CAG
Citizen consumer and civic Action Group

Consumer perspectives on health insurance

Understanding consumers' knowledge and awareness of health insurance

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About CAG

CAG is a 37-year-old non-profit and non-political organisation that works towards protecting citizens' rights in consumer, civic and environmental issues and promoting good governance processes including transparency, accountability and participatory decision-making.

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Executive Summary

Medical insurance or health insurance covers medical expenses for illnesses and injuries. The fundamental duty of a health insurance plan is to protect people from unavoidable medical expenses, offering some safeguards from financial constraints. Health Insurance either reimburses the expenditure incurred during the process of treatment or directly pays the hospitals on behalf of the insurer. While there are various health insurance plans in India, each with its own advantages and disadvantages, the decision of which is the best fit for their needs is made by the insurance taker. To make an informed policy purchase and thereafter, to benefit adequately from any bought coverage, consumers need a good understanding of what they are covered for, what the claim mechanisms are, and what could scupper a claim.

To understand how well the average consumer knows and interprets her health insurance policy, CAG developed and administered a survey targeting general consumers across 22 districts in Tamil Nadu. The survey looked at respondents' grasp of insurance policies, awareness of premium payments and consumer benefits. The study followed a random sampling technique with close-ended questions and targeted around 500 participants.

The survey findings indicate that the majority of consumers who had approached the insurance companies for claims have had a positive experience with their companies with 80% of claims being approved, and 73.4% of consumers believing that their insurance companies are transparent when disclosing required information to their customers. Most consumers also appear knowledgeable about their policies with 86% saying they have read and understood the terms and conditions of their policies, 77.5% understanding that their premium payments are connected to their age and 70% understanding that non-disclosure of pre-existing conditions could preclude any claims. All this constitutes an aware and informed user base. On the downside, 53% of respondents were unaware of the presence and role of the Insurance Ombudsman.

1 INTRODUCTION

The share of India's national budget spent on healthcare continues to remain one of the lowest in the world. This means that expenditure for healthcare is usually out of pocket. (Source: Tanja Ahlin, Mark Nitcher & Gopukrishnan Pillai). The vast majority of people are aware of, even afraid of, such unplanned expenditures, and try to live healthy lifestyles to avoid this. Nonetheless, there are unforeseen circumstances that affect our health, for example, an accident. It is at such times that health insurance helps us in protecting ourselves from the financial burden caused by these unforeseen circumstances, thus offering us a feeling of financial security.

Recently, India has been advocating health insurance plans for those living below the poverty line as a means of providing financial security in times of medical distress. Pradhan Mantri Jan Arogya Yojana (PMJAY) is one such step towards "Universal Health Care by 2030" which primarily focuses on providing insurance coverage to the poorest 40% of the population. The plan covers approximately 50 crore Indians, with insurance coverage of up to Rs 5 lakhs per. The scheme can be availed for complete hospitalisation coverage for both secondary and tertiary care (Source: NITI Aayog). In Tamil Nadu, the Chief Minister Comprehensive Health Insurance Scheme (CMCHIS) was launched as Kalaingar Kaappittu Thittam in 2009, and for the next five years from 2022, the same scheme is to be provided under United India Insurance Company. This scheme aims to offer cashless hospitalisation for particular illnesses or treatments covered under the plan and for such illnesses and treatments, coverage is offered up to Rs. 5,00,000 per family, per year, on a floater basis.

1.1 Policy framework of the Health Insurance industry

Insurance in India saw its early roots in 1818 when the Oriental Life Insurance company was first set up in Calcutta. The Indian Life Assurance Companies Act in 1912 was the first statutory measure to regulate these businesses. Both the businesses and the regulations around these have been constantly evolving since then. Now, the Insurance Regulatory and Development Authority of India (IRDAI) protects insurance policyholders through regulations and rules that range from the registration of companies to the promotion of competition in the industry. "To protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto" (Source: IRDAI) is the mission recognized by the IRDAI. The Insurance Act of 1938 is the fundamental act governing and providing powers to the IRDAI for implementing policies and guidelines to maintain the insurance sector. All Life, General, and Health Insurance companies that are registered with IRDAI sell indemnity-based and benefit-based health insurance products. Fixed benefit policies pay a

set amount after a claim is made. Indemnity plans reimburse you for the money you spend on medical treatment. (Source: IRDA FAQs)

The Office of Insurance Ombudsman, established under the Insurance Ombudsman Rules, 2017, is a grievance redressal platform established with the goal of resolving grievances of aggrieved policyholders against Insurance Companies and their Intermediaries or Insurance Brokers in a timely and cost-effective manner. The Insurance Ombudsman Offices are administered by the Council for Insurance Ombudsmen (CIO).

2 Data Collection

The study was done by deploying a questionnaire targeting general consumers across 22 districts in Tamil Nadu viz. Chennai, Trichy, Udumalpet, Tirupur, Tuticorin, Thiruvallur, Theni, Thanjavur, Sivagangai, Salem, The Nilgiris, Namakkal, Madurai, Krishnagiri, Dindugal, Karur, Kanyakumari, Erode, Cuddalore, Coimbatore, Chengalpattu, and Ariyalur. The study focused on: 1) Understanding health insurance policies 2) Awareness of premium payments 3) Consumer Benefits. The study followed a random sampling technique with close-ended questions and targeted around 500 participants.

3 Findings from the study

3.1 Health insurance policyholders:

The majority of the respondents (92%) have health insurance policies individually or along with their families.

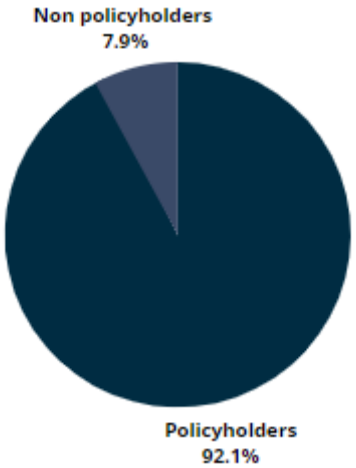


Fig 1: Health insurance policyholders

3.2 Policyholders details:

- The policyholders fall between the age group of 13 and 59.
- 47% of the respondents were female and 53% were male
- Around 2% have held policies since the 1990s.
- 23.2% have their whole family members covered in the policy.

3.3 Terms and conditions:

It was interesting to find that 86% of the policyholders had read and understood the terms and conditions of the policy, showing a significant increase in consumer awareness. The remaining 14% either did not read or did not understand the terms and conditions even after reading them.

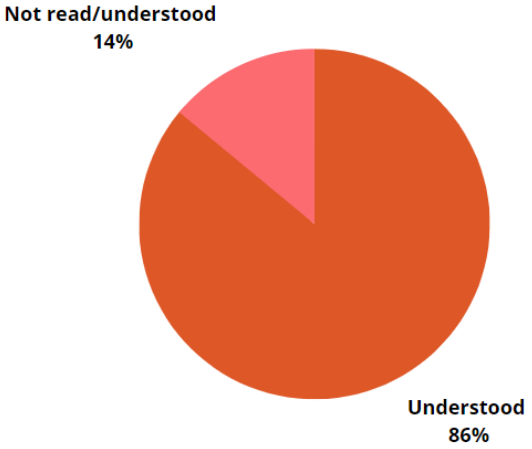
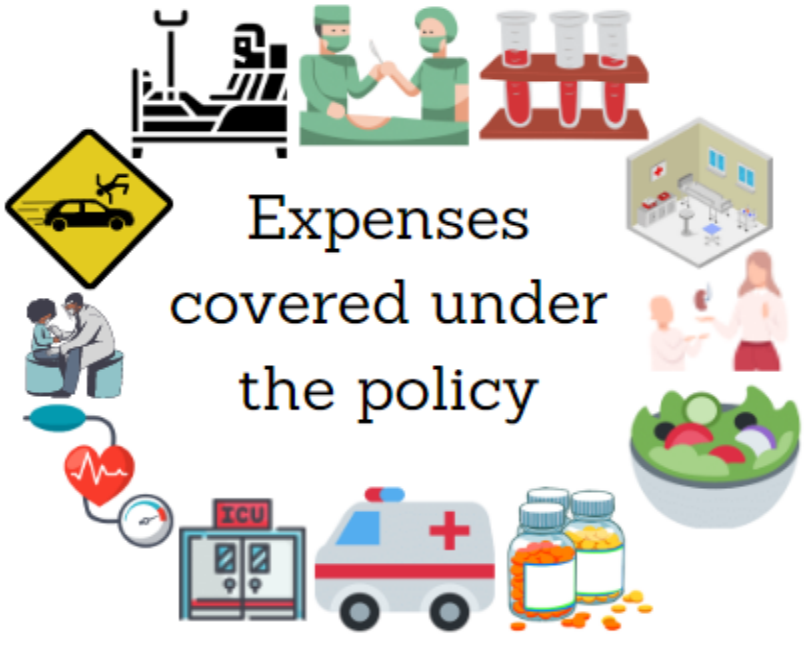


Fig 2: Understanding terms and conditions

3.4 Expenses covered under the policy:



The major expenses covered under the policy to the extent of the available cover, as mentioned by the respondents are pre/post hospitalisation charges, master health checkups, surgery and ICU charges, accident coverage, bloodwork, ambulance, medicines, food, room charges, doctor

consultation, nursing, mental health care charges, daycare charges, and donor transplant expenses.

3.5 Illnesses/ Expenses not covered under the policy:

Respondents were asked to list those illnesses or the expenses that are not usually covered in their policies. The respondents came up with the following: COVID charges, dental surgery, eye checkups, AIDS, ailments due to intoxication of drugs and alcohol, self-inflicted injuries, skin and hair treatment, plastic surgery, pre-existing diseases, x-ray charges, genetic disorders, abortion, venereal diseases, common illnesses (e.g.fever and cough), buying medical devices, health supplements, off label use, proportionate clause/ deduction, and admission fee.

3.6 Pre-existing diseases:

An individual's medical condition existing at the time of purchasing a health insurance policy is termed as pre-existing disease. Medical conditions such as blood pressure, diabetes, depression, etc are common examples of pre-existing diseases. According to the survey undertaken 380 (77%) respondents were aware of the term 'pre-existing diseases'.

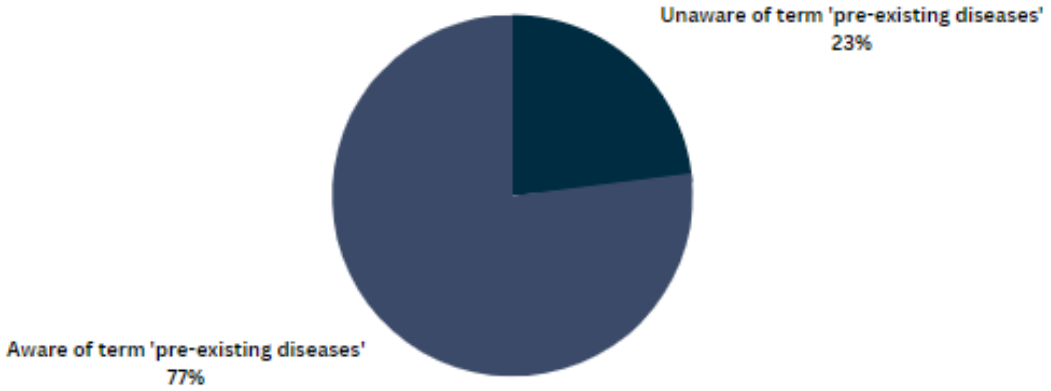
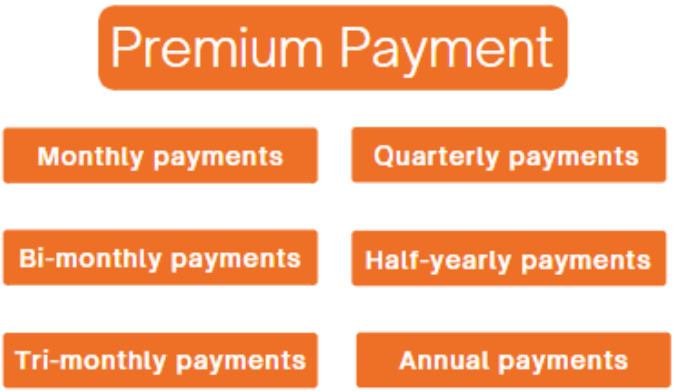


Fig 3: Awareness of term 'pre-existing diseases'

3.7 Premium payment

The policyholders have reported that they pay their premiums as either monthly, bi-monthly, tri-monthly, quarterly, half-yearly, or annual payments.



3.8 Premium payment intimation:

Respondents reported premium payments reminders being sent as (i) just a reminder of the total amount to be paid (48.5%), (ii) the total amount with break-up details (43.2%), (iii) debited from their accounts as a recurring payment (8.3%).

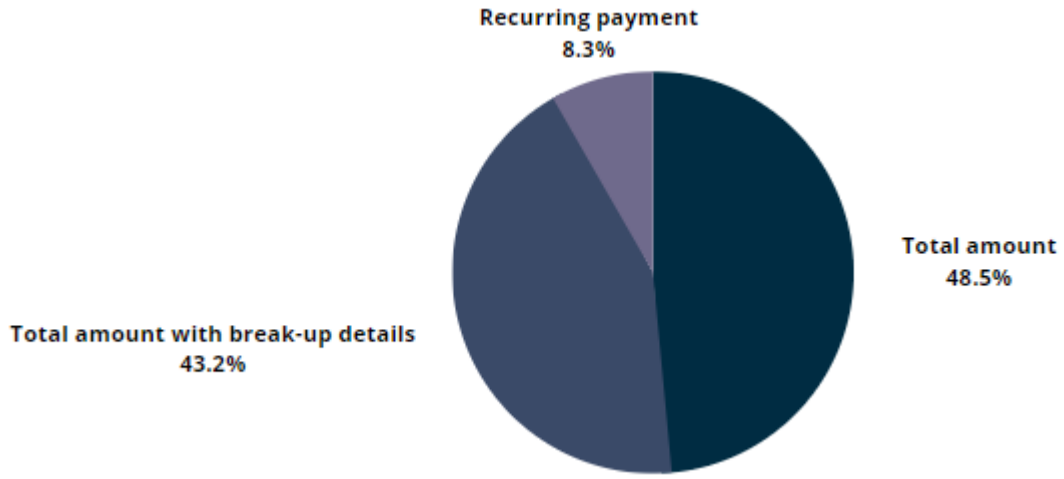


Fig 4: Premium payment intimation

3.9 Premium amount during the last three years:

3.9.1 Consistency:

Around 63% of policyholders reported that their premium payment has remained unchanged over the last 3 years while 37% of the policyholders have seen an increase. Among the 37%, the increase in their premium payment ranged between 5% and 20%, (an increase between Rs 250 to Rs 20,000). Policyholders felt the substantial increase was due to their old age.

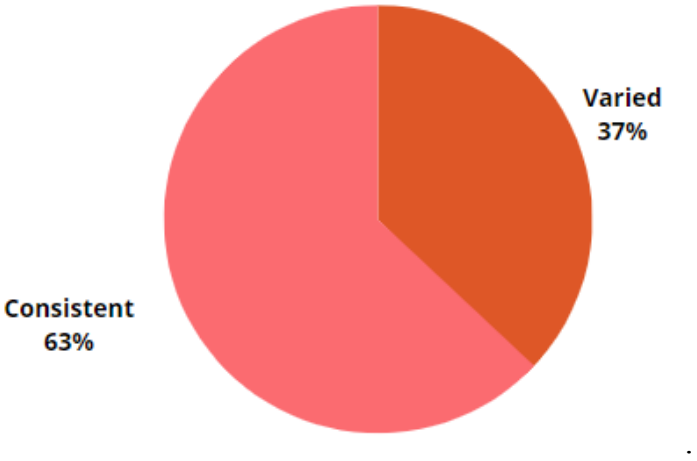


Fig 5: Consistency of amount paid as premium

3.9.2 Concerns behind sharp hikes:

44.8% of policyholders have seen sharp increases in their premium payments, enough to concern them in the last three years.

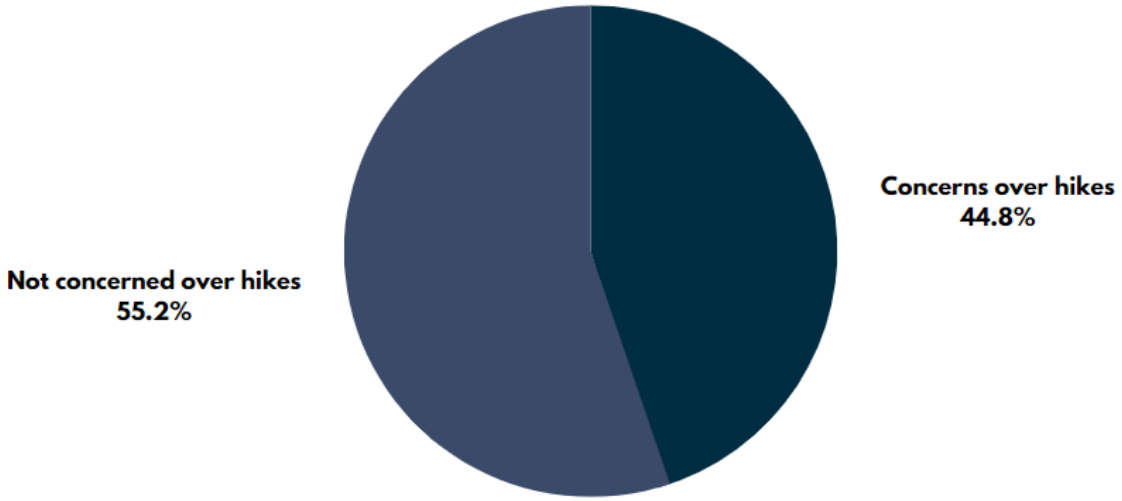


Fig 6: Concerns over sharp hikes

3.9.3 Knowledge of payments being proportional to age:

One of the most important factors that influence premium health insurance policies is the age of a policyholder. Generally, insurance providers demand higher premiums for older policyholders. According to the survey, 77.5% of policyholders are aware that the premium paid is proportional to their age.

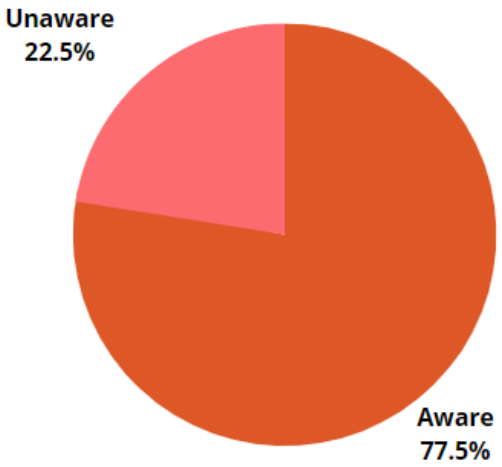


Fig 7: Knowledge of payments being proportional to age

3.10 Mediclaim

3.10.1 Issues in filing

Respondents listed the following issues when filing a medi-claim:

- Time taken to file a claim
- Complex documentation process
- Lengthy formalities
- Delayed response from hospital and insurance provider
- Delay in processing the claim
- Lack of knowledge and language barriers

3.10.2 Reasons for rejection of claims

According to respondents, the most common reasons for which medi-claim is usually rejected are poor documentation, verification and submission; exceeding claim amount; non-disclosures, partial disclosures and wrong disclosures of important details; mismatch between documents; and claims for illness/expense that are not covered under the policy.

3.11 Seeking an insurance claim and the experience

Out of the 500 participants, 181 policyholders said that they had filed for a claim. Of these, 89 (61%) respondents replied that they received cashless treatment and 56 (39%) respondents filed for reimbursement post illness, totalling to 145 respondents.

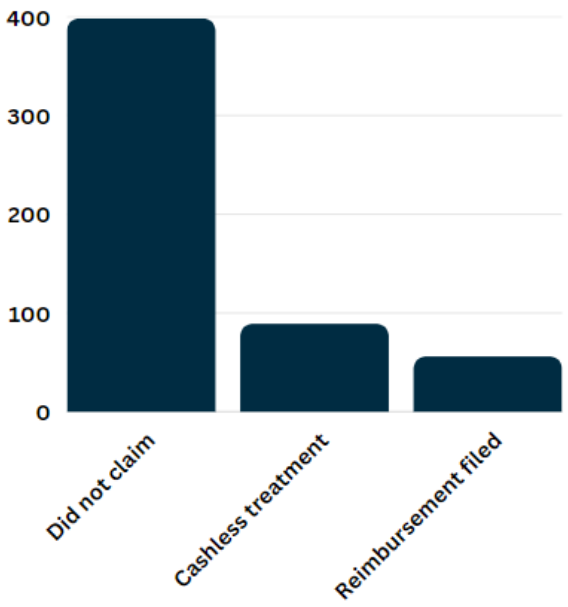


Fig 8: Insurance claim sought

To the question on their experience about the claim settlement, 140 participants responded, of which, 71.4% mentioned that the insurance amount was settled immediately, 20.7% experienced a delayed settlement and 7.9% reported that their claim was rejected.

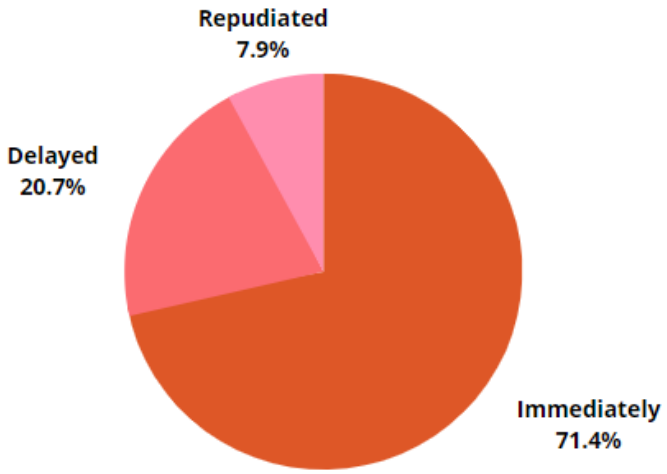


Fig 9: Experience of claiming

3.12 Mis-selling/ salesmen peddling the policies

According to reports, insurance policies are frequently mis-sold. Giving incorrect information about a policy's features or inflating returns happens quite regularly. 40% of

respondents in this study agreed that this was an issue. However, none of them had faced any problems due to mis-selling.

3.13 Disclosure of required information

The majority of the policyholders, about 73.4%, accept that insurance companies are transparent in disclosing the required information to consumers.

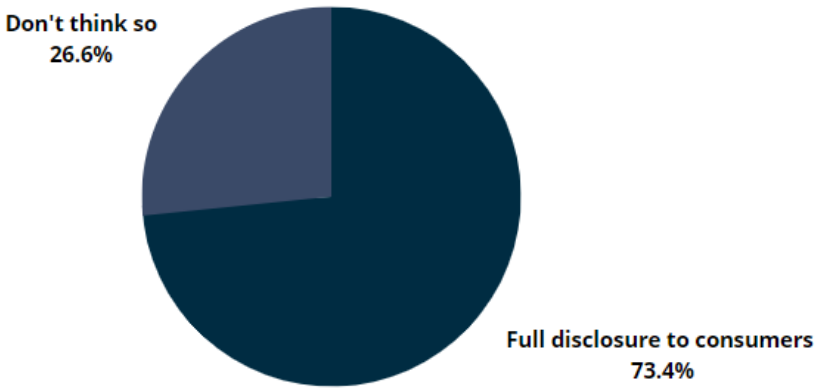


Fig 10: Disclosure by company of required information

3.14 Insurance Ombudsman

The survey revealed that the knowledge about the Insurance Ombudsman was incredibly low. Around 57% of the respondents have not heard about the Insurance Ombudsman and only 43% have heard about the Insurance Ombudsman.

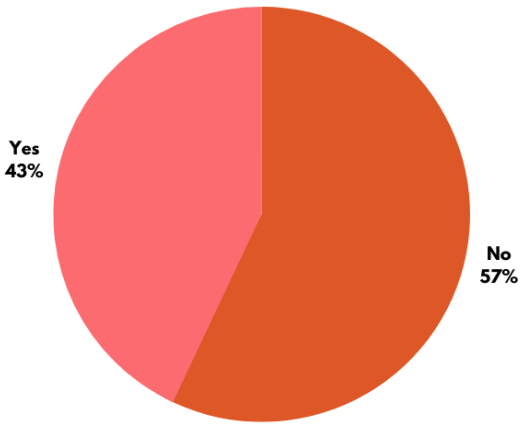


Fig11: Knowledge about insurance ombudsman

4 Inferences

The insurance sector has grown and diversified over the years. Thanks to India's low budget allocation for public health services, a large number of people depend on health insurance policies to keep them safe from unexpected medical expenditure. This, therefore, leaves several thousands of people at the mercy of the insurance industry. The IRDAI's regulations appear to have kept the industry competitive and people-oriented, as apparent from the survey, which found that a good majority of the respondents report positive experiences with this sector. This finding goes contrary to popular belief.

There also appears to be a trusting relationship between policyholders and companies, with a good majority of policyholders believing that companies are open and transparent about the information they share with their customers. However, this data must be interpreted on the basis of the fact that the vast majority of respondents have not yet tried claiming on their policy (63%). The point of claim is typically the acid test, where policyholders are suddenly made aware of clauses that they did not know existed; or denied claims for reasons they disagree with. This remains a limitation of the study.

The worrying finding here is that the public is unaware of the resolution and mediation services offered by the Ombudsman. This is an important lacunae that must be addressed.

Conclusion

Even as the insurance industry grows to keep up with the needs of the population, it is important that regulations and laws are kept renewed and current, to keep the public protected at all times. Apart from this, there is a pressing need to keep the public informed about mediation and resolution measures, especially those available through the Ombudsman. This is particularly important as with the purchase of health insurance policies surging, the number of claims is likely to increase in the near future. We need awareness campaigns to help the general public and policyholders aware of their coverage, rights and obligations related to insured interest, claim settlement, surrender value and other terms and conditions etc of the insurance policies. This role needs to be played by both the public and private sector insurance companies.