



The Health Insurance Enigma Called "PED"

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The Pre-Existing Disease (PED) Clause in health insurance causes as much worry as the confusion it generates in the minds of the insuring public. All the stakeholders in the industry, including the intermediaries and the consumers, use this vague clause to take full advantage of the unwary client, and, the end result is the cause for much disconnect and loss of credibility in the insurance industry itself. This is the one term that is the reason for the maximum number of claim rejections.

This article attempts to bring out the areas of misperception among the insurers and consumers, explain the need to simplify the clause for improved understanding and interpretation.

Similar words/clause used in certain parts of the world are also discussed to show how the wording can be improved and remove the disconnects and reinforce faith in health insurance as a genuine tool for mitigating financial worries on account of medical treatment.

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The "Pre-existing disease" (known as PED in health insurance parlance and circles) clause is capable of throwing a scare into the minds of the best of the insurance literate, and even the green-horn new buyers.

Let us examine the term and try to understand it from a common man's point of view. Put plainly, pre-existing diseases are medical disorders or illnesses that a person may have on the date of buying an insurance policy for the first time.

Like *paap* or *punya*, these are baggages that a person acquires and endures during one's journey of life. Unlike the *paap* or *punya*, which are singled out and piled together and deliberated only on the

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Judgement Day after one is through with life's journey, the insurance companies give their judgment as one starts the health insurance journey, not after it.

The medical conditions/diseases that exist before one opts for a health insurance policy are deemed significant by the insurance companies and in the normal course, they do not grant cover to a person for the pre-existing conditions. The premise is that the cover is designed and premium arrived at, keeping only the healthy and balanced risks in view. The load of pre-existing diseases naturally would upset the mathematical calculations and create upsets in the final outcomes expected.

No wonder, the insurance companies accept persons with a PED load with a pinch of salt. There is an extra cushion required for covering that extra load. This can be either as a loading on the premium for the additional risk or an additional period of waiting for any claim benefit to be availed just to balance the extra load that follows the PED risks. All insurance companies also take a considered decision as to whether the PED load is within the narrow acceptable bandwidth or not. Only if they are still within acceptable bandwidth will they offer cover even with a waiting period of 48 months. Otherwise, it is otherwise!

In India, it is normal for the insurance industry to withhold cover for the PED load for consecutive four-policy terms (or 48 months) for the first policy to be issued. Any claim for treating such pre-existing conditions are considered after completion of four straight years of continuous insurance cover after the commencement of first policy. Some insurers do resort also to an additional loading of premium to adjust for the extra load.

From this angle, any and every health disorder ranging from chronic health issues, like asthma, hypertension diabetes and many others could be falling under the term "PED". Buying a health insurance policy with a pre-existing disease may not be easy, because the insured loses his advantage as a balanced risk. The reasoning is plain enough. The individuals who have existing health problems may have a higher incidence of claims or even have recurrent claims than those persons with no adverse medical history at all. So from this angle, persons with PED are at a disadvantage when attempting to avail a health insurance cover.

Pre-IRDA Era

In the pre-IRDA era, it used to be at the sole discretion of the insurer whether to accept a PED risk or not. Insurers had the freedom to decide each case on individual merit/s and treat PED cases on a person to person basis. The PED clause of those days read as follows:

4. "EXCLUSIONS: The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 "All diseases/injuries which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial medi-claim policy taken from any of the Indian Insurance Companies shall be taken, provided the renewals have been continuous and without any break. (See Ref¹)."

As opposed to the current practice, insurance companies had the right to exercise individual freedom to express their individual risk appetite. Traditionally in pre-regulated days, insurance companies used to examine the whole range of declared medical history, and accept exposures with certain types of medical disorders permanently excluded, and certain ailments and its treatment kept outside the purview of the policy for a given waiting period. So, persons with a history of chronic illnesses also could get into the policy cover, with their chronic illnesses permanently excluded, and with an insurance cover available to them for all remaining health conditions and illnesses.

Present Position

However, post-introduction of Health Insurance Regulations, the Regulator directed that the terms and conditions governing the policy should be standardized and uniform among all service providers for the benefit of customers. The Regulator felt that the common body of general insurers called General Insurance Council (GIC) should make a unanimous agreement among the members and make PED terms uniform across all players.

The General Insurance Council of India (GIC) is a statutory body under the Insurance Act. All the public and private sector general insurance companies are governed by its decisions. The Council's PED definition is uniformly applicable to all medical insurance policies since June 1, 2008.

The definition of a pre-existing disease as defined by the Body and in vogue is: ***"PRE-EXISTING CONDITION/DISEASE means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or for which you/insured member received medical advice/ treatment within 48 months prior to the first policy issued by the insurer.*** (See Ref²).

The wording that an insurer puts in the policy is also defined and specified by the Council. The clause proposes to exclude pre-existing diseases up to a maximum of 48 months. Insurers are free

to reduce the waiting period, but cannot expand the duration. A typical waiting period clause reads as follows:

"Pre-existing conditions/Diseases etc: The benefits will not be available for any condition(s) as defined in the policy, until 48 months of Continuous Coverage have elapsed, since inception of the first Policy with the Company. (See Ref³)"

Thus, according to the Council, a PED is a medical condition/disease that existed before one obtained the first health insurance policy. Additionally, such medical condition should have been diagnosed and/or received medical advice/treatment within the immediate 48 months prior to availing the first policy. Insurance claims for such pre-existing conditions will be admissible only after the completion of further 48 months of continuous insurance cover. This may sound simple, but it tricky. There are multiple reasons for that.

Disconnect 1

The first disconnect is the misunderstanding of the PED clause by the common man (the insured) and the misinterpretation and the subjective application by the shrewd insurer. In fact their views are worlds apart! The simplistic understanding is that the 'Pre-existing' conditions are those that are declared in the Proposal Form by the insured, which have existed and/or have been diagnosed and/or are actively being treated during the immediately previous four years prior to the starting date of the first insurance policy.

But the insurers will not be satisfied with such a simplistic an outlook. For them, the pre-existing illnesses will mean to extend to include all co-morbidities and complications arising from the original ailment, *directly or indirectly related*. For example, apart from complications, which are due to progression of the disease, there are several types of co-morbidities which are associated with diabetes. Not to be confused as symptoms of diabetes, co-morbidities are diseases or medical conditions that may (or may not) coexist with primary diseases, but also stand on their own as specific diseases. An example of this would be the relationship between diabetes and hypertension. It can be said that a person can suffer from hypertension and not have diabetes, *but someone suffering from diabetes frequently has hypertension*.

Thus, when a person declares diabetes as PED, the insurer not only excludes diabetes from payable claims, but also any treatment in respect of other co-morbidities such as hypertension, cholesterol abnormalities, triglycerides, heart attack, non-alcoholic fatty liver disease, cardiovascular diseases, kidney problems and/or obesity.

So also, an insurer might not be satisfied without also excluding heart failure, heart attack, heart disease, recurrent strokes, diabetes and chronic kidney disease as co-morbidities of hypertension.

Co-morbidity is associated with worse health conditions requiring more complex clinical management, and increased health-care costs. Attempts to study the impact of co-morbidity are complicated by the lack of consensus about how to define the concept and measure the malady. There is no agreement, among the medical fraternity, on the meaning of the term, and related constructs. The terms, such as multi-morbidity, morbidity burden, and patient complexity, are yet not well conceptualized or understood.

Now a compelling question that is thrown up is : how justified is the insurance company in extending the scope of PED to medical conditions beyond the existing primary illnesses? What the clause points to is that a PED is considered a PED when there is an identified symptom or when it is diagnosed or when a treatment is being taken for the PED. A co-morbid condition is a potential complication or future possible worsening of the existing medical condition with no symptom shown or diagnosis done or treatment taken as of date for the existing complication.

It is a moot point that co-morbidities are wide-ranging generalizations and are not based on assessment of any individual indexing of definite progression status of the disorder. Besides, these are not strictly pre-existing conditions, but future possibilities that might or might not happen after purchasing the policy; not evident and direct but definitely an existing medical condition at the time of taking the cover. It can as well be argued that the insurer's choice to underwrite a risk based on existing conditions having been exercised, how justified is the insurer in spurning future claims on the mere possibility or condition that may develop later? More so, when these co-morbidities are not all that direct and conclusive spinoff from the existing condition/s. It will depend on how good or bad the person is in controlling and monitoring his/her own medical disorder that s/he has at the time of purchasing an insurance policy. The insurer's obligation to determine the typing and character of the risk it chooses to underwrite cannot be discounted with the attendant responsibility shifted to a blanket ban on wider risks to protect its own turf.

More than that, all the co-morbidities have an independent status as a medical condition, in their own way. Looked at from this angle, can an insurance company morally and ethically justify its action to deny claims from co-morbidities in a blanket manner without any effort to attempt a precise disease indexation?

Legal circles seem to support this contention and have given decisions reinforcing the fact that PED clause cannot be arbitrarily applied to reject the rights of the policyholders. One such decision that typically brings out the facts is enshrined in the decision of the Madurai Bench of Madras HC on January 30, 2014. In the case, "Manivasagam Vs National Insurance Co Ltd. [W.A.(MD)No.956 of 2011]", the policyholder underwent a bye-pass surgery. The insurer's rejection was on the ground that the Coronary Artery Disease (CAD) was a **pre-existing disease**

when the policy was issued. The declared pre-existing conditions were diabetes and hypertension. CAD was taken as an extension of the PED by the insurer. This was strongly refuted and the judges observed: "The insurance companies are strictly bound by the disease or ailment specified in the policy as pre-existing disease. No addition or deletion by way of interpretation can be done. The authority cannot read something more into the terms and conditions of the policy and come to the inference that one disease is relatable to other disease and, therefore Medi-claim is rejected."

Disconnect 2

The second disconnect is a vital issue regarding the diseases/conditions that occurred before the defined time frame of 'four' years. What is the obligation of the proposer in revealing surgeries/medical disorders that fall outside the four-year period prior to the first policy? Since the clause does not explicitly assert it as a requirement, is the proposer under any obligation to declare such incidents as history? Would non-declaration of medical history older than four years prior to the first policy be deemed a concealment of fact? The clause now appearing in the policy is inconclusive in this context. Thanks to the clause, the proposer cannot be held to be on the wrong side of the law if he confines himself to just four years of medical history, which is what the clause demands of him/her.

True enough, if a disease/medical disorder in the 'older-than-four-year period' is active and is being managed, then naturally it should be declared and get reflected as a PED. Even if something significant has happened in the life of the insured in the said period, unless it has a medically active and discernible impact within the PED boundary period, the prevailing clause does not give any formal power to the insurer to question the non-declaration of a medical event in the distant past.

But, in practice, the insurers do insist on the total medical history and often refuse claims on grounds of non-declaration of medical events even older than 4 years.

The decision of the "**National Consumer Disputes Redressal Forum**", in *New India Assurance Co. Ltd., Mr. ... vs Vasant Rao, Ms. Manjula N.* on 3 April, 2006 (RP2640-4105)" exposed the divergence clearly evident in the wordings and the insurance industry's actual practice. In the case, Vasant Rao had taken a Mediclaim policy from New India Assurance, effective from March 1, 1995. In the 4th year of the policy (01.03.1998 till 28.02.1999), during February 1999, Mr. Rao was hospitalized for a heart-related complication and he underwent a coronary artery bypass graft. The insurance company promptly rejected the claim under the pre-existing disease clause, since he had undergone a bypass surgery nine years before he purchased the policy. Mr. Rao contested the rejection before the district forum and got a favorable decision. The insurer challenged the decision before the State Commission and later before the National Commission.

The insurance company's version was that Mr. Rao having undergone a bypass surgery in 1986 (a decade before taking the policy for the first time in 1995), the claims were non-tenable and were rejected under the clause providing for exclusion with respect to the diseases/injuries existing when the cover incepts for the first time. The commission concluded that after having undergone a bypass surgery in 1986, Rao was on medication only for three months. He took the policy 10 years later, and, during this period, he did not suffer from any heart problem and was in active service till retirement. Merely because a heart problem occurred again four years after having taken the policy, it could not lead to the inference the disease was continuing after the successful bypass surgery. The commission thus ruled that the repudiation cannot stand. Both are not one-off decisions in its class, but one in a series of such observations.

Responsibility for the Disconnects

Who is at fault for this kind of faux pas? If a clause can remain open and vulnerable to such widely varying interpretations, is it good for an industry which is expected to catapult itself to the next level? Will it instill the kind of faith that consumers would have on the mechanism called (health) insurance for driving growth or the lack of it? What qualitative change was the outcome of the PED wording change required to be introduced as part of the General Insurance Council's initiative in the year 2008?

The change introduced additionally brought in a period restriction of 4 years prior to the first policy start date, and the wordings qualified any ailment to be a PED, if the ailment is diagnosed and treatment taken during the term of 4 years! In effect, the remedy suggested turned out to be more disagreeable than the ailment it tried to cure.

Going by the Court verdicts cited earlier, what will happen to medical issues that happened 4 years prior to the starting date of the first policy? Is the proposer, who is now asymptomatic and not undergoing any medication, relieved of the responsibility of declaring the medical history falling outside the 48-month window just prior to the start date of the proposal for health insurance? If the proposer does not, is the insurer, later on coming to knowing of it, justified in accusing the insured of withholding PED information leading to the cancellation the policy?

The intermediaries working in the sector, recognizing the gaps, are, as observed from frequent customer outbursts, are known to advise wrongly and even mislead the insuring public, thus widening the credibility gaps. And this is happening across the country in varying degrees and volumes, as evident from the swelling number of consumer complaints with regard to PED clause application.

Ideally, the wordings should be simple and direct so that the intent and meaning become clear to the all stakeholders and there is no ambiguity in the understanding and application. The practice should be strictly in alignment with the spirit of the wordings, so that the understanding and the implications are transparent.

First of all, let there be clarity about what is a PED. The Regulator and the industry should introspect whether the practice of including the co-morbidities and future complications are to be included within the bracket of PED or not. It speaks poorly of an industry poised to advance into the next level to adopt such protective and limited approach which practically inhibit its growth vertically and horizontally.

The clause should also cast out the uncertainty and obscurity about the pre-insurance window period, and clarify whether the object is to strictly confine itself to the 4 years or even beyond, in which case, that clause should undergo changes.

If we look at the world-wide practices, we may appreciate that the wordings are not ambiguous in their contracts. For example, in Australia, PED is defined as follows:

"A pre-existing condition is defined as any illness, ailment or condition that existed in the six months prior to joining a health insurance policy. **It is not necessary for a condition to have been diagnosed** (highlight provided by me) in order to be considered pre-existing. **The applicant and his/her doctor may not have even been aware of the condition, but if it was there prior to joining the health insurance policy, it will be classified as pre-existing**" (highlight provided by me).

However, signs or symptoms should have been **reasonably evident** in order for this to be considered (i. e. evident to the applicant, or to his/her doctor if s/he had been medically examined anytime during the 6-month period). If the condition is considered to be pre-existing, the health insurance policy require the imposition of a 12-month waiting period before the applicant will be covered for benefits relating to that condition. It is as simple as that.

A similar check on the UK practice also reveals that insurers adopt a similar approach and clarify the situation as follows:

"A pre-existing condition is anything you have had medical treatment for in the past. This includes consultations, medication, surgery or any other treatment from the NHS (National Health Scheme) or a private company."

Pre-existing conditions include:

- Diabetes
- High blood pressure
- Heart diseases
- Asthma
- Osteoarthritis
- Strokes
- Cancer
- Back pain requiring surgery.

Most insurers take into count any condition that shows symptoms or require treatment during the past five years as pre-existing, even if it was diagnosed more than five years ago. But some insurers approach it differently, and, include any condition for which treatment was availed during the past three or seven years. Most of the health insurance policies can be issued even if the existing conditions were present, but in most cases they do not pay out for their treatment.

However, since insurers in the UK are free to re-word the PED; some insurers agree to cover certain medical conditions, especially if they decide that they are minor problems or are unlikely to occur again. Most insurers agree to start covering a condition after the insured remains symptom-free for five years.

The issue is not "whose terms are better" but more important is the drawing up of the terms in such a way that the application of the terms too is clear both to the insurance practitioner and also to the insurance consumer. If the practice is transparent and easy to understand, there would be more confidence and credibility on the concept and practical application.

In insurance the words are as important as the practice that follows. There must be as much sync between the two, as conceived by Kalidasa in the first shloka of Raghuvamsha, "Vak arthaaviva samprukthow..." (Intertwined and interlinked like word and its meaning)." The word used and the practice followed must stay together so interlinked and intertwined like word and its meaning. No doubt should ever arise in the minds of consumers as to how they are going to be treated after issuance of the policy has been taken.

The Regulator cannot afford to turn its eyes away from market practices and examine why a certain type of consumer gripes or grievances are on the rise. Addressing complaints effectively and keeping multiple options open for redressing the consumer complaints are good policies, but that would only be as good as treating symptoms. Unless the root causes of the complaints are explored and remedied or corrected, the cause of such complaints will subsist in the system engendering regular breeding of such complaints.

An ideal market is only a Utopian dream. Flaws and blots are bound to exist within every system. But a Regulator is expected to do the difficult task of keeping the eyes open, and yet dreaming. Eyes open to address disconnects arising from the system and dreaming with wide open eyes to reach the land where there are no systemic shortcomings. Only then can the insurance industry expect to realize that ideal dreamland where no customer will ever have a reason to complain!

References

- ^1 Mediciam Policy of United India Insurance Co Ltd, Prior to 2008. (Item no.4.1, under 4 EXCLUSIONS of United India Insurance Mediciam Policy for the years prior to 2012).
- ^2 Current version of Bharti AXA GIC Ltd SmartSuper Health Insurance Policy. Product code UIN: BHAHLIP18014V01 171 8. (Clause no.1.45)
- ^3 Current version of Bharti AXA GIC Ltd SmartSuper Health Insurance Policy; Product code UIN: BHAHLIP18014V01 171 8. (Clause no.3 under Section 6: Pre-Existing Diseases etc. listed under sub clause 6.1)



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