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Mis-Selling in Insurance Industry
- Things to know & learn

भारतीय बीमा विनियामक और विकास प्राधिकरण

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Mis selling of Health Insurance Policies

- Prof . D.Chennappa

Abstract

The Indian Health Insurance (HI) Sector is the fastest growing sector in Non- Life Insurance sector. However, it is suffering a lot due to 'Mis Selling' of policies. Mis selling is selling a policy by giving wrong picture of the policy. It may include, giving wrong information, giving unrealistic information, and not giving full details of the product. This paper covers the reasons for mis selling in the H I and its consequence, prevalent of customer from mis selling of the product and the role IRDAI in preventing mis sellings in HI.

It concludes that most of the people don't care to check the fine print of the policy and simply believing the agents, who does the practice of luring the customers with a range of attractions and unrealistic

offerings. In order to protect the policy holders from mis selling IRDAI says that to use the provision of FREE LOOK period wherein a policy holder can return the policy within 15 days from the date of receipt if terms and conditions are not agreeable or suitable.

Therefore, an attempt is made in this paper to identify the areas of mis selling in HI and to create alertness about the mis selling of HI products.

Key words: Misselling, Free Look period, policy exclusions, fraudulent misrepresentation, spurious calls, sub limits, co-payment, lapsation, cognitive dissonance, fraud claims and Common Service Centres (CSC).

1) INTRODUCTION

The health insurance sector in India is growing at a Compound Annual

Growth Rate (CAGR) of about 35%. It is the highest growth rate among all non - life insurance segment. However, despite the growth, insurance industry is stumbling in India after 15 long years the sector was opened for private players in year 2000 due to more number of claims and mis-selling of the policies. And, it's observed that mis-selling has been the major roadblock in the growth of insurance industry in India. Most insurer / insured have experienced mis-selling at some point or other.

Mis-selling is very common in insurance sector. It involves selling of insurance products either by hiding facts or giving false information to the buyers. Normally, the agents / intermediaries lure customers with unrealistic benefits of the policy. Some agents succeed convincing customers in such a way that they end up buying an

unsuitable product. In most of the cases, exclusions under the policy are kept hiding from the buyers. Thus, the most prolific reason why insurance industry not penetrating. Although, the health insurance business has been booming for the non-life insurance since then but the pace has been considerably very low.

Today, medical costs are rising in the double digits. A heart bypass surgery that cost about Rs 130,000 two years ago now costs about Rs2 lakh. A coronary angiogram now costs Rs 18,000, up from around Rs 14,000. But the awareness about medical insurance is still very low in the country. An IRDA study shows that only 17 per cent of the people in India own any form of health insurance with a large number using group health covers taken by the government or their employer and only 2 per cent of the people own voluntary private health insurance policies. Therefore, an attempt is made in this paper to identify the areas of mis selling in HI policies and to create alertness about the mis selling of HI products.

2) MIS SELLING OF HEALTH INSURANCE POLICIES

1) **Agents:** Insurance agents have been an irreplaceable part of the insurance purchase process since time immemorial. And in

most cases, instead of reading the document and fully understanding what insured are getting into sign up based on what the agent says. The result is that when it is time to raise a claim, policy holder realises that they don't get what were promised. It is observed that insurance agents are mostly interested in selling plans which get them high rates of commissions. They are less bothered about the requirements of their clients and more interested in their own income.

2) Policy exclusions

On an average, a regular conversation between a customer and an insurance agent is all about premiums. Most people look at insurance as another investment option, so premiums and returns become central to their understanding of the policy. But there are ignoring to understand the especially exclusions of the policy. Even Policy holders are also ignoring to ask for limits, hospitals covered, diseases covered and see if it suits to their requirements. They are not sure about main and sub clauses of insurance wordings.

3) Buyer doesn't care to check the fine print of the policy

The buyer (insured) is in a hurry and doesn't care to check the fine print or Often, the intermediary does not fully explain the policy details to the customer. There have been cases reported where the agent deliberately misguided the buyer. Discussing an example of mis-selling: A person aged 54, having a handsome amount of savings with him and having no dependents (no kids and wife has passed away a few years ago), has no need of a term insurance (death benefit) but the agent may sell him this policy.

4) Fraudulent Misrepresentation Of Material Facts

A common practice that is seen in this regard is where the agent sells the policy promising a single premium mode or a limited term policy but it actually turns out to be a regular premium mode. And the customer has no option but to surrender the policy or stop paying the premium. According to a survey conducted by Ernst & Young³, compared to different types of frauds, insurance companies are most affected by "mis-selling" due

to premeditated fabrication or fraudulent misrepresentation of material facts. Insurance continues to be mis-sold with senior citizens being the softest targets as they do not understand new products.

5) Product related issues

The complexity of the insurance product and asymmetry of information between the insured and insurer or his agent has led to a minefield of mis-selling. Also the policy document is full of jargons and fine prints which make it beyond the comprehensive ability of the insured to interpret the real meaning. This leads to controversies between the policyholder and the insurer.

6) Aggressive marketing

निवेश करे रु. 25,000/- एक मुश्त
एवं प्राप्त करें
7 वर्षों की सर्वोच्च NAV से रु. 2,14,690/-*

The insurance products are promoted aggressively by the companies and the agents have no option but to sell it by hook or crook. Often, they show a performance chart to the proposer which shows astronomical returns of 15% over a period of one year. Many times customers of ULIPS's

complain that they were told that they need to pay the premium only for three (or five) years and would receive guaranteed tax-free returns, but when they check the actual condition after three years they get shocked to see that their fund had actually diminished. IRDA has recently brought out many corrective and preventives measures to curb this problem but it will take some time for the consumers to realize the consequences.

7) Lack of awareness

People are not aware about their financial goals and hence they are not able to analyse their needs and buy products which are not in tuned with them. What they end up doing is help the agent in achieving his goals rather than theirs.

8) Dearth of qualified agents

Most agents do not take this profession seriously and end up terminating their agencies sooner than later. The policies sold by these incompetent agents become "orphan policies" and without servicing they lapse. In the financial year 2013-14, 11.45 lakh agents left the insurance business while only 9 lakh joined which has led to a fall of 35%. The companies

are finding it really hard to recruit good agents.

9) Lack of patience

After the customer agrees to buy the policy, he does not see the policy literature carefully. They are in a hurry to wrap up the procedure and they don't even study the features properly. The agent no doubt should produce all the facts correctly, but the insured is also liable to check what he has purchased. Prompt inspection can lead to utilization of the "free-look period" in a better manner.

10) Reward system of Insurance agents

Since agents are paid heavily front loaded commissions, they indulge in unethical practices. It brings in product bias as an agent has an incentive to recommend a particular product irrespective of the client's need. This fact became more evident when the agent commission's for ULIP products was capped post September' 2010 IRDA guidelines. Insurance companies have lost almost 21% of their business after these reforms.

11) Fancy clauses

An insurance agent might go into a sales pitch that includes at least one fancy item and weave a rosy picture. The truth is you might not even require it, but policy holder may get caught up in the pitch. Though, these come with a higher premium cost.

12) Commission, processing costs

No insurance agent will ever tell the policy holder that his commission is the primary reason behind him pushing one policy over another. Besides, he doesn't reveal the percentage of premium that the insurance companies take as a processing surcharge. Policy holders end up by paying higher processing fees due to ignorance and at the end losing the interest on renewals.

13) Un realistic predictions of returns

Misguiding about the terms and conditions of a policy and showing unrealistic predictions of the returns (20%-30% returns) are the sort of tactics and surprisingly, that most of the policy holders are being attracted.

14) Aggressive sales targets

All the private insurers give aggressive sales targets to their sales teams which are impractical to achieve. And Employees who have a family to support go to any lengths to keep their job. To meet the targets agents are forced to sell the policies by false promises, or using chain marketing tactics to the unwanted people and they might not renew the policies or they might be opting for claims, ignoring locking period.

15) Claim settlement

It is a nightmare to run behind an insurance company to get your claim settled. The worst scenario is that claims getting stuck in unwarranted objections. Insurance companies will do according to the policy clauses and the processes.

16) Health Claims: TPAs Pay Less Than Promises

The average claim amount of health insurance policies settled by intermediaries, such as Third-Party Administrators (TPAs), is 5 per cent lower than those settled by in-house claim settlement teams set up by insurers, reveals Insurance

Information Bureau data for 2012-13.

Most insurers outsource claims processing to TPAs, who act as intermediaries between hospitals and insurers, to save on administrative and distribution costs. As TPAs get a commission for cutting down claims, they often question the treatment and tests the insured undergo, resulting in a reduction in the claim settlement amount and creating ambiguity among customers.

17) Fraud Claims

Today's insurance fraudster is tech-savvy and murderous even. When a life insurance company began receiving a huge number of claims from Maharashtra's Nandurbar, Dhule and Jalgaon regions, it was more than a little surprised. So many people dying in succession in the same places seemed unusual enough for it to hire an external investigating company.

What came to light was a fake death certificate racket involving several doctors and hospitals in these areas, as well as individuals masquerading as doctors to provide the insurers

false information on policyholders.

18) Policies Were Issued For Terminal- ill / Death People

Policies were fraudulently issued in the names of terminally-ill people, including many suffering from tuberculosis, HIV or cancer, and alcoholics who were dead or in poor health. Many of these unwitting 'policyholders' belonged to lower-income groups and neither they nor their families were aware of the insurance policies existing in their names. The racket – which involved paying the premiums and claiming the insurance amount on the death of the 'insured'.

The methods used to defraud insurance companies commonly range from taking policies in the name of deceased persons to surrendering policies without

the knowledge of the policyholder and embezzlement of customers' premium payments in cash.

19) Spurious Call & fictitious offers in the name of IRDAI

There is spurious calling in the name of the insurance regulator IRDA, or as an insurance company selling policies or offering false benefits like policy bonus for a payment. Certain regions in the country appear more fraud-prone – northern and southern Maharashtra, and parts of Uttar Pradesh, Gujarat, Rajasthan, Assam, Orissa, Karnataka and Andhra Pradesh.

When a fraudster strikes, apart from the loss to the insurer, customers too end up paying a price in the form of higher premiums to make good the insurer's loss.

20) Issues of Policies on Nominees Name

An agent some time issues the policies on nominees name.

21) Differences in Promises

The nature of complaints includes malpractices, difference in promised and actual features in products, non-refund of premium on policies cancelled during the free-look period, tampering or forgery of proposal forms and alteration in policy tenure without consent.

22) Hospital Room Eligibility Capping

Now this is the big one. This single condition could depreciate the value of your health insurance with inflation. Many Health Insurance policies have room rent capping, which

Table 1: Room Rent Capping As Per the Limits
(no.of days hospitalised = 5 days)

	Hospital bill	How much would be paid	Payable amount explained
Room charges	Rs 40,000 (Rs 8,000 per day for 5 days)	Rs 20,000	Eligibility (5 days @ Rs 4,000 per day)
Surgical cost	Rs 1,00,000	Rs 50,000	50% eligible
Doctor visits	Rs 5,500	Rs 2,750	50% eligible
Medical tests	Rs 4,500	Rs 2,250	As per limit
Medicine	Rs 10,000	Rs 10,000	MRP price
Total	1,60,000	Rs 85,000	Expectation defences Rs 75,000

means you are eligible to claim expenses only up to a room costing below this capping. In case you opt for a room above this cap, you will have to bear the additional proportionate expenses on your own. Let me give you an example

Lets say, as per the policy room rent limit is Rs 4,000 per day . Now if policy holder get hospitalized and choose a room which has room rent of Rs 10,000 . policy holder might think that he will just get 4,000 per day for room rent from insurance company and other charges you will get as per the limit. But that's not true. In reality, room rent limit is 50% of the room rent chosen, hence all other expenses will be paid by 50% margin only. So overall, expectation differences arise due to not noticing the capping and limits of policy.

23) Sub limit/Co-Payment

There are clauses like sub-limits and co-payment in most of the insurance policies. They put a sub limit on a particular expenses (like 2% of sum assured). There are few Insurance products that have limits for specified surgeries also. So even if your sum assured is Rs 5 lacs, they might

4.22 Any kind of Service charges/Surcharges, unless payable to the Govt. Authority, levied by the hospital.

4.23 Compulsory Co-Payment: Under the SILVER plan the insured has to bear 10% of admissible claim amount in each and every claim.

restrict a particular surgery expenses to 50% of your sum assured. There are words like "limits", "co-pay" or "deductible" in the policy. These are set deductions in claims.

4 MIS-SELLING AND ITS CONSEQUENCES

a) Lapsation

Lapsation has been one of the major concerns for insurance companies. Generally, once the policy is accepted in life insurance, the insurer undergoes costs for administrative processes, agent's commission and medical charges, which many times eat up almost whole the first years premium collected as well as the major part of second year premium. After incurring these expenses if there is an early lapse in the policy then it poses a major financial threat to the insurer. A major reason for lapsed policies is the lack of communication between the insured and insurer after the sale of policy, leading to strained relationships.

• Cognitive Dissonance

Often the misalignment in the objectives of the parties involved

triggers mis-selling. For example, insured's major objective may be to save taxes or built a corpus rather than life protection whereas the agent may be looking at earning higher commissions and helping him reach his target faster. This misalignment at the initial stage of policy itself may cause a huge divide at later stages. In case of insurance, cognitive dissonance will cause a previously cheated customer to never trust an insurance agent again, however good the policy may be.

• Bad word of mouth

The industry is facing the risk of bad publicity due to mis-selling. There are instances when people decline insurance policies just because of bad publicity by friends, relatives etc as they lose faith in it.

• Post sales of services

Policy holders even need a post-sales services like claim assistance and helping out in co-ordinating with the health insurance company. If policy holders find themself a policy through an Insurance Broker, if required, he/she may also be able to help you through dispute resolutions with Insurers, in the long run, if any.

Let me show you an example of a claim rejection case with Max Bupa (company was right in rejecting the claim) . One of the readers among you had bought a policy through Max Bupa (through some individual agent, not broker) and he bought two different policies for himself and wife . He wanted a maternity cover and the agent told him that its covered in the policy. It was even written in the policy document, but it was clearly written that both husband and wife have to be in a single policy (floater policy) . But agent and client both didn't pay much attention to it. And after 4 years, company rejected the case based on their terms and conditions (the claim itself was not valid) . Below you can see the scanned letter which company had sent to the client. Here company was correct in rejection of claim because client wanted something which was never covered in the policy. However if had paid more attention or had a great advisor on his side, he might have been informed in a better way.

Suggestions

1) Insurers :

- a. Drafting product literature in vernacular languages which will be easier for a layman to understand and it will also widen the reach. The terms and conditions, benefits, charges,

lock-in period etc should be specified in bold and simple language.

- 2) **Policy exclusions:** To buy an insurance plan that can cover policy holder during a financial emergency, take note about exclusions. This will help policy holder understand the policy better and get you more value for money.

3) Common service center

Marking the opening of a new sales channel aimed at increasing insurance penetration in rural areas, insurance companies today launched sale and services through the common service centres (CSC) across India.

The CSC platform is currently being used by citizens to access and pay for the services offered by multiple government agencies and private sector players.

Set up under the national e-governance plan, about 140,000 CSCs are functioning under different names in different states.

- 4) **Video calling:** India Infoline, an insurance broking firm, has come with a novel idea of video calling, in a bid to avoid mis-

selling of insurance plans. The sector suffers from a very high degree of distrust because of agents who sell irrelevant insurance plans to people.

- 5) **Awareness:** Make the consumer aware at the ground level. It was believed that after opening of insurance sector the insurance companies would make the consumer aware at ground level. Though sale of policies has increased but the awareness is still a far cry. By organising some seminars at 5 stars hotels will not make the rural customers aware of insurance.

Companies and IRDA must reach at ground level. Organise ground level meeting involving panchayats, local administration, clubs, village head, School Head Masters, NGO's to spread awareness about insurance. Give them case studies of misspelling so that they may be aware.

- 6) **Ban Chain Marketing System:** Again officially chain marketing system is not permissible in insurance industry but still most of the insurance companies are utilising this channel to get bulk business. In India we follow a rule everything is fair in love and war till anyone is caught.

So everyone utilises this channel unless some serious fraud is found and IRDA bans it after few years. By the time damage is already done. Still chain marketing business is being done on a very large scale in insurance and companies are getting good business. Everyone is busy finding new ways and rules to break the law. In India the politicians does not find themselves guilty till convicted by Court. They know very well that it will take 10-15 years to get a decision and meanwhile they will continue siphoning and by the time evidence will die or matter will get off from public attention.

7) **Chit Fund Companies:** Just to take an example in Bengal chit fund companies have mushroomed like anything. They are doing brisk insurance business. One recent case came to my knowledge. A person was approached by an insurance advisor who was not licensed to sell insurance policy. He gave him the details of the policy but the papers signed for insurance was not for insurance policy, it was for monthly instalment for purchasing a property. Shocking isn't it? On query the customers are told that since officially they cannot commit such high return so they are giving under

this cover. IRDA should ban chit fund companies from selling insurance products in this manner.

8) **Long term damage:** This misselling is causing long term damage to the industry. Since in India the uncovered market is huge the misselling will continue as the advisors will catch hold of new customers anyhow. The Insurers should seriously think about it as if this trend continues the people would no more trust insurance as an effective protection tool and shy away from this. Though in short term insurance companies may sell the policy but in long term they are killing the huge prospective insurance market.

9) **Undue Pressure on Sales force:** Most of agents/officials are of the opinion that undue pressure from management forces them to any how sell the policy to save their job or agency. The Insurance Company management will have to draw a line when to stop forcing the employees for business and differentiate the quality of business. If the insurance company will insist on quality business misselling will reduce to a great extent. The philosophy of management has a great impact on misselling.

10) **45 days FREE Look Period:** IRDA has a system of Free Look Period of 15 days for returning a policy if not liked by the customer. This period should be increased to 45 days. It will also reduce chances of fraud where the policy document is delayed deliberately or the advisor accepts the delivery on behalf of customer.

11) **Compare the policies through on line web sites.**

It is suggested to the customers to compare the policies through official websites and customers need to check up the initial waiting period, specific waiting period, pre existing disease waiting period, no claim bonus, sub limits of the policies, co-payment and annual premium.

In case, any customer is looking for low premium then they can opt for Religare CARE health policy. Any insured looking for more no claim bonus so they can opt for Appollo Munich where no claim bonus is highest. If any individual doesn't wait for specific waiting period and they want immediate benefit with 1 % of the room rent on sum assured, such people can opt for Max Bupa - health best Individual gold policy.

Table : Health insurance policy for a 35 year -old male and sum for insured of Rs 5 lakh

Company	Product	Initial waiting period (days)	Specific Waiting period# (years)	Pre-Existing Disease Waiting Period (years)	No. Of Claim Bonus	Sub-limits*	Annual Premium (Rs)
Religare	Care	30	2	4	10-50%	No	5,612
HDFC ERGO	Health Suraksha	30	2	4	5-50%	No	5,582
Star Health	Mediklassic	30	2	4	5-25%	Yes	6,124
Royal sundaran	Lifeline Supreme	30	2	3	20-100%	No	6,235
Reliance General	Health Gain	30	2	3	33.33-100%	No	6,601**
Bajaj Allianz General	Individual Health guard	30	2.4	4	10-50%	Limit on Cataract Surgery	6,917
Appo Munich	Optima Restore	30	2	3	50-100%	No	7,298
Cigna TTK	Prohealth Plus	30	2	3	10-50%	Limit on ambulance expenses	8,584***
ICICI Lombard	Health Protect Plus	30	2	2	10-50%	Limit on cataract survey	9,762
Max Bupa	Healthbest Individual Gold	90	NA	2	10-50%	Room Rent 1% of the sum insured	9,977

Source: Business Line, February 2, 2015, p,no2.

*on surgery / treatment / room rent; **for sum insured of Rs 6 lakh, *** for sum insured of Rs 5.5 lakh # for listed diseases

Based on the observation and interpretation, it can be concluded that there are more and more tailor made/ multifull product are available based on their requirements. Therefore customers are suggested check the suitability of the product for their requirement before buying it.

CONCLUSION

The health Insurance sector in India is growing at Compound Annual Growth Rate (CAGR) of 35 %. But, most of the companies are

affected by 'mis- selling' of HI products due to premeditated fabrication, fraudulent misrepresentation of material facts. All the HI policy documents are full of jargons and which make it beyond the comprehensive ability of the insured to interpret the meanings for various wordings.

Mis selling of the policies lead to lapsations, cognitive dissonance, bad word of mouth and effects post sales services (claims). It aggregates there strain the relations between insurers and insured. However, customers/ policy holders

are urged to read the policy documents fine prints, cross check the benefits offered by the insurer or agents and suggested to fill the form with their hand writings after careful reading of the exclusions, free look period and coverage of the policy.

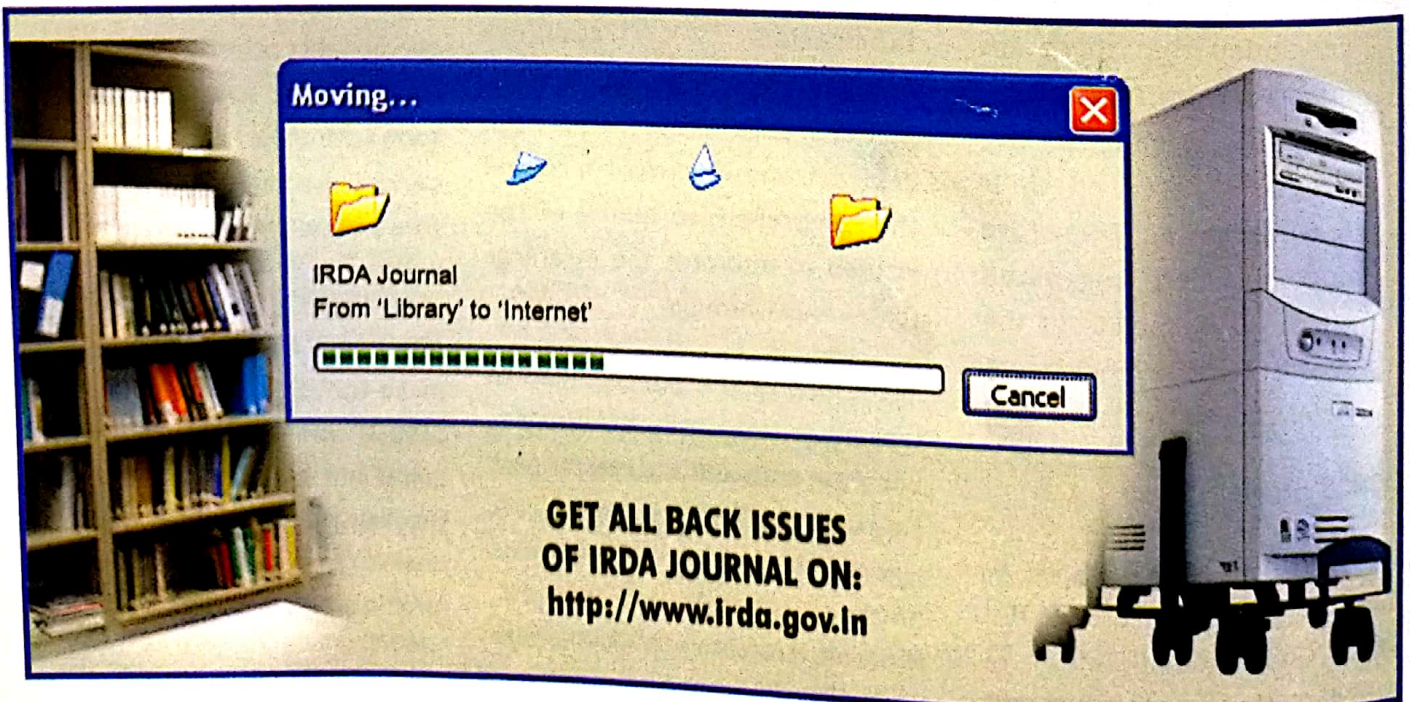
IRDAI says that customers should make use of the Free Look Period clause and suggest to make a compliant at ombudsman against the mis selling. However, it is a high time to create awareness among the rural customers and make them to

compare the policy coverage before buying the policies.

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