REPORT OF THE WORKING GROUP FOR STANDARDIZATION OF EXCLUSIONS IN HEALTH INSURANCE CONTRACTS

OCTOBER 2018

CHAIRMAN,
Insurance Regulatory and Development Authority
Hyderabad

Respected Sir,

Report of the Working Group for standardization of exclusions in Health Insurance Contracts

I have immense pleasure in submitting the Report of the Working Group constituted vide order Ref: IRDAI/HLT/ORD/Misc/113/07/2018 dated 24th July,2018 for standardization of exclusions in Health Insurance Contracts.

The Report and the Recommendations contained is an outcome of extensive review of literature on the subject, meetings with various stakeholders and elaborate internal discussions by the Working Group. This analysis broadly covered the following terms of reference:

1. Examine the exclusions that are prevalent in the health insurance policies.
2. Rationalize the exclusions by minimizing the number, so as to enhance the scope of health insurance coverage granted.
3. Rationalise the exclusions that disallow coverage with respect to new modalities of treatments and technologically advanced medical treatments.
4. Identify the type of exclusions which shall not be allowed.
5. Study wordings/language of the exclusions and standardize the wordings of exclusions in a simple and easily understandable language.
6. Study the scope for allowing individual specific and/or ailment /disease specific permanent exclusions at the time of underwriting so that the policyholders are not denied health insurance claims unrelated to the exclusions.
7. Any other matter relevant to the subject of exclusions.

On behalf of the Members of the Working Group, and on my own behalf, I sincerely thank you for entrusting this responsibility to us.

Place: Hyderabad
Date: 31st October 2018

Suresh Mathur
Chairman of the Working Group

भारतीय बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND
DEVELOPMENT AUTHORITY OF INDIA

Ref: IRDAI/HLT/ORD/Misc/113/07/2018

24th July, 2018

ORDER

Re: - Constitution of working group for standardization of exclusions in Health Insurance Contracts

Considering the importance of standardization in health insurance and to enhance transparency and uniformity the Authority had from time to time issued guidelines on standardization such as; standardization of terminology to be used in Health Insurance Policies and Standard Nomenclature and Procedure for Critical Illnesses. With the increase in the number of companies providing Health Insurance there is an increase in the number of products offered. It is desired that the industry adopts a uniform approach while incorporating the 'exclusions' as part of product design as well as for the wording of the 'exclusions'.

In order to examine the above issue and submit suitable recommendations a working group is constituted with the following Members.

1. Mr Suresh Mathur, E D (Health), IRDAI
2. Mr Harish Nadkarni, CEO, NABH
3. Mr Annaswamy Vaidheesh, Chairman, CII Sub-committee Health Insurance
4. Mr RM Singh, G M, New India Assurance Co
5. Mr D Sai Srinivas, Appointed Actuary, Bajaj Allianz Life Insurance Co
6. Mr Shreeraj Deshpande, SVP & Head - Operations, Future Generali General Insurance Co
7. Dr Vikram Jit Singh Chhatwal, Whole-Time Director, Medi Assist TPA
8. Dr S Prakash, COO Star Health
9. Mr D V S Ramesh, G M (Health), IRDAI
10. Dr Pankaj Sharma – Convener

Mr Suresh Mathur, E D (Health) shall be Chairman of the working group.

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Terms of reference for the working group shall be: -

i. Examine the exclusions that are prevalent in the health insurance policies.

ii. Rationalize the exclusions by minimizing the number, so as to enhance the scope of health insurance coverage granted.

iii. Rationalise the exclusions that disallow coverage with respect to new modalities of treatments and technologically advanced medical treatments.

iv. Identify the type of exclusions which shall not be allowed.

v. Study wordings/language of the exclusions and standardize the wordings of exclusions in a simple and easily understandable language.

vi. Study the scope for allowing individual specific and/or ailment/disease specific permanent exclusions at the time of underwriting so that the policyholders are not denied health insurance claims unrelated to the exclusions.

vii. Any other matter relevant to the subject of exclusions.

It is advised that the working group may hold meetings as and when needed and submit a report with recommendations within eight weeks from the date of this order. The working group may invite other persons to the meeting(s) as special invitees as may be required.

Member (Non-Life)

The report and the recommendations reflect the collective views and opinions of the members of working group. These views are a result of the analysis, synthesis and deliberations with different stakeholders of health insurance products.

Acknowledgements

At the outset, the Working Group places on record its thanks to Chairman, IRDAI and Member (Non-Life) for providing an opportunity to review the existing exclusions and suggest recommendations which may standardize the exclusions in the Health Insurance contracts.

The Working Group would like to profusely thank various stakeholders for sharing their valuable inputs and suggestions. These suggestions provided an outlook on collective industry view and were useful in striking a balanced approach between regulation and development.

The Working Group places on record its sincere appreciation and thanks to the various General Insurance companies, Standalone Health Insurance companies, Life Insurance Companies, Reinsurance Companies and representatives of Insurance Brokers, agents, TPAs and consumer groups who have given their time and shared their view points at several meetings, both in person and through emails and letters. The Working Group acknowledges the contributions of Mr. Sanjib Chaudhuri, Policyholders' Representative in Executive Committee of General Insurance Council and thanks for his participation in various meetings of the working group.

The Working Group wishes to acknowledge with gratitude the help, assistance and co-operation rendered by the Health department in IRDAI and its team.

The Working Group would like to specially thank the Confederation of Indian Industry, New India Assurance Company Limited, Star and Allied Health Insurance Co Ltd and Medi Assist Insurance TPA Private Ltd. for providing the space and infrastructure in facilitating the discussions.

The Working Group also acknowledges the report prepared by the CII subcommittee on the exclusions.

Last but not the least; the Working Group is extremely grateful to the managements of the companies/organizations that the Working Group members represent for having provided the members with time and resources for completing this report.

EXECUTIVE SUMMARY

Background

Health Insurance has undergone various changes and improvements over the years. One of the most important aspects in changes which have taken place is that the regulator has involved the industry as well as the various stake holders to make continuous improvements and help growth of the health insurance sector. Various industry bodies have actively participated in this growth journey. The IRDAI Health Insurance Regulations as well as the TPA Regulations have brought in standardization of various practices in the health insurance industry keeping the customer in focus. The standardization of Data, Pre-Authorisation and Claim forms, introduction of ROHINI, Standardization of definitions, Portability, introduction of Customer Information Sheet(CIS), etc., have brought in uniformity in health insurance practices in the country.

The health insurance industry has tried to keep pace with the advancement in technologies taking place in the healthcare industry over the years in-spite of the fact that the healthcare sector in India largely remains unregulated.

With the increase in number of health insurance companies as well as health insurance products in the market, it has been desired that the health insurance industry adopts a uniform approach while incorporating exclusions in the health insurance products.

The working group, as part of its methodology, met various stakeholders of the health insurance industry including the representatives of Health Insurers, General Insurers, Life Insurers, Insurance Brokers, TPAs, Agents, Ministry officials, NGOs, Consumer Activists, Experts from the field of Medicine, reinsurers and collected their views. In addition to this, the working group also studied the practices in some other countries as well as the Indian laws, regulations and regulatory guidelines that could have an impact on the health insurance products. The recommendations of the working group are largely based on the interactions with stakeholders and are in the context of the prevailing laws and regulations.

The Working group further subdivided into smaller sub groups to focus and deliberate on specific areas and then the entire group deliberated on the collated observations and discussions and arrived at the recommendations.

RECOMMENDATIONS:

The Working Group has carefully examined the suggestions received from various stakeholders in the industry, studied different exclusions used in Indian industry as well studied the practices followed in some of the developing and developed countries and deliberated on the same. The Working Group while making the recommendations have also taken into consideration the type of healthcare Sector in the country, the lack of uniformity as well as regulatory provisions in the healthcare sector. While comparing with some of the provisions and practices abroad the Working Group observed that in many countries State has a major role to play in the healthcare sector, there is good amount of regulations in the healthcare sector and in many countries some amount of protection is mandatory either through the Public System or Private voluntary system reducing the chances of anti-selection against the insurers. The committee took all these aspects into consideration while making the following recommendations.

1. The Working Group recommends that all health conditions acquired after policy inception, other than those that are not covered under the policy contract (such as Infertility and Maternity) should be covered under the policy and cannot be permanently excluded. Thus, Exclusion of diseases contracted after taking the health insurance policy such as for Alzheimer's disease, Parkinson's disease, AIDs/HIV infection, Morbid obesity, etc., cannot be permitted.

2. The Working Group recommends that there should not be any permanent exclusions in the policy wordings for any specific disease condition(s), whether they are degenerative, physiological, or chronic in nature. Permanent exclusions can be incorporated only at the time of underwriting as being recommended in point number 5 below.

3. The Working Group recommends that insurers may be allowed to incorporate waiting periods for any specific disease condition(s) however to a maximum of 4 years. Sub limits or annual policy limits for specific diseases / conditions in terms of amount, percentage of sums insured or number of days of hospitalisation/ treatment would be part of the product design. Further, words like "directly or indirectly related", "such as" shall not be allowed in the exclusions. However, any limits or waiting periods incorporated by the Insurers as part of product design shall be based on objective criteria and sound actuarial principles. Waiting period for conditions namely, Hypertension, Diabetes, Cardiac conditions may not be allowed for more than 30 days.

4. Insurers be allowed to incorporate permanent exclusions with due consent of the proposer which will allow a wider section of the population who have serious pre-existing diseases including persons with disabilities to be insured under health insurance. The permanent exclusion would be specific for conditions which are listed, and this list may be reviewed on a yearly basis by the committee that may be set up by the regulator. However, these permanent exclusions shall be allowed only in cases where the policyholder may be denied coverage as per the underwriting policy of the Insurer for the diseases disclosed at the point of underwriting.

5. The Working Group has initially recommended a list of 17 conditions for which insurers can incorporate permanent exclusions if they are pre-existing at the time of underwriting. It is suggested a standard format of consent letter to be given by the proposer may be specified.

6. The Working Group also felt that Non-declaration/ Misrepresentation of material facts is a major concern in health insurance contracts. There may be cases where major ailments are detected as pre-existing during 4th or 5th renewal when a person is admitted for some other ailment. As a practice insurer may generally invoke the cancellation clause for non-disclosure/misrepresentation. The working Group recommended the following options which an insurer may adopt

a) If the non-disclosed condition is from the list of the Permanent exclusions as per point 5 above the insurer can take a consent from the insured person and permanently exclude the condition and continue with the policy.

b) If the non-disclosed condition is other than from the list of permanent exclusions, then the insurer can incorporate additional waiting period for the maximum period of 4 years for the condition non-disclosed from the date the non-disclosed condition was detected and continue with the policy.Additional waiting period for such conditions may be allowed notwithstanding the moratorium period referred in point no. 7 below. However, after expiry of this additional waiting period, the policyholder is entitled to the rights accrued after the moratorium period. But, the additional waiting period proposed to be incorporated shall be only in the instances where, had the disclosures been made by the policyholder at the point of underwriting the policy at inception,it would have led to the imposition of similar waiting period by the insurer.

c) The above two options will not prejudice the rights of the insurer to invoke the cancellation clause under the policy for non-disclosure /misrepresentation.

7. The working group recommends a moratorium period of 8 years of continuous renewals after which the claim shall not be questioned based on non-disclosures or misrepresentations at the time of taking the policy. This would mean the policy would be incontestable in terms of application of any exclusions except for proven fraud as well as permanentexclusions specified in a policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy. This is applicable to the health insurance policies issued by General and Health Insurers. Health Insurance Policies issued by Life Insurers are guided by the provisions of Section 45 of Insurance Act, 1938.

8. The working group recommended that the exclusions applied by insurers for alcohol and substance abuse must be reviewed and standardised. This exclusion shall be modified to exclude only treatments for alcoholism and drug or substance abuseunless associated with mental illness.

9. The Working Group recommends the formation of Health Technology Assessment Committee. This Committee shall examine and recommend the inclusion of advancements in medical technology as well as new treatments / drugs introduced in the Indian market for coverage under Insurance.

10. The Working Group has recommended a detailed procedure based on international practices to be followed by this committee for inclusion / exclusion of modern / new technologies / treatments.

11. The working Group has examined a sample list of procedures / treatments under technological advancements and have given their specific recommendations against each of the procedure / treatment.

12. The Working Group also recommended that “No exclusions” should be permitted for any advancement in technology / advance treatments if they are in the list approved by Health Technology Assessment committee. However, insurers can either incorporate co-payments for such treatments or subject them to the usual, customary and reasonable clause.

13. The Working Group also specifically recommended that insurers should not deny coverage for claims of Oral Chemo therapy, where Chemo therapy is allowed and Peritoneal Dialysis, where dialysis is allowed.

14. The Working Group felt that with advancement in technologies as well as covers the policies are moving from hospitalisation insurance policies to comprehensive coverage including outpatient. The Working Group suggested that Insurers start adopting an Explanation of Benefits (EOB) in their prospectus as well as Policy schedule / wordings which would be easily understandable by the customers.

15. The Working Group also recommended a list ofexclusions which should not be allowed in health insurance policies offered by all Insurers.

16. The Working Group has also recommended a list of exclusions for which a uniform standard wording to be used by all insurers in the industry.

17. The Working Group has revisited the definition of pre-existing diseases and has recommended a definition for consideration.Further, on migration to another policy of the same insurer, only in case of product withdrawal, the policyholder shall be granted credit to the accrued gains of PED waiting period to the extent that is permitted either in the porting out product or porting in product, whichever is less.In the event of the migration to the product of another insurer, the policyholder shall be entitled to the benefit of accrued gains only to the extent of the coverage elapsed under the existing product and the residual waiting period shall be limited to the residual period or the PED waiting period option available under the porting in policy (whichever is less).

18. The Working Group also reviewed the entire list of “Optional Items”. The Working Group recommended that the existing ‘Optional Items’ may be classified into the following categories.

i. Items that may be retained as it is as optional items.

ii. Costs that are to be subsumed into the Room Charges

iii. Costs that are to be subsumed into the specific (say surgical) procedure charges

iv. Costs that are to be subsumed into the costs of treatment

v. Costs that are to be subsumed into the diagnostics et al.

19. The Working Group also recommends for transparency and clarity every insurer publish the list of items which will not be paid if billed separately and make it available to the insured either in the policy contract or as a link on the website.

20. The Working Group also noted that the changes recommended in this report would have some effect on pricing of the respective products. The policy wordings would also have to be reworded and filed with the regulator.

21. It is recommended that all deaths due to vector borne disease should be classified as death due to disease and cannot be classified as death due to accident.Injuries / death caused by mauling by wild animals, snake bite, scorpion bite or even dog bites can be termed as accidental injuries.

CHAPTER 1

Introduction, Objectives and Methodology

Health Insurance in India is the second largest portfolio only next to Motor Insurance among the General Insurance business. This is also the fastest growing portfolio. Health Insurance (Excl PA & Travel) premiums have grown from INR 741 crores in 2001-02 to INR 37,000 crores in 2017-18. The industry is expected to grow at a rate of 24-25 % for the next 5-6 years and projected to reach 100,000 crores in 2022. The Standalone Health Insurers are growing at over 40% annually with growth being driven by Retail Health Business. The growth however in the retail sector is still low. In terms of number of retail policies, the overall industry growth has been sub 10%. The Government has announced the Ayushman Bharat – PMJAY scheme which would be the largest such scheme in the world covering various targeted sections of the society. There is huge potential for growth of health insurance business in the country especially in the retail health segment.

With the increasing number of companies entering into the field of health insurance the number of products in the market have increased substantially. There is innovation of products with comprehensive products, specific disease products, niche products, etc., being introduced in the market. It has been felt that there is a need to adopt a uniform approach by the insurance companies while incorporating the exclusions in the policies. The regulator along with the industry has taken various steps to streamline and standardize the health insurance sector by introducing the Health Insurance Regulations, TPA Regulations, Uniform Claim form & Pre Auth-forms, introducing data standards, standard definitions, portability, Registry of Hospitals in the Network of Insurers (ROHINI), etc.

While the healthcare sector remains largely unregulated, the insurance regulator and the health insurance industry has put in substantial efforts for standardization as well as self-regulations in the health insurance sector. Healthcare industry has been growing at a very fast pace with introduction of newer technologies and treatments on regular basis. While the insurers have kept pace in covering many of the newer technologies (increasing list of day care procedures), it is felt that a structured methodology be adopted to cover newer methods of treatments and procedures.

There are about 27 General Insurance Companies, 24 Life Insurance companies and 7 Standalone Health Insurance companies in India. Health insurance is mainly transacted by the General Insurance and the Health Insurance companies while Life Insurers transact long term benefit policies. Out of the total Health Insurance (Excl PA & Travel) Business in India, around 58% is controlled by the Public-Sector companies, 21% by the Private Sector General Insurance companies and 21% by the Standalone health insurance companies. The Health Insurance Business in India is mainly classified as Government Sponsored Schemes (such as RSBY, AB-PMJAY), Group Health Business (Other than Govt schemes) and Individual Health Business. While in terms of premiums Group Health business continues to be the major portion of Health Business followed by Individual Health Business and then the Govt Business. However, in

terms of number of lives covered the maximum number that is,74% of the coverage is under Government sponsored schemes, 19% in other Group Policies and only 7% of the members are covered under Individual or Retail Health Insurance. Even the growth under retail health insurance in terms of numbers covered remains sub 10%.

The Government of India has along with the State Governments launched the largest State Sponsored Health Insurance scheme in the World – AB-PMJAY (AyushmanBharat-PradhanMantri Jan ArogyaYojana). This scheme targets to cover nearly 10 crore families of the targeted sections of the society numbering nearly 50 crore individuals. With the introduction of this scheme we do expect an increase in awareness levels for health insurance in the country and this would give a boost for development of healthcare infrastructure across the country.

Health Insurance in India is purely voluntary health insurance with no mandate from the government for every citizen not being covered under the government schemes to buy a health insurance cover from Insurers.

While the awareness and penetration levels have been low in the country, insurers as well as the regulator have brought in a lot of standardization into the health insurance industry. One of the most important regulatoryprovisions was the adoption of Lifelong renewals for health insurance policies for the benefit of the insured population of the country. The Insurance industry came forward to adopt the common definition for Pre-existing conditions by limiting the exclusion waiting periods to a maximum of 4 years. The regulator brought in Portability for the benefit of the customers.

IRDAI has ensured structured growth of the Health Insurance Industry in the country involving all the stake holders. The regulator has also brought in an effective grievance redressal mechanism to address the grievances of the customers.

However, one of the major drawbacks has been that the Healthcare Sector in the country largely remains unregulated without any uniformity. This remains one of the most important impediments for the growth of the health insurance industry. The providers / Hospitals who are an important stake holder in the health insurance industry are not regulated and are not answerable to any regulatory body. There is lack of uniformity in treatment practices as well as cost across the country. There are no ways for a customer to redress his grievances against hospitals other than to adopt a long drawn legal route.

The consumers look at the insurance companies to address their grievances as they have no other window to approach. Insurers have developed fraud detection mechanisms but there is noregulatory body to act on frauds committed by the providers. Insurers find it very difficult to access data from Hospitals / Doctors, etc., and are purely dependent upon what is shared with them. India does not have Electronic Health Records. A majority of Medicines are available without prescriptions. For the same treatment and in a similar room the charges are very different across similarly placed hospitals of the same geographic location. Insurers face difficulty in product innovations as well as pricing their products due to lack of uniformity in Healthcare Sector.

Various initiatives of the Government may help in growth of health insurance.

Health insurance in India got introduced as Hospitalization expense insurance where most policies covered hospitalization expenses rather than specifically the diseases and treatments. Over the years the industry has introduced Outpatienttreatment insurance, wellness and preventive featuresand expanded the coverage in terms of sums insured limits. With many new products being introduced there have been increased variations in the exclusions being used in the policies. Some of the exclusions in policies not understood by layman.Trust and confidence plays a very major role for development of health insurance in the country. Retail Health segment has the highest potential to grow and to ensure that the growth happens in a more appropriate manner with increasing levels of confidence and trust in insurance which eventually becomes the major mode of healthcare financing. The terms and conditions of insurance policies, scope, sum insured limits, inclusions and exclusions have been changing with the advancements in science and technology and they will keep changing as newer covers and medical advances become evident. Increasing healthcare cost coupled with claims experience has also resulted in insurers revising the prices as well as terms and conditions. It is very important for the regulator to step in and create an approach on how the exclusions are rationalised to ensure the rights of the policyholders are protected without breaching into the prerogative of the insurers in product construct and pricing. Thus, with this objective the working group examined the terms of reference.

Methodology:

1. The working group created three sub groups to focus on the following issues:

SINo.	Sub-Group	Issues examined
	1	1. Rationalize the exclusions by minimizing the number, to enhance the scope of health insurance coverage granted. a. Under this scope identify the types of exclusions which are open ended and such exclusions shall be clear and specific. b. Rationale of exclusion of diseases contracted after taking the mediclaim policy. For e.g. permanent exclusion of Alzheimer's disease, Parkinson's disease, Aids/HIV infection, psychiatric conditions, sleep disorders, Morbid obesity etc. 2. Identify the type of exclusions which shall not be allowed
	2	3. Rationalise the exclusions that disallow coverage with respect to new modalities of treatments and technologically advanced medical treatments. 4. Study the scope for allowing individual specific and/or ailment/ disease specific permanent exclusions at the time of underwriting so that the policyholders are not denied health insurance claims unrelated to the exclusions.

	3	5. Study wordings/language of the exclusions and standardize the wordings of exclusions in a simple and easily understandable language. 6. Under Any Other Matter; a. Definition of PED b. How PED is effective in the extant regulatory framework. Guidelines only defined PED. It did not specify that insurers shall cover treatments from 48 months onwards. c. Where Insurers reduce the PED waiting period to less than 48 months whether that reduced period shall be reckoned for protecting the accrued gains. d. Review of optional items specified under Annexure – 1 of Chapter III of IRDAI Guidelines on Standardization in HealthInsurance, 2016.

2. The Working Group met various stake holders involved including the following

   a) Representatives from Health Insurance Companies, General Insurance Companies as well as Life Insurance Companies

   b) Representatives from Brokers Associations

   c) Representatives from Agents Associations

   d) Representatives of TPAs

   e) Representatives from Reinsurance Companies

   f) Representatives from the NitiAyog, Ministry of Health & Family Welfare, NACO & National Health Agency.

   g) Representatives of Consumer Associations

   h) Experts in the field of Health Insurance

   i) Actuarial representatives from Insurers as well as reinsurers

   j) Other stake holders like providers of modern medicine / newer treatments

   k) Representative of GICouncil

3. The Working Group also received written suggestions and comments from various stake holders.

4. The Working Group studied International practices from some countries.

5. The Working Group collated all information and deliberated and came out with recommendations to the IRDAI.

6. The recommendations may not be applicable to Government Sponsored Schemes.

CHAPTER 2

International Experience

Healthcare Financing Models: Healthcare financing models world over can be broadly classified into three

a) **Predominantly Tax Funded:** Funds are raised through general or dedicated taxes and these funds are transferred to regional authorities who act as third-party payers by financing health service providers. Prominent *Examples are UK and Canada.*

b) **Predominantly Social Insurance Based:** Membership of Social Insurance Programs (often called Sickness Funds) is compulsory for all or most citizens. Sickness Funds reimburse health service providers via negotiated contracts. Example-*France and Netherlands*.

c) **Predominantly Voluntary Insurance Based**: Health Care Finance is Raised by competing Private Insurance Companies which then reimburse providers for services delivered to their members.*Example-USA*

Most of the countries either adopt one of the above health care financing models or a hybrid of the above. In countries with tax based or social insurance-based systems, people supplement their entitlement with private Insurance. Private Insurance is affected to cover co-payments /deductibles required under the public system or cover services which are fully not covered under public system. In some countries private insurance can be opted as an alternative to public System.

If we look at the insurance arrangements around the world it indicates that the borders between public insurance and private insurance are becoming very thin. Three important dimensions characterise the way insurance works.

a) Enrolment: whether insurance is mandatory or voluntary;

b) Underwriting/Pricing: whether contributions are risk-rated (minimal risk transfer), community-rated (transfers between healthy and sick), or income-based (transfers between higher income and lower income individuals);

c) Organizational structure: whether management of the insurance arrangement is commercial for-profit, private non-profit, or public/quasi-public.

On the dimension of enrolment, generally private insurance is voluntary however though there are exceptions. In Switzerland and Uruguay, the purchase of private insurance is mandatory (like public insurance systems). Private insurance though traditionally voluntary, can be made mandatory for the entire population or for certain segments, such as the formal sector. Mandatory coverage reduces the risk of adverse selection but is difficult to implement in the informal sector.

It is important to note that no developed country including the United States, uses voluntary private insurance to cover the poor or elderly. High risk individuals may be part of the risk pools and unless there are mechanisms to safeguards for both insurers and individuals such high risk individual groups will be left without affordable coverage. If high-risk persons are covered by public programs and are not part of the private insurance market,then fewer restrictions may be needed in the voluntary health insurance coverages.

Voluntary Health Insurance (VHI) generally have limited coverage of pre-existing conditions, exclusions and waiting periodsare stipulated in most policies to discourage adverse selection and keep premiums affordable. Most developed countries allow exclusions for certain conditions in primary insurance policies but set guidelines on exclusionsand maximum periods.

In the European markets VHI insurers generally stipulate entry age up to 65 years. Cover is mostly short-term (annual) contract and insurers are generally free to reject applications, exclude or charge higher premiums for pre-existingconditions, rate premiums based on individual health risk, set limits to benefits and impose waiting periods and user charges. Dependents must be covered separately at additional cost. Group policies often benefit from community-rated premiums and less stringent policy conditions. In most countries insurers can exclude covering pre-existing conditions or cover them for a higher premium or longer waiting periods. The exceptions are Germany (for the basic substitutive policy only), Ireland and Slovenia.

Practices on Treatment of Pre-Existing Conditions:

Excluding pre-existing conditions (PECs) from health insurance coverage is common today in almost all individual health products around the world. It does enable coverage to remain affordable by minimizing anti-selection risk which, in turn, lowers premium costs.

In some countries, such as Hong Kong, Italy and Mexico, insurers are free to design their own PEC exclusion clauses. In other countries, including Malaysia, the U.K., Singapore, South Korea, Australia, the U.S. and Dubai, insurers do not have the same freedom. Either local regulatory authorities or self-regulatory market practices govern insurer treatment of the PEC exclusion, including policy language and guidelines for the application.

Malaysian insurance regulator states that a PEC is: Disability that the Insured Person/Covered Person has reasonable knowledge of, before the commencement or reinstatement of this Policy/Certificate.

The Insured Person/Covered Person is considered to have reasonable knowledge of a pre-existing illness if:

a) The person had received or is receiving treatment for that disability.

b) The person has been advised for further medical investigations, diagnosis, care or treatment.

c) Clear and distinct symptoms of the disability were evident.

d) The condition would have been apparent to a reasonable person in the circumstances.

The *U.K.'s Association of British Insurers (ABI)* has a Statement of Best Practice to which insurers voluntarily adhere. The common definition states a PEC: Any disease, illness or injury for which:

• The person has received medication, advice or treatment; or

• The person has experienced symptoms; whether the condition has been diagnosed or not in the xxx years before the start of cover. (The same period is not common to all insurers.)

In *South Korea,* the PEC exclusion is a standard provision, regulated by the government under the Health Insurance Act. The exclusion clause language states:

a) In cases where an insured was treated or diagnosed with a disease associated with the pre-issue declaration obligation on an application form (limited to material parts) in the past (the period for disclosure on an application form), benefits related with the disease among benefits listed under "types of benefits and claim reasons" shall not be paid.

b) A disease diagnosed before the application date will, however, be covered after five years (including a case after five years from auto-renewal) after the application date as defined within the policy, if additional diagnosis (excluding screening medical exam) or treatment for the condition was not done for the five years.

In *Australia,* "best practice" regulatory guidelines govern how PEC clauses are to be applied. The guidelines define signs and symptoms and provide an assessment form to assist appointed doctors in making a clear determination of whether the condition is pre-existing. Australia's National Health Act also specifies that assessing whether a condition is pre-existing or not must always be done from the claimant's individual circumstances. Only the medical practitioner appointed by the health fund has the authority to assess pre-existing conditions.

Practices on Exclusions:

In addition to pre-existing conditions, the list of typical exclusions from Voluntary Health Insurance (VHI) policies can be very long. In most countries in Europe, insurers do not cover drug abuse, self-inflicted injuries, HIV/AIDS, infertility, cosmetic surgery, sex reassignment, experimental treatments and drugs, organ transplants, war risks and injuries arising from hazardous pursuits.

In *United Kingdom,* VHI provides cover for treatment of acute conditions and is not designed to cover the cost of ongoing chronic care. Ongoing care will usually be covered for a limited time or up to a certain cost. VHI plans fall into three broad categories – comprehensive, standard and budget – and into a further category of what might be called restricted plans. These categories differ primarily in the range of services they cover, in price and in the extent of choice over provider (although this can also vary within categories and be reflected in price). Budget plans can include those that pay a cash sum to the policyholder if they use NHS care instead of their VHI policy or plans that provide cover only if NHS waiting times exceed a predetermined length. Restricted cover plans are those that focus on a very narrow range of services – for instance, cover for high-cost cancer medicines or cover for diagnostics – or on a condition or set of related conditions only.Across categories, pre-existing conditions are not covered, and premiums are risk rated for age, risk behaviours and other factors.

Common Health Insurance Exclusions in United Kingdom:

1. Ageing, puberty and menopause
2. Treatment to correct eyesight
3. AIDS/HIV
4. Pandemic or epidemic disease
5. Allergies or allergic disorders
6. Birth control, conception, sexual problems and sex changes
7. Learning difficulties, behavioural and developmental problems
8. Chronic conditions
9. Overseas treatment and repatriation
10. Chronic mental health conditions
11. Physical aids and devices
12. Pre-existing or special conditions
13. Contamination, wars and riots
14. Pregnancy and childbirth
15. Convalescence, rehabilitation and general nursing care
16. Screening, monitoring and preventative treatment
17. Cosmetic, reconstructive or weight loss treatment
18. Sleep disorders
19. Deafness, Speech disorders
20. Dental/oral treatment
21. Experimental drugs and treatments
22. Sport – professional sports

*South Africa:*The South African private health insurance market is regulated by the Council of Medical Schemes (CMS). In general, there are limits to clinical and appropriate treatments. Other than for reconstructive benefits of cosmetic surgery after an accident, cosmetic surgery is not payable. Similarly, medicines that are experimental are not payable unless there is specific approval from the medicines regulator. Dental implants are excluded since the alternatives or a bridge or crown or dentures are more cost effective to bring the member to a functional state. The exclusions are reviewed by the regulator as part of the Rules submission and if acceptable approved. Exclusions in South Africa are generally the same (and adopted in the rest of Africa too) and have been developed over several years.

Common Health Insurance Exclusions in South Africa:

1. Pre-existing conditions
2. Treatment within specified waiting period
3. Wilful participation in a riot, civil commotion, war, invasion, terrorist activity or rebellion
4. Hazardous activities
5. Unregistered Health Care Providers

6. Expenses for recuperative purposes
7. All costs for treatment if the efficacy and safety of such treatment cannot be proved;
8. Cosmetic treatment, transsexual procedures;
9. Obesity;
10. Costs for attempted suicide (beyond minimum prescribed limits)
11. Breast reduction and breast augmentation, gynaecomastia, otoplasty and blepharoplasty;
12. Circumcision, unless clinically indicated, and any contraceptive measures or devices;
13. Frail care;
14. Reversal of Vasectomies or tubal ligation (sterilisation);
15. Injuries resulting from narcotism or alcohol abuse except for the Prescribed Minimum Benefits;

*United States of America (USA):*The *USA* Affordable Care Act sets federal standards for insurers that sell products in both the individual and group health insurance markets. The purpose of these standards, as noted, is to ban discrimination against women, older people, and children and adults in less than perfect health. Thus, the Act bans lifetime and most annual dollar coverage limitations, the use of pre-existing condition exclusions, and excessive waiting periods (i.e., longer than 90 days), and requires the use of "modified community rating" so that prices can vary only to a limited degree based on age, as well as by family size and tobacco use. In the United States citizens are required to have some form of health insurance or pay a penalty. Coverage can be cancelled only in case of fraud.

Common Health Insurance Exclusions in United States:

1. Alcohol and substance abuse
2. Mental/nervous diseases
3. War or acts of war
4. Suicide attempts
5. Normal pregnancy
6. Injuries on the job
7. Intentional acts causing disability

*Australia:*The Australian Competition and Consumer Commission has released a report on the private health insurance industry, highlighting concerns about the impact of complex information on consumers and the market.The report reveals the increasing challenges facing consumers in choosing between many policies with greater exclusions.

*Brazil:*Brazil's private sector does not have a mandatory requirement for individuals to purchase insurance, nor does it permit underwriting. This combination has resulted in significant adverse selection in the private sector, because primarily those with the greatest need for highly specialized medical care that is not provided by all public hospitals have purchased coverage, which can be obtained with few limitations.

Practices on Inclusion of Newer medical technologies and treatments under ambit of Insurance:

With the dynamic nature of healthcare delivery system focused on newer, shorter treatments, better outcomes and ease will keep on evolving. Health insurers world over must be dynamic and aligned to these developments. The healthcare delivery system is evolving fast with innovations in treatments, new drugs therapies and new medical devices. Health Insurance must adapt, evolve and accommodate for changes in Healthcare delivery. Further it needs to plan how to cover and reimburse these developments in their health policies. Most developed countries have developed Health Technology Assessment (HTA) approach. There are institutions which are authorized to carry this out.

Generally, in these countries the following process is followed:

A) The organization or the company bringing the new technology facilitates in submitting a detailed evidence-based document with the following details.

B) This document is generally called “reimbursement dossier”. The document has the following details. It consists of both country specific and international requirements and perspectives.

i. Detailed description Treatment / Procedure

ii. Prevalence of the disease/symptoms and its burden on the population

iii. Requirement of this treatment (explain how this treatment will be different and better)

iv. Rationale behind this treatment

v. Patient Selection Criterion

vi. Infrastructure and related requirements

vii. Details of Clinical Outcomes with Evidence

viii. Details of Risks of the treatment

ix. Health Economic Analysis – Comparative studies, Cost effectiveness and budget impact.

x. Pricing of the procedure

xi. Long term Safety and efficacy

xii. Benefits to the stakeholders like employers and payers

xiii. Regulatory and Approval status in the country and other countries (with ICD 10, CPT, SnowMed CT and other technical codes)

xiv. Availability of the treatment in the country

xv. Reference to the Published Clinical Literature

In addition to the above document the organization also is required in some countries to provide information on the doctors trained for doing this procedure, number of procedures done, selection criterion of patients and the outcomes.

In *Germany* from 2004 the systematic assessment of health technologies (health technology assessment, HTA) was institutionalized with the establishment of the Federal Joint Committee (G-BA) and IQWiG. As the first European country, Sweden had already established an HTA agency in 1987. In the 1990s various national HTA programmes were followed in several European countries. Today, with about 90 HTA agencies and institutes in Europe, HTA is a firmly established instrument for informing decision-making in the healthcare system.

The German parliament passed the Act on the Reform of the Market for Medicinal Products (AMNOG) on 11 November 2010. It completely revises pricing regulations for newly authorized pharmaceuticals and their reimbursement by statutory health insurance providers.It also assigns a key responsibility to the Federal Joint Committee (G-BA) and the Institute for Quality and Efficiency in Health Care (IQWiG): that of conducting benefit assessments of newly authorized pharmaceuticals in accordance with SGB V, section 35a. Since 2011, their findings form the basis of decisions on the prices statutory health insurance providers pay for new pharmaceuticals with new active ingredients. For the first time, pharmaceutical companies are obliged to submit a dossier on product benefit when a new product is launched. Initially started in 2006 only as a project, as a working network of ministries, authorities, and scientific institutes from the EU member states, the European Network for Health Technology Assessment (EUnetHTA) has developed into a stable construct with a positive perspective. IQWiG is a founding member of the network.

CHAPTER 3

PRE-EXISTING DISEASES

The Working Group also discussed and reviewed the regulatory provisions, definition of pre-existing conditions and its applicability in the Indian Health Insurance sector. Clause 33 of Guidelines on Standardization in Health Insurance issued vide Circular dated 29thJuly, 2018 defined PED as under.

Pre-Existing Disease (not applicable for Overseas Travel Insurance): *Pre-existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously.*

It may be observed from the above definition, any ailment or injury or related condition for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice / treatment was received within 48 months are covered as PED. Thus, the working group noted that the word 'or' is making it clear; that all conditions, ailments or injuries which were diagnosed whether *'medical advice / treatment was received within 48 months'* are to be treated as 'PED'. Thus, there is no distinction between a *'PED diagnosed / treated'* and a *'PED for which no active treatment was received'*. The group discussed there could be instances where an individual would be having pre-existing conditions diagnosed but may not be taking any active treatment.

It is also debated whether the existing definition of 'Pre-existing Disease' needs to be revised or simplified. The disclosure of 'PED' by a policyholder is an essential pre-requisite to an Insurer so that the Insurer as part of underwriting for providing the health insurance coverage has to examine whether or not to grant coverage. As all contracts of Health Insurance are also contracts of 'uberrimafedei', in the absence of specific disclosure by a person proposed to be insured about his / her pre-existing disease Insurers may not be in a position to access the relevant material information and may not be in a position to have complete information regarding the health condition or diseases or ailments *et al* which were diagnosed or contracted by / on the life to be insured (proposed to be covered) to take a call whether or not to accept the liability. It is expected that the Insurers seek specific information from the persons to be insured as part of the Proposal Forms before underwriting.

It is further debated that - The first condition is "*whether an ailment showed symptoms or was diagnosed, or a treatment received*". It is considered that there may be instances where it could be just sign or symptom and the person need not visit a medical practitioner to diagnose it. The second condition (or a pre-requisite) is '*a need to declare by the applicant about the condition to which he / she is privy while taking a policy'*. It was also discussed that proving a non-disclosure of "*sign or symptom to which a prospect is privy*" is mostly contentious. It was also noted that most proposal forms do not specifically ask for symptoms and even if it does and the prospect may declare "NO", a benefit of doubt goes to the applicant. So, should we retain "sign or symptom"? It is felt that it would be advisable to deal with known & diagnosed conditions for which treatment is taken or not taken (treatment can be postponed for some conditions). It is of the view that the words 'signs or symptoms' are also so primitive that they necessarily do not establish the prevalence of a disease or ailment, except if the disease or ailment is specifically diagnosed.

Further, the words “and renewed continuously” is considered not needed as we are defining what is a PED (pre-existing at the point of taking a new policy). These words will be a part of each insurers exclusion clause where they will state “*Expenses related to the treatment of a pre-existing disease (PED) shall be excluded until the expiry of xxxmonths of continuous coverage after the date of inception of the first policy with us.”*

During the discussions it is concluded that any prudent insurer will not be repudiating claims without complete evidence that substantiates the case. It is a known fact that the insurer may not be privy to any consultations / treatment any person has undertaken unless the person himself is ready to disclose the same and this exclusion is mainly to take care of non-disclosure. It was also pointed out that there are no centralized electronic health records or data which can be accessed by insurers with written consent of the individual by using any unique identification to find out prior medical status.

Thus, non-disclosure / misrepresentation is one of major concerns.The members were of the view that Insurers should be very prudent and just in establishing non-disclosure but also need to safe guard the interests as otherwise any such gaps would in fact penalize good insured population.

The approach adopted by different countries in defining pre-existing conditions as well as usage of the same was also taken into consideration and also discussed under Chapter No. 2– International practices. Wherever Voluntary Health Insurance is complementary / supplementary or “substitute” or compulsory and the healthcare sector has some regulations including EHRs, the definitions are very much restricted. In many developing countries including India there is a selection involved, the unregulated healthcare sector and the very fact whether a person has consulted a doctor and was diagnosed or treated or not is only known to the person concerned and treating doctor. Such data is not an easily accessible data.

The simplest definition of a Pre-existing Condition is: a health condition or ailment or injury or disease that existed either at the time of or prior to an individual’s purchase of a health insurance policy. When evaluating whether a condition should be deemed pre-existing, insurers normally look to prove either of two qualifying elements:

a) At the time of application, the claimant was undergoing treatment for, and/or had been treated previously for, a medical condition.

b) At the time of application, the claimant was aware of the medical condition for which the claim had been submitted. The awareness was due to signs &symptoms experienced by the claimant that are associated with the claimed-for condition. The signs & symptoms for which a prudent individual would have sought medical treatment or advice.

The working group studied the definitions used in various countries in voluntary health insurance and noticed that “Signs& Symptoms” do form an integral part of most definitions.

The working group reviewed various definitions that are prevalent in various health insurance products offered across the globe, which are;

a) **Pre-existing conditions (Egypt)** are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during the INSURED PERSON's lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which the INSURED PERSON (or his/her dependents) could reasonably have been assumed to have known, will be deemed to be pre-existing. Conditions arising between completing the relevant application form and the start date of the POLICY will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

b) **Pre-existing Illness (Malaysia):** Pre-existing Illness shall mean Disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:

i. the Insured Person had received or is receiving treatment;
ii. medical advice, diagnosis, care or treatment has been recommended;
iii. clear and distinct symptoms are or were evident; or
iv. its existence would have been apparent to a reasonable person in the circumstances.

c) A **pre-existing medical condition (Qatar)** or related medical condition that, within a 24-month period before the date of joining or the date shown on the special terms section of your Certificate of insurance, has one or more of the following characteristics:

i. Was foreseeable
ii. Clearly showed itself
iii. You had signs or symptoms of
iv. You asked for advice about
v. You received treatment for
vi. To the best of your knowledge, you were aware you had

d) **Pre-existing medical conditions (UK)** or related medical conditions may be covered after you have had 24 months' continuous cover under the plan and within that time you have not:

i. experienced symptoms,
ii. asked for advice, or
iii. needed or received treatment, medication, or a special diet.

If you have:

i. experienced symptoms,
ii. asked for advice, or
iii. needed or received treatment, medication, or a special diet,

then you will have to wait until you have completed a continuous 24-month period when none of these apply to you. Pre-existing medical conditions or related medical conditions may then be covered. This is the rolling part of the moratorium.

e) **Pre-existing medical conditions (China & Hong Kong)** Any medical condition or related condition for which you have received treatment, had symptoms of, to the best of your knowledge existed or you sought advice for prior to your date of entry (pre-existing medical condition), except where such medical conditions have been declared to us and accepted in writing. After two years' continuous membership, any pre-existing medical conditions (and related conditions) will become eligible for benefit provided (in respect of that condition) you have not during that period:

a) consulted any medical practitioner or specialist for treatment or advice (including check-ups)

or

b) experienced further symptoms

or

c) taken medication (including drugs, medicines, special diets or injections)

f) **Pre-existing Condition (USA):** A condition:

i. That is diagnosed by a physician prior to the effective date of the policy or its reinstatement, or

ii. For which medical advice or treatment was recommended by, or received from, a physician prior to the effective date of the policy or its reinstatement, or

iii. For which any symptom and/or sign, if presented to a physician prior to the effective date of the policy, would have resulted in the diagnosis of an illness or medical condition.

Definition that may be considered by IRDAI: After going through the various wordings theworking group preferred to recommend the following definition to make it simpler or unambiguous.

Pre-existing Condition means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician prior to the effective date of the first policy issued by the insurer **or**

b) For which medical advice or treatment was recommended by, or received from, a physician prior to the effective date of the policy or its reinstatement,

The Working Group also noticed, that except the PED definition, there are no other regulatory provisions specified in Health Insurance Regulatory framework requiring the Insurers to cover the pre-existing diseases from 49thmonth onwards. It is also recommended that the waiting period to the PEDs be limited to forty-eight months as is prevailing. Therefore, it was felt necessary to incorporate specific regulatory provisions that the Insurers shall cover all PEDs disclosed by the persons to be insured immediately after the expiry of the forty-eight months waiting period or such lower period as stipulated in the product. It is also noted that as part of product innovation, some insurers are covering the PEDs with a lesser waiting period than the stipulated maximum waiting period of 48 months.

The working group also recommends that where as part of product features, if Insurers allow lower waiting period for the existing PEDs (say 12 months or 24 months or 36 months) and in the event of withdrawal of the product, the existing Insurer shall give credit to the accrued waiting period benefits of PED gained under the withdrawn product and allow coverage on any of the health products available in his product portfolio with no additional waiting period beyond the stipulated PED / chosen PED period of the withdrawn product. Protecting the credit of the accrued waiting period is important since, while granting lesser waiting period, the Insurer had already factored the costs towards lower waiting periods in the withdrawn product and hence shall not be subjected again to any additional waiting period in the product migrated. Therefore, on migration to another policy of the same insurer, only in case of product withdrawal, the accrued gains of PED waiting periods shall be continued in the porting in product.

However, taking into cognizance, the varying product features that are offered by various insurers, in case of migration to another insurer, the working group considered that the new insurer shall be allowed to impose only the unexpired / residual waiting period up to 48 months from the date of issuance of porting out policy. Thus, in the event of the migration to the product of another insurer, the policyholder shall be entitled to the benefit of accrued gains only to the extent of the coverage elapsed under the existing product and the residual waiting period shall be limited only to the residual period or the PED waiting period option available / option chosen under the porting in policy (whichever is less).

CHAPTER 4

Rationalization of Exclusions

Suggestions of Stakeholders: The working group, as part of its approach, met various stakeholders of the health insurance industry and received some suggestions. Details of some important suggestions and views of the working group on each of the suggestion are placed in Annexure-1 of the report. However, variousSuggestions and comments received are summarizedin brief as under:

1. Exclusions for Specific disease conditions are incorporated as permanent exclusions in the policy wordings. This results in many claims becoming not payable for diseases being contracted even after the policy has been incepted. Specific cases were highlighted where claims were repudiated when the policy has been in force for 6 -7 years for conditions like Parkinson'sdisease, Alzheimer's disease, etc.

2. From some of extant wording it is noticed that there are some open ended exclusions including "Stress, run down conditions, debility, convalescence etc." in a number of policies. The stakeholders were of the view that there is a case of rationalising the same.

3. User charges for external devices used as part of treatments in hospitals during the period of hospitalisation are also excluded and are specially incorporated as permanent exclusions.

4. Surgeries recommended medically for life threatening conditions like Bariatric surgeries for morbid obesity are excluded.

5. Sovereign risk exclusions should be removed or rationalised to delete wordings such as "War like situations", etc.

6. Genetic diseases as well degenerative or developmental diseases detected even significantly long after inception of the policies are excluded.

7. Some of the Insurers represented that there is considerable fraud & abuse in the system that directly impacts larger set of customers. In the portfolio of insurance companies, it is seen that there is sudden rise in claim ratio (upto 25%) right after the two-year waiting period for defined conditions and treatments gets over. All the conditions in the waiting period are of a nature that a person can live with and defer treatment. For many conditions, the frequency is much higher in insured population than general population. That apart, industry is faced with significant non-disclosure. All these regularly add avoidable premium burden for the large segment of insurance sensitive customers.

8. Some of the Insurers suggested that provisions of the policies on 'fraud &non-disclosure' should be stringently applied including an industry database anchored by IRDAI / IIB. People / providers who commit fraud should become part of a non-insurable list (like no flyer list in aviation industry).

9. Some Insurers as well as some of the Intermediaries also suggested that a reasonably long moratorium period can be decided after which no look back to be applied. This

period should not be equated with the pre-existing waiting period. Long term nature of development of severe complications of current conditions is inherent to health. Example: Development of Cirrhosis or hepatocellular carcinoma in Hepatitis C, B; Renal failure in Diabetics etc. In absence of a fairly long period, this point is likely to have an adverse impact of enhancing 'adverse selection and non-disclosure' even further.

10. Life time exclusion and / or life time limits on specific conditions disclosed at the time of taking policy should be allowed leaving to the underwriting prerogative of the Insurers. This would allow to offer insurance coverage excluding just a condition to many people and help enhance penetration.

11. Insurers use words such as "directly or Indirectly caused by" in the exclusions especially when they underwrite proposals and disease specific exclusions in policy wordings which should be disallowed.

12. Usual customary and reasonable (UCR): Currently there is considerable difference between the amount charged by similar or even same hospital and doctors for the same procedure. The variability is extremely wide and is not commensurate with the complexity and / or severity (e.g. claims for bypass surgery CABG are reported as low as Rs. 3 lacs and as high as Rs. 30 Lakhs from similar class of providers in similar class of cities).

13. Many conditions are discovered during investigation for infertility which are later treated. Being related to infertility, these treatments would not be admissible. However, if the condition is such which would require to be treated irrespective of its association with infertility, then the claims need to be admitted; e.g. large fibroids of uterus, large ovarian cysts, etc.

14. Clear cut standard wordings for covering Animal Bite, snake bites, etc., under personal accident policies and excluding vector borne diseases from accident policies should be incorporated.

15. Exclusions on alcohol, drug abuse, tobacco, etc., needs to be standardised as these are interpreted and misused.

16. Hospitalisation only for diagnostic purpose – delete positive existence of disease from the conditions

17. Insurers incorporate conditions like Diabetes, Hypertension, cardio vascular conditions, etc., under two year waiting periods. It is viewed that the clauses are open ended and not specific.

18. There needs to be standardization of the exclusion on medically necessaryCosmetic surgery.

19. There are certain inclusions incorporated by insurers which are difficult to understand and should not be allowed. The sample wordings are;

a) **Off- label drug or treatment:** Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO) to be not allowed.

b) **Puberty and Menopause related Disorders:** Treatment for any symptoms, **Illness**, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.

RECOMMENDATIONS ON THE SUGGESTIONS RECEIVED FROM STAKEHOLDERS

The Working Group has carefully examined the suggestions received from various stake holders in the industry, studied different exclusions used in Indian industry as well studied the practices followed in some of the developing and developed countries and deliberated on the same. The Working Group while making the recommendations have also taken into consideration the type of healthcare Sector in the country, the lack of uniformity as well as absence of regulatory oversight on the healthcare sector. While comparing with some of the provisions and practices abroad the Working Group observed that in many countries, the State has a major role to play in the healthcare sector, there is a good amount of regulations in the healthcare sector and in many countries some amount of protection is mandatory either through the Public System or Private voluntary system reducing the chances of anti-selection against the insurers. The Working Group took all these aspects into consideration while making the following recommendations.

1. It is considered that Health Insurance plays a very important role. Especially, as age advances or more number of policy years elapse, the need for health insurance coverage is normally felt more. The expectations of policyholders who were healthy individuals at the point of underwriting would be also normally high to get coverage for any type of disease, if contacted, during their lifetimeafter taking a policy. Under these circumstances, if individuals who have been insured continuously for many years are denied claims for conditions which are contracted after being insured for a long time, it defeats the very purpose of insurance and reduces confidence levels of customers in health insurance. Therefore, the Working Group recommends that all health conditions acquired after policy inception should be covered under the policy and cannot be excluded. Exclusion of diseases contracted after taking the health insurance policy cannot be permitted thus permanent exclusions such as for Alzheimer's disease, Parkinson's disease, AIDs/HIV infection, Morbid obesity, etc., cannot be permitted. It is also recommended that there should not be any permanent exclusions in the policy wordings for any specific disease condition(s), whether they are of; degenerative, physiological, or chronic in nature. Permanent exclusions can be incorporated only at the time of underwriting as being recommended below.

2. It is also considered that the fundamental concerns of the Insurance Business, Adverse Selection and Moral Hazard, remain the concerns despite various concomitant developments in the Insurance industry. It is important that the prospects do not enter into health insurance by staging treatments for certain diseases, like cataract, knee replacement etc. Further, certain conditions may have very high frequency and/or of high severity which may impact the pricing. Hence, keeping in view these issues insurers historically incorporate waiting periods or impose sub limits or annual policy limits for specific diseases / conditions in terms of amount, percentage of sums insured or number

of days of hospitalisation/ treatment. It is recommended that insurers may be allowed to incorporate waiting periods for any specific disease condition(s) however to a maximum of 4 years.The insurers may be also allowed to impose sub limits or annual policy limits for specific diseases / conditions in terms of amount, percentage of sums insured or number of days of hospitalisation/ treatment in the policy. This should be the prerogative of the insurance companies while designing products and pricing them. These should be clearly listed in the clause and words like "directly or indirectly related" should be avoided.However, Insurers be advised that they shall adopt an objective criterion while incorporating any of these limitations and shall be based on sound actuarial principles.

3. It may be observed that people who already suffer from certain chronic illnesses or non-curable illness or disabilities are denied insurance cover as there is no provision of accepting a proposal by incorporating a permanent exclusion as part of the board approved underwriting policy of the Insurer. Allowing an option of excluding coverage only to the illness / disease which was known and prevalent, which otherwise, not insurable with any waiting period or sub limit may enable a wider section of the population who have serious pre-existing conditions to get health insurance coverage, if Insurers accept such proposals by incorporating a permanent exclusion with written consent of the proposer. Thus, the group recommends that Insurers be allowed to incorporate permanent exclusions with due consent of the proposer to grant health insurance to those people who have a disease / illness at the point of underwriting and which is not insurable as per the underwriting policy of the Insurer, be it with waiting period or by imposing a sub-limit. The permanent exclusion would be specific for conditions which are listed, and this list may be reviewed on a yearly basis by the committee appointed by the regulator. While incorporating this individual policyholder specific permanent exclusion, Insurer shall be allowed to exclude these disease conditions, only in such instances, where, as per the underwriting policy of the Insurer the Insurer would not grant the health insurance coverage for the disclosed medical conditions. If the disclosed medical conditions allow the Insurer to impose a time bound waiting period of not exceeding forty-eight months, then the Insurers shall not be allowed to permanently exclude the medical conditions / diseases disclosed at point of underwriting. Insurers shall not deny any other claim attributing the cause of ailment, disease or treatment to the conditions excluded. Initially, the following 17 conditions / illnesses / diseases were recommended for which insurers can incorporate permanent exclusions if they are pre-existing and disclosed at the time of proposing for insurance. The specific exclusions which can be incorporated as permanent exclusions against each of the conditions are also recommended.

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of

Sr. No.	Disease	ICD Code
		mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy,
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05),

Sr. No.	Disease	ICD Code
		I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - OtherCrohn's disease; K50.9 - Crohn's disease,unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis andcirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.- Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent(coinfection) with hepatic coma; B16.1 - Acutehepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic

Sr. No.	Disease	ICD Code
		viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9Dementia in Alzheimer's disease,unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15	Any Physical Disability	Existing Physical disabilities to be excluded.
16.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
17.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

Note: Proposer's consent is mandatory so that the proposer may take an informed decision. Further, permanent exclusion with specific ICD codes is allowed to make the exclusion specific without any scope for subjective interpretation at the time of claim settlement.

4. With reference to Sl No. 13 of the above table, the Working Group has taken cognizance of the provisions of Section 3 (j) of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act 2017 which specifies that no *person shall discriminate against the protected person on any ground including the denial of, or unfair treatment in, the provision of insurance unless supported by actuarial studies.* The Authority Vide Circular Ref: IRDA/HLT/MISC/CIR/169/10/2018dated 08th October, 2018has instructed all the Insurers to comply with the provisions of the HIV and AIDS (Prevention and Control) Act 2017. While complying with the provisions of the HIV and AIDS (Prevention and Control) Act 2017, Insurers shall be bound by these provisions, where the Actuarial studies support the denial of the health insurance coverage, the above approach of allowing to incorporate HIV / AIDS (refer Sl No. 13) as the permanent exclusion at the point of underwriting, may enable these sections of policyholders to get the health insurance coverage for conditions other than the conditions referred in Sl No. 13 above.

5. As developments in Healthcare sector are dynamic, there is a need to regularly review the list of permanent exclusions allowed at the time of underwriting. Hence, the Working group also recommends that the above list should be reviewed on a continuous basis to include / exclude conditions by a health technical committee that may be set up by the regulator. The Working Group also suggests a standard format of consent letter may be specified for obtaining the prior consent of the policyholder.

6. The Working Group also felt that Non-declaration/ Misrepresentation of material facts is a major concern in health insurance contracts. There are cases where major ailments are detected as pre-existing during 4th or 5th renewal when a person is admitted for some other ailment. As a practice insurer may generally invoke the cancellation clause for non-disclosure/misrepresentation. On a review of this, it is considered that the insurers may be allowed to have more options to handle the cases of Non-declaration/Misrepresentation especially when the policy has been renewed continuously for many years. It is also in the interest of the policyholders. In this, regard, the working Group recommended the following options which an insurer may adopt in relation to cases relating to non-disclosure / Misrepresentation of material facts:

   a) If the non-disclosed condition is from the list of the Permanent exclusions as per point no. 3 above the insurer can take a consent from the insured person and permanently exclude the condition and continue with the policy.

   b) If the non-disclosed condition is other than from the list of permanent exclusions, then the insurer can incorporate additional waiting period for the maximum period of 4 years for the condition non-disclosed from the date the non-disclosed condition was detected and continue with the policy. Additional waiting period for such conditions may be allowed notwithstanding the moratorium period referred in Point no. 7 hereunder. However, the additional waiting period referred herein, shall be imposed, only in those cases where had the medical condition / disease been disclosed by the policyholder at the point of underwriting, the insurer would have imposed the waiting period not exceeding forty-eight months at the time of underwriting.

c) The above two options will not prejudice the rights of the insurer to invoke the cancellation clause under the policy for non-disclosure /misrepresentation subject to its underwriting policy.

7. It is considered very important to protect the interests of policyholders who have taken a policy by reposing faith in the insurance industry. While Insurers do adopt an underwriting policy at the point of granting health insurance coverage to a new person who is taking the policy, nevertheless, the policyholders are also responsible to the disclosures made that culminated issuance of an insurance policy. Therefore, to protect the interests of policyholders who have continuously renewed the policies, without any break-in policy, to avoid denial of certain claims after fairly long period of Insurance, the working group felt that there shall be a specific period, beyond, which there shall be no look-back and no claim shall be questioned, except for the proven fraud and permanent exclusions specified in the terms and conditions of policy contract. This period may be referred as Moratorium Period. This period should not be equated with the pre-existing waiting period because non-disclosure is a very significant factor in Health Insurance. Long term nature of development of severe complications of current conditions is also inherent in health. In the absence of a fairly long period, this can have an adverse impact of enhancing 'adverse selection and non-disclosure' even further. The working group recommends a moratorium period of 8 years of continuous renewals after which no look back to be applied. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. This would mean the policy would be incontestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy.

8. The working group recommended that the exclusions applied by insurers for alcohol and substance abuse must be reviewed and standardised. This is because of possible misuse of this exclusion. Even persons hospitalised for medical ailments may be potentially denied coverage and claims may be denied if a mention of alcohol is found in the case papers. Similarly claims of a person who is just a passenger in a vehicle may be potentially denied if medical reports indicate presence of alcohol. Even in personal accident claims where the rider / driver has consumed alcohol and met with an accident it is difficult to repudiate the claim because the alcohol percentage as required by law to prove intoxication is seldom available. This exclusion could be modified to exclude only treatments for alcoholism and drug or substance abuse.Thus, the treatment for Alcoholism, drug or substance abuse or any addictive condition of any kind should only be excluded unless associated with mental illness.

9. To make the exclusions specific so that there is no scope of subjectivity in interpretation at the time of claim settlement the working group recommended that no open-ended exclusionslike"Directly or indirectly related to", "such as", "etc."" be allowed while as part of exclusions. Even such terminologies should not be permitted in the waiting periods.

10. Taking into consideration the lifestyle diseases for which treatment cannot be delayed, it is suggested that waiting period for conditions namely, Hypertension, Diabetes, Cardiac

conditions may not be allowed for more than 30 days except if these diseases are pre-existing.

11. It is understood that peritoneal dialysis is having similar results as haemodialysis and is the only option available due to scarcity of resources at many places especially smaller towns and villages. In many patients like elderly, cardiac patient's and children, peritoneal dialysis is the modality of choice. Countries like Thailand and Hong Kong have a government policy of "PD first" unless there is contradiction. This does not require any infrastructure and can be used in most remote areas also. Visit to hospital to seek haemodialysis cause additional financial burden and also physical strain for the patient. Similarly, including Oral Chemotherapy also provides comprehensive coverage for cancer. Hence, the Working Group also specifically recommended that insurers should not deny coverage for claims of Oral Chemo therapy, where Chemo therapy is allowed and Peritoneal Dialysis, where dialysis is allowed.

12. Examining the extant wordings in the health insurance policy contract and the prevailing exclusions, the Working Group also recommended thatthe following exclusionsshall not be allowed in health insurance (Other than PA & Travel) policies

    a. Injury or illness associated with hazardous activities

    b. Impairment of Persons' intellectual faculties by abuse of drugs, stimulants or depressants.

    c. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.

    d. Treatment of mental illness, stress or psychological disorders or Parkinson's or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness.

    e. Off- label drug or treatment:Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO).

    f. Puberty and Menopause related Disorders:Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.

    g. Age Related Macular Degeneration (ARMD)

    h. Behavioural, Neurodevelopmental and Neurodegenerative Disorders:

        i. Disorders of adult personality including gender related problems, gender change;

        ii. Disorders of speech and language including stammering, dyslexia;

    i. All Neurodegenerative disorders including Dementia, Alzheimer's disease and Parkinson's disease;Treatment that does not require hospitalization.

j. Expenses related to any admission primarily for enteral feedings and other nutritional and electrolyte supplements are excluded.

k. Exclusions on internal congenital diseases, genetic diseases.

l. Exclusion of Pre/Post hospitalization cover under Domiciliary Treatment benefit is not to be permitted. On a review of the definition given to domiciliary treatment, the working group is of the view that this treatment is taken only under certain unavoidable circumstances that may be beyond the control of the policyholder. Hence, in fitness of things it is important that the policyholder can have pre / post hospitalization expenses as are otherwise made available in case of in-patient hospitalization.

m. It is observed that there are certain exclusions that do allow coverage if as per any or all the Medical references herein below containing guidelines and protocols for Evidence Based Medicines, the Hospitalisation for treatment under claim is not necessary or the stay at the hospital is found unduly long:

i. Medical text books,

ii. Standard treatment guidelines as stated in clinical establishment act of GOI

iii. World Health Organisation (WHO) protocols,

iv. Published guidelines by healthcare providers,

v. Guidelines set by medical societies like cardiological society of India, neurological society

The Working Group is of the view that Insurers shall increasingly have arrangements with the network providers for following the protocols that are considered best both to a policyholder as also to the industry.

n. It is further observed that there are certain exclusions that do not allow a claim *"If specified aetiology for the defined critical illness is not known".* The working group is of the view that such type of exclusions are not policyholder friendly, as it may not be possible to provide the specific aetiology for a defined CI.

o. Permanent exclusions of a medical condition do not prevent Insured Member from travelling or working shall not be allowed.

13. To make the exclusion wordings uniform and specific across the Industry the working Group recommends that the following exclusions must be standardised as permanent exclusions in policies. However, insurers do reserve the right to drop these exclusions though cannot use any other wordings other than these if used.

A. **Exclusion Name: Pre-Existing Disease**

a) Expenses related to the treatment of a pre-existing disease (PED) shall be excluded until the expiry of #### months of continuous coverage after the date of inception of the first policy with us.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the IRDAI portability guidelines, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of ##### months for any pre-existing past illness/condition or surgery is subject to the same being declared at the time of application and accepted by us.

B. **Exclusion Name: Specified disease/procedure waiting period**

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of <####> months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for cancer and claims, not specified in the list, arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The listed conditions are excluded even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the IRDAI portability guidelines, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

C. **30-day waiting period**

a) Expenses related to the treatment any illness for which appearance of signs/symptoms (signs / symptoms here may not be required, as it is very primitive, we may say 'Expenses related to the treatment of any illness which is diagnosed within 30 days…. The usage of words signs and symptoms are not allowed by IRDAI in this 30 days waiting period for the last two years, especially in critical illness policies and Insurers are readily obliging) started within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) If the Insured Person is continuously covered without any break as defined under the IRDAI portability guidelines, then waiting period for the same would be reduced to the extent of prior coverage. (I think this (c) is not applicable for this one month waiting period)

D. **Investigation & Evaluation**

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded even if the same requires confinement at a Hospital.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

E. **Exclusion Name: Rest Cure, rehabilitation and respite care**

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment, that normally requires admission, would be excluded.

b) This would also exclude:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

Note: However, Working Group is of the view that Insurers are to be encouraged to develop add-on riders to offer respite care and home care, especially, the coverage that kicks in at age 65 onwards, provided the coverage under base policy is continued without break.

F. **Obesity/ Weight Control:** Expenses related to the surgical treatment of obesity that does not fulfil the below conditions:

a) Surgery to be conducted is upon the advice of the Doctor

b) The surgery/Procedure conducted should be supported by clinical protocols

c) The member has to be 18 years of age or older and

d) Body Mass Index (BMI) greater than or equal to 40

e) BMI is greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

G. **Change-of-life treatments:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are excluded.

H. **Cosmetic or plastic Surgery:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless necessary as a part of medically necessary treatment are excluded. For this to be considered a medical necessity it must be certified by the attending Medical Practitioner for reconstruction following an Accident, Burns or Cancer.

I. **Adventure sports:** Expenses related to any treatment necessitated due to participation as a professional in adventure or hazardous sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba

diving, hand gliding, sky diving, deep-sea diving are excluded. Any person getting paid for these services would be considered a professional in the context of the definition.

J. **Breach of law:** Expenses for treatment directly or indirectly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent are excluded.

K. **Excluded Providers:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization phase are payable but not the complete claim. (Note: Insurers shall use various means of communication to notify the policyholders, such as e-mail, SMS about the updated list being uploaded in the website.).

L. Treatment for Alcoholism, drug or substance abuse or any addictive condition of any kind unless associated with Mental Illness.

M. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a Hospital where the Hospital has effectively become the Insured Person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

N. Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances.

O. Refractive Error: *Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres is excluded.*

P. Unproven Treatments: *Expenses related to any treatment, services and supplies for or in connection with experimental, investigational or unproven services are excluded. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.*

Q ***Birth control, Sterility and Infertility:*** *Expenses related to Birth Control, sterility and infertility are excluded. This includes:*

(i) *Any type of contraception, sterilization*

(ii) *Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI*

(iii) *Gestational Surrogacy*

(iv) *Reversal of sterilization*

14. While Insurers may minimize the number of exclusions, where the above referred exclusions are proposed to be incorporated in the policy wordings, it shall be mandated that Insurers shall use the uniform wordings.

15. It is also recommended that a unique reference code may be allocated to each of the above wordings, so that the rejection of claims based on the exclusions could be duly captured in the systems of Insurers and TPAs for developing the analytics in due course.

CHAPTER 5

Inclusion of Modern Treatment Methods and Advancement in Technologies

The working group based on the interactions with various stake holders and the suggestions, comments and representations received summarized the major issues/suggestions into the following

1. Various new treatments which are advancements in medical science are not covered by insurers and are totally rejected or denied. There is no upfront disclosure on what treatments are covered and what are not. The TPAs are guided by product specific claim guidelines given by insurers.

2. Medical advancements must be factored into treatment protocols**.** Specifically, the following treatments, currently excluded, should be allowed: Immunotherapy, In Age Related Macular Degeneration (ARMD) intraocular injections such as Lucentis and Avastin, Coblation Assisted Tonsillectomy because of lesser intra-operative complications and morbidity, For Varicose Veins, RFA and endovenous laser treatment, Surgeries using laser for prostrate, URS, Haemorrhoidectomy, and Photocoagulation , Stem Cells for treatment of certain cancers, Stereotactic Radio Surgeries (Targeted radiotherapy)fully payable in brain tumours and malignancies, Hormone therapy in cancer, adjuvant therapy, etc., Injection Zoledronic Acid should be allowed in the case of Multiple Myeloma, Keratoconus Treatment should be paid if it is not a complication of LASIK surgery, Bariatric Surgeries, etc

Recommendations

To avoid ambiguity related to inclusion of advancements in technology as well as new treatments / drugs introduced in the Indian market for reimbursement under Insurance, it may be important to review the developments on an ongoing basis. It is also considered that the improvements in healthcare sector are dynamic, which is to be closely followed before any specific decision is taken. Hence, to ensure the policyholders are not denied availability of health insurance coverage to these treatment procedures and to have clarity to the Insurers on the impact of these procedures on pricing, the Working Group recommends the formation of Health Technology Assessment Committee consisting experts, medical doctors, representatives of insurers and TPAs who will certify for inclusion of advancements in technology as well as new treatments / drugs introduced in the Indian market for reimbursement under Insurance.

1. The Health Technology Assessment Committee may consist of the following members

    i. A reputed Medical Practitioner / Surgeon

    ii. One representative from a TPA

    iii. One representative each from Standalone Health Insurance Company, General Insurance Company, Reinsurance Company and Life Insurance Company

iv. One Appointed Actuary or an independent actuarial professional

v. Representative from Central Drugs Standard Control Organization (CDSCO)

vi. The committee may co-opt any other expert professional as per requirement.

This committee can be appointed for a period of 24 months and should meet not less than every 6 months.

2. To put in place an objective assessment, the working group has recommended a draft procedure based on international practices that may be followed by this committee for inclusion of modern / new technologies / treatments as below

A. The organization or the company bringing the new technology facilitates in submitting a detailed evidence-based document with the following details.

B. This document is should be called “reimbursement dossier”. The document should consist of the following details. It consists of both country specific and international requirements and perspectives.

a) Detailed description Treatment / Procedure

b) Prevalence of the disease/symptoms and its burden on the population

c) Requirement of this treatment (explain how this treatment will be different and better)

i. Rationale behind this treatment

ii. Patient Selection Criterion

iii. Infrastructure and related requirements

d) Details of Clinical Outcomes with Evidence

e) Details of Risks of the treatment

f) Health Economic Analysis – Comparative studies, Cost effectiveness and budget impact.

i. Pricing of the procedure

ii. Long term Safety and efficacy

iii. Benefits to the stakeholders like employers and payers

g) Regulatory and Approval status in the country and other countries (with ICD 10, CPT, SnowMed CT and other technical codes)

h) Availability of the treatment in the country

i) Reference of the Published Clinical Literature

C. The HTA committee will then assess the new treatment / procedure / device covering the following aspects.

a) Physics Principle on which the technology works

b) Physiologic Principle on which technology works

c) Role of technology in management of disease(s)

d) Current methodologies of management

e) Comparison with the current methodology.

f) Is the technology established? Check references in standard medical textbooks.

g) Pro and cons with respect to frauds

3. The working Group examined a sample list of procedures / treatments under technological advancements and have made the following recommendations.

A. **Uterine Artery Embolisation and HIFU** are alternative treatment for Fibroid uterus and it can be allowed with proper indication (Reproductive age group / Significant Co morbidity in elderly age group).

B. **Balloon Sinuplasty**: Newer modality for sinus surgery- insurance can cover. Balloon sinuplasty is a promising treatment for people with chronic sinus problem. Though the surgery is relatively new, it should be considered a valid and safe option for people who have tried other conventional treatment. The committee recommended this can be covered.

C. **Deep Brain stimulation:** For Parkinsonism, obsessive compulsive disorder etc. - High cost, NEWER TECHNOLOGY, insurance can cover upto the costs of conventional treatment. The Group was of the opinion that this can be covered as per market guided expenses (subject Reasonable and Customary Charges), across all policies.

D. **Oral chemotherapy:** Insurance should cover but these drugs are expensive and must be consumed daily for a prolonged period (Years). The Group recommended that this can be covered with a sub limit as a percentage of SI

E. **Immunotherapy- Monoclonal Antibody to be given as injection:** They are very expensive but If the indication is proven and it is absolutely needed- insurance should cover.The committee recommended that this can be covered with a sub limit as a percentage of Sum Insured. Exclusion in its entirety shall not be allowed.

F. **Intra vitreal injections- Avastin, Lucentis (Bevacizumab, Ranibizumab):** Insurance can come forward to cover as day care procedure (subject to a specified number of injections per annum or during the entire policy period).

G. **Robotic surgeries*:*** Insurance should cover.

H. **Stereotactic radio surgeries:** Insurance should cover where it is indicated.

I. **BronchicalThermoplasty:** - Treatment of Severe Persistent Asthma - Makes anatomical corrections in lung lobes. Has a defined patient selection criterion.

J. **Vaporisation of the prostrate:** - Green Light treatment - Prostate Hyperplasia. Bloodless procedure in day care setting. Shorter recovery time, preservation of sexual functions, can be used on Cardiac patients and has good outcomes.

K. **Therapeutic treatments using SpyGlass:** Pancreatic and biliary stones lithotripsy, strictures management and accurate cancer diagnosis. Also used for Migrated Plastic stent removal.

L. **IONM - (Intra Operative Neuro Monitoring):** Supports Neuro and Spine surgeries efficacy. The surgeons are able to monitor the functional integrity/viability of the nervous system of a patient undergoing surgery. It minimises risks of quadriplegia or paraplegia. Additional Cost per procedure is involved.

M. **Stem cell therapy:** Hematopoietic stem cells for bone marrow transplant for haematological conditions may be covered. All other Stem cell therapies not to be covered.

4. The Group recommended that Insurers can cover the above treatments / procedures wherever indicated.

5. The Working Group also recommended that any other treatments / procedures other than which have been agreed to above shall be covered after an HTA assessment and/ or as part of the policy design. Procedures that are experimental and unproven shall remain a permanent exclusion.

6. The HTA committee should review newer technologies, etc., at least twice a year for coverage under insurance policies.

7. The Working Group felt that with advancement in technologies as well as covers in the policies are moving from hospitalisation insurance policies to comprehensive coverage including outpatient. Hence, to enhance transparency and increase the understanding to the policyholders, it is suggested that Insurers start adopting anExplanation of Benefits (EOB) in their collaterals as well as Policy schedule / wordings which would be easily understandable by the customers.

CHAPTER 6

Optional Items

The Authority as part of Guidelines on Standardization in Health Insurance vide Circular Ref: IRDA/HLT/REG/CIR/146/07/2016 dated 29thJuly, 2016 has notified various norms of standardization concerning the health insurance. Chapter III of these Guidelines specified Items for which optional cover may be offered by Insurers. It is, inter alia, specified that Insurers may endeavour covering all or some of these items or design add-ons or optional covers for these items. Insurers are advised to mention in the policy about the lists of expenses not covered under the policy and put up the detailed list in the website to enable the policyholder refer the details as and when required.

As these *'items for which optional cover may be offered by Insurers'* specified by IRDAI, also lead to exclusion of certain costs incurred by the policyholders during the treatment, the working group considered to take up the review of these items. On a detailed examination of the extant items specified in the Guidelines, it is noticed that the list is not the exhaustive list. There is no restriction that the insurers shall not add additional items that are not payable to the policyholders. However, certain items that are part of the list either have to be deleted or they have to be subsumed into the cost of treatment or room charges or specific procedure charges. Item wise action, that may be considered by IRDAI are placed in the remarks column hereunder.

S.No	Item	Remarks
I	**TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE ITEMS/SIMILAR EXPENSES**	
1	HAIR REMOVAL CREAM	To be deleted as this is part of any surgical preparation (alternative to shaving) and is to be subsumed into surgical procedure charge.
2	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)	To be deleted; as baby charges are part of the bed / room charge
3	BABY FOOD	To be retained as an optional item as per the extant list of items
4	BABY UTILITIES CHARGES	Point 5-8 below cover baby utility charges and is not an independent cost line item, hence there is no reason to mention the items 5 – 8 separately. Hence, items 5 – 8 may be deleted. Item – 4 Baby Utilities Charges to be retained as an optional item as per the extant list of items
5	*BABY SET*	May be deleted
6	*BABY BOTTLES*	May be deleted
7	*BRUSH*	May be deleted
8	*COSY TOWEL, etc.*	May be deleted
9	HAND WASH	To be deleted, as it is part of Point 107, below
10	MOISTURISER PASTE BRUSH	To be subsumed into baby utility charges of item no. 4, above. Hence, this line item to be deleted.

SNo	Item	Remarks
11	POWDER	To be subsumed into baby utility charges of item no. 4, above. Hence, this line item to be deleted.
12	RAZOR	To be deleted in line with Point 1, above
13	SHOE COVER	To be deleted as is part of Point 107, below
14	BEAUTY SERVICES	To be retained as an optional item as per the extant list of items
15	BELTS/ BRACES	To be retained as an optional item as per the extant list of items
16	BUDS	To be retained as an optional item as per the extant list of items
17	BARBER CHARGES	To be deleted in line with Point 1, above
18	CAPS	To be deleted as is part of item no. 107, below
19	COLD PACK/HOT PACK	To be retained as an optional item as per the extant list of items
20	CARRY BAGS	To be retained as an optional item as per the extant list of items
21	CRADLE CHARGES	To be deleted; as baby charges are part of the bed / room charge
22	COMB	To be deleted as its part of the ROOM Charge.
23	DISPOSABLES RAZORS CHARGES (for site preparations)	To be deleted as this is part of any surgical preparation and is to be covered under surgical procedure charge.
24	EAU-DE-COLOGNE / ROOM FRESHNERS	To be deleted as it is part of ROOM Charge
25	EYE PAD	To be deleted as this is part of any surgical preparation (alternative to shaving) and is to be covered under surgical procedure charge.
26	EYE SHEILD	To be deleted as this is part of any surgical preparation (alternative to shaving) and is covered under a specific procedure charge.
27	EMAIL / INTERNET CHARGES	To be retained as an optional item as per the extant list of items
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	To be retained as an optional item as per the extant list of items
29	FOOT COVER	To be deleted as its part of the ROOM Charge.
30	GOWN	To be deleted as its part of the ROOM Charge.
31	LEGGINGS	To be retained as an optional item as per the extant list of items

SNo	Item	Remarks
32	LAUNDRY CHARGES	To be retained as an optional item as per the extant list of items
33	MINERAL WATER	To be retained as an optional item as per the extant list of items
34	OIL CHARGES	This item is out of date and may be deleted
35	SANITARY PAD	To be retained as an optional item as per the extant list of items.
36	SLIPPERS	To be deleted as its part of the ROOM Charge.
37	TELEPHONE CHARGES	To be retained as an optional item as per the extant list of items
38	TISSUE PAPER	To be deleted as its part of the ROOM Charge.
39	TOOTH PASTE	To be deleted as its part of the ROOM Charge.
40	TOOTH BRUSH	To be deleted as its part of the ROOM Charge.
41	GUEST SERVICES	To be retained as an optional item as per the extant list of items
42	BED PAN	To be deleted as it is part of the ROOM Charge.
43	BED UNDER PAD CHARGES	To be deleted; this is not a term used in a provider setting and does not relate to a specific charge
44	CAMERA COVER	To be deleted as is part of the surgical procedure charge, wherever applicable
45	CLINIPLAST	This is a BRAND and is covered under Point 87, below. This item to be deleted here.
46	CREPE BANDAGE	To be retained as an optional item as per the extant list of items
~~47~~	CURAPORE	This is a BRAND and is covered under Point 87, below. To be deleted here.
48	DIAPER OF ANY TYPE	To be retained as an optional item as per the extant list of items
49	DVD, CD CHARGES	To be deleted; this is part of a specific procedure (be it diagnostic or therapeutic)
50	EYELET COLLAR	To be retained as an optional item as per the extant list of items.
51	FACE MASK	To be deleted as it is part of the ROOM Charge.
52	FLEXI MASK	To be deleted as it is part of the ROOM Charge.
53	GAUSE SOFT	To be deleted as is part of a specific procedure charge, wherever applicable
54	GAUZE	To be deleted as is part of a specific procedure charge, wherever applicable

SNo	Item	Remarks
55	HAND HOLDER	To be deleted as it is part of the ROOM Charge.
56	HANSAPLAST/ ADHESIVE BANDAGES	To be deleted this line item here; already covered under Point 87, below
57	INFANT FOOD	To be deleted this as a line item here, as it is already covered under item no. 3 above
58	SLINGS	To be retained as an optional item as per the extant list of items
59	WEIGHT CONTROL PROGRAMS/SUPPLIES / SERVICES	To be deleted as line item here. It is subject to product design. No need to specify as an optional item.
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.	To be deleted as a line item here. It is subject to product design where OPD is available.
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Already deleted by IRDA
62	HORMONE REPLACE MENT THERAPY	Already deleted by IRDAI
63	HOME VISIT CHARGES	To be deleted as a line item here. It is part of product design and may be part of post hospitalization or domiciliary treatment
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Already deleted by IRDAI
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Already deleted by IRDAI
66	PSYCHIATRIC AND PSYCHOSOMATIC DISORDERS	Already deleted by IRDAI
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Already deleted by IRDAI
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Already deleted by IRDAI
69	DONOR SCREENING CHARGES	To be deleted as a line item here. It is part of product design.

SNo	Item	Remarks
70	ADMISSION/REGISTRATION CHARGES	To be deleted as a line item, as it is part of hospitalization expenses.
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	To be deleted as a line item here, as it is not to be an option item. Subject to terms and conditions and also subject to the treatment for which the policyholder admitted.
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	This cannot be part of any POLICY COVER and should remain an **exclusion (not covered).** Hence, need not be shown as a line item. To be deleted here.
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Deleted by IRDAI
74	STEM CELL IMPLANTATION/ SURGERY and storage	Deleted by IRDAI
75	WARD AND THEATRE BOOKING CHARGES	To be incorporated in the IP admission charges (bed charges) and cannot be charged separately. Hence, to be deleted as a line item here.
76	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	Instrument rental charges, if any, to be part of the procedure charges for **Arthroscopy + Endoscopy + Laparoscopy + Robot assisted** procedures. Hence, to be deleted as a line item here.
77	MICROSCOPE COVER	To be incorporated in the Diagnostic (Laboratory) charge master for each test needing a microscopic examination of the sample/specimen. Hence, to be deleted as a line item here.
78	SURGICAL BLADES, HARMONICSCALPEL, SHAVER	To be incorporated into the specific procedure charges, hence to be subsumed into the surgical procedure charges. Hence, to be deleted as a line item here.
79	SURGICAL DRILL	To be incorporated into the specific procedure charges, hence to be subsumed into the surgical procedure charges. Hence, to be deleted as a line item here.
80	EYE KIT	To be incorporated into the specific procedure charges, hence to be subsumed into the surgical procedure charges. Hence, to be deleted as a line item here.
81	EYE DRAPE	To be incorporated into the specific procedure charges, hence to be subsumed into the surgical procedure charges. Hence, to be deleted as a line item here.

SNo	Item	Remarks
82	X-RAY FILM	To be incorporated into the specific procedure charges, hence to be subsumed into the surgical procedure charges. Hence, to be deleted as a line item here.
83	SPUTUM CUP	To be incorporated in the bed charges. Hence, to be deleted as a line item here.
84	BOYLES APPARATUS CHARGES	To be subsumed into the surgical charges needing 'general anesthesia. Hence, to be deleted as a line item here.
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	To be retained as an optional item as per the extant guidelines.
86	ANTISEPTIC OR DISINFECTANT LOTIONS incorporated into	the Procedure Charges (bedside procedure and/or surgical procedure) and to be subsumed accordingly.2. Hand Sanitizers and Disinfectants to be subsumed into the Bed/ room Charges.To be deleted as a line item here.
87	BAND AIDS, BANDAGES STERLILE INJECTIONS, NEEDLES, SYRINGES	This need not be a part of Optional item as it is essential to patient safety and infection control.To be incorporated into the Procedure Charges (bedside procedure and/or surgical procedure) and to be subsumed accordingly.To be deleted as a line item here.
88	COTTON	This need not be part of an Optional Cover as it is essential to patient safety and infection control.To be incorporated into the Procedure Charges (bedside procedure and/or surgical procedure) and cannot be billed separately.To be deleted as a line item here.
89	COTTON BANDAGE	This need not be part of an Optional item as it is essential to patient safety and infection control.To be subsumed the Procedure Charges (bedside procedure and/or surgical procedure).To be deleted as a line item here.
90	MICROPORE/ SURGICAL TAPE	Micropore is a BRAND and thus to be deleted. Surgical tape is to be part of procedure charges. Hence, to be deleted as a line item here.
91	BLADE	To be deleted as a line item here for the reasons specified at Item 78 above.
92	APRON	To be deleted as this is part of the patient room charges and/or surgical charges
93	TORNIQUET	This need not be part of an Optional item as it is essential to patient safety and infection control.To be subsumed into the Procedure Charges (bedside procedure and/or surgical procedure). Hence, to be deleted as a line item here.
94	ORTHOBUNDLE, GYNAEC BUNDLE	To be deleted as this is a NON-STANDARD medical term and is used by some providers to define a surgical tray (to be part of instruments)

SNo	Item	Remarks
95	URINE CONTAINER	To be subsumed into the Diagnostic (Laboratory) charge for each test needing a urine container
II	**ELEMENTS OF ROOM CHARGE**	
96	LUXURY TAX	"All applicable taxes" to be subsumed into ROOM CHARGES.To be deleted as a line item here.
97	HVAC	This is to be part of a ROOM CHARGE, if applicable. To be deleted as a line item here.
98	HOUSE KEEPING CHARGES	This need not be an Optional Item and is to be part of a ROOM CHARGE. To be deleted as a line item.
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	To be retained as an optional item as per the extant guidelines.
100	TELEVISION AND AIR CONDITIONER CHARGES	Air Conditioning Charges to be part of room charges. Television to be retained as an optional item as per the extant guidelines.
101	SURCHARGES	To be retained as an optional item as per the extant guidelines.
102	ATTENDANT CHARGES	To be retained as an optional item as per the extant guidelines.
103	IM IV INJECTION CHARGES	This is not an Optional Cover Item and is Mandatorily part of a ROOM CHARGE as an associated medical expense. To be deleted as a line item here.
104	CLEAN SHEET	This is not an Optional Cover Item and is Mandatorily part of a ROOM CHARGE as an associated medical expense. To be deleted as a line item here
105	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	To be retained as an optional item as per the extant guidelines.
106	BLANKET/WARMER BLANKET	This is not an Optional Cover Item and is to be subsumed as part of a ROOM CHARGE
III	***ADMINISTRATIVE OR NON-MEDICAL CHARGES***	
107	ADMISSION KIT	To be part of ROOM Charge. To be deleted as a line item here.
108	BIRTH CERTIFICATE	To be retained as an optional item as per the extant guidelines.
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	To be deleted; as it becomes (squared off) when the patient consumes the IP services and to be subsumed suitably to the relevant charges.

SNo	Item	Remarks
110	CERTIFICATE CHARGES	To be retained as an optional item as per the extant guidelines.
111	COURIER CHARGES	To be retained as an optional item as per the extant guidelines.
112	CONVEYANCE CHARGES	To be retained as an optional item as per the extant guidelines.
113	DIABETIC CHART CHARGES	To be deleted and is part of the ROOM CHARGES, to be subsumed accordingly.
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES, to be subsumed accordingly.
115	DISCHARGE PROCEDURE CHARGES	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES.
116	DAILY CHART CHARGES	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES.
117	ENTRANCE PASS / VISITORS PASS CHARGES	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES.
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES
119	FILE OPENING CHARGES	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES
121	MEDICAL CERTIFICATE	To be retained as an optional item as per the extant guidelines.
122	MAINTAINANCE CHARGES	Not a specific charge normally levied by network providers / hospitals and may be deleted
123	MEDICAL RECORDS	To be retained as an optional item as per the extant guidelines.
124	PREPARATION CHARGES	This is a non-standard term in inpatient care and may be deleted
125	PHOTOCOPIES CHARGES	To be retained as an optional item as per the extant guidelines.
126	PATIENT IDENTIFICATION BAND / NAME TAG	To be deleted from OPTIONAL LIST and is part of the ROOM CHARGES

SNo	Item	Remarks
127	WASHING CHARGES	To be deleted; refer item no. 32, above
128	MEDICINE BOX	This is a non-standard term in inpatient care and may be deleted
129	MORTUARY CHARGES	To be retained as an optional item as per the extant guidelines.
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	To be deleted; as this cannot be part of the bill to a patient and is a STATUTORY requirement that a hospital has to fulfil.
IV	**EXTERNAL DURABLE DEVICES**	
131	WALKING AIDS CHARGES	To be retained as an optional item as per the extant guidelines.
132	BIPAP MACHINE	BIPAP is not a single use device and a DAILY CHARGE while the patient is in the hospital should be part of the treatment costs. To be deleted as a line item here.
133	COMMODE	In-patient use of a COMMODE should be part of the bed-charges. To be deleted as a line item here.
134	CPAP/ CAPD EQUIPMENTS	CPAP is not a single use device and a DAILY CHARGE while the patient is in the hospital, to be part of costs of treatment. To be deleted as a line item here.
135	INFUSION PUMP-COST	Infusion Pump is not a single use device and a DAILY CHARGE while the patient is in the hospital to be part of the cost of treatment. To be deleted as a line item here.
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	To be retained as an optional item as per the extant guidelines.
137	PULSEOXYMETER CHARGES	To be deleted; as this is part of the Bed Charge.
138	SPACER	To be retained as an optional item as per the extant guidelines.
139	SPIROMETRE	To be retained as an optional item as per the extant guidelines.
140	SPO2 PROBE	To be deleted; already covered in Point 137, above
141	NEBULIZER KIT	To be retained as an optional item as per the extant guidelines.
142	STEAM INHALER	To be retained as an optional item as per the extant guidelines.
143	ARMSLING	To be retained as an optional item as per the extant guidelines.
144	THERMOMETER	To be retained as an optional item as per the extant guidelines.

SNo	Item	Remarks
145	CERVICAL COLLAR	To be retained as an optional item as per the extant guidelines.
146	SPLINT	To be retained as an optional item as per the extant guidelines.
147	DIABETIC FOOT WEAR	To be retained as an optional item as per the extant guidelines.
148	KNEE BRACES (LONG/ SHORT/ HINGED)	To be retained as an optional item as per the extant guidelines.
149	KNEE IMMOBILIZER/ SHOULDER IMMOBILIZER	To be retained as an optional item as per the extant guidelines.
150	LUMBO SACRAL BELT	To be retained as an optional item as per the extant guidelines.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	To be retained as an optional item as per the extant guidelines.
152	AMBULANCE COLLAR	To be retained as an optional item as per the extant guidelines.
153	AMBULANCE EQUIPMENT	To be retained as an optional item as per the extant guidelines.
154	MICROSHEILD	This is a brand; to be deleted
155	ABDOMINAL BINDER	To be retained as an optional item as per the extant guidelines.
V	**ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION**	
156	BETADINE\ HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC	Betadine is a BRAND. To be deleted. These are items of patient safety. To be deleted as a line item here.
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	To be retained as an optional item as per the extant guidelines.
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	This is service and NOT a CONSUMABLE/DEVICE and to be part of the treatment. To be deleted here.
159	SUGAR FREE Tablets	To be retained as an optional item as per the extant guidelines.
160	CREAMS POWDERS LOTIONS	(Toiletries are not payable, only prescribed medical pharmaceuticals payable) To be retained as an optional item as per the extant guidelines.
161	Digestion gels	To be deleted as this is a pharmaceutical product and not a CONSUMABLE/DEVICE
162	ECG ELECTRODES	To be retained as an optional item as per the extant guidelines.

SNo	Item	Remarks
163	GLOVES	To be retained as an optional item as per the extant guidelines.
164	HIV KIT	To be deleted as this is part of the TEST CHARGE and not a standalone charge item
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Listerine is a BRAND. To be deleted. Antiseptic mouthwash to be part of cost of treatment / Pharmacy (if supported by bill). To be deleted as a line item here.
166	LOZENGES	To be part of Pharmacy (if supported by prescription). To be deleted as a line item here.
167	MOUTH PAINT	To be part of Pharmacy (if supported by prescription). To be deleted as a line item here.
168	NEBULISATION KIT	To be retained as an optional item as per the extant guidelines.
169	NOVARAPID	NOVARAPID is a brand of INSULIN. To be deleted as a line item here.
170	VOLINI GEL/ ANALGESIC GEL	VOLINI is a BRAND of Analgesic. To be deleted here. Analgesic gel is part of treatment costs to be deleted.
171	ZYTEE GEL	ZYTEE is a BRAND. To be deleted.
172	VACCINATION CHARGES	Part of cost of treatment subject to terms and conditions. To be deleted here.
VI	**PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE**	
173	AHD	No such cost. May be deleted.
174	ALCOHOL SWABES	To be part of treatment. May be deleted.
175	SCRUB SOLUTION/ STERILLIUM	STERILLIUM is a BRAND to be deleted. Scrub Solution to be part of treatment. To be deleted
VII	**OTHERS**	
176	VACCINE CHARGES FOR BABY	To be part of terms and conditions of policy contract. To be deleted
177	AESTHETIC TREAT-MENT / SURGERY	Deleted by IRDAI
178	TPA CHARGES	TPA Charges are subsumed into the premiums. To be deleted.
179	VISCO BELT CHARGES	VISCO is a BRAND and is covered in Point 145/146, above. To be deleted.
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	To be retained as an optional item as per the extant guidelines.

SNo	Item	Remarks
181	EXAMINATION GLOVES	CONFLICT WITH Point 163, above (there is no separate class of examination gloves). To be deleted.
182	KIDNEY TRAY	To be retained as an optional item as per the extant guidelines.
183	MASK	To be retained as an optional item as per the extant guidelines.
184	OUNCE GLASS	To be retained as an optional item as per the extant guidelines.
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	To be part of the terms and conditions of policy contract. To be deleted.
186	OXYGEN MASK	To be retained as an optional item as per the extant guidelines.
187	PAPER GLOVES	CONFLICT WITH Point 163, above. To be deleted here.
188	PELVIC TRACTION BELT	To be retained as an optional item as per the extant guidelines.
189	REFERAL DOCTOR'S FEES	To be part of the terms and conditions of policy contract. To be deleted.
190	ACCU CHECK (Glucometer& Strips)	ACCU Check is a BRAND. Delete it. Glucometer and Strips are part of the cost of treatment. To be deleted.
191	PAN CAN	To be retained as an optional item as per the extant guidelines.
192	SOFNET	SOFNET IS A BRAND. To be deleted.
193	TROLLY COVER	To be retained as an optional item as per the extant guidelines.
194	UROMETER, URINE JUG	To be retained as an optional item as per the extant guidelines.
195	AMBULANCE	To be retained as an optional item as per the extant guidelines.
196	TEGADERM / VASOFIX SAFETY	TEGADERM is a BRAND. To be deleted. Vasofix Safety, to be retained as an optional item as per the extant guidelines.
197	URINE BAG	To be part of cost of treatment to be deleted.
198	SOFTOVAC	SOFTOVAC is a BRAND. To be deleted.
199	STOCKINGS	Already covered at item no. 31 above. (as Stockings and Leggings are the same). To be deleted here.

1. With reference to Sub-Group IV (items which are referred as External Durable Devices), it is considered very important to differentiate what is being used at the provider as part of patient care vis-a-vis items that the patient is taking HOME, at discharge. If the patient takes it home at DISCHARGE, then the INSURER may be allowed to offer such items as OPTIONAL COVERs.

2. With reference to sub-group VI (items which are referred as part of hospital's own costs and not payable) the working group is of the view that instead of making these items as part of optional covers, it may be mandatedto the insurers to make it part of their service level agreement with the network providers (hospitals) in case of cashless cases and in case of reimbursements (with other than network providers) settle the claims as per the terms and conditions of the policy contract.

3. On a review of the above, it may be observed that the existing 'Optional Items' may be classified into the following categories.

   i. Items that may be retained 'as it is' as optional items – These Items may be continued as Optional Items to which Insurers may offer coverage.

   ii. Costs that are to be subsumed into the Room Charges – These Items are to be deleted and Insurers shall consider as part of room charges

   iii. Costs that are to be subsumed into the specific (say surgical) procedure charges – These Items are to be deleted and Insurers shall consider as part of procedure charges.

   iv. Costs that are to be subsumed into the costs of treatment – These Items are to be deleted and Insurers shall consider as part of costs of treatment.

   v. Costs that are to be subsumed into the diagnostics et al. - These Items are to be deleted and Insurers shall consider as part of costs of treatment.

4. Where the costs are to be subsumed into the room charges or procedure charges or costs of treatment or diagnostics, it is considered that every prudent insurer as part of policyholder friendly initiative would have already put in place measures for settlement of claims in accordance to the terms and conditions of the policy contract. Therefore, deletion of the items from the existing list of items will not have any impact on the prices. As service level agreements are normally entered with several network providers (hospitals) and that cashless claims are predominant in health insurance space (56% of total claims in terms of claim amount settled), it is expected that the Insurers will have complete understanding in terms of various items which are to be borne by the hospitals.

5. The Working Group also recommends for transparency and clarity that items which are part of room / surgical procedure / treatment / diagnostic as referred above shall not be billed to the policyholders by the hospitals and every insurer shall publish the list of items which will not be paid, if billed separately.

Annexure - 1

S.no	Category	Suggestions	Remarks
1	**Cancer**	Insurer should cover all the cancer treatments (like Immunotherapy, Targeted Therapy, Hormone Therapy, Oral Chemotherapy and stem cell implant) or specify the treatments which are not allowed in the policy to avoid any confusion to policyholders.	Examined and addressed in respect of Immunotherapy, Oral Chemotherapy and stem cell therapy.
2	**Eye Treatments**	Eye treatment generally does not require hospitalization. Therefore, most of the treatments other than cataract are disallowed on the pretext that the procedure does not figure in day care list. i.e., Intravitreal injections like acentrix, resumabetc) /Photo dynamic therapy (PDT).	It shall be subject to day care procedures specified by the Insurer.
3	**Age related macular degeneration**	It should be covered under the policy subject to waiting period clause.	It is examined and addressed.
4	**Cataract-Base Rate**	There should a uniform base rate for cataract claims	Treatment Costs are determined by hospitals, Further, the costs may also differ from hospital to hospital based on the type of hospital / expertise of surgeon.
5	**Treatment under improved technology / implants/stents/ knee replacement/ multifocal lens**	Insurer should not restrict liability under reasonable and customary. Insured should have the option to avail implants within his sum insured.	It is related to product design. However, application of reasonable and customary clause should be as per the definition specified.
6	**Advanced Technology**	Advanced Technology should be covered.Example – Availing Target therapy instead of chemotherapy, eye treatments avoiding surgery (Photo dynamic therapy)	This is examined and addressed.
7	**Peritoneal Dialysis , ECP, Sleep Study , Dental Implants , Sound wave therapy for heart and Erectile dysfunction, Bariatric Surgery etc**	Peritoneal Dialysis , ECP, Sleep Study , Dental Implants , Sound wave therapy for heart and Erectile dysfunction , Bariatric Surgery etc should be covered	Peritoneal Dialysis and Bariatric Surgery reviewed and addressed. In respect of others: i. Sleep study- Shall be subject to product design. ii. Dental Implants – To be dealt as per product design. iii. Sound wave therapy for Erectile dysfunction – Part of product design.
8	**Non-payables Items**	List of non-payable items should be brought to the notice of Insured whilst proposing the insurance itself.	Prospectus does have a reference of non-payable items.

S.no	Category	Suggestions	Remarks
9	**Time limit for disclosure of Pre-existing Diseases (PED)**	It is often seen that a claim is rejected on ground of non-disclosure of previous health condition which might have existed but cured completely in distant past and insured person is not on a continued medication. If timeline for disclosure of PED is Indefinite, it may not be possible to remember and provide the same in proposal form. It is suggested that a timeline of say 5 years or more may be fixed in proposal form.	Concept of moratorium period discussed in the report to address this.
10	**Coverage of people with PED**	People with PED should be covered	Reviewed and addressed.
11	**Co-relation with PED**	Insurance companies should not co-relate each and every claim with PED. eg. Cause of death is cancer but repudiation of claim is on grounds of long standing diabetes status.	Issues related to PED are reviewed and addressed.

Particulars of Stakeholders Presented:

1. Mr.Shivakumar Shankar, LexisNexis risk solutions
2. Mr.SanjibChaudhuri , Policyholders Representative
3. Mr.Devanathan , GI Council
4. Ms.LimatulaYaden, MoHFW
5. Dr.PrabhaArora, MoHFW
6. Mr. Ajay Kumar,MoHFW
7. Dr.NareshGoel,NACO
8. Ms.NidhiRawat, NACO
9. Ms.MaltiJaswal,Insurance Professional
10. Mr.Kapil Mehta ,SecureNow Insurance Brokers
11. Mr.AshimSanyal,Consumer Voice
12. Ms.AnuradhaSriram, Aditya Birla Health Insurance Co. Ltd
13. Mr.AshishMehrotra , MaxBupa Health Insurance Co. Ltd
14. Dr Nandini Ali, Apollo Munich Health Insurance Co. Ltd
15. Dr.Bhabatosh Mishra, Apollo Munich Health Insurance Co. Ltd
16. Mr. Manish Dodeja, Religare Health Insurance Co. Ltd
17. Mr. Hitesh Kotak, Munich Re
18. Dr.NileshDighe, Munich Re
19. Mr. Deepak Mendiratta, Insurance Professional
20. Dr.Nayan Shah , Paramount Health services & Insurance TPA
21. Mr.RajanSubramaniam , VipulMedCorp Insurance TPA
22. Dr.AbhitabhGupta,Paramount Health services & Insurance TPA
23. Mr.SoumitraNarain, SBI General Insurance Co. Ltd
24. Dr.Meenal,SBI General Insurance Co. Ltd
25. Mr.AtulDeshpande, HDFC Life Insurance Co. Ltd
26. Mr.AnkurNijhawan , Axa French Vie India
27. Mr. Deep Narayan, NHA
28. Mr.DigvijaySandhu, NHA
29. Dr.ArunTiwari, NHA
30. Ms.PriyaGilbile,MaxBupa Health Insurance Co. Ltd
31. Dr, AslamNaori,MaxBupa Health Insurance Co. Ltd
32. Mr. Anil Kumar, Axa French Vie India
33. Mr.SuhasTiwari, Consumer Voice
34. Mr.PrashantMhatre, GIAFI
35. Mr.K.Raja, GIAFI
36. Dr NirmalaSrinivasan, FACEMI

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- Assessment of medical devises: https://www.iqwig.de/en/about-us/10-years-of-iqwig/assessing-medical-devices.6334.html