Fundamentals of Medical Insurance Underwriting

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1. Overview

The underwriting philosophy and objective should be to build up a strong and healthy Medical portfolio in the growing economy and increasing work force in the country whereby the Company continues to play its leading role in the region. And to ensure continues product enhancement and new products development to meet customers' demands and market needs in compliance with the regulations and company guidelines.

Preference is usually for medium to large size groups with good demographic spread within, so that balanced results of entire portfolio can be achieved reasonably. In view of the very subjective nature, group medical insurance is an important business tool when considering the overall portfolio of corporate clients.

2. Medical Underwriting

A company can provide coverage for both inpatient and outpatient medical expenses. Different levels of coverage are provided based on the network which can be used (there being various levels starting from the Exclusive Network, Standard Plus Network, Standard Network and Economy Network.

Tariffs can be set by the company annually based on advice from the lead reinsurer as well as based on a review of the results of the previous year, increase in provider costs and the general trend in the market. The tariff is applied for small to medium sized groups. For larger groups the company generally obtains facultative quotes from reinsurers and quotes on the basis of reinsurance rate plus commission plus its own margins.

Medical underwriting for Individual Medical is usually carried generically out as follows:

- The received request from the customer is studied and processed based on the chosen plan by the customer.
- The rates and deductibles are subjected as per age, family size as per the guidelines of the treaty underwriter.
- The applied medical insurance facility is priced, based on the plan chosen by the customer.
- A network of designated providers and in-house team administers the medical scheme.
- The Company pre-approves the medical service providers and obtains an agreement on the SLA's with each provider to ensure smooth operations.
- Review of claims experience under Medical insurance is done on fortnightly basis for readjusting of rates and terms.

Medical underwriting for Group Medical is generically carried out as follows:

- All proposals for group health insurance are underwritten as per the guidelines of the treaty underwriter.
- Authorization from the head of underwriting is obtained in case of any amendments and addition made on covers.
- Depending on the group size, the head of underwriting has the sole authority to decide on the cover for pre-existing and chronic conditions for group medical.
- A network of designated providers and in-house team administers the medical scheme.
- Company shall pre-approve the medical service providers & obtain an agreement on the SLA's with each provider to ensure smooth operations.
- Review of claims experience under medical insurance is done on a quarterly basis for monitoring and intimating the insured.
- On renewal, the claim experience is reviewed for re-adjustment of rates and terms

Following are some of the general underwriting principles which should be kept in mind when quoting for a group medical scheme:

- Inpatient can be covered on a standalone basis
- Out-patient benefits can be covered in combination with inpatient benefits only
- A group may have several sub-groups of employees who are eligible for different plans and plan levels
- The maternity benefit cannot be covered on an isolated basis and must be applied for both in-patient

and out-patient covers
- The maternity benefit - if selected - should be compulsory for all married females in the age brackets 16 – 45 of a group including all sub-groups.
- All employees and their dependents should be covered under the same plan and benefit level.

Plans Structure

The following plans are offered to choose from, with flexibility to tailor made as per requirements of the client. These plans offer various annual limits and deductible options. The geographical scope of cover and applicable networks should also be specified.

Scope of Cover

Benefits covered as In-Patient

This coverage shall apply in the event of non-excluded health conditions requiring hospitalization, and/or day-hospitalization and/or emergency services and/or in-hospital minor surgery/procedures. The costs covered as In-patient are broadly determined as under:

- Room and board according to the hospitalization class as specified in the schedule of benefits
- Intensive care unit and coronary artery disease treatment
- Surgeon and anesthesiologist fees
- Hospital services (surgery, theatre, anesthesia, pharmacy, laboratory, radiology, etc.)
- Use of hospital medical equipment (e.g. heart and lung support systems, etc.)
- Intra-venous infusions, injections, etc.
- Diagnostic and laboratory tests, x-rays, electrocardiograms, scans, etc. (only related to the original cause of covered hospitalization)
- Various therapies including physiotherapy, chemotherapy, radiation therapy, etc.
- Physician and other specialist hospital consultation related to the original cause of covered hospitalization
- Home nursing care, if medically necessary and pre-approved by the TPA
- Recipient transplantation services
- Ambulance services.
- Incidental companion expenses.
- Repatriation expenses in the event of death of the insured following admission and during hospitalization for a non-excluded bodily injury or sickness
- Costs related to delivery (if maternity benefit chosen).

Benefits covered as Out-Patient

Out-patient benefits are services such as the following that do not require hospitalization or in-hospital treatment/observation.

- Physician Consultation
- Diagnostic Tests
- Pharmaceuticals
- Physiotherapy

Other Benefits Structure

Maternity Benefit

The maternity benefit is usually compulsory many plans. The maternity benefit mainly covers the following:

Definition: Hospital Confinement for Normal or Cesarean Delivery, Medically Necessary abortion or miscarriage and/ or any complications arising there from, ante-and post-natal Treatment as Medically Necessary.

Basis of cover: usually compulsory for all married Females

Dental Benefit

The dental benefit is optional with payment of additional premium. Once dental benefit is selected, it must be compulsory for all members or all members of any one category (if more than one category in the group) subject to a minimum of 30 members.

Annual Limit: Varies according different plan. Co-insurance is usually 25% participation by the member on each and every claim

The following Dental treatment are typically covered on reimbursement basis:

1. Dental Consultation 2. Tooth Extraction 3. Amalgam / Composite Filling 4. X-rays as part of the treatment 5. Root Canal treatment 6. Prescribed drugs

Optical Benefit

The Optical benefit is optional with payment of additional premium. The benefit will cover optical examination conducted for the purpose of obtaining eye glasses or upgrading existing lenses, excluding the cost of lenses or glasses.

Definition of Group

A group must be composed of a minimum number of 10 eligible employees.

Basic requirements of acceptable groups:

- All the members are resident of the country.
- All employees should be active at work.

Examples for acceptable groups:

- Employer group: An employer (or several companies under one holding) who takes out group insurance for their employees and their dependents.

Examples for non-acceptable groups:

- Groups with less than 10 employees
- Families
- Private clubs
- Social clubs
- Credit card schemes
- Groups, where the members are professionally (as their occupation) involved in sport activities
- Provider of health care services such as hospitals, clinics etc.

Sub-Groups and Plan Categorization

A group may have several sub-groups of employees who are eligible for different plans and plan levels.

Each sub-group must have a precise definition for the plan eligibility, which could either be:

- Hierarchy, e.g. managers, executives, supervisors, factory workers
- Salary bands, grades

The plan categorization cannot be made on the basis of:

- Marital status
- Number of children
- Nationality
- Years of employment
- Etc.

It is important that where felt necessary, individual underwriting, i.e. filling in the Medical Application Form and subsequent risk assessment is performed.

Eligible Persons

Employee and must be active at work on a permanent full-time basis

To be active at work means that the employee reports regularly on a permanent full-time basis to his/her workplace and performs his/her usual and normal duties of his/her occupation in conformity with the employment conditions.

Dependents: • The legal spouse of an enrolled employee

• The unmarried legal children up to the age of 18 (or 25 if under full-time education) of an enrolled employee.

Coverage of Dependents; The following rules are applicable for coverage of dependents:

If it is decided that dependents shall be included under the insurance policy, all dependents of the employees shall be covered. There is no free choice whether to be covered under the insurance policy or not.

Coverage begins with the commencement date of the insurance policy, given the employee is actively at work on that date.

New Spouse/New Arrival

• Coverage begins with the date of marriage.

New-born Child/New Arrivals

• Coverage begins at the date of birth

• Coverage begins with the date of arrival to the country. The legal documentation has to be provided to the Company.

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The underwriting Process

Check List: The following points are given due consideration before preparing the quote:

• Group Size (minimum 10 employees)

• Nature of work

• Residency

• Benefit requirements- major deviations for large groups require reinsurer's approval.

• Census Details (Group Name, Members Names, Date of Birth, Gender, Marital Status, Place of work/residence etc.

• Detail of benefits required

• For groups with existing health insurance scheme, the following additional information is available:

• Claims Experience / Loss Ratio

• Current Table of Benefits

• Renewal Date of Scheme

• Continuity of Cover

• Whether the group is of permanent nature and has a fairly constant size

• Eligibility rules.

• Referral to reinsurer whenever required, such as:

o Group size more than 1000 principal members o Groups with Loss Ratio over 120% o In case reduction in net premium rate is required o Groups having members aged above 65 years for additional premium.

The Tariffication:

• Review the benefits requested

• Match with our standard plans

• Age banding of the census list

• Categorization of the members as per the plan

• Premium Rates for New Schemes:

o Use Standard net rates for new business as provided by reinsurer. o Apply loadings for TPA Fee, Administration Fee and Broker / Agent Commission (if any)

• Premium Rates for existing schemes: Review the claims experience & estimate required premium by:

o Calculating` annualized claims o Adding margin for Inflation to the annualized claims value

o Apply loading factors for TPA Fee, Administration Fee and Broker / Agent Commission (if any).
o Calculate premium using standard net tariffs and apply the loadings.

o Adjustment of premium based on the claims experience and /or additional benefits

Exclusions in health insurance

The list of exclusions in health insurance are normally:

1. Healthcare Services, which are not medically necessary
2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.
3. Domiciliary care; private nursing care; care for the sake of travelling.

4. Custodial care that includes:
a. Non-medical treatment services; or (2) Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services which do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).
7. Healthcare Services and associated expenses for replacement of an existing breast implant. Cosmetic operations which improve physical appearance and which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Breast reconstruction following a mastectomy for cancer is covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medically non-approved experimental, research, investigational healthcare services, treatments, devices and pharmacological regimens.
10. Healthcare Services that are not performed by Authorized Healthcare Service Providers, apart from Healthcare Services rendered in a Medical Emergency.
11. Healthcare services, treatments & associated expenses for alopecia, baldness, hair falling, dandruff or wigs.
12. Supplies, Treatment and services for smoking cessation programs and the treatment of nicotine addiction.
13. Non-medically necessary Amniocentesis
14. Treatment, services and surgeries for sex transformation, sterility and sterilization
15. Treatment and services for contraception
16. Treatment and services related to fertility / sterility (treatment including varicocele / polycystic ovary / ovarian cyst / hormonal disturbances / sexual dysfunction).
17. Prosthetic devices and consumed medical equipment, unless approved by the insurance company
18. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities
19. Growth hormone therapy.
20. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
21. Mental Health diseases, in-patient and out-patient treatments, unless the condition is a transient mental disorder or an acute reaction to stress.
22. Patient treatment supplies (including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments, excluding such supplies required as a result of Healthcare Services rendered during a Medical Emergency).
23. Preventive services, including vaccinations, immunizations, allergy testing and desensitization; any physical, psychiatric or psychological examinations or testing during these examinations.
24. Services rendered by any medical provider relevant of a patient for example the Insured person and the Insured member's family, including spouse, brother, sister, parent or child.
25. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during treatment.
26. Healthcare services for adjustment of spinal subluxation, diagnosis and treatment by manipulation of

the skeletal structure, by any means, except treatment of fractures and dislocations of the extremities.

27. Healthcare services and treatments) by acupuncture; acupressure, hypnotism, rolling, massage therapy, aromatherapy, homeopathic treatments, and all forms of treatment by alternative medicine.
28. All Healthcare services & Treatments for in-vitro fertilization (IVF), embryo transport; ovum and male sperms transport
29. Elective diagnostic services and medical treatment for correction of vision
30. Nasal septum deviation and nasal concha resection.
31. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related test/treatment or procedure.
32. Treatments and services related to viral hepatitis and associated complications, except for treatment and services related to Hepatitis A.
33. Birth defects, Congenital diseases for newborn &/or Deformities unless life-threatening.
34. Healthcare services for Senile dementia and Alzheimer's disease
35. Air or Terrestrial Medical evacuation except for Emergency cases or unauthorized transportation services.
36. Circumcision healthcare services.
37. Inpatient treatment received without prior approval from the insurance company including cases of Medical Emergency which were not notified within 24 hours from the date of admission.
38. Any inpatient treatment, tests and other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health
39. Any test or treatment, for purpose other than medical such as tests related for employment, travel, licensing or insurance purposes.
40. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions) and all equipment not primarily intended to improve a medical condition or injury, including but not limited to air conditioners or air purifying systems, arch supports, convenience items / options, exercise equipment and sanitary supplies.
41. More than one consultation or follow up with a medical specialist in a single day unless referred by a physician.
42. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or recipient.
43. Services and educational program for handicaps.
44. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
45. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type
46. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.
47. Injuries resulting from natural disasters (including but not limited to) earthquakes, tornados and any other type of natural disaster.
48. Injuries resulting from criminal acts or resisting authority by the Insured Person.
49. Healthcare services for patients suffering from AIDS and its complications.
50. Healthcare services for work illnesses and injuries as per Federal Laws concerning the Regulation of Work Relations, as amended, and applicable laws in this respect.
51. All cases resulting from the use of alcohol, drugs and hallucinatory substances.

52. Any test or treatment not prescribed by a doctor.
53. Injuries resulting from attempted suicide or self-inflicted injuries.
54. Diagnosis and treatment services for complications of exempted illnesses.
55. All healthcare services for internationally and locally recognized epidemics.
56. Venereal sexually transmitted diseases. A list with respect thereto is set out by the General Authority of Health Services.

Medical claims processes for network based claims are usually generically as follows:

- Claims are received from the TPA in the form of a letter identified as 'batches'.
- The TPA's IT system is accessed and data is downloaded batch wise.
- Downloaded data is filtered by insured and policy.
- Claim numbers are generated per insured on a 'bulk' basis through the insurer's IT system.
- Claim approvals are prepared for formal sign off by head of department and higher management.
- Credit notes are generated and forwarded to finance for payment.
- Payments are made to the TPA.
- Since the number of outpatient claims is large, these are booked on bulk basis, by way of policy number for ease of administration.
- Inpatient claims are generally subject to a pre-approval and each inpatient claim, regardless of the size of the claim and policy is allocated a separate claim number.
- All inpatient claims and out-patient claims are selected at random and reviewed by the claims department prior to effecting settlement.

Medical claims processes for reimbursement based claims are usually and generically as follows:

- Claims are received by hand via the HR department/Account Executive.
- The documents are reviewed and each claim is registered in the IT system.
- Original Documents are attached with a claim form and submitted to the TPA for review and processing
- Following a review of the claims, the TPA provides feedback in the form of reports
- If a claim falls outside the scope of the Policy, the claim is repudiated the same is indicated in the IT system.
- Claim approvals are placed for formal sign off by Head of Department and Higher Management.
- Credit notes are generated and forwarded to finance for payment
- Payments are made to individual member or to the insured
- Reports are generated which contain detailed adjustment of the claims per claimant, convey account controls and details of reimbursements given by the insurer.

The Companies usually have assigned underwriting authority limits for each individual which is embedded into the system so that no possible breaches occur. They also document key performance indicators to monitor the business and also have a checklist document to ensure compliance to policies and procedures before a policy document is issued.

For Group, Medical, underwriting and pricing strategy is conventionally:

- Withdrawal from certain high frequency claim accounts.
- Regular review of portfolio based on group size, network, hospital, average utilization, average visits, reimbursement, territorial limit, disease, age, TPA etc.
- Increased pricing of loss making accounts on renewal.
- More use of deductible/co-insurance as a control measure.
- Limited benefits for small sized groups.

There is less focus on Individual Medical but it is to be arranged reinsurers to explore feasibility of expanding Individual Medical and its business prospects.

Company's strategy for agents and branches with respect to Life and Medical are detailed below:

- Training branches and agents for Individual Life and Individual Medical quotes and to optimize the wide branch network and their location proximity to bank branches.
- Better coordination with brokers by allocating exclusive marketing resources for Medical & Life broker support.
- Leveraging on collaborator and introducing more pre-underwritten products as in Banks, where in sale can be made through Brokers' office, agents' office or clients' office.
- Web based selling of pre-underwritten individual products would be explored for brokers.

The Company needs to determine the credibility of a client that is having positive loss ratios for the last three to four years. The company also needs to incorporate credibility analysis in their quarterly pricing reviews so as to avoid being potentially volatile in their pricing decisions and as credible pricing analysis is more reliable over time. Moreover, the congruency of results of loss ratios with pure premiums should be continuously inspected and any discrepancies explained adequately. The Company should in addition aim to carry out two-way analysis as well such as behavior of each segment along with the behavior of the make/model within each segment.

Medical Claims

The insurance companies have a network of providers and has standard agreements with them. Providers include hospitals, clinics, pharmacies and diagnostic centers. All providers other than pharmacies are categorized with respect to which network category they are included in.

All confinements are pre-authorized as are (separately) all high cost procedures. Any request for pre-authorization which comes in gets recorded in the system. Any update is also similarly recorded. Approvals are printed and sent to the provider. A reserve is set up in the system for any amounts authorized. Out-patient claims over a specified limit also need pre-authorization.

3. Risks Management and Control

All groups with total principal member's number less than 15 are normally considered to be "Individual" or 'family' in case of takaful. For groups with total number of members less than 25, individual medical underwriting will most likely be applied.

Risks are analyzed, measured, assessed and selected based on underwriting information as per quotation filled forms.

Based on Claims records, demographic structure and the following criteria, terms and conditions should be generated:

- Geographical Limits
- Size of the Group
- Deductibles
- Annual Limit per person
- Network Providers

Underwriter to fill in the "underwriting Assessment" sheet with risk factors analysis

Large groups with total number of members greater than let's say 4,000 should be referred to company Actuary for pricing based on company's portfolio analysis, and send back to Underwriter for deciding final terms and conditions.

Groups with smaller total number of members have to be priced by Underwriters based on underwriting guidelines for the technical premium to issue the terms and conditions.

Renewal Underwriting Process is generically:

1) Receives notification daily through email for the list of accounts due for renewal 45 days prior to due date.

2) Generates claims and premium information from MIS/business intelligence (actuarial data).

3) Generates Renewal Optimizer (Renewal optimizer for groups having more than 100 members)

3) For small groups, burning cost analysis should be done using basic spreadsheet calculator tool. Larger groups should be done along with the company actuary.

4) Sends the renewal quote to the client/BDM/broker.

5) Upon confirmation, notice is sent to Operation to proceed for policy set up and card generation.

Mandatory Requirements that have to be extracted from the client when quoting for insurance are generally:

▪ Population

o Current year o Population Breakdown (Employees/ Spouses/children) o Date of birth per person o Population breakdown (citizens / Expatriates) o Population breakdown (urban/rural, north/south etc.) o Population breakdown (Nationalities) o Class/category breakdown (if more than 1 class)

▪ Current Claims experience (if available claims experience for the past years)

o Total Claims amount (not LR) o Any high cost files cases

▪ Company activity

▪ Required Scale of benefits and any additional optional covers e.g. (Dental / Emergency evacuation etc.)

▪ Current insurer

▪ Current benefits scheme

Others (if applicable)

▪ Claims breakdown per benefit (outpatient / inpatient / dental etc.)

▪ Past years population and expected population next year

For Groups less than 25 members, the terms are usually subject to duly filled medical questionnaire per member and will be given a plan.

Health Pricing should be conducted and designed by analyzing company's own portfolio and would help in keeping the rates consistent across all underwriters and branch offices. The final pricing reflects all the factors that we have analyzed which could affect the burning cost and therefore pricing.

Clean application / Standard cases are normally approved by a company immediately, and non-clean application / substandard cases are referred to the Reinsurance for underwriting decision

Basis for underwriting

The rating & underwriting for the above classes of insurance depends on the following:

Size of the group

Age brackets

Gender

Risk location

Nature of business

Claims experience

Depending upon the medical history revealed in the application forms, appropriate medical checkups and investigations are carried out so as to establish insurability and setting terms and conditions.

For certain common health conditions, applicants may be accepted/charged a higher rate or offered limited coverage taking into consideration also the following aspects;

- Height,
- Weight
- Moral Hazard
- Lifestyle
- Profession
- Hobbies

The following medical conditions form some of the exclusions of Medical Insurance Scope Applicant with the following medical conditions is considered "High Risk", however, as per local regulations, a Company might not be able reject or decline quoting for any individual:

• Venereal sexually transmitted diseases

• Cosmetic treatment

• Patients suffering from AIDS and its complications

• Healthcare service for senile dementia and Alzheimer's disease.

• All healthcare services & treatments for in-vitro fertilization (IVF), embryo transport; ovum and male sperms transport.

Risk categories:

Class I risks:

Employees of Banks, Government Institutions, Hospitals, Hotels (Chain of hotels managed by reputed international/regional group), National Airlines, Oil & Gas Companies, Real Estate, Large Commercial /Trading Groups etc.

Class II risks:

Employees of Construction Companies, Engineering & Electromechanical Companies, Ship building, Marine Dredging Companies, Paint Factories, Automobile garages, plastic factories etc.

Excluded Risks

Shown previously.