CHAPTER 20

HEALTH INSURANCE UNDERWRITING

Chapter Introduction

This chapter aims to provide you detailed knowledge about underwriting in health insurance. Underwriting is a very important aspect of any type of insurance and plays a vital role in issuance of an insurance policy. In this chapter, you will get an understanding about basic principles, tools, methods and process of underwriting. It will also provide you the knowledge about group health insurance underwriting.

Learning Outcomes

A. What is underwriting?
B. Underwriting - Basic concepts
C. File and Use guidelines
D. Other health insurance regulations of IRDAI
E. Basic principles and tools for underwriting
F. Underwriting process
G. Group health insurance
H. Underwriting of Overseas Travel Insurance
I. Underwriting of Personal Accident Insurance

After studying this chapter, you should be able to:

a) Explain what is meant by underwriting
b) Describe the basic concepts of underwriting
c) Explain the principles and the various tools followed by underwriters
d) Appreciate the complete process of underwriting individual health policies
e) Discuss how group health policies are underwritten

Look at this Scenario

Manish aged 48 years, working as a software engineer, decided to take a health insurance policy for himself. He went to an insurance company, where they gave him a proposal form in which he was required to answer a number of questions related to his physical build and health, mental health, pre-existing illnesses, his family health history, habits and so on.

On receipt of his proposal form, he was also required to submit many documents such as identity and age proof, proof of address and previous medical records. Then they told him to undergo a health check-up and some medical tests which frustrated him.

Manish, who considered himself a healthy person and with a good income level, started wondering why such a lengthy process was being followed by the insurance company in his case. Even after going through all this, the insurance company told him that high cholesterol and high BP had been diagnosed in his medical tests, which increased the chances of heart diseases later. Though they offered him a policy, the premium was much higher than what his friend had paid and so he refused to take the policy.

Here, the insurance company was following all these steps as part of their underwriting process. While providing risk coverage, an insurer needs to evaluate risks properly and also to make reasonable profit. If the risk is not assessed properly and there is a claim, it will result in a loss. Moreover, insurers collect premiums on behalf of all insuring persons and have to handle these moneys like a trust.

A. What is underwriting?

1. Underwriting

Insurance companies try to insure people who are expected to pay adequate premium in proportion to the risk they bring to the insurance pool. This process of collecting and analyzing information from a proposer for the risk selection is known as underwriting. On the basis of information collected through this process, they decide whether they want to insure a proposer. If they decide to do so, then at what premium, terms and conditions so as to make a reasonable profit from taking such risk.

Health insurance is based on the concept of morbidity. Here morbidity is defined as the likelihood and risk of a person becoming ill or sick thereby requiring treatment or hospitalization. To a large extent, morbidity is influenced by age (generally being higher in senior citizens than in young adults) and also increases due to various other adverse factors, such as being overweight or underweight, personal history of certain past and present diseases or ailments, personal habits like smoking, current health status and also occupation of the proposer if it is deemed to be hazardous. Conversely, morbidity also decreases due to certain favourable factors like lower age, a healthy lifestyle etc.

Definition

Underwriting is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted. Thus, it is a process of risk selection and risk pricing.

2. Need for underwriting

Underwriting is the backbone of an insurance company as acceptance of the risk carelessly or for insufficient premiums will lead to insurer's insolvency. On the other hand, being too selective or careful will prevent the insurance company from creating a big pool so as to spread the risk uniformly. It is therefore critical to strike the correct balance between risk and business, thereby being competitive and yet profitable for the organization.

This process of balancing is done by the underwriter, in accordance with the philosophy, policies and risk hunger of the insurance company concerned. The job of the underwriter is to classify the risk and decide the terms of acceptance at a proper price. It is important to note that acceptance of risk is like giving a promise of future claim settlement to the insured.

3. Underwriting – risk assessment

Underwriting is a process of risk selection which is based upon the characteristics of a group or individual. Here based on the degree of the risk, the underwriter decides whether to accept the risk and at what price. Under any circumstances, the process of acceptance has to be done with fairness and on an equitable basis i.e. every similar risk should be classified equally without any prejudice. This classification is normally done through standard acceptance charts whereby every represented risk is quantified and premiums are calculated accordingly.

Although age affects the chance of sickness as well as death, it must be remembered that sickness usually comes much before death and could be frequent. Hence, it is quite logical that the underwriting norms and guidelines are much tighter for health coverage than death coverage.

Example

An individual who is diabetic has a far higher chance of developing a cardiac or kidney complication requiring hospitalization than of death, and also health episodes can happen multiple times during the course of insurance coverage. A life insurance underwriting guideline might rate this individual as an average risk. However, for medical underwriting, he would be rated as a higher risk.

In health insurance, there is a higher focus on medical or health findings than financial or income based underwriting. However, the latter cannot be ignored as there has to be an insurable interest and financial underwriting is important to rule out any adverse selection and ensure continuity in health insurance.

4. Factors which affect chance of illness

The factors which affect morbidity (risk of falling ill) should be considered carefully while assessing risk are as follows:

a) **Age:** Premiums are charged corresponding with age and the degree of risk. For e.g. the morbidity premiums for infants and children are higher than young adults due to increased risk of infections and accidents. Similarly, for adults beyond the age of 45 years, the premiums are higher, as the probability of an individual suffering from a chronic ailment like diabetes, a sudden heart ailment or other such morbidity is much higher.

b) **Gender:** Women are exposed to additional risk of morbidity during child bearing period. However, men are more likely to get affected by heart attacks than women or suffer job related accidents than women as they may be more involved in hazardous employment.

c) **Habits:** Consumption of tobacco, alcohol or narcotics in any form has a direct bearing on the morbidity risk.

d) **Occupation:** Extra risk to accidents is possible in certain occupations, e.g. driver, blaster, aviator etc. Likewise, certain occupations may have higher health risks, like an X-Ray machine operator, asbestos industry workers, miners etc.

e) **Family history:** This has greater relevance, as genetic factors influence diseases like asthma, diabetes and certain cancers. This does impact the morbidity and should be taken into consideration while accepting risk.

f) **Build:** Stout, thin or average build may also be linked to morbidity in certain groups.

g) **Past illness or surgery:** It has to be ascertained whether the past illness has any possibility of causing increased physical weakness or even recur and accordingly the policy terms should be decided. For e.g. kidney stones are known to recur and similarly, cataract in one eye increases possibility of cataract in the other eye.

h) **Current health status and other factors or complaints:** This is important to ascertain the degree of risk and insurability and can be established by proper disclosure and medical examination.

i) **Environment and residence:** These also have a bearing on morbidity rates.

Test Yourself 1

Underwriting is the process of _____.

I. Marketing insurance products
II. Collecting premiums from customers
III. Risk selection and risk pricing
IV. Selling various insurance products

B. Underwriting – Basic concepts

1. Underwriting purpose

We begin with examining the purpose of underwriting. There are two purposes

i. To prevent anti-selection that is selection against the insurer
ii. To classify risks and ensure equity among risks

Definition

The term **selection of risks** refers to the process of evaluating each proposal for health insurance in terms of the degree of risk it represents and then deciding whether or not to grant insurance and on what terms.

Anti-selection (or **adverse selection**) is the tendency of people, who suspect or know that their chance of experiencing a loss is high, to seek out insurance eagerly and to gain in the process.

Example

If insurers were not selective about whom and how they offered insurance, there is a chance that people with serious ailments like diabetes, high BP, heart problems or cancer, who knew that they would soon require hospitalization, would seek to buy health insurance, create losses for the insurer.

In other words, if an insurer did not exercise selection it would be selected against and suffer losses in the process.

2. Equity among risks

Let us now consider equity among risks. The term "Equity" means that applicants who are exposed to similar degrees of risk must be placed in the same premium class. Insurers would like to have some type of standardization to determine the premiums to be charged. Thus people posing average risks should pay similar premium while people who pose higher risks should pay higher premium. They would like standardization to apply to the vast majority of individuals who pose average risks while they could devote more time to decide upon and rate risks which are more risky.

a) Risk classification

To usher equity, the underwriter engages in a process known as **risk classification** i.e. individuals are categorized and assigned to different risk classes depending on the degree of risks they pose. There are four such risk classes.

i. Standard risks

These consist of those people whose anticipated morbidity (chance of falling ill) is average.

ii. Preferred risks

These are the ones whose anticipated morbidity is significantly lower than average and hence could be charged a lower premium.

iii. Substandard risks

These are the ones whose anticipated morbidity is higher than the average, but are still considered to be insurable. They may be accepted for insurance with higher (or extra) premiums or subjected to certain restrictions.

iv. Declined risks

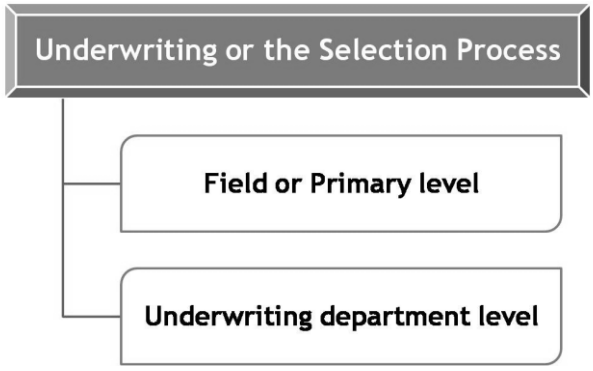
These are the ones whose impairments and anticipated extra morbidity are so great that they could not be provided insurance coverage at an affordable cost. Sometimes an individual's proposal may also be temporarily declined if he or she has been exposed to a recent medical event, like an operation.

3. Selection process

Underwriting or the selection process may be said to take place at two levels:

- ✓ At field level
- ✓ At underwriting department level

Diagram 7: Underwriting or the selection process



c) Field or Primary level

Field level underwriting may also be known as **primary underwriting**. It includes information gathering by an agent or company representative to decide whether an applicant is suitable for granting insurance coverage. The

agent plays a critical role as primary underwriter. He is in the best position to know the prospective client to be insured.

A few insurance companies may require that agents complete a statement or a confidential report, asking for specific information, opinion and recommendations to be provided by the agent with respect to the proposer.

A similar kind of report, which has been called as **Moral Hazard report**, may also be sought from an official of the insurance company. These reports typically cover the occupation, income and financial standing and reputation of the proposed life.

What is Moral Hazard?

While factors like age, gender, habits etc. refer to the physical hazard of a health risk, there is something else that needs to be closely watched. This is the moral hazard of the client which can prove very costly to the insurance company.

An extreme example of bad moral hazard is that of an insured taking health insurance knowing that he will undergo a surgical operation within a short time but not disclosing this to the insurer. There is thus a deliberate intention of taking insurance just to collect a claim.

Indifference towards loss is another example. Because of the existence of insurance, the insured may be tempted to adopt a careless attitude towards his health knowing that any hospitalization would be paid by his insurer.

Another type of hazard called 'morale hazard' is also worthy of mention. Here the insured would not commit any fraud but, knowing that he has a large sum insured, he would prefer to take the most expensive treatment, staying in the most expensive hospital room etc. which he would not have done had he not been insured.

Fraud monitoring and role of agent as primary underwriter

Much of the decision with regard to selection of a risk depends on the facts that have been disclosed by the proposer in the proposal form. It may be difficult for an underwriter who is sitting in the underwriting department to know whether these facts are untrue and have been fraudulently misrepresented with deliberate intent to deceive.

The agent plays a significant role here. He or she is in the best position to ascertain that the facts that have been represented are true, since the agent has direct and personal contact with the proposer and can thus monitor if any willful non-disclosure or misrepresentation has been made with an intent to mislead.

d) Underwriting department level

The second level of underwriting is at the department or office level. It involves specialists and persons who are proficient in such work and who consider all the relevant data on the case to decide whether to accept a proposal for insurance and on what terms.

C. File and Use guidelines

It must be remembered that every insurer has to create it products before marketing them and this is also one of the functions of the underwriting department. The IRDAI has issued guidelines for this which are summarized below:

Every company designs its products keeping in mind the target customers' needs, wants and affordability, underwriting considerations, actuarial pricing, competitive conditions in the market etc. Thus we see high number of options for different categories of customers to choose from even though at the base level, hospitalization expense indemnity products dominate the Indian market.

Every new product needs approval of IRDA before introduction. The product needs to be filed with the Regulator under 'File and Use' provisions as mentioned below. Once introduced, product withdrawal also needs to follow guidelines. Students are advised to familiarize themselves with all provisions, forms, returns etc. related to File and Use guidelines.

File and use procedure for health insurance products as per IRDA guidelines:

a) No health insurance product shall be marketed by any insurer unless it has the prior clearance of the Authority accorded as per the File and Use Procedure.

b) Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.

   1. Any revision or modification in a policy which is approved by the Authority shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.

   2. The possibility of a revision or modification of the terms of the policy including the premium must be disclosed in the prospectus.

c) The File and Use application form has been standardized by IRDAI and has to be sent along with many annexures including the Database sheet and the Customer Information Sheet.

   The Customer Information Sheet which is to be given to every insured along with the prospectus and the policy contains details of the cover, the exclusions, waiting period if any before claim becomes payable, whether the payout will be on reimbursement basis or a fixed amount, renewal conditions and benefits, details of co-pay or deductible and cancellation conditions etc.

The File and Use application for the prior approval of the Authority shall be certified by the Appointed Actuary and the CEO of the insurance company and shall be in such formats and accompanied by such documentation as may be stipulated by the Authority from time to time.

d) Withdrawal of health insurance product

1. To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing - policyholders.

2. The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.

3. If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.

4. The withdrawn product shall not be offered to the prospective customers.

e) All particulars of any product shall after introduction be reviewed by the Appointed Actuary at least once a year. If the product is found to be financially unviable, or is deficient in any particular the Appointed Actuary may revise the product appropriately and apply for revision under File and Use procedure.

f) Five years after a product has been accorded File and Use approval, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

D. Other Health Insurance regulations of IRDAI

In addition to the File and Use guidelines, the Health Insurance regulations also require the following:

a. All Insurance Company's shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. The policy should among other matters prescribe the proposal form in which prospects may apply for purchasing a Health Policy. Such form should capture all the information necessary to underwrite a proposal in accordance with the stated Policy of the Company.
b. The Underwriting Policy shall be filed with the Authority. The Company retains the right to modify the Policy as it deems necessary, but every modification shall also be filed with the Authority.
c. Any proposal for health insurance may be accepted or denied wholly based on the Board approved underwriting policy. A denial of a proposal shall be communicated to the prospect in writing, recording the reasons for denial.
d. The insured shall be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
e. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it shall prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document, clearly state the events which will require the submission of such information and the conditions applicable in such event.
f. Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use guidelines.

Guidelines regarding portability of health policies

IRDAI has brought out very clear guidelines regarding portability of life and health insurance policies. These are enumerated below:

1. Portability shall be allowed in the following cases:
   a. All individual health insurance policies issued by non-life insurance companies including family floater policies
   b. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right for portability at next renewal.

2. Portability can be opted by the policyholder only at renewal and not during currency of the policy.

3. A policyholder wanting to port his policy to another insurance company has to apply to such insurance company, to port the entire policy along with all the members of the family, if any, at least 45 days before the premium renewal date of the existing policy.

4. The new insurer may or may not offer portability if policyholder fails to make an application in the IRDAI-prescribed form at least 45 days before the premium renewal date.

5. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'I' to the IRDAI guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.

6. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.

7. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA.

8. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.

9. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it shall be viewed as violation of directions issued by the IRDA and the insurer shall be subject to penal provisions under the Insurance Act, 1938.

10. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders' interest) Regulations, 2002.

11. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.

12. Where the outcome of acceptance of portability is still awaited from the new insurer on the date of renewal

a. the existing policy shall be allowed to be extended, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and

b. the existing policy shall not be cancelled until such time a confirmed policy from new insurer is received or at the specific written request of the insured

c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.

d. if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.

13. In case the policyholder has opted short period extension as stated above and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claims is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.

14. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.

15. No commission shall be payable to any intermediary on the acceptance of a ported policy.

16. For any health insurance policy, waiting period already elapsed under the existing policy with respect to pre-existing diseases and time bound exclusions shall be taken into account and reduced to that extent under the newly ported policy.

    Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.

    Note 2: For group health insurance policies, the individual member's shall be given credit as stated above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions.

17. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. - If a person had a SI of Rs. 2 lakhs and accrued bonus of Rs. 50,000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs. 2.50 lakhs by charging the premium applicable for Rs. 2.50 lakhs. If insurer B has no product for Rs. 2.50 lakhs, insurer B would offer the nearest higher slab say Rs. 3 lakhs to insured by charging premium applicable for Rs. 3 lakhs SI. However, portability would be available only up to Rs 2.50 lakhs.

18. Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:

    a. all health insurance policies are portable;

    b. policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

E. Basic principles of insurance and tools for underwriting

1. Basic principles relevant to underwriting

In any form of insurance, whether it is life insurance or general insurance, there are certain legal principles which operate along with acceptance of risks. Health insurance is equally governed by these principles and any violation of the principles results in the insurer deciding to avoid the liability, much to the dissatisfaction and frustration of the policyholders. These core principles are:

1. Utmost good faith (Uberrima fides) and the insurable interest

2. Tools for underwriting

These are the sources of information for the underwriter and the basis on which the risk classification is done and premiums finally decided. The following are the key tools for underwriting:

a) Proposal form

This document is the base of the contract where all the critical information pertaining to the health and personal details of the proposer (i.e. age, occupation, build, habits, health status, income, premium payment details etc.) are collected. This could range from a set of simple questions to a fully detailed questionnaire according to product and the needs/policy of the company, so as to ensure that all material facts are disclosed and the coverage is given accordingly. Any breach or concealment of information by the insured shall render the policy void.

b) Age proof

Premiums are determined on the basis of the age of the insured. Hence it is imperative that the age disclosed at the time of enrollment is verified through submission of an age proof.

Example

In India, there are many documents which can be considered as age proof but all of them are not legally acceptable. Mostly valid documents are divided into two broad categories. They are as follows:

a) Standard age proof: Some of these include school certificate, passport, domicile certificate, PAN card etc.
b) Non-standard age proof: Some of these include ration card, voter ID, elder's declaration, gram panchayat certificate etc.

c) Financial documents

Knowing the financial status of the proposer is particularly relevant for benefit products and to reduce the moral hazard. However, normally the financial documents are only asked for in cases of

a) Personal accident covers or
b) high sum assured coverage or
c) when the stated income and occupation as compared to the coverage sought, show a mismatch.

d) Medical reports

Requirement of medical reports is based on the norms of the insurer, and usually depends upon the age of the insured and sometimes on the amount of cover opted. Some replies in the proposal form may also contain some information that leads to medical reports being asked for.

e) Reports of sales personnel

Sales personnel can also be seen as grassroots level underwriters for the company and the information given by them in their report could form an important consideration. However, as the sales personnel have an incentive to generate more business, there is a conflict of interest which has to be watched out for.

Test Yourself 2

The principle of utmost good faith in underwriting is required to be followed by _____.

I. The insurer
II. The insured
III. Both the insurer and the insured
IV. The medical examiners

Test Yourself 3

Insurable interest refers to _____.

I. Financial interest of the person in the asset to be insured
II. The asset which is already insured
III. Each insurer's share of loss when more than one company covers the same loss
IV. The amount of the loss that can be recovered from the insurer

F. Underwriting process

Once the required information is received, the underwriter decides the terms of the policy. The common forms used for underwriting health insurance business are as below:

1. Medical underwriting

Medical underwriting is a process in which medical reports are called for from the proposer to determine the health status of an individual applying for health insurance policy. The health information collected is then evaluated by the insurers to determine whether to offer coverage, up to what limit and on what conditions and exclusions. Thus medical underwriting can determine the acceptance or declining of a risk and also the terms of cover.

However, medical underwriting involves high costs in terms of receiving and examining medical reports. Also, when insurers use a high degree of medical underwriting, they are blamed for 'cream-skimming' (accepting only the best kind of risk and denying others). It also causes frustration among prospective clients and reduces the number of people willing to insure with those insurers as they do not want to provide the requisite information and detail and to undergo the required tests.

Health status and age are important underwriting considerations for individual health insurance. Also current health status, personal and family medical history enable an underwriter to determine presence of any pre-existing diseases or conditions and eventually the probability of future health problems that may require hospitalization or surgical intervention.

Further proposal forms are designed in a manner to elicit information about past treatments taken, hospitalizations and surgeries undergone. This helps an underwriter to evaluate the possibility of recurrence of an earlier ailment, its impact on current or future health status or future complications. Some diseases for which the proposer is taking medicines only may soon require hospitalization any time soon or recur.

Example

Medical conditions like hypertension, overweight/obesity and raised sugar levels have a high probability of future hospitalization for diseases of the heart, kidney and the nervous system. So, these conditions should be carefully considered while assessing the risk for medical underwriting.

Since adverse changes in health status generally occur post 40 years, mainly due to normal ageing process, insurers do not require any medical examination or tests of the proposer earlier than the age of 45 years (some insurers could raise this requirement to 50 or 55 years too). Medical underwriting guidelines may also require a signed declaration of the proposer's health status by his/her family physician.

In the Indian health insurance market, the key medical underwriting factor for individual health insurance is the age of the person. Persons above the age of 45-50 years, enrolling for the first time are normally required to undergo specified pathological investigations to assess health risk profile and to obtain information on their current health status. Such investigations also provide an indication of prevalence of any pre-existing medical conditions or diseases.

Example

Drugs, alcohol and tobacco consumption may be difficult to detect and seldom declared by the proposer in the proposal form. Non-disclosure of these poses a major challenge in underwriting of health insurance. Obesity is another problem which threatens to become a major public health problem and underwriters need to develop underwriting tools to be able to adequately price the complications arising out of the same.

2. Non-medical underwriting

Most of the proposers which apply for health insurance do not need medical examination. If it could be known with a fair degree of accuracy that only one-tenth or less of such cases will bring the adverse results during medical examination, insurers could dispense with medical examination in majority of the cases.

Even, if the proposer were to disclose all material facts completely and truthfully and the same were checked by agent carefully, then also the need for medical examination could have been much less. In fact, a slight increase in the claims ratio can be accepted if there is savings in the costs of medical checkup and other expenses and also as it will reduce the inconvenience to the proposer.

Therefore, insurance companies are coming up with some medical policies where the proposer is not required to undergo any medical examination. In such cases, companies usually create a 'medical grid' to indicate at what age and stage should a medical underwriting be done, and therefore these non- medical limits are carefully designed so as to strike a proper balance between business and risk.

Example

If an individual has to take health insurance coverage quickly without going through a long process of medical examinations, waiting periods and processing delays, then he can opt for a non-medical underwriting policy. In a non-medical underwriting policy, premium rates and sum assured are usually decided on the basis of answers to a few health questions mostly based on age, gender, smoking class, build etc. The process is speedy but the premiums may be relatively higher.

3. Numerical rating method

This is a process adopted in underwriting, wherein numerical or percentage assessments are made on each component of the risk.

Factors like age, sex, race, occupation, residence, environment, build, habits, family and personal history are examined and scored numerically based on pre-determined criteria.

4. Underwriting decisions

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories. Based on the above tools and his judgment, the underwriter classifies the risk into the following categories:

a) Accept risk at standard rates
b) Accept risk at an extra premium (loading), though it may not be practiced in all companies
c) Postpone the cover for a stipulated period/term
d) Decline the cover
e) Counter offer (either restrict or deny part of the cover)
f) Impose a higher deductible or Co-pay
g) Levy permanent exclusion(s) under the policy

If any illness is permanently excluded, it is endorsed on the policy certificate. This becomes an additional exclusion apart from the standard policy exclusion and shall form the part of the contract.

Expert individual risk assessment by underwriters is vital to insurance companies as it keeps the insurance system in balance. Underwriting enables insurers to group together those with the same level of expected risk and to charge them the same premium for the protection they choose. The benefit for the policyholder is availability of insurance at a fair and competitive price whereas the benefit for an insurer is the ability to maintain the experience of its portfolio in line with the morbidity assumptions.

5. Use of general or standard exclusions

The majority of policies impose exclusions that apply to all their members. These are known as standard exclusions or sometimes referred to as general exclusions. Insurers limit their exposure by the implementation of standard exclusions.

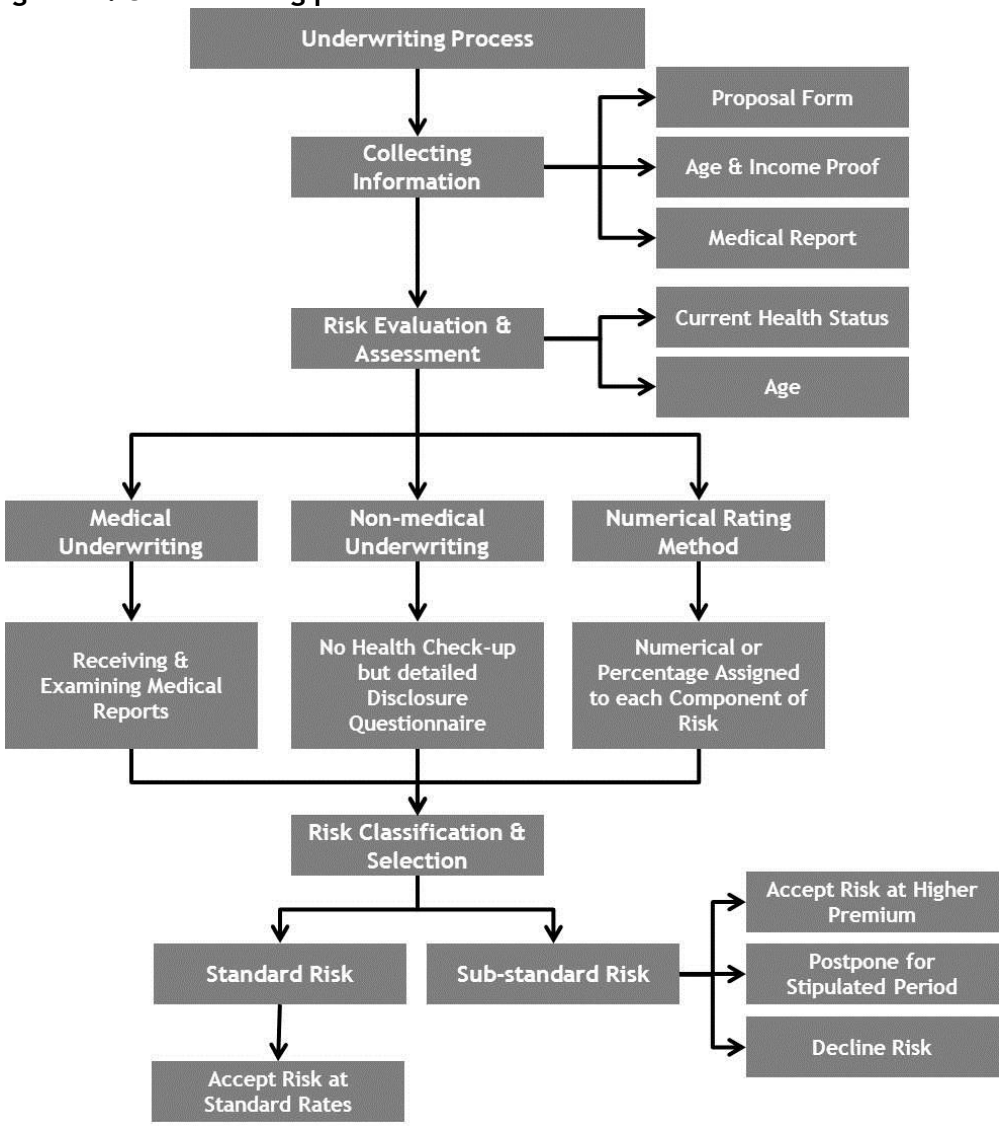
The same have been discussed in earlier chapter.

Test Yourself 4

Which of the following statements about medical underwriting is incorrect?

I. It involves high cost in collecting and assessing medical reports.
II. Current health status and age are the key factors in medical underwriting for health insurance.
III. Proposers have to undergo medical and pathological investigations to assess their health risk profile.
IV. Percentage assessment is made on each component of the risk.

Diagram 1: Underwriting process



G. Group health insurance

1. Group health insurance

Group insurance is underwritten mainly on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer. Thus, while accepting a group for health insurance, the insurers take into consideration the possibility of existence of a few members in the group who may have severe and frequent health problems.

Underwriting of group health insurance requires analyzing the characteristics of the group to evaluate whether it falls within the insurance company's underwriting guidelines as well as the guidelines laid down for group insurance by the insurance regulators.

Standard underwriting process for group health insurance requires evaluating the proposed group on the following factors:

a) Type of group

b) Group size

c) Type of industry

d) Eligible persons for coverage

e) Whether entire group is being covered or there is an option for members to opt out

f) Level of coverage – whether uniform for all or differently

g) Composition of the group in terms of sex, age, single or multiple locations, income levels of group members, employee turnover rate, whether premium paid entirely by the group holder or members are required to participate in premium payment

h) Difference in healthcare costs across regions in case of multiple locations spread in different geographical locations

i) Preference of the group holder for administration of the group insurance by a third party administrator (of his choice or one selected by the insurer) or by the insurer itself

j) Past claims experience of the proposed group

Example

A group of members working in mines or factories is at higher health risk than a group of members working in air-conditioned offices. Also the nature of diseases (thereby claims) are also likely to be quite different for both groups. Therefore, the insurer will price the group health insurance policy accordingly in both the cases.

Similarly to avoid adverse selection in case of groups with high turnover such as IT companies, insurers can introduce precautionary criteria requiring employees to serve their probationary period before becoming eligible for insurance.

Due to highly competitive nature of group health insurance business, insurers allow substantial flexibility and customization in benefits of the group insurance plans. In employer-employee group insurance plans, the benefits design is usually developed over time and used as an employee retention tool by the human resources department of the employer. Often, the flexibility is the result of competition among insurers to match or improve the benefits of the existing group insurance plan given by another insurer to capture and shift business.

2. Underwriting other than employer- employee groups

Employer-employee groups are traditionally the most common groups offered group health insurance. However, as health insurance gains acceptance as an effective vehicle of financing healthcare expenditure, different types of group formations have now developed. In such a scenario, it is important for group health insurance underwriters to take into consideration the character of the group composition while underwriting the group.

In addition to employee-employer groups, insurers have provided group health insurance coverage to varied type of groups such as: labour unions, trusts and societies, multiple-employer groups, franchisee dealers, professional associations, clubs and other brotherhood organizations.

Governments in different countries have been buyers of group health insurance coverage for poorer sections of the society. In India, governments both at the central and state level have aggressively been sponsoring group health insurance schemes for the poor e.g. RSBY, Yeshaswini etc.

Though basic underwriting considerations for such diverse groups are similar to generally accepted group underwriting factors, additional aspects include:

a) Size of the group (small group size may suffer from frequent changes)
b) Different levels of healthcare cost in different geographical regions
c) Risk of adverse selection in case all group constituents do not participate in the group health insurance plan
d) Continuation of members in the group in the policy

There has been a growth in irregular types of group formations just to take advantage of such group health insurance benefits at cheap prices, called

'groups of convenience'. The insurance regulator IRDA has therefore issued group insurance guidelines with a view to regulate the approach to be adopted by insurers in dealing with various groups. Such non-employer groups include:

a) Employer welfare associations
b) Holders of credit cards issued by a specific company
c) Customers of a particular business where insurance is offered as an add-on benefit
d) Borrowers of a bank and professional associations or societies

The rationale of the group insurance guidelines is to restrict formation of groups for the sole purpose of availing insurance with advantage of flexible design, coverage of benefits not available on individual policies and cost savings. It has been observed that such 'groups of convenience' have often led to adverse selection against the insurers and eventually high claim ratios. Group insurance guidelines by the regulatory authority, thus, help in responsible market conduct by the insurers. They instill discipline in underwriting by insurance companies and also in canvassing group insurance schemes by setting up administration standards for group schemes.

H. Underwriting of Overseas Travel Insurance

Since the main cover under Overseas Travel Insurance policies is the health cover, the underwriting would follow the pattern for health insurance in general.

The premium rating and acceptance would as per individual company guidelines but a few important considerations are given below:

1. Premium rate would depend on the age of the proposer and the duration of foreign travel.

2. As medical treatment is costly overseas, the premium rates are normally much higher compared to domestic health insurance policies.

3. Even among the foreign countries, USA and Canada premium is the highest.

4. Care should be taken to rule out the possibility of a proposer using the policy to take medical treatment abroad and hence the existence of any pre-existing disease must be carefully considered at the proposal stage.

I. Underwriting of Personal Accident Insurance

The underwriting considerations for personal accident policies are discussed below:

Rating

In personal accident insurance, the main factor considered is the occupation of the insured. Generally speaking exposure to personal accidents at home, on the street etc. is the same for all persons. But the risks associated with profession or occupation varies in accordance with the nature of work performed. For example, an office manager is less exposed to risk at work than a civil engineer working at a site where a building is being constructed.

It is not practical, to fix a rate for each profession or occupation. Hence, occupations are classified into groups, each group reflecting, more or less, similar risk exposure. The following system of classification is simple and found to be feasible in practice. Individual companies may have their own basis of classification.

Classification of Risk

On the basis of occupation, the risks associated with the insured person may be classified into three groups:

- **Risk group I**
  Accountants, Doctors, Lawyers, Architects, Consulting Engineers, Teachers, Bankers, persons engaged in administration functions, persons primarily engaged in occupations of similar hazards.

- **Risk group II**
  Builders, Contractors and Engineers engaged in superintending functions only, Veterinary Doctors, paid drivers of motor cars and light motor vehicles and persons engaged in occupation of similar hazards.
  All persons engaged in manual labour (except those falling under Group III), cash carrying employees, garage and motor Mechanics, Machine operators, Drivers of trucks or lorries and other heavy vehicles, professional athletes and sportsmen, woodworking Machinists and persons engaged in occupations of similar hazards.

- **Risk group III**
  Persons working in underground mines, explosives magazines, workers involved in electrical installation with high tension supply, Jockeys, circus personnel, persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hang gliding, river rafting, polo and persons engaged in occupations / activities of similar hazard.

Risk groups are also known in the form of 'Normal', 'Medium' and 'High' respectively.

Age Limits

The minimum and maximum age for being covered and renewed varies from company to company. Generally a band of 5 years to 70 years is the norm. However, in case of persons who already have a cover, policies may be renewed after they complete 70 years but up to the age of 80 subject to a loading of the renewal premium.

No medical examination is usually required for renewal or fresh cover.

Medical Expenses

The medical expenses cover is as follows:

- A personal accident policy can be extended by endorsement, on payment of extra premium to cover medical expenses incurred by the insured in connection with the accidental bodily injury.
- These benefits are in addition to the other benefits under the policies.
- It is not necessary that person has to be hospitalised.

War and Allied Risks

War risk cover may be covered to Indian personnel / experts working in foreign countries on civilian duties with additional premium.

- P.A. policies issued during peace time or normal period would be at say 50 percent extra over the normal rate (i.e. 150 percent of the normal rate.)
- P.A. policies issued during abnormal/ apprehensive period (i.e. during the period when warlike conditions have already occurred or are imminent in foreign country/i.e. where the Indian personnel are working on civilian duties) at say 150 percent extra over the normal rate (i.e. 250 percent of the normal rate)

The Proposal Form

The form elicits information on the following:

- Personal details
- Physical condition
- Habits and pastimes
- Other or previous insurances
- Previous accidents or illness

- Selection of benefits and sum insured
- Declaration

The above required details can be explained as follows:

- Personal details relate to, inter alia, age, height and weight, full description of occupation and average monthly income.

- Age will show whether the proposer is within the limits of age for entrants for the policy desired. Weight and height should be compared with a table of average weight for sex, height and age and further investigation would be made if the proposer is say 15 percent or more over or under the average.

- Physical condition details relate to any physical infirmity or defect, chronic diseases etc.

- Proposers who have lost a limb or the sight of an eye may only be accepted on special terms in approved cases. They constitute abnormal risks because they are "less able to avoid certain types of accidents and in view of the fact that if the remaining arm or leg is injured or the sight or the remaining eye is affected, the degree and length of disablement is likely to be much greater than normal.

- Diabetes may retard recovery as the wound may not heal quickly and the disablement may be unduly prolonged. The medical history of the proposer must be examined in order to determine whether and to what extent injuries or illnesses may affect the future accident risks. There are many complaints of such an obviously serious nature as to make the risk uninsurable, e.g. valvular disease of the heart.

- Hazardous pastimes like mountaineering, polo, motor racing, acrobatics etc., require extra premium.

Sum Insured

The sum insured in a personal accident policy has to be fixed with caution, as they are benefit policies and not subject to strict indemnity. Care should be taken to consider income derived through 'gainful employment'. In other words, income which will not be affected by accident to the proposer should not be considered while determining the sum insured.

As practices of fixing the S.I varies among insures/underwriters, the exact amount for which the cover could be granted depends on the underwriters. However the general practice that the cover granted should not exceed the equivalent of 72 months / 6 years' earning of the insured.

This restriction is not strictly applied if the policy is for capital benefits only. For temporary total disablement cover however it should not happen that in the event of compensation payable, the same is disproportionate to his earnings during the same period. If the cover is for weekly compensation for TTD, the sum insured usually does not exceed twice his/her annual income.

While giving cover to persons who are not gainfully employed e.g. housewives, students etc. the insurers make sure that they provide for capital benefits only and that no weekly compensation is provided for.

Family Package Cover

For children and non-earning spouse the cover is limited to death and permanent disablement (total or partial). However, based on individual company's norms the Table of Benefits may be considered. Some Companies allow TTD cover to non-earning spouse also up to a particular limit.

A discount of 5 percent is usually granted on the gross premium.

Group Policies

A group discount is allowed off the premium, if the number of insured person exceeds a certain number say 100. Group policy however may be issued when number is smaller, say 25 but without any discount.

Normally, policies on unnamed basis are issued only to very valued clients, where the identity of the member is clearly ascertainable beyond doubt.

Group discount criteria

Group policies should be issued only in respect of the named groups. For the purpose of availing of group discount and other benefits, the proposed "Group" should fall clearly under any one of the following categories:

- Employer – employee relationship including dependents of the employee
- Pre identified segments / groups where the premium is to be paid by the State / Central Governments
- Members of a registered co-operative society
- Members of registered service clubs
- Holders of credit card of banks / Diners / Master / Visa
- Holders of deposit certificates issued by banks / NBFC's
- Shareholders of banks / public limited companies

In case of proposals relating to any further category different from the above categories, they may be deliberated and decided upon by the technical department of the respective insurers.

No group discount can be offered on the 'anticipated' group size. Group discount is to be considered and worked out only on the actual number of members registered in the 'Group' at the time of taking out the policy. It can be reviewed at renewals.

Sum insured

The sum insured may be fixed for specific amounts separately for each insured person or it may be linked to emoluments payable to the insured persons.

The principle of 'All or None' applies in a group insurance. Additions and deletions are made thereto with pro rata additional premium or refund.

Premium

Varying rates of premium are applicable to named employees as per the classification of risks and the benefits selected. Thus rates will vary according to the occupation of persons covered.

Example

The same rate will apply to well defined groups of employee all of whom, broadly speaking follow the same type of occupation.

In respect of unnamed employees the employer is required to declare the number of employees in each classification based on authentic records maintained by him.

Premium rates for named member of an association, clubs etc. apply according to the classification of risk.

When the membership is of a general nature and not restricted to any particular occupation, underwriters use their discretion in applying the rates.

On-duty covers

The cover provided during the on-duty hours is as follows:

- If P.A cover is required only for the restricted hours of duty (and not for 24 hours a day), a reduced premium say 75 percent of the appropriate premium is charged.

- The cover applies to accident to the employees arising out of and in the course of employment only.

Off-duty covers

If cover is required only for the restricted hours, when the employee is not at work and/or not on official duty, the reduced premium of say 50 percent of the appropriate premium may be charged.

Exclusion of death cover

It is possible to issue group P.A. policies excluding the death benefit, subject to individual company guidelines.

Group discount and Bonus/Malus

Since a large number of persons are covered under one policy, there is less administrative work and expense. Besides, usually all members of the group will be insured and there will be no adverse selection against the insurers. Hence, a discount in premium is allowed, according to a scale.

Rating under renewal of group policies is determined with reference to the claims experience.

- Favourable experience is rewarded with a discount in the renewal premium (bonus)
- Adverse experience is penalised by loading of renewal premium (malus), according to a scale
- Normal rates will apply for renewal if the claims experience is, say, 70 percent

Proposal form

- It is customary to dispense the forms for completion by the members and to have one document only, completed by the insured.
- He is required to make a declaration that no member suffers from a physical infirmity or defect that would render his participation unacceptable.
- Sometimes even this precaution is waived, it being understood and/or made clear by endorsement that disability prior to the commencement of cover and also any cumulative effect as a result of such disability stand excluded.

However the practice may vary among the companies.

Test Yourself 5

1) In a group health insurance, any of the individual constituting the group could anti-select against the insurer.
2) Group health insurance provides coverage only to employer-employee groups.

I. Statement 1 is true and statement 2 is false
II. Statement 2 is true and statement 1 is false
III. Statement 1 and statement 2 are true
IV. Statement 1 and statement 2 are false

Information

As part of the risk management process, the underwriter uses two methods of transferring his risks especially in case of large group policies:

Coinsurance: This refers to the acceptance of a risk by more than one insurer. Normally, this is done by way of allocating a percentage of the risk to each insurer. Thus the policy may be accepted by two insurers say, Insurer A with a 60% share and Insurer B with a 40% share. Normally, insurer A would be the lead insurer handling all matters relating to the policy, including issuance of the policy and settlement of claims. Insurer B would reimburse insurer A for 40% of the claims paid.

Reinsurance: The insurer accepts risks of various types and sizes. How can he protect his various risks? He does this by re-insuring his risks with other insurance companies and this is called reinsurance. Reinsurers therefore accept risks of insurers either by way of standing arrangements called treaties or on a case to case basis called facultative reinsurance. Reinsurance is done word-wide and hence it spreads risk far and wide.

Summary

a) Health insurance is based on the concept of morbidity which is defined as the risk of a person falling ill or sick.

b) Underwriting is the process of risk selection and risk pricing.

c) Underwriting is required to strike a proper balance between risk and business thereby maintaining the competitiveness and yet profitability for the organisation.

d) Some of the factors which affect a person's morbidity are age, gender, habits, occupation, build, family history, past illness or surgery, current health status and place of residence.

e) The purpose of underwriting to prevent adverse selection against the insurer and also ensure proper classification and equity among risks.

f) The agent is the first level underwriter as he is in the best position to know the prospective client to be insured.

g) The core principles of insurance are: utmost good faith, insurable interest, indemnity, contribution, subrogation and proximate cause.

h) The key tools for underwriting are: proposal form, age proof, financial documents, medical reports and sales reports.

i) Medical underwriting is a process which is used by the insurance companies to determine the health status of an individual applying for health insurance policy.

j) Non-medical underwriting is a process where the proposer is not required to undergo any medical examination.

k) Numerical rating method is a process adopted in underwriting, wherein numerical or percentage assessments are made on each aspect of the risk.

l) The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.

m) Group insurance is mainly underwritten based on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer.

Answers to Test Yourself

Answer 1

The correct option is III.

Underwriting is the process of risk selection and risk pricing.

Answer 2

The correct option is III.

The principle of utmost good faith in underwriting has to be followed by both the insurer and the insured.

Answer 3

The correct option is I.

Insurable interest refers to the pecuniary or the financial interest of a person in the asset he is going to get insured and can suffer financial loss in the event of any damage to such asset.

Answer 4

The correct option is IV.

Percentage and numerical assessment is made on each component of the risk in numerical rating method, and not medical underwriting method.

Answer 5

The correct option is IV.

In a group health insurance, when all members of a group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer.

In addition to employee-employer groups, insurers have provided group health insurance coverage to varied type of groups such as: labour unions, trusts and societies, professional associations, clubs and other fraternal organisations.