3,250	0.980	3,316	66
Jun	3,200	0.962	3,325	125
Jul	2,500	0.919	2,721	221
Aug	2,500	0.800	3,124	624
Sep	1,100	0.411	2,677	1,577
Total Reserves	**15,050**		**17,663**	**2,613**

[1/2 marks to be deducted for each wrong calculation in Reserve calc, upto max 2 marks]

(D) Adjustments can be useful in developing representative factors without being unduly biased and can include:

- Simple averaging **[1/2]**
- Remove large claims (outliers) **[1/2]**
- Weighted averaging **[1/2]**
- Geometric means **[1/2]**

(E)

- Key assumption is that past experience is representative of the future. Reasons why this may not be appropriate include: **[1]**
  - Change in claim systems
  - Change in backlog levels/processing times
  - Change in benefits

- Also need to determine how much smoothing or adjustments to the completion factors is appropriate. **[1/2]**

- Finally, major problem is credibility in recent months where completion is low and paid-to date is volatile. May want to use some other methods to replace recent month's volatile figures. **[1/2]**

[Total Marks – 11]

Solution 3 :

Ans:

IIP					
Claims Amount	**Probability**	**Deductible**	**Co - insurance**	**Member Contribution**	**Member Total Cost**
0	20%	-	-	(700)	(700)
2,000	35%	(1,000)	-	(700)	(1,700)
8,500	35%	(1,000)	-	(700)	(1,700)
20,000	10%	(1,000)	-	(700)	(1,700)

[1/2 marks for each claim amount upto a maximum of 2]

GHP					
Claims Amount	**Probability**	**Deductible**	**Co - insurance**	**Member Contribution**	**Member Total Cost**
0	20%	-	-	-	-
2,000	35%	(200)	(360)	(750)	(1,310)
8,500	35%	(200)	(1,660)	(750)	(2,610)
20,000	10%	(200)	(3,960)	(750)	(4,910)

[1/2 marks for each claim amount upto a maximum of 2]

Claims Amount	Probability	IIP	GHP	Higher Cost
0	20%	(700)	-	IIP
2,000	35%	(1,700)	(1,310)	IIP
8,500	35%	(1,700)	(2,610)	GHP
20,000	10%	(1,700)	(4,910)	GHP

[1]

The employee pays more in cost sharing in one year only when the claim amount is Rs. 0 and Rs. 2,000 and the probability of the same is 55%. **[2]**

[Total Marks – 7]

Solution 4 :

(A) **<u>Wellness:</u>** Wellness initiatives comprise of various activities aimed at improving health and wellbeing of employees resulting in overall higher productivity and reduced absenteeism. Following are some of the examples of wellness activities undertaken by employers for improving health status and safety of its employees:

1. Screening employees by organising various diagnostic camps to assess their health status, so that, appropriate advice can be offered to them.
2. Help chronically sick patient to manage their condition in a better way
3. Educate employees about general health and hygiene.
4. Encourage employees to incorporate exercise in their daily schedule and follow other fitness activities.
5. Conduct sessions about ensuring safety at work place, while driving, etc.
6. Encourage preventive care related to lifestyle related diseases
7. Offer various vaccinations and other preventive measures.
8. Conduct sessions about nutrition, healthy eating habits, obesity control, etc.
9. Smoking, tobacco and alcohol cession programs.
10. Training employees how to manage stress, overcome depression, etc.

[1/2 mark for each valid mark subject to maximum 4 marks]

(B) These wellness initiatives are important tools in the hands of HR department of any corporate to attract and retain talent. The recent studies indicate that focused wellness activities also result in increase in productivity and lower absenteeism. Since, Health Insurance companies are expert in understanding medical needs of employees they are best suited to provide wellness initiative to the employees. Bundling Wellness activities with their insurance cover makes overall package more attractive to corporate customers.

Not only this is a marketing tool in the hand of insurers, it also results in health cost containment in the long run. Insurance companies who are handling client account for a no. of years can assess which program will be more successful in which companies. They can also offer program best suited to a particular kind of industry, e. g., manufacturing, IT & ITES, BFSI, etc. Detailed analysis of claims can also throw light on which kind of claims are coming more from a specific company, like, infectious diseases, accidental, lifestyle related, etc. Thus a focused program will result in long run and permanent saving in claims cost resulting in lower future premium.

[Credit to be given if the points are reasonably explained]

(C) In order to calculate saving we need to compare 'with intervention' claims outgo and 'without intervention' claims outgo. Historical, figures are irrelevant in this case. The following table gives the saving in claims outgo including claim handling expenses:

Health Category	Employees	No Intervention			With Intervention			Saving
		Incidence	Claim Size	Claim Cost	Incidence	Claim Size	Claim Cost	
A	16,000	2.50%	25,200	1,00,80,000	2.50%	25,200	1,00,80,000	-
B	30,000	3.60%	31,800	3,43,44,000	3.50%	31,500	3,30,75,000	12,69,000
C	4,000	5.50%	43,200	95,04,000	4.50%	42,000	75,60,000	19,44,000
Total Claim				5,39,28,000			5,07,15,000	32,13,000
Claim Cost (5%)				26,96,400			25,35,750	1,60,650
Total Cost				5,66,24,400			5,32,50,750	33,73,650

The following table shows the cost of running wellness program:

Head	Details	Amount	Remarks
Registration		2,50,000	One time
Monthly Charges	75000 X 12	9,00,000	
Enrolment:			
	16000 X 10	1,60,000	A
	30000 X 20	6,00,000	B
	4000 X 50	2,00,000	C
Co-ordinator		5,00,000	Annual CTC
Nursing Staff	200000 X 4	8,00,000	4 Nos.
Total Cost		34,10,000	

Total cost exceeds the total saving by Rs. 36,350/- and in pure monetary terms it may not be worthwhile to go for wellness program. But this is not the complete picture and the above analysis needs to be read with the following comments.

Comments, Suggestions and Recommendations:

- It may not be proper to look at benefits and costs for a single year horizon only. Most of the wellness activities have far reaching effects and it may not be possible to reap the benefits of all activities in one year's time. As a matter of fact, benefits of wellness initiative increase with passage of time and costs reduce with learning curve effect.

- We are just considering monetary benefits in our above Cost-Benefit-Analysis (CBA) while there can be many non-monetary benefits also, for example, it may be used as an effective marketing tool.

- If pilot program is successful, we may decide to scale up the wellness program and in house lot of processes which are at present outsourced. This may result in huge saving in cost which may make this initiative worthwhile.

- Considering all above I would recommend going ahead for this pilot wellness program even if the cash flow is slightly negative in the first year. The benefits that will accrue in the future may outweigh the costs of this activity. I would also suggest to once again verify the saving nos. given by wellness vendor from some independent source to avoid conflict of interest.

[Total Marks – 18]

Solution 5 :

(A) The following are the points that highlight the importance of appropriate claim system from actuarial point of view:

1.

Actuarial team needs quick and correct information on claims to compute reserves, e.g., calculation of IBNR depends on claims data to a large extent. Any issues in claims management system will affect the accuracy of reserves. **[1]**

2.

Actuarial team is also involved in performing product performance review. In order to accomplish this task they need detailed data of policy and claims. Here appropriate claims system that is able to capture detailed information will come handy. **[1]**

3.

Actuarial team has responsibility of pricing and re-pricing of products. In order to price new products with innovative features the detailed claims information is required which can be provided by comprehensive Claims Management System only which is designed keeping in mind all these future requirements. Similarly, for pricing Group Health Insurance policies which can have very different features actuarial team depends on claims data. For re-pricing existing products also detailed claims information is a pre-requisite. **[1]**

4.

Actuarial team needs detailed claims data for various regulatory reporting. **[1/2]**

5.

Detailed claims information will be required for developing various analytical models for forecasting, prediction, etc. **[1/2]**

To sum up, actuarial tasks cannot be performed without data and claims data is one of the most important sources, therefore, it is important to have an appropriate Claims Management System in place.

(B) The following are the expectations from the proposed Claims Management System:

1. The Claims System should either be integrated with policy administration system or it should be able to take inputs from policy administration system seamlessly. In order to settle claims it is important that all information about claimant including his/ her eligibility of benefits should be retrieved easily and quickly.

2. The output data can be obtained from the system easily and in the required format.

3. The Claims Management System should be able to capture all the data required as per regulatory requirements and it should be able to deliver the mandatory reports.

4. It should be able to deliver all metrics related to efficiency of claims departments, like, turnaround time, outstanding claims, no. of claims processed during a period by categories, backlog of claims, etc.

5. There should be a payment mechanism in the claims system which should be able to handle issues like, provider discount, TDS, etc. It is also important to either integrate it with financial system of the company or generate an output from claims system and provide that as input in financial system.

6. The Claims Management System should be able to provide all the existing MIS reports and other desired reports. The reports can be in the form of claims paid in amount and numbers by ICD, hospital category, geography, age, gender, etc. If the system is integrated with policy administration, then it should be able to generate reports related to incidence rate, loss ratio and claim per capita by slicing and dicing data by different factors.

[1/2 mark for each point including any other relevant point not appearing above subject to maximum of 3 marks]

(C) Following are some criteria that need to be considered in technical evaluation of Claims Management System:

1. What are the IT requirements of Claims Management System in the form of hardware, operating system, software, etc.? Whether the requirements are being fulfilled presently or not? If not, what are the resources required?

2. Whether Claims Management System has inherent capability to trigger for claims where there is a suspicion of fraud. There are various rule engine based Claims Management Systems which have inbuilt algorithm and can raise a flag if some claim is looking fraudulent.

3. The Claims Management System should be scalable to handle future volume of business.

4. The system should be flexible to handle not only present array of products but also the future products which will be developed.

5. Whether present claims team can start working on the system with little bit of training or it requires special expertise to configure, enter data, take out reports, etc.

6. If 'off-the shelf' system is being purchased from some vendor what is the track record of the vendor, his standing, the support vendor is extending, upgrades to be provided, extent of customisation, etc.

7. In case of the system is being developed in-house, what is the timeline and whether we can wait for that long. The in-house system can be flexible and may accommodate lot of present and future requirements but will take longer to develop. On the other hand readymade system can be implemented very fast but may not have that many features to suit the specific requirement.

8. The front end of the system should be such that data can be entered quickly and accurately. For this there should be automatic checks on reasonability of values, fields where compulsory inputs need to be provided, drop down instead of free text, etc.

9. The back end of the system should be robust where huge volume can be easily handled. The data integrity should be ensured. Provision of automatic backup is also an important feature.

10. Data security is paramount. Users should have different levels of access and system of password should be such that cannot be easily tempered with.

At the core of evaluation all shortcomings of existing system should be looked at and proposed system should be evaluated based on the fact whether it fulfils those requirements adequately or not.

[1/2 mark for each point subject to maximum 5 marks. Appropriate credit to be given for any other relevant point]

[Total Marks – 12]

Solution 6 :

(A) Trend in Health Care Cost is generally divided in the following two components:

1. **Frequency Trend:** This measures the change in incidence rate of claim.

2. **Severity Trend:** This measures the change in average claim size of claims.

There can be different reasons for dividing them in frequency and severity. For example, ease in measurement, the two behave differently, the use of both can be different, the two may be impacted by different factors. **[3]**

(B) Following factors can influence the overall trend in health care cost of insured population:

1. Medical Inflation can have impact on severity trend.
2. Development in health care, like change in treatment protocol, new systems of treatment due to medical advancement, etc.
3. Change in demographic mix, age, gender, geography, etc.
4. Change in benefit structure of the product
5. Lapse, especially, if it is selective
6. Economic changes
7. Increase in awareness about the product features
8. Overuse of care by provider or insured member **[3]**

(C) The trend in health care cost can be used for variety of purposes. Pricing is one of the most important areas where trend is measures based on the past data and future cost is assessed to determine the premium to be charged. It is important to study trend of incidence rate and average claim size separately. Equally important is the influencing factors on trend because if somehow we can ascertain the impact of each of the factor, it will be useful to arrive at future trend based on the movement of these factors in future period. If we want to control trend it will be important to control factors that have influence on trend, like, geography mix, impact of medical advances, selective lapsing, etc.

Trend can be equally used in forecasting the performance of the portfolio in coming time for planning purpose. **[2]**

(D) Following are some of the methods to measure trend in health care cost:

1. Analysing simple average of utilisation of benefits and cost of each service
2. Analysing the rates of medical service providers for different services to assess the impact over time
3. Curve fitting to historical averages like, exponential smoothing, logarithmic fit, polynomial of 'n-order', etc.
4. Regression analysis to separate various impacts
5. Using time series, for example, ARIMA model **[2]**

(E) Following are some of the challenges in trend study:

1. The data may not be available in the format as may be required to compute trend properly.
2. It may not be easy to decompose the trend in various influencing factors. This limits its use to predict in future the claims outgo.
3. Even if the trend is decomposed in various influencing factors, it may not be easy to assess which factor will move how in future to predict the overall impact.
4. It may be difficult to decide which method to apply to measure trend because there are many methods available. The suitability of method depends on many factors, like, availability of data, expertise of staff, level of sophistication required, use of trend factor, etc.
5. If the data is not available in enough volume, the credibility of the result may be questionable. **[2]**

[Total Marks – 12]

Solution 7 :

Historical Background: In India insurance industry was opened for private players in the year 2000 and it has seen tremendous growth since then. The no. of players have increased considerably in last 12 years and at present there are more than 20 insurance companies dealing in General and Standalone Health Insurance and we are one of them. India was having fixed tariff regime in many of the P & C lines of business where tariff is fixed by independent body which all insurance companies were required to follow. However, Health was one line which was not coming in the purview of fixed tariff regime. Therefore, Group Health as a product was used as a means of giving discount for other profitable lines of business indirectly. This has obstructed emergence of Group Health as a profitable independent product for a long time. But at the same time it has increased the visibility of Group Health in the eyes of big and medium size Corporates in India. Some 5-6 years have already passed since the Tariff Regime has been

discontinued gradually and insurance companies are free to charge premium independently for different products based on their experience. Discontinuance of this practice of cross subsidisation along with the advent of Standalone Health Insurance Companies has brought some relief in the form of hardening of rates in Group Health Insurance but there is still more to be done which we have described in the following note.

Nature of Product: Group Health Insurance is generally sold to any group formed not for the purpose of buying insurance. In most of the cases it is employer-employee groups but other groups, e. g., specific group of customers of a bank, members of an NGO, etc. are also allowed in the definition of Group for the purpose of coverage in this product.

Motive behind Product: Lot of companies in India provide this cover to its employees in order to attract, retain and motivate talent. The industries in which Group Health Insurance is common are IT & ITES, manufacturing, Banking and Financial Services, etc. Competition and peer pressure are also reasons to provide such cover to employees.

Product Benefit Structure: The benefits provided under group health are very comprehensive and flexible. Sum insured ranges from less than 1 Lac to over 10 Lac. Sum insured can be on either Individual or Family Floater basis. Maternity can be included at the option of the insured company generally with sub-limit. Often very liberal benefits are provided, like, outpatient treatment, diagnostic tests, treatment of psychological conditions, corporate buffer, etc. which may not be otherwise available in retail insurance products. Various waiting periods like, 30 days, 2 years and pre-existing condition can be waived off on payment of additional premium. Coverage is wide and depending on offering may include employees, spouses, children and parents. Sometime even very distant relatives like, siblings and in-laws can be covered. Recently, corporate customers have started asking cover for the retiree employees also under Group Health Product. There can be a maximum age limit for coverage but that can be also waived off. Sometime, personal accident and critical illness can also be provided as additional benefits.

Pricing: All insurance companies do not follow technical approach to pricing. This is the reason of high loss ratio for this portfolio. The constraints can be many, like, unavailability of required data to price scientifically, lack of expertise in the form of actuaries and underwriters to price this product, fear of losing customer in case resultant premium is high, etc. Even when approach to pricing is actuarially sound, discount may be extended due to commercial reasons resulting in higher loss ratio. The actuarial approach to product pricing may involve blend of table rate and experience based rates based on credibility factor which in turn depends on group size.

Recent Trends: The premium for Group Health has hardened in last couple of years and therefore it has compelled corporates to device various cost sharing arrangements with employees without curbing on the benefits they have been enjoying. The cost sharing methods include co-payment on claims, part of premium to be borne by the employees, deductible on each and every claim, premium of parents or other dependents to be borne by the employees. In some scenario these cost sharing measures are used in combination.

Underwriting of Group Health Products and Adverse Selection: The underwriting norms are very liberal in Group Health Insurance Products. All regular full time employees and employees on contract basis are covered in this insurance. A 'Fit-to-work' criterion is generally considered enough for coverage and because of compulsory coverage the chances of adverse selection are also not there. But sometimes coverage is optional, for example:

- Corporate recovering a substantial portion of premium from employees who want to get covered,
- Corporate only providing for base cover and employees having option to choose for top-up cover to enhance the sum insured,
- Employer paying for only employees, spouse & children and employees having option to get parents covered by paying premium from their pocket without subjecting them to medical underwriting.

In such circumstances the impact of adverse selection can be easily seen and often base cover for employees cross subsidise these optional benefits in the absence of any restrictions.

Sources of Business: The two major channels used in sourcing Group Health Products are, Brokers and Direct Sales Force of Insurance Company. As in other markets, brokers play a significant role in influencing the decision of corporates in terms of product design, choice of carrier, premium, terms and conditions, etc. They generally work for commission but of late started accepting fee also from clients. Employees in Direct Sales Force dealing in Group Health Product are experienced and trained in dealing with this product specifically. Direct Sales Force is an economical channel given the size of the deals.

Wellness: Wellness benefit to employees covered in Group Health policies has become an important differentiator. Some employers are concerned about the health and wellbeing of their work force and prefer companies that provide wellness benefits along with insurance cover.

Conclusion: There is undoubtedly lot of scope to grow portfolio in the Group Health Products but given the industry dynamics and present scenario it will be challenging to grow the portfolio profitably. Any effort to grow in this line rapidly may result in giving hefty discounts which may not be beneficial in the long run. The approach should be to create a niche by product and process differentiation. There is also a possibility to cross sell the retail products. The strategy should be to work intelligently in this area and use our expertise to grow Group Health portfolio profitably over period of time.

[11]

Points industry should take into account:

1) Industry should collaborate in pulling data to price the Group Health Product. Ways should be designed to cooperate in this regard without losing the confidentiality of data of individual company.

2) Insurance companies and brokers should come together to improve the quality of demographic and claims data of corporates available for determining premium for the policy. Norms

regarding minimum data requirement of expiring policy to be shared for quoting premium by different insurance companies should be determined and adhered to.

3) The undercutting of premium should be avoided. Too much movement of corporate from one insurer to another may result in instability and may not be in the long term interest of Insurance Industry.

4) I

n many cases TPA's are involved in claims settlement. They should make sure proper data is captured and made available quickly to those who have right to it (insurer, corporate, broker involved, govt. body, etc.). **[4]**

[Appropriate credit to be given for any other relevant point based on depth of understanding of Indian Insurance Industry rather than sheer knowledge of Group Health Product]

[Total Marks – 15]

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