Ref: IRDAI/ENF/ORD/ONS/070/04/2015 April 09th, 2015

ORDER

In the matter of Reliance General Insurance Company Limited

Based on the reply to Show Cause Notice dated 03.12.2014 and submissions made during Personal Hearing Chaired by Sh. M. Ramaprasad, Member (Non-Life), IRDAI, on 26.03.2015 at 11.30 AM at the office of Insurance Regulatory and Development Authority of India, 3rd Floor, Parishrama Bhavan, Basheerbagh, Hyderabad, 500004.

The Insurance Regulatory and Development Authority of India (hereinafter, referred to as 'the Authority') carried out an onsite inspection of **Reliance General Insurance Company Limited** having registered office at 570, Rectifier House, Naigaum Cross Road, Wadala (W) Mumbai 400 031, referred to as Insurer, from 16th July 2014 to 17th July, 2014.

The Authority forwarded the inspection report to the Insurer vide letter dated 4th September, 2014 seeking their comments on the same. The Insurer responded to the observations as contained in the inspection report vide their communication dated 20th September, 2014. On examining the submissions made by the Insurer it was observed that the Insurer has not complied with the provisions of the IRDA regulations and the guidelines framed there under. On the observed deficiencies, in the functioning of the Insurer a Show Cause Notice was issued on 03.12.2014 which was replied by the Insurer vide their communication number RGICL/IRDA/59/2014-15 dated 24.12.2014 with a request for personal hearing.

Accordingly a personal hearing was held on 26.03.2015 under the Chairmanship of the Member (Non-Life), IRDAI, Sh. M. Ramaprasad. The personal hearing was attended by Sh. Rakesh Jain, Executive Director & CEO, Sh. Hemant Jain, CFO, Sh.

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Anand Singhi, Head Services of Reliance General Insurance Company Limited. On behalf of the Authority Sh. Lalit Kumar, FA and HoD (Enforcement), Smt. Yegnapriya Bharath, JD (Health), Sh. P. K. Maiti, JD (Enforcement) and Smt. Jyoti Vaidya, DD (Enforcement) were present in the personal hearing.

The submissions made by Reliance General Insurance Company Limited in their written reply to the Show Cause Notice and also those made during the course of the personal hearing along with written submissions made thereafter (dated 27.03.2015), were taken into account. The explanation offered by the Insurer to various charges as regards violation/non-compliance as indicated in the Show Cause Notice and the decisions thereon are as follows:

Charge No. 1:

Concern/Violation: It has been observed that RGICL is advancing the monies to TPAs for making claim payments from TPAs end to the network provider or the insured. The TPA raises debit notes to RGICL. The amount is released to the TPAs and the claim payment is passed by the TPA to the network provider or the insured.

It is a violation of Regulation 11 of IRDA (Health Insurance) Regulations, 2013 and Guidelines of Standardization in health insurance, IRDA/HLT/CIR/03 dated 20.02.2013 (Agreement- insurer, TPA & Network provider) for not making direct payments to the Network provider and to the policyholders by integrating their banking system platform with the network provider or the insured.

Submissions made by the Insurer: Insurer has submitted that they have entered into agreement with majority of their network partners (TPAs and hospitals) and in 99.7% (as on date) cases the payments are made directly to the network hospitals and customers.

Further, they have submitted that advance float payment to TPAs has been stopped with effect from March 2015. Now wherever there are no float payments, the payments are made to TPAs against a net of claims and no advance float is being enjoyed by TPAs.

Decision:

The regulation 11 of the IRDA (Health Insurance) Regulation 2013, provides for payment to the Network providers and settlement of claims of policyholders and according to which the insurers shall make direct payments to the network provider and to the policyholder by integrating their banking system platform with the network provider or the insured and where the insured desires to be reimbursed by cheque or demand draft the same shall be allowed by the insurer. The implication of this regulation is to ensure that the TPA is not allowed to settle claims on behalf of the insurer and to discontinue the system of maintaining a float/corpus fund with the TPA for any purpose. From the submissions made by the insurer it is evident that the amount against the claims to be paid to the network providers/policyholders is still routed through the TPAs. The insurer can directly transfer funds through electronic means to the network providers/policyholders. The intent or the purpose of following the practice of routing claim amounts through TPAs has not been made clear. This is a clear violation of the above-referred regulation. Thus, the Authority in exercise of its powers under section 102(b) imposes a penalty of Rs. 5 Lakh on the insurer.

Charge No. 2:

Concern/Violation: It was mentioned that the insurer provided the list of 30 network providers with whom tripartite agreement has been entered. In this regard, the insurers vide e- mail dated 28th June, 2014 informed IRDA that the process of finalization of the tripartite agreement will take some more time.

It is a 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/TPAs.

Submissions made by the Insurer:

Insurer has submitted that they have entered into agreement with majority of their network partners (TPAs and hospitals). However, they have mentioned that in case of some corporate and large hospitals they are facing some issues in entering into formal agreements.

Decision:

In view of submissions made by the Insurer, the Authority is not pressing the charges. However, the insurer is directed to ensure that all such agreements are finalized within the next three months and submit a status report.

Charge No. 3:

Concern/Violation: It was observed that the insurer has Login IDs available for five TPA's namely Paramount Health Services (TPA) Pvt Ltd, Family Health Plan (TPA) Ltd, Mediassist India Pvt Ltd, Dedicated Healthcare Services (India) Pvt Ltd and Unitedhealthcare Parekh TPA Pvt Ltd out of 17 TPAs. However, Document Management System (D.M.S.) access is available only with Paramount Health Services (TPA) Pvt Ltd System. It was informed by the insurer that the DMS provided by PHS (TPA) is not used at present due to technical reasons.

The insurer, therefore, has not fully complied with the system requirements prescribed under Regulation 15 of IRDA (Health Insurance) Regulations, 2013.

Submissions made by the Insurer: The insurer has submitted that their standard operating system takes care that there is flow of underwriting and claims data between them and the TPAs as provided in the Regulation 15 of IRDA (Health Insurance) Regulations, 2013. SoP is used by all the TPAs engaged by the insurer and all transactions such as claims settlements, repudiation etc. are routed through the system.

Decision:

In view of submissions made by the Insurer, the Authority is not pressing the charges.

The penalty amount of **Rs. 5 Lakh** shall be paid thorugh Demand Draft drawn in favour of **Insurance Regulatory and Development Authority payable at Hyderabad** within 15 days from the receipt of this letter. The Demand Draft is required to be forwarded to Sh. Lalit Kumar, FA and HoD (Enforcement). The insurer is required to ensure compliance with the above directions under information to the Authority.

Place: Hyderabad
Date: 9th April 2015

M. Ramaprasad
Member (Non-Life)