PRESS RELEASE

OFFICE OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA

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Audit Report on Third Party Administrators in Health Insurance business of Public Sector Insurance Companies tabled in Parliament

The Compliance Audit Report No.1 of 2022 of the Comptroller and Auditor General of India on "Third Party Administrators in Health Insurance business of Public Sector Insurance Companies" was tabled in both the Houses of Parliament here today.

There are 32 general insurance companies doing health insurance business in India. Out of these, four are public sector general insurance companies (PSU insurers) viz. The New India Assurance Company Limited (NIACL), United India Insurance Company Limited (UIICL), The Oriental Insurance Company Limited (OICL) and National Insurance Company Limited (NICL) offering various health insurance products. The four insurance companies are functioning under the administrative control of Ministry of Finance (Department of Financial Services).

Health insurance business is the second largest line of business of the PSU insurers (the first being motor insurance) having gross direct premium of ₹1,16,551 crore during the five-year period from 2016-17 to 2020-21. In health insurance business, TPAs are engaged to have better expertise, specialization in provider interface, medical adjudication of claims and technologically driven customer services. Audit examined performance of health insurance portfolio of PSU insurers for the last five years i.e., from 2016-17 to 2020-21. Also, underwriting and claim settlement records of PSU insurers for three-years (i.e., from 2016-17 to 2018-19) were examined based on sample selection. The main audit findings are as under:

Audit Findings

Performance of PSU insurers in Health Insurance

- All the four PSU insurers incurred losses in the health insurance portfolio in all the five years from 2016-17 to 2020-21. Aggregate loss of the four PSU insurers was ₹26,364 crore during 2016-17 to 2020-21. The losses of health insurance business of PSU insurers either wiped out/decreased the profits of other lines of business or increased the overall losses. The losses were on account of group health insurance policies where premium charged was less and claim outgo was more in comparison to retail policies. PSU insurers' market share in health insurance business is also reducing continuously vis-à-vis the Stand-Alone Health Insurers and private insurers.

(Para 2.1, 2.2 & 2.3)

- Ministry of Finance (MoF) laid down (September 2012/May 2013) guidelines for underwriting of Group policies as per which the Combined Ratio[1] of Standalone Group policies shall not exceed 95 *per cent* and for group policies involving cross subsidy, the Combined Ratio shall not exceed 100 *per cent*. Audit noticed that MoF guidelines were not complied with by the PSU insurers and the combined ratio of group health insurance segment as reported by PSU insurers ranged from 125–165 *per cent*.

(Para 2.2)

Empanelment of TPAs and enrolment of network providers

- TPA management policy was in place in NIACL and OICL and after Audit pointed out the lack of policy, UIICL framed a policy and NICL is in the process of framing a policy. The PSU insurers (except UIICL) carried out empanelment of TPAs, but NIACL and OICL allocated business to non-empanelled TPAs also. Review of performance of TPAs was not carried out regularly by the insurance companies.

(Para 3.1, 3.2 & 3.3)

- Audit analysed TPA-wise allocation of business (annual premium) and TPA-wise Incurred Claims Ratio (ICR)[2] and found that all the four PSU insurers allocated major share of business (15 to 44 *per cent*) to one TPA (Medi Assist India TPA Pvt. Ltd.) despite high ICR of above 100 *per cent* in the claims serviced by the TPA in some year(s). For other TPAs also allocation of business was either increased or maintained at same level despite high ICR in the claims serviced by the TPAs in previous years.

(Para 3.2)

- Safeguards such as timely signing of Service Level Agreements with TPAs, maintaining valid bank guarantees of TPAs and regular collection of claim records from TPAs were not prevalent. Resultantly, when fraudulent activities by a TPA came to light and their registration was cancelled by IRDAI, the PSU insurers could not carry out a proper investigation into claims settled by the TPA.

(Para 3.5 and 3.6)

- Health Insurance TPA (HITPA) is a joint venture of PSU insurers, formed with an objective to enhance customer experience and bring greater efficiency in health insurance claim processing. Despite, HITPA having comparable performance parameters and presence in major cities, allocation of business to HITPA by the PSU insurers was minimal.

(Para 3.4)

- PSU insurers took the initiative to have their own network of hospitals by forming Preferred Provider Network (PPN) but even after 10 years, enrolment of hospitals under PPN coverage was inadequate. The four PSU insurers together have PPN agreements with only 2,552 hospitals (as against 9,900 hospitals in the network of

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[1] ***Combined ratio – Incurred Claim Ratio plus management expenses plus agents'/brokers' commission plus TPA fees and any other expenses***

[2] ***Incurred Claims Ratio = claims incurred/earned premium***

Star Health Insurance Co. Ltd. and 10,000 hospitals in the network of HDFC Ergo General Insurance Company Ltd.). This indicates inadequate efforts by PSU insurers in tying up with a greater number of hospitals for wider coverage and geographical spread.

(Para 3.7)

Claims Management

- The processing of claims is largely on digital platform both at PSU insurer level as well as TPA level. The IT systems in PSU insurers lacked appropriate validation checks and controls, undermining the smooth functioning and reporting system. This has resulted in lapses such as multiple settlement of claims, excess payment over and above the sum insured, excess payments due to ignoring waiting period clause for specific diseases, non-application of co-payment clause, breaching of capping limit for specific diseases, incorrect assessment of admissible claim amount, irregular payments on implants, non-payment of interest on delayed settlement etc.

(Para 4.2 and 4.3)

- Data analysis by Audit revealed that NIACL and UIICL have settled claims more than once on different dates although the policy number, insured name, beneficiary name, hospitalization dates, illness code, hospital name and disease were the same. Audit pointed out 792 cases (₹4.93 crore) of multiple settlements in NIACL and 12,532 cases (₹8.60 crore) of multiple settlements in UIICL, as seen from database. Further, Audit observed in NIACL that the claims settled to policyholder exceeded the sum insured plus cumulative bonus in 139 retail claims indicating excess payment of ₹33 lakh. In UIICL the claim paid exceeded sum insured in 2,223 claims involving ₹36.13 crore, which included group claims. For group policies, there is a provision in the policy for such excess payment over sum insured by way of 'Corporate buffer'. However, the claim processing sheet/ note verified did not indicate use of buffer or available balance of buffer and utilization, etc.

(Para 4.2.1 and 4.2.2)

- TPAs need to carry out mandatory investigation of claims as per Service Level Agreement but in NIACL, UIICL and OICL, 562 claims (for ₹40.46 crore) out of 2,735 sample claims did not contain investigation reports.

(Para 4.4)

- As per Regulation 19(6) of IRDAI (TPA-Health Services) Regulations 2016, TPA should submit or handover all the files, data and other related information pertaining to the settlement of claims to the respective insurers on a quarterly basis within fifteen days after the close of each quarter and the insurer should accept the same under acknowledgement. Audit noticed that as on 31 March 2020, 1.03 crore claim files have not been transferred to the four PSU Insurers by 16 to 19 TPAs.

(Para 4.7)

Underwriting of Group Health Insurance Policies

- Implementation of Underwriting policy of PSU insurers through test check of 188 group health insurance policies of PSU insurers revealed that non-adherence to outgo calculator and non-loading for adverse claim experience resulted in

undercharging of premium of ₹1548 crore in 155 policies and excess discount of ₹9.28 crore in 3 policies (out of 188 policies examined).

(Para 5.2)

- Incurred Claims Ratio (ICR) of coinsurance business of PSU insurers during the three financial years from 2016-17 to 2018-19 ranged from 85.31 *per cent* to 196.54 *per cent*. In all the companies and in all the years, this was higher than the ICR of total health insurance business (except during 2016-17 in OICL and NICL). Hence the incoming coinsurance business was not profitable for PSU insurers.

(Para 5.3)

Internal Audit and Fraud Control

- Systems and procedures for Internal Audit / Health Audit were inadequate and number of audits carried out was insignificant as compared to the targets fixed/ total number of claims settled.

(Para 6.1)

- During the three financial years ended March 2019, 659 audits of claims processed by TPAs were conducted by Health Audit teams constituted by PSU insurers and a recovery of ₹14.30 crore was pointed out, however, PSU Insurers so far recovered only ₹6.06 crore.

(Para 6.2)

- Analysis of fraudulent cashless claims in NIACL indicated that in 122 claims (₹1.39 crore) management of PPN hospital or its employees were involved and in 105 claims (₹75 lakh) management of other than PPN hospitals or its employees were involved. NIACL failed to initiate action against such hospitals in line with de-empanelment clause and investigate all claims relating to such hospitals to safeguard its financial interest. Also, TPAs failed to report such fraudulent reimbursement claims to NIACL and continued to settle claims from the insured even after their earlier claims were proved to be fraudulent, instead of taking up with NIACL to cancel the policy, by invoking the clause regarding cancellation in the policy.

(Para 6.3)

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