FAQs on Health Insurance Regulations

1. **What is Health Insurance Business?**

   Ans: Section 2 (6C) of Insurance Act, 1938 defines Health Insurance Business as under:
   "health insurance business" means the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover.

2. **Which Insurance Companies offer Health Insurance Policies in India?**

   Ans: Health Insurance policies are offered by all Life, General and Health Insurance companies that are registered with IRDAI. While General and Heath Insurance Companies offer both indemnity based and benefit based health insurance policies, Life Insurance Companies offer benefit based policies as per the extant Health Insurance Regulations. All General and Health Insurance Companies also offer Personal Accident Policies, Domestic Travel Policies and Overseas Travel Policies. The names of the Insurance companies that are registered with IRDAI are available in IRDAI website www.irdai.gov.in.

3. **What is the maximum age at entry for taking a Health Insurance policy? Whether Health Insurance is available lifelong once taken a policy?**

   Ans: In accordance to the provisions of Regulation 12(i) of IRDAI (Health Insurance) Regulations 2016 (HIR 2016), all health insurance policies shall ordinarily provide for an entry age of at least up to 65 years. There are also Health Insurance Products that offer Health Insurance Coverage beyond age 65 years. In accordance to the provisions of Regulation 12(ii) of HIR 2016,once a proposal is accepted in respect of a health insurance policy (except Personal Accident and Travel Policies) and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on the grounds of age of the Insured. Thus, health insurance policies are lifelong renewable.

4. **What is pre-existing disease?**

   Ans: As part of Guidelines on Standardization, IRDAI has defined Pre-Existing Diseases (reproduced below in verbatim), at Clause 33 of Chapter I of Guidelines on Standardization in Health Insurance under Sec 1 of IRDAI Master Circular ref IRDAI/HLT/REG/CIR/193/07/2020 dated 22.07.2020:

   > *Pre-existing Disease means any condition, ailment, injury or disease:*
   > *a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or*

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
(Life Insurers may define norms for applicability of PED at Reinstatement)

5. **Whether pre-existing diseases are covered under a health insurance policy?**

Ans: Offering health insurance coverage to any person who has suffered / suffering from any disease / illness is subject to underwriting policy and product design of an insurer. Insurers design products keeping in view certain factors such as viability and self-sustainability of products and the needs of the intended target market segment. Where a pre-existing disease(s) is disclosed and a health insurance policy is granted, such pre-existing disease(s) shall be covered after a waiting period as specified in the policy, which at the maximum shall not be exceeding 48 months.

However, in terms of Chapter IV of the Guidelines on Standardization of Exclusions in Health Insurance Contracts under Sec 1 of IRDAI Master Circular ref IRDAI/HLT/REG/CIR/193/07/2020 dated 22.07.2020, certain existing diseases disclosed by the prospect are allowed to be permanently excluded.

6. **Are there any principles on charging premium for Health Insurance coverage?**

Ans: IRDAI (Health Insurance) Regulations, 2016 at Regulation 10 have specified certain principles on pricing of Health Insurance Products offered by Life, General and Health Insurers. These principles are placed hereunder (in verbatim).

Principles of Pricing of Health Insurance Products offered by Life, General and Health Insurers:

a. *Insurers shall ensure that the premium for a health insurance policy shall be based on,*

   i. *Age: for individual policies and group policies.*

   ii. *Other relevant risk factors as applicable*

b. *For provision of cover under family floater, the impact of the multiple incidence of rates of all family members proposed to be covered shall be considered.*
c. *The premiums filed shall ordinarily be not changed for a period of three years after a product has been cleared in accordance to the product filing guidelines specified by the Authority. Thereafter the insurer may revise the premium rates depending on the experience subject to (d) (e) and (f) hereunder. However, such revised rates shall not be changed for a further period of at least one year from the date of launching the revision.*

7. **Is any additional loading levied / charged on premium?**

Ans: In terms of Regulation 8(e) of the IRDAI (Health Insurance) Regulations 2016, the insured shall be informed in writing of any underwriting loading charged over and above the premium as filed with the Authority and specific consent for such loadings shall be obtained before issuance of the policy.

8. **Whether Premium rates are unchanged?**

Ans: The Premium rate shall be unchanged for all group products and for all individual and family floater products, other than travel insurance products, offered by General and Health Insurers, for the term of the policy. For further information, Regulation 10 (d) (e) and (f) of IRDAI (Health Insurance) Regulations 2016 may be referred.

9. Whether health insurance premium can be collected by insurance company any number of days in advance?

Ans: Premiums can be collected in advance maximum upto a period of 90 days before the renewal date.

10. Who is Third Party Administrator (TPA)?

Ans: Regulation 2(1)(m) of IRDAI (Third Party Administrators ï Health Services) Regulations 2016, defines Third Party Administrator (TPA) as under:

"Third Party Administrator (TPA)" means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under these regulations."

11. **What is Cashless facility? Whether cashless facility is offered at all hospitals?**

Ans: Cashless facility means a facility extended by the Insurer or Third Party Administrator (TPA) on behalf of the Insurer to the insured, where the payments for the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved. Cashless facility shall be offered only at Network Providers which have entered into an agreement with the insurer to extend such services**.**

12. Whether reimbursement of claim can be availed for treatment taken at any hospital.

Ans: Reimbursement of a claim shall be allowed at any hospital or medical establishment subject to the terms and conditions of the policy contract. However such establishments must be licensed or registered as may be required by any Local, State or National Law as applicable.

13. What is AYUSH Treatment? Whether AYUSH Treatment is allowed in all Health Insurance Policies?

Ans: AYUSH Treatment refers to the medical and / or hospitalization treatments given under ó Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systemsô

Whether or not AYUSH treatment is allowed in a Health Insurance Policy is subject to the product features offered by the insurers. The AYUSH treatment taken shall be covered as per the terms and conditions of policy contract.

14. What is AYUSH Hospital?

Ans: As part of Guidelines on Standardization, IRDAI has defined AYUSH Hospital (reproduced below in verbatim), at clause 45 of Chapter I of Guidelines on Standardization in Health Insurance under Sec 1 of IRDAI Master Circular ref IRDAI/HLT/REG/CIR/193/07/2020 dated 22.07.2020:

AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. *Central or State Government AYUSH Hospital; or*
b. *Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or*
c. *AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:*

    i. *Having at least 5 in-patient beds;*
    ii. *Having qualified AYUSH Medical Practitioner in charge round the clock;*
    iii. *Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;*
    iv. *Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.*

15. What is AYUSH Day Care Centre?

Ans: As part of Guidelines on Standardization, IRDAI has defined AYUSH Hospital (reproduced below in verbatim), at clause 46 of Chapter I of Guidelines on Standardization in Health Insurance under Sec 1 of IRDAI Master Circular ref IRDAI/HLT/REG/CIR/193/07/2020 dated 22.07.2020

AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

[Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner" under Chapter I of Guidelines]

16. What are the Regulatory provisions for settlement of Health Insurance claims by TPAs/Insurers?

Ans: Regulatory Provisions for settlement of Health Insurance claims by Insurers/TPAs are mentioned below:

1) An insurer shall settle or reject a claim, within thirty days of the receipt of the last ónecessaryôdocument.

2) Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed ónecessaryô The insurer shall also ensure that all the documents required for claims processing are called for at one time and that the documents are not called for in a piece-meal manner.

3) Every Insurer may stipulate a period within which all necessary claim documents should be furnished by the policyholder/insured to make a claim. However, claims filed even beyond such period should be considered if there are valid reasons for any delay.

4) Every Insurance Claim shall be disposed of in accordance to the Terms and Conditions of the policy contract and the extant Regulations governing the settlement of Claims.

5) Where a claim is denied or repudiated, the communication about the denial or the repudiation shall be made only by the Insurer by specifically stating the reasons for the denial or repudiation, while necessarily referring to the corresponding policy conditions. The insurer shall also furnish the grievance redressal procedures available with the Insurance Company and with the Insurance Ombudsman along with the detailed addresses of the respective offices.

For further details please refer Regulation 26, 27 and 33 of IRDAI (Health Insurance) Regulations 2016.

6) Further as per IRDAI (Protections of PolicyholdersôInterests) Regulations 2017,

a) In case of delay in payment of a claim, the insurer shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

b) However, where circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.

(i) In case of delay beyond stipulated 45 days the Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

17. How Cost of pre-insurance health checkup is treated by Life, General and Health Insurers:

Ans: The cost of any pre-insurance medical examination shall generally form part of the expenses allowed in arriving at the premium. However, in case of products with term of one year and less, if such cost is to be incurred by the insured, not less than 50% of such cost shall be borne by the insurer once the proposal is accepted, except in travel insurance policies.

18. If a person is having multiple policies, are there any norms that specify the manner of settlement of claims?

Ans: The norms on multiple policies are as under:

i. In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer

shall make the claim payments independent of payments received under other similar polices.

ii. If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1) In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

2) Balance claim or claims disallowed under the earlier chosen policy/policies may be made from the other policy/policies even if the sum insured is not exhausted in the earlier chosen policy/policies. The insurer(s) in such cases shall independently settle the claim subject to the terms and conditions of other policy / policies so chosen.

3) If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

4) Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

19. Whether any proposal or medical examination is required at renewal stage?

Ans: No Insurer shall resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in Sum Insured offered.

20. What is Copayment?

Ans: Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

21. What is Cumulative Bonus?

Ans: Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

22. What is deductible?

Ans: Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

23. What is Grace Period?

Ans: Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.