Working Group Report Summary

Standardisation of Exclusions in Health Insurance Contracts

- The Insurance Regulatory and Development Authority of India (IRDA) had constituted a Working Group on 'Standardisation of Health Insurance Contracts' in July 2018. The Group was tasked with reviewing existing exclusions (conditions or claims not covered by a policy) in health insurance contracts and presenting recommendations that lead to their standardisation across the healthcare sector. The Group submitted its report in November 2018.[1] Key observations and recommendations include:

- **Reduction in the number of exclusions:** The Group stated that denying coverage for diseases, contracted after an individual has been insured, defeats the purpose of health insurance and leads to a loss of confidence in the healthcare sector. To reduce the overall number of exclusions that may be included in a contract, the Group made the following recommendations:

  (i) All health conditions contracted after policy inception, other than those that are not covered under the policy or listed as permanent exclusions, should be covered.

  (ii) Permanent exclusions may only be incorporated within a policy if: (a) they are pre-existing at the time of underwriting and included in an approved list of conditions, (b) if they are later incorporated into the policy with the consent of the insured.

  (iii) No exclusions pertaining to any pre-approved advancements in technology or treatment be permitted.

  Areas of exclusion: The Group noted that developments in the health sector are often dynamic and rapidly-changing. Hence, it suggested that the list of exclusions that are included in contracts be reviewed regularly. It presented a list of 17 conditions, such as epilepsy, chronic liver disease and pancreatic disease, that may be incorporated as permanent exclusions. The Group also recommended that the list of permanent exclusions allowed at the time of underwriting be reviewed on a yearly basis by a committee set up by IRDA. Further, a Health Technology Assessment Committee be formed to examine and approve the inclusion of advancements in medical technology and treatments.

- **Pre-existing diseases:** Currently, pre-existing diseases (PEDs) are defined as conditions with signs or symptoms for which medical advice or treatment has been received. After considering the definition of PEDs circulated in Clause 33 of the Guidelines on Standardisation in Health Insurance, the Group put forth a new definition for consideration. This definition described a PED as a condition which is diagnosed by a physician or for which medical advice or treatment was recommended or received prior to the effective date of the policy.

- Further, the Group observed that there were few regulatory provisions ensuring coverage of pre-existing diseases. Therefore, it recommended that (a) the waiting period before a pre-existing disease is covered be limited to 48 months, and that (b) in the event that insurers allow a lower waiting period and if the product is withdrawn, the insurer pay the policyholder any accrued benefits and allow coverage on any of the health products available in his or her portfolio.

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November 26, 2018

[1] Report of the working group for standardization of exclusions in health insurance contracts", Insurance Regulatory and Development Authority, November, 2018, https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3660&flag=1.

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