Ref.No: IRDA/ENF/ORD/ONS/142/07 /2016

Final Order in the matter of M/s Bharti Axa General Insurance Company Limited

Based on reply to the Show Cause Notice dated 18th December, 2015 and submissions made during Personal Hearing on 4th February, 2016 at 11.00 am taken by Member (F&I) at the office of Insurance Regulatory and Development Authority of India, 3rd Floor, Parishrama Bhavan, Basheerbagh, Hyderabad.

The Insurance Regulatory and Development Authority of India (hereinafter referred to as "the Authority") carried out an onsite inspection of **M/s Bharti Axa General Insurance Company Limited** (hereinafter referred to as "the insurer") from 18.07.2014 to 19.07.2014. The Authority forwarded the copy of the Inspection Report to the insurer and the insurer responded vide letter dated 25.11.2014. A preliminary meeting was conducted with the insurer on 14.10.2015 to understand whether any corrective measures have been taken by the insurer in regard to the issues raised in the inspection report. Subsequent to the said meeting, the insurer submitted certain clarifications and documents to appraise the Authority of the current status. Upon examining the submissions made by the insurer vide letter dated 20.10.2015, the Authority issued Show Cause Notice on 18.12.2015 which was responded to by the insurer vide letter dated 07.01.2016. As requested therein, a personal hearing was given to the insurer on 04.02.2016. Sh. Parag Gupta, Chief Underwriting Officer, Sh. Rajgopal Gopalam, Sr. Vice President (Head Operations & Claims), Sh. Subbaraju Bhupatiraju, Vice President (Health – Claims), Sh. Ashish Sarma Vice President & Chief Compliance Officer and Sh. Kiran Kumar, Assistant Vice President (Compliance) were present in the hearing on behalf of the insurer. On behalf of the Authority, Ms. V. R. Iyer, Member (F&I), Sh. Lalit Kumar, FA & HOD (Enforcement), Sh. Prabhat Kumar Maiti, JD (Enforcement), Ms. Yegnapriya Bharath, JD (Health) and Ms. Jyoti Vaidya, DD (Enforcement) were present during the personal hearing.

The submissions made by the insurer in their written reply to the inspection observations, Show Cause Notice and also those made during the course of the personal hearing have been taken into account. The findings on the explanations offered by the insurer to the Show Cause Notice and the decisions thereon are detailed below.

1. Charge – 1 & 2

Charge -1:

It was observed that the insurer had not entered into tripartite-agreement with any of the network provider hospitals.

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Violation of

Regulation 10 of IRDA (Health Insurance) Regulations, 2013 and Guidelines of Standardization in health insurance, IRDA/HLT/CIR/03 dated 20.02.2013 which states that Insurance Companies may offer policies providing cashless services to the policyholders provided the agreement is entered between insurers, network providers and TPAs.

Submission of the insurer:

Insurer submitted that Regulation 9 (b) of IRDA (Health Insurance) Regulations, 2013 provides an agreement between insurer and network providers. Regulation 10 a (i) provides for a direct agreement between the insurer and the network hospital or an agreement amongst insurer, network hospital and the TPA. Regulations 10 a (ii) further states that "the agreements which shall be entered into between insurers, network providers/TPAs shall cover....". The combined reading of these two provisions clearly establishes the intent that the agreement could either be bi-partite or tri-partite.

Charge – 2

It was submitted by BAXA that they were not maintaining float funds accounts with TPAs. However, it was noted from the FHPL and Vidal TPA records that BAXA was maintaining float funds with the TPA.s.

a. **FHPL TPA**: As per data submitted by FHPL TPA, they had maintained claim float account for BAXA bearing Ale no. '912020026294689 with Axis Bank. The balance of this float account as on 01-10-2013 was Rs. 4.69 Lakhs. During the period from 01-10-2013 to 30-06-2014, FHPL TPA had settled 1263 claims amounting to Rs. 544.08 Lakhs from this float account.
b. As on 30-06-2014 the balance of this float account was Rs. 1.58 lakhs. It was evident from the above that BAXA has advised FHPL TPA to maintain an account on their behalf for making claims payment from the bank account of FHPL TPA.
c. **Vidal TPA**: As per data submitted by Vidal TPA, they had maintained claim float account for BAXA bearing details A/C no. 909020041056277 with Axis Bank. It was also informed by the Vidal TPA that they would raise the debit note to BAXA and BAXA would upload particular amount in the above mentioned bank account. It was evident from the above that Vidal TPA on behalf of BAXA was making claims payment from their bank account.

Violation of

Regulation 11 (a) of IRDA (Health Insurance) Regulations, 2013 which stipulates that for the purpose of claim settlement, insurer shall make direct payments to the Network provider and to the policyholders by integrating their banking system platform with the network provider or the insured, as the case may be.

Submission of the insurer:

The insurer submitted that they had never maintained float accounts with any of the TPAs. The accounts that were opened by the TPAs were primarily to pay the claim on a case by case basis from the company. These accounts were never operated or were intended as float accounts, inasmuch as they never maintained any pool money (float) with the TPAs from which they could settle the claims payments.

The insurer further confirmed and declared that all payments routed through the TPAs prior to commencement of the new IRDAI (Health Regulations) 2013 were with respect to and against individual claims.

It may also be noted that TPA fee has also been paid into the same account from time to time. The insurer confirmed that no lump sum payment was ever made to make the account a float account.

Decision :

In case of cashless services if TPA is involved in an agreement, the agreement shall be a tripartite agreement between the health service provider, TPA and the Insurer as per Regulation 10 (a)(i) of IRDA (Health Insurance) Regulations, 2013 and Guidelines of Standardization in health insurance, IRDA/HLT/CIR/03 dated 20.02.2013. The issue was discussed by the Authority with all insurers while implementing IRDA (Health Insurance), Regulations, 2013. The same was again discussed with the insurer during the preliminary meeting on 14.10.2015. The Insurer has not taken/initiated any remedial action in the matter.

Authority warns for the violation of Regulation 10 of IRDA (Health Insurance) Regulations, 2013 and Guidelines of Standardization in health insurance, IRDA/HLT/CIR/03 dated 20.02.2013.

Also by maintaining account with the TPA which is of the nature of floating account the Insurer violated Regulation 11 (a) of IRDA (Health Insurance) Regulations, 2013. Authority warns for the said violation

The insurer is further directed to put in place tripartite agreement and not to maintain any floating account with the TPA, as required by the regulation / guideline with immediate effect under intimation to the Authority.

2. **Charge 3**

It was noted that in five claim cases out of nine sample repudiation claim cases selected, the TPA had not taken proper written approval of the insurer before denial/ repudiation of the claim.

In balance repudiation cases, upon approval from insurer, the TPA had sent denial letter to the claimants. It was further noted that the TPA had given grounds of denial in words but had not mentioned the exact policy clause, terms and condition number, based on which the said claim was denied. Moreover, the wordings to be used while sending the denial letter to claimant as specified in Health Insurance Regulation, 2013, were not used by the TPA in their denial letters sent to claimants.

Vidal TPA Claim no. BLR-1213-CL-0002250 underBAXA Policy No.GHS/00049468/41;'As per Vidal TPA records the said claim was denied due to delay in intimation. As per records furnished by Vidal TPA, they had not obtained written permission from insurer for denial of claim due to delay in intimation.

Violation of

Regulation 12(b)(i), Reg. 12 (d) (ii) and (iii) of IRDA (Health Insurance), Regulations ,2013. It stipulates that TPA should not reject a claim under health insurance policy and also deals with the correspondence to be sent to insured regarding settlement and or denial of claim.

This is also in violation of Regulation 8 d (v) of IRDA (Health Insurance) Regulation 2013 which stipulates that claims filed even beyond such period should be considered if there are valid reasons for any delay.

Submission of the insurer:

The insurer has submitted that they had regret for the lapse and same had been rectified. They had ensured that TPAs were instructed to send the repudiation letter only after written approval from the insurer. The insurer had further submitted that they had put in place a process audit program which included the verification of records of TPAs to ensure that TPAs should adhere to all the provisions of the regulations and guidelines of the insurer. Any deviations from the set process would be taken up with for taking immediate preventive/corrective measures.

Decision:

The Authority has noted the submission of the insurer. As the insurer has strengthened the internal controls to avoid such errors in future the Authority is not pressing any charges. However, it is observed that the TPA has repudiated some cases due to delay in submission. Hence the insurer is directed not to repudiate such claims and to settle on merits in future.

3. **Charge 4**

It was observed that the claims received by Vidal TPA are not registered by BAXA. This issue of receipt of claim by Vidal TPA but non registration of claim by BAXA was examined against claims guidelines issued by BAXA. As per Document no.L3/O&C/TPA/V0, Version 1 of claims guidelines dated 14-11-2013 issued to TPA the process to be followed by TPA w.r.t. intimation of claims and information of the same to BAXA is as under:

"Once TPA receives claim intimation for Retail policy the same will be intimated to INS call center every hour to claims@bharti-axagi.co.in. INS call Centre will register the claim and send back to TPA with intimation, policy schedule and proposal form (if any) and with claim number within 2-3 hours. In case of Claims where there is no INS 10 available, claim to be intimated on every Friday through an excel sheet."

"Once TPA receives claim intimation for Group policy (cashless or re-imbursement) the same

will be intimated to INS call center every day at 4 p.m. to claims@bharti-axagi.co.in with details in prescribed format. INS call Centre will register the claim and send back to them with intimation & with claim number by next 2 working days/48 hours".

Thus, the insurer failed to adhere with its own claim guidelines in the matter of registration of claim lodged on their policies. It is evident from the above that insurer does not have effective and sufficient control on registration of health claims in their systems, which were received by TPAs.

Violation of:

Point no. 6.1 of Authority circular Ref. No. IRDA/F&A/CIR/025/2009-10, dated 5-8-2009 which deals with internal controls of insurance company.

Submission of the insurer:

The insurer submitted that TPA had registered the same claim twice and one claim is duly closed by the TPA while reconciling at a later date. The claim has been properly registered at insurer's end and processed for payment.

Decision:

The insurer is advised to strengthen the internal controls and processes to avoid any errors while settling the claims in future.

4. Charge 5 , 6 and 7

Charge 5

Under FHPL Claim No. 508978 (policy no. BIH/00060369/41 in Basic Smart Health Policy), it was noted from the claim billing sheet of FHPL that close to Rs. 23000/- were deducted from the claim amount towards proportionate charges in proportion of room rent. Basic Smart Health Policy wordings/terms/conditions do not specify any such proportionate deduction in proportion to room rent. The said query about deduction of amount was raised with TPA in context of concern policy wordings/terms/conditions. In turn FHPL TPA vide e-mail dated 19-07-2014 had submitted that the said deduction was made as per policy benefit chart which is clear about " associate charges" supported by, clarification of insurer vide e-mail dated 05-07.

Under FHPL Claim No. 557230 (policy no. BIH/J9100042/2C is Basic Smart Health Policy), it was noted from the claim billing sheet of FHPL TPA had deducted Rs.2550/- towards proportionate charges in proportion of room rent. However, Basic Smart Health Policy wordings/Terms/conditions do not specify any such proportionate deduction in proportion to room rent.

Violation of:

- **Reg. 4 (a) and 4 (b) of IRDA (Health Insurance) Regulations, 2013 which stipulates "file and use" procedure for health insurance products.**

- **Reg. 7 (h) and 7 (m) of IRDA (Protection of Policyholders' Interest) Regulation, 2002 which stipulates disclosure of deductible applicable, and any special conditions attaching the policy to be disclosed in the policy document**

Submission of the insurer:

The insurer submitted that as per the F&U document dated 30th June 2008, there was specified limits on certain plans (plans up to Rs 3 lakh SI), benefits under section 1 (includes hospital room, boarding, Ops theater, admission charges and registration charges, fees, diagnostics, appliances etc), with a proviso reads... "Room rent and associated charges limit: normal hospitalization Rs. 1000 and ICU/CCU Rs. 2000 per day" (this is the example in case of Rs 50,000 Sum insured plan).

The above clearly states the limit includes the associated charges (usually vary with the category of room rent limit).However, we are considering the limit only on the room rent and all other associated charges are paid in addition to such room rent limit, but paid proportionately (in the proportion of room rennet limit to the actual room rent utilized). Thus, the payment method followed by us clearly demonstrates that we are paying more than the benefits filed and promised to our customers.

Charge 6

It was noted that FHPL TPA had deducted Registration charges amounting to Rs. 400/- from the claim amount. The said registration charges are payable as per Section- (a) of policy wordings for Smart Health Policy. Thus, TPA had made wrong deduction from claim amount.

It was noted that FHPL TPA had deducted RMO charges amounting toRs.900/- from this claim amount. However, the supporting policy wordings of claim guidelines, based on which said deduction was made, were not made available for examination of inspection team.

In addition to the above FHPL TPA had deducted DMO charges amounting to Rs. 1050/- from the claim amount. However, the supporting policy wordings and claim guidelines, based on which said deduction was made, were not made available for examination of inspection team.

Violation of:

This is in violation of Reg. 4 (b) of IRDA (Health Insurance) Regulations, 2013 which stipulates "file and use" procedure for health insurance products.

Submission of the insurer:

The insurer submitted that they would infer that RMO and DMO charges are not envisaged as charges that are admissible charges. These general expenses are in any case included while arriving at the package charges and room rent etc.

Charge 7

It was observed that the insurer in Group Health Policies added a condition of proportionate deduction in proportion to room under the head "Incremental Charges Condition". Under the said condition the insurer kept the provision to reduce amount payable for various charges in case insured opts for higher room rent category. However it was noted that the said condition is not a part of policy wordings filed with the Authority for Group Health Insurance Policy.

Violation of:

- **Reg. 4 (a) and 4 (b) of IRDA (Health Insurance) Regulations, 2013 which stipulates "file and use" procedure for health insurance products.**
- **Reg. 7 (h) and 7 (m) of IRDA (Protection of Policyholders' Interest) Regulation, 2002 which stipulates disclosure of deductible applicable, and any special conditions attaching the policy to be disclosed in the policy document**

Submission of the insurer:

The insurer submitted that Group Health Insurance Policy had been filed with the regulator as per F&U document. Insurer further submitted that as per F&U guidelines dated 28th September 2006, page 9, para 19 B , specifies- "these are products where the rates, terms and conditions of cover are determined by reference to the requirements of and actual claims experience of the insured concerned. These will typically be insurances with a high frequency but low intensity of loss of occurrence."

It is further submitted that the incremental charges had been incorporated as a special condition which is in agreement with the insured/broker and not as a special benefit.

Decision:

As per the policy terms and conditions of Basic Smart Health Policy filed with and approved by the Authority, do not define the terms – associated charges, general administration charges. It is incorrect to make any proportionate deduction in proportion to room rent without proper disclosure to the policyholders. The insurer has also deducted DMO / RMO charges without proper disclosure to policyholders.

Looking at the seriousness of the violation of Reg. 7 (h) and 7 (m) of IRDA (Protection of Policyholders' Interest) Regulation, 2002, the Authority in exercise of the powers vested under Section 102(b) of the Insurance Act, 1938 imposes a penalty of Rs. 5 lakh.

Further, insurer is directed to ensure that no claim is settled based on the product features and conditions that is not filed and approved under File and Use procedure and thereby complying with Reg. 4 (a) and 4 (b) of IRDA (Health Insurance) Regulations, 2013 which stipulates "file and use" procedure for health insurance products.

In conclusion, as directed under the respective charges, the penalty of Rs.5 Lakh (Rupees Five Lakh only) shall be debited to the shareholders' account of the general insurer and the amount shall be remitted to Insurance Regulatory and Development Authority of India within a period of 15 days from the date of receipt of this order. The penalty shall be remitted through the NEFT as per details being intimated to the insurer as per a separate e-mail. The transfer shall be made under intimation to Mr Prabhat Kumar Maiti JD-Enforcement.

Further,

a) The insurer shall confirm compliance in respect of all the directions referred to in this Order, within 15 days from the date of issuance of this order. Timelines, if any as applicable shall also be communicated to the Authority.

b) The Order shall be placed before the Audit committee of the insurer and also in the next immediate Board meeting and to provide a copy of the minutes of the discussion.

c) If the insurer feels aggrieved by any of the decisions in this order, an appeal may be preferred to Securities Appellate Tribunal as per Section.110 of the Insurance Act, 1938.

Place: Hyderabad
Date: 20.07.2016

(V R IYER)
Member (F&I)