

Master Circular on Health Insurance Business



Version:1

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

Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024

Date: 29.05.2024

To

All General Insurers, Health Insurers and Life Insurers

Sub: Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance

- A. This Master Circular is issued under the section 14(2)(e) of the IRDAI Act 1999 and section 34 of the Insurance Act, 1938 read with Regulation 7 of schedule-III of IRDAI (Insurance Products) Regulations 2024.
- B. The Master Circular shall be reviewed every year unless review or repeal is warranted earlier.
- C. The Returns referred under this circular shall be submitted as per the provisions herein and the Master Circular on submission of returns.
- D. All words and explanations used herein and not defined in this Master Circular but defined in the Insurance Act, 1938 (4 of 1938) or Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) or Rules or Regulations made thereunder shall have the meanings respectively assigned to them in those Acts or Rules or Regulations.
- E. In Order to remove any doubts or difficulties that may arise in the application or interpretation or any of the provisions of this Master Circular, the Competent Authority may issue appropriate clarifications, as and when deemed necessary.

This has approval of the Competent Authority.

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Chief General Manager

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Effective date:

- (1) This Master circular shall come into force with immediate effect except for provisions where specific effective date is mentioned.
- (2) The existing products which are not complying with the IRDAI (Insurance Products) Regulations 2024 and this Master Circular shall be modified on or before 30.09.2024. Revision in terms and conditions of the products that are warranted exclusively due to the application of any of the updated provisions contained in this circular or the IRDAI (Insurance Products) Regulations, 2024 shall be carried out under the extant UIN, with the approval of Product Management Committee (PMC).

The PMC shall ensure that the benefits such as waiting period, Moratorium period accrued to the credit of the policyholder are protected and carried forward to the new policy issued.

- (3) The Insurer may extend the benefits arising out of the revised regulatory framework to the existing policyholders.

Chapter I: General Information for the Policy Holder/Prospect/Customer:

1)	a. Insurers are required to make available products/add-ons/riders to provide wider choice to the policyholders/prospects catering to i. all ages; ii. all types of existing medical conditions; iii. pre-existing diseases and chronic conditions; iv. all systems of medicine and treatments including Allopathy, AYUSH and other systems of medicine; v. every situation of treatment including domiciliary hospitalization, outpatient treatment (OPD), Day Care and Homecare treatment; vi. all regions, all occupational categories, persons with disabilities and any other categories
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	vii. all types of Hospitals and Health Care Providers to suit the affordability of the policyholders/prospects. Policyholder shall not be denied coverage in case of emergency situations. Note: The above does not imply that the Insurer shall have one product to cater to all of the above b. Insurers shall allow for customization of products by customer by providing the flexibility to choose products/add-ons/riders as per his/her medical conditions/specific needs.
2)	<u>Products are available to cover Technological Advancements & Treatments:</u> Insurers shall endeavour to cover Technological Advancements and Treatments in their products. Examples of prevalent treatment / procedures that need to be included, and not limited to the following: a. Uterine Artery Embolization and HIFU b. Balloon Sinuplasty c. Deep Brain stimulation d. Oral chemotherapy e. Immunotherapy- Monoclonal Antibody to be given as injection f. Intra vitreal injections g. Robotic surgeries h. Stereotactic radio surgeries i. Bronchial Thermoplasty j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment) k. IONM - (Intra Operative Neuro Monitoring) l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered. j. Any other treatment using advanced technology, as per the product design.
3)	<u>Products are to be made available in compliance with various laws:</u> Insurers shall offer products in accordance with relevant provisions of the following Laws: a) The Mental Healthcare Act, 2017; b) The Rights of Persons with Disabilities Act, 2016; c) The Surrogacy (Regulation) Act, 2021; d) The Transgender Persons (Protection of Rights) Act, 2019, and e) The HIV and AIDS (Prevention and Control) Act, 2017

4)	<u>Customer Information Sheet (CIS):</u> CIS is to be provided with every policy in the format as given in Annexure 1. It is a document provided by the Insurer along with the policy document that explains in simple words, basic features of a policy at one place. The CIS shall a) be provided to every policyholder in case of both Individual Insurance policy holder as well as a Member of Group Insurance Policy. b) have details like i. type of insurance, ii. sum Insured, iii. coverage provided, iv. summary of exclusions which policy does not cover, v. sub-limits (a pre-defined limit above which insurance company will not pay), vi. deductibles (specified amount upto which an insurance company will not pay any claim/which will be deducted from total claim, if the claim amount is more than the specified amount), vii. waiting period(s) (time period during which specified diseases/ treatments are not covered), and viii. certain important things such as Free Look Period, Policy Renewal, Migration, Portability and Moratorium Period. c) contain information regarding the Claims Procedure, Policy Servicing and Grievance Redressal Mechanism including contact details of Insurance Ombudsman of appropriate jurisdiction. Acknowledgment in physical or digital will have to be obtained from the Policyholder. On request, CIS will be made available in local language.
5)	<u>Free Look Period:</u> A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.
6)	<u>Cancellation of indemnity based health insurance policy by the policyholder:</u> The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall

	a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period. b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.
7)	<u>Nomination:</u> a. The policyholder shall give his nomination for the purpose of payment of claims. In the event of death of the policyholder, the claim proceeds will be paid to the nominee. b. Nomination can be changed any time during the term of the policy. Insurer shall put in place a simple and seamless procedure for registering and change in nomination in the policy.
8)	<u>Grace Period for payment of premium:</u> a) The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium. b) If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. The same is applicable for both Indemnity and Benefit products.
9)	<u>Availability of insurance coverage during grace period:</u> If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
10)	<u>Renewal of Health Insurance Policy:</u> a. A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate as per the procedure stated under Chapter II of this circular. b. An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years. c. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested

	by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
11)	<u>Migration in case of Indemnity policies:</u> In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.
12)	<u>Portability in case of Indemnity Policies:</u> - A Policyholder has the choice to port his/ her policies from one Insurer to another. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred. - The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal. - The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer. - The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.
13)	<u>Policy/Claim cannot be contested:</u> No policy and claim of health insurance shall be contestable on any grounds of non-disclosure and/or misrepresentation except for established fraud, after the completion of the Moratorium Period, i.e. 60 months of continuous coverage Note :The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.
14)	<u>No Claim Bonus:</u> The Insurer may reward the policyholders who do not make claim in the form of No Claim Bonus (NCB). Such NCB shall be paid as per the choice/ express consent of the policyholder in the following forms at the time of every renewal: Cumulative Bonus: Addition in the Sum Insured without an associated increase in premium.

	and/or b) Discount in renewal Premium
15)	<u>Approval for Cashless facility:</u> - Every insurer shall strive to achieve 100% cashless claim settlement in a time bound manner. The insurers shall endeavor to ensure that the instances of claims being settled through reimbursement are at bare minimum and only in exceptional circumstances. - Insurer shall decide on the request for cashless authorization immediately but not more than one hour of receipt of request. Necessary systems and procedures shall be put in place by the Insurer immediately and not later than 31st July, 2024. - Insurers may arrange for dedicated Help Desks in physical mode at the hospital to deal and assist with the cashless requests. - Insurers shall also provide pre-authorization to the policyholder through Digital mode.
16)	<u>Final authorization for Discharge from the hospital:</u> - Insurer shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital. In no case, the policyholder shall be made to wait to be discharged from the Hospital. - If there is any delay beyond three hours, the additional amount if any charged by the hospital shall be borne by the insurer from shareholder's fund. - In the event of the death of the policyholder during the treatment, the insurer shall: - immediately process the request for claim settlement. - get the mortal remains (dead body) released from the hospital immediately
17)	<u>Settlement of Claims:</u> - No claim shall be repudiated without the approval of PMC or a three-member sub-group of PMC called the Claims Review Committee (CRC). - In case, the claim is repudiated or disallowed partially, details shall be conveyed to the claimant along with full details giving reference to the specific terms and conditions of the policy document. - Pursuant to intimation of the claim, Insurers and Third Party Administrators (TPAs) shall collect the required documents from the Hospitals. Policyholder shall not be required to submit the documents.

18)	<u>Claims in respect of multiple Policies held by policyholders:</u> a) Indemnity Policies: A policyholder can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder. b) Benefit based Policies: On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.
19)	<u>Redressal of Grievances of the Policyholder:</u> The Insurer is required to have robust system of Grievance Redressal Process. The response letter of the Insurer in any grievance shall include the contact details of concerned insurance ombudsmen where his/her complaint can be escalated in case, the policyholder is not satisfied by the grievance redressal provided by the Insurer.
20)	<u>Implementation of Ombudsman Award:</u> The Insurer is required to comply with the award of the Insurance Ombudsman within 30 days of receipt of award by the Insurer. In case the Insurer does not honour the ombudsman award, a penalty of Rs. 5000/- per day shall be payable to the complainant. Such penalty is in addition to the penal interest liable to be paid by the Insurer under The Insurance Ombudsman Rules, 2017.

The detailed provisions in respect of paras 4,5,7,12,17,18,19 and 20 above will be given in the Master Circular issued under IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024.

Chapter II: Broad Requirements to be complied with by the Insurer in Health Insurance Business

A. General Principles

All Insurers shall ensure the following Principles while conducting Health Insurance Business:

I. All the Insurers shall: -

(1) Have in place board approved **underwriting policy**: -

- a. Covering its approach and aspects relating to offering health insurance coverage across all ages and medical conditions in line with Para 1 of Chapter I.
- b. That ensure Ayush treatments at par with the other treatments so as to provide option to the policyholders to choose treatment of their choice.

(2) Have in place board approved policy on quality standards and benchmarks for **empanelment of Hospitals and Health Care Providers**:

- a. striving to provide 100% cashless services to the policyholders. The said policy should enable empanelment of all categories of hospitals considering the affordability of different segments of population
- b. for every situation of treatment including domiciliary hospitalization, outpatient treatment (OPD), Day Care and Homecare treatment;

(3) **Proposal Forms/ Customer Information Sheet (CIS)**

- a. Design the **proposal forms in simple language** and may also provide the proposal form and policy document in the scheduled languages.
- b. Disseminate information about the products to the prospects and policyholders in a transparent manner. Insurers shall mandatorily forward **CIS in the specified format** and obtain acknowledgement of the policyholder.

(4) Claims Handling and Settlement process:

- a. Have in place well defined claims handling, claim settlement procedures, turnaround times (TATs) for settlement of claims and policy servicing.
- b. Constitute a **Claims Review Committee (CRC)**: Either the PMC or three-member sub-group of PMC may act as CRC which shall independently take final decision on repudiation of every claim.

(5) Display on Insurers Website: Display the following prominently on their website:

- a. List of the following
 - i. hospitals/healthcare service providers with whom they have tie up for cashless claim settlement
 - ii. hospitals/healthcare service providers which are in the list of common network of hospitals as referred at para VI of Chapter 2.
- b. Specifically indicate that if the policyholder avails services in hospitals / healthcare service providers other than the (a) above reimbursement of claim will have to be filed with the Insurer
- c. Procedures to be followed by the policyholder for claim settlement under cashless facility and reimbursement of claims
- d. Turn Around Time for policy servicing, approvals of cashless as well as reimbursement claim settlement
- e. List of products on offer and products withdrawn

(6) Training: Provide periodical training to Intermediaries, distribution channels and employees of the Insurers on their products (existing and new), TATs in policy servicing, changes in the regulations etc.

(7) Put in place end to end technology solutions so as to ensure an effective, efficient and a seamless onboarding of policyholders, renewal of policy, policy servicing, grievance redressal and claim settlement process.

- II. In order to provide cashless claim settlement from the date of commencement of cover, the Insurer shall obtain the details of members of the group from the master policyholder, at the earliest. No claim shall be denied for non-availability of details of members of the group.
- III. **Combi Product:** Insurers may offer Health Plus Life Combi products.
- IV. Insurers along with the Insurance Councils may endeavor to -
 - a. Have in place **common empanelment of hospitals/healthcare providers**, so that cashless facility can be availed anywhere;
 - b. Provide seamless journey to the policyholder at each point of sale, service and claim;
 - c. Onboard Hospitals and Health Care Providers on **National Health Claims Exchange (NHCX)** for faster payment/ settlement of claims.

B. Performance Monitoring of TPAs

- 1. Insurers shall have Board approved criteria
 - a. for monitoring the
 - a. performance of TPAs,
 - b. servicing of the customers,
 - c. TATs and service level parameters.

In no case, the remuneration of TPAs shall depend upon the Incurred Claim Ratio (ICR) of the policies served by the TPAs;

 - b. for obtaining feedback from the customers on the settlement of claims;
 - c. for **claw back of remuneration/charges** paid to TPA based on the customer feedback. The clawed back amounts shall be passed to the customer.
- 2. Insurers shall ensure that the payments are made to the TPAs only after availing the services and upon full discharge of services by the TPA satisfactorily.

C. Product Management Committee and Advertisement Committee

I. Product Management Committee(PMC):

1. The PMC shall ensure:
 - a. that all the matters referred under regulation 6(1)(b) of IRDAI (Insurance Products) Regulations, 2024 are complied with;
 - b. compliance with circulars, guidance, if any, issued / communicated by the Competent Authority;
 - c. that the benefits reflecting in sales literature, terms and conditions reflecting in policy document shall be consistent with the design approved;
2. The PMC shall be constituted with Appointed Actuary (AA), Chief Marketing / Distribution Officer, Chief Investment Officer, Chief Technology Officer, and Chief Compliance Officer of the Insurer as members. In addition to the above, the Insurer may include other members of its senior management in the PMC as members or as invitees (refer under 6(1)(b) of IRDAI (Insurance Products) Regulation, 2024).
3. The PMC shall carry out proper due diligence and record its concurrence/sign off on various product related risks (such as risks related to capital requirements, profitability, underwriting, reinsurance etc.) before approval of the product by PMC.
4. The quorum for the PMC shall be three members in addition to Appointed Actuary
5. The CEO of the Insurer shall have an overall responsibility for ensuring that a robust due diligence process is in place to mitigate risks arising from the products and shall countersign the relevant certifications.

II. The Advertisement Committee (AC):

1. The AC shall approve every advertisement of the Insurer in compliance with the provisions of IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and Master Circular issued thereunder.
2. The AC shall be constituted with a minimum of two Key Management Persons (KMP), three Senior Management Officials one level below the KMP and a permanent invitee from PMC of the Insurer (refer under 6(1)(c) of IRDAI (Insurance Products) Regulation, 2024).
3. The quorum for the AC shall be 3 members including one KMP and the permanent invitee from PMC

D. Product Filing

I. Product Filing Procedure with PMC

1. Any new product or Rider or Add-on or modification of an existing Individual product or Rider or Add-on shall be approved by the Product Management Committee (PMC) of the Insurer.
2. Insurers shall file the proposed name of the product, date of approval by PMC as per the Format at Annexure-2 and shall obtain the Unique Identification Number (UIN). However, Life insurers may obtain UIN as per the procedure applicable to Life insurance products.
3. Insurers shall maintain details of the
 - (a) individual products /Riders/Add-Ons in the specified Form - IRDAI –HIP (Annexure - 3).
 - (b) Group products (including Government Sponsored Schemes) in the Form IRDAI-HLTGRP (Annexure-4)
4. All categories of the products, namely, Health plus Life Combi Products and Health Package Products are also allowed to be launched under the above procedure stated in paras (1), (2) and (3).
5. Insurers shall not alter the contents of the products without following due process of modification specified under para (1).
6. Modification of an existing product shall be approved by PMC. An Application as specified at Annexure 3 (Form - IRDAI –HIP) of this Circular shall be filed with PMC.
7. If an Insurer does not launch the product or modified product within a period of 30 days from the date of generation of UIN, the Insurer shall be required to undertake the process for obtaining approvals of the product or the modification afresh from the PMC.

II. Withdrawal of Products

1. Where Insurers wish to withdraw any product(s), add-on(s), rider(s), the same shall be informed vide Form IRDAI-HPW (Annexure – 5) within 30 (thirty) days from the date of withdrawal.
2. The decision to withdraw any Health Insurance product /add-on/rider shall be taken by the PMC. The reason for withdrawal of the product shall be clearly documented and filed with the PMC.

3. The Policy document shall clearly indicate the possibility of withdrawal of the product/add-on/rider in future and suitable options that would be made available to the policyholder on withdrawal of the products.
4. A withdrawn Individual Health Insurance product/add-on/rider shall not be offered to new customers after the date of the withdrawal.
5. The existing customers of a withdrawn product shall be provided the following options:
 - a. A one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product; or
 - b. Migrate to any other suitable product (any other existing product or modified version of the withdrawn product) as per the choice of the policyholder
6. Any Individual or Group Health Insurance Product offered with a term exceeding one year, shall be continued on the agreed terms for all the existing policyholders for the entire policy term.

Provided in case of Group Health Insurance Product, the PMC shall put in place guidelines for withdrawal. The guidelines, inter alia, shall address the basis of the withdrawal, the notice period to be made available to the Master Policyholder, options to be offered if any, to the Master Policyholder and/or the insured members of the Group.

7. All the distribution channels shall be informed about the withdrawal of a product well in advance.
8. Any premiums or deposit received towards the product that is withdrawn, but where no policy has been issued, shall be refunded to the policyholders immediately. Such monies shall not be adjusted for issuance of any other policies except with specific consent of the policyholder and the consent of the policyholder shall be recorded in written or digital mode.
9. Insurers shall also put in place measures for immediate withdrawal of sales literature, prospectus and publicity material that is issued in respect of the product withdrawn.

Chapter III: Miscellaneous Provisions

I. **Model Product for Persons with Disabilities (PWD), Persons afflicted with HIV/AIDS, and those with Mental Illness:**

1. All general and health Insurers shall offer a specific cover for Persons with Disabilities (PWD), persons affected with HIV/AIDS, and those with mental illness in compliance with the following provisions;
 - I. Section 21(4) of The Mental Healthcare Act, 2017;
 - II. Section 3 of The Rights of Persons with Disabilities Act, 2016; and
 - III. Section 3(j) of The HIV and AIDS (Prevention and Control) Act, 2017;
2. A model product setting out the minimum scope and parameters for design of the product is as per Cir. No. IRDAI/HLT/CIR/MISC/58/2/2023 dated 27.02.2023 and the CIS shall be as per the format attached at Annexure 1. **Insurers may widen the scope of the product** but in no case the scope of the product can be narrowed down.

II. **Ayushman Bharat Health Account (ABHA) number:**

1. *“Ayushman Bharat Health Account” (ABHA) number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescriptions and diagnosis seamlessly from verified healthcare professionals and health service providers.*
2. With specific consent of the policyholder, Insurers may facilitate creation of ABHA number as per procedures laid down.
3. Further, express consent of the policyholder shall be obtained for sharing of medical records and any other related information in every instance.

III. **Submission of Returns:**

Insurers shall submit periodic returns on Premium, claims etc. as per the provisions of the master circular on submission of returns issued by the Competent Authority.

IV. **Repeal of the Guidelines /Circulars:**

This Circular supersedes all the Guidelines/Circulars listed in Annexure-6.
