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Health Insurance in India and Third Party Administrators

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Abstract: *Health Insurance is emerging fast as an important mechanism to finance the healthcare needs of people. History of Health Insurance, its need, challenges are discussed. Later, role of Third Party Administrators (TPA), their service demerits and challenges faced by them are elaborated.*
Key Words *: Health Insurance,TPA*

I. Introduction

Growing cost of medical care and increasing sense of insecurity among the public have prompted the necessity of some sort of health insurance, over the years. The health infrastructure in India is facing daunting challenge of meeting the health goals and complexities emerging from the changing disease pattern. The proliferation of various healthcare technologies and increase in cost of care has necessitated the exploration of health financing options to manage problems arising out of increasing healthcare costs. Health insurance is emerging fast as an important mechanism to finance the healthcare needs of people. Further, the uncertainty of disease or illness is accentuating the need for insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalization by charging premium from a wider population base of the same community.

II. History Of Health Insurance

It started first in the USA in the form of Merchant Marine Hospital Services Act (1798) and was followed later in 1943 by the Emergency Maternal and Infant Care Act. Medicaid (1967), Prepaid Health Care Act (1974), Health Maintenance Organizations (HMO) and Preferred Provider Organizations Programmes. Compulsory Sickness Insurance for the general public was started for the first time in Germany in 1883, followed by England in 1911 and France in 1928.

Russia was the first country to socialize medicine completely and give its citizens a constitutional right to all health services.

In India, towards the end of 1923 social security introduced with the Workmen's Compensation Act (amended in 1962 and 1984). But the Employee State Insurance (ESI) Act (1948) (amended in 1975 and 1984) and Central Government Health Services (CGHS) Scheme (1954) was the first major legislations in the field of health insurance. Later, in 1961, Maternity Benefits Act was passed. For the public sector employees in Defense, Railways, Post & Telegraph, etc., there is a comprehensive system of health insurance. For a large majority of the general public (self-employed), however, there is still no government sponsored scheme. Mediclaim, Bhavishya-Arogya and Medinova Gold Card Schemes have been started recently but these are purely in private hands.

However, the complexity of health insurance industry has been much talked about but less understood, especially in Indian scenario.

Major milestone of insurance sector in India
1912: Insurance Act passed
1938: Insurance Act 1938
1948: ESI Act ushered health insurance in India
1956: Life Insurance industry nationalized
1972: General Insurance industry nationalized
1987: Mediclaim of GIC as the first health insurance product
1999: IRDA bill passed allowing entry of foreign players
2001: Insurance amendments bill 2001 passed

III. Need Of Health Insurance

India has developed an extensive network of healthcare infrastructure. The system envisages availability and accessibility of publicly funded healthcare to all, regardless of their ability to pay. However, over a period of time due to the expansion in size and shortfall in budgetary support, the public healthcare system has lagged behind in terms of its ability to meet the challenge of fulfilling the health needs of large

segment of population.

To meet this challenge partially, private healthcare sector has grown in size and scope. Consequently, the present healthcare system is characterized by having providers belonging to ownership of both public and private and providers practicing in different systems of medicine. Both public and private facilities provide health services, but the bulk of the curative services are skewed towards the urban areas and dominated by the private sector.

According to the recent Human Development Report (2004), India ranks 171 out of 175 countries in terms of public spending on health, while in terms of private spending, the country ranks 18. Increasing per capita income in the country is further increasing the skew ness of health expenditures. For every 1 per cent increase in state per capita income, per capita public health expenditure has increased by around 0.68 per cent while for every 1 per cent increase in real per capita income the real per capita expenditure on health has gone up by 1.95 per cent (Bhat and Jain 2004a and 2004b). Private health expenditure in nominal terms is growing at 18 per cent per annum. With the proliferation of medical technology and new treatment protocols, the health care costs are increasing. These developments justify the need for health insurance. Though the need for health insurance is high but its growth has been slow. One of the reasons for its slow growth has been regulations in this sector.

With the passage of the Insurance Regulatory and Development Authority (IRDA) Bill 1999, the industry has undergone a transformation. It has opened the insurance sector for private players. This opening up of insurance sector and growth of private healthcare system, particularly characterized by setting-up of corporate hospitals, poses lot of challenges to be addressed by the insurance industry and its regulators.

IV. Challenges Faced By Health Insurance Industry

The insurance sector faces challenge of institutionalizing the TPA services and there is substantial scope for improvements. Gupta, Roy and Trivedi (2004) argued that the current health insurance sector would require substantial amount of working capital and bank guarantee to finance operations of TPAs.

According to Matthias and Cahill (2004) some of the key challenges faced by the industry are summarized below:

1. lack of data to determine price of products and ability to negotiate payment rates with providers,
2. a regulatory framework that does not recognize the unique features of health insurance products,
3. lack of quality assurance measures for health providers,
4. Lack of consumer awareness about the benefits of health insurance.
5. An estimated one-third increase in claim amount due to the moral hazard, the adverse selection problem and/or the provider-induced demand;
6. Rationalizing the cost structure of treatment in a private healthcare sector that is characterized by uncontrolled and unregulated expansion. Currently more than one-third of reimbursements are made towards doctor's fees, followed by diagnostic charges which accounts for about one-fourth;
7. Lack of actuarial data, lack of standardized billing and under reporting of information by private providers;
8. High administrative cost of insurance companies;
9. Slow claim processing. Insurance companies took on an average 121 days to settle the claim (Bhat and Reuben 2002).

The evolution of a new body for cash-less claim processing in the form of Third Party Administrators (TPAs) marks a new chapter towards addressing some of the problems of health insurance industry.

V. Third Party Administrators

The advent of Third Party Administrators (TPAs) is expected to play an important role in health insurance market in ensuring better services to policyholders. In addition, their presence is expected to address the cost and quality issues of the vast private healthcare providers in India. However, the insurance sector still faces challenge of effectively institutionalizing the services of the TPA. A lot needs to be done in this direction.

Hospital industries foresee business potential in their association with TPA in the long-run. The regulatory body needs to focus on developing mechanisms, which would help TPAs to strengthen their human capital and ensure smooth delivery of TPA services in emerging health insurance market.

Third Party Administrator (TPA) was introduced through the notification on TPA-Health Services Regulations, 2001 by the IRDA. TPAs are presumed to infuse new management system and enrich knowledge base of managing healthcare services and costs. Their presence is aimed at ensuring higher efficiency, standardization and improving penetration of health insurance in the country. TPAs potentially

have a wider role to play in standardization of charges and managing cash-less services in health insurance. However, their actual roles and responsibilities have remained less understood, less clear and much debated. As of July 2004, 24 TPA-Health Services are registered with the IRDA

TPAs earn their major revenue from fees charged as commission on insurance premium. Insurance Regulatory and Development Authority (IRDA), the regulatory body for insurance sector in India has standardized this rate. For this service they are paid a fixed per cent of insurance premium as commission. This commission is currently fixed at 5.6 per cent of premium amount. Besides this, TPAs have a potential source of revenue from benefit management, medical management, provider network management, claim administration and information and data management. The influence of TPAs to a large extent would be determined by their activities, the way they organize their services and their revenue generation model.

Role of Third Party Administrators

Their basic role is to function as an intermediary between the insurer and the insured and facilitate the cash-less service of insurance. Figure 1 provides a graphical representation of working environment of insurance industry and role of the TPA in the system. The core product or service of a TPA is ensuring cashless hospitalization to policyholders. Intermediation by TPAs ensures that policyholders get hassle-free services, insurance companies pay for efficient and cost-efficient services, and healthcare providers get their reimbursement on time. By doing this it is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs, developing protocols to minimize unnecessary treatments/investigations, improve quality of services and ultimately lead to lower insurance premiums. However, the system is currently going through teething troubles. Cash-less policies, where the insurer directly pays the hospital bills to the healthcare provider, have not yet fully materialized (Kalyani 2004).
Role:

i) From Health Provider's Perspective

*** Standardizing Treatment Norms and Cost of Procedures:**

One of the problems with the private healthcare sector has been its uncontrolled and unregulated expansion. There is lack of adequate standards. Problems of poor billing system and under-reporting have resulted into lack of availability of information for decision making at various levels. Absence of regulation and lack of standardization of the private healthcare market has led to high claim ratio. This also leads to problem of the moral hazard resulting into over-billing.

*** TPA Services:**

TPAs can follow each case in an individualized way, arrange for specialized consultation for the patient, ascertain false claim and thereby reduce the moral hazard and provider induced demand. TPAs could also do comprehensive review of records and maintain constant communication with healthcare providers and families and evaluate the outcome of treatment and have adequate data to compare it across different service providers. TPAs can also play important role in tracking the case of the insured at the hospital and streamline the claim process. They collect all the bills, reimburse them and send all necessary documents for the consideration of claims to the insurer. This gives them an opportunity to design and develop information systems which would allow them to analyze data regarding hospital admissions, ascertain the health needs of patients and check for effective treatment protocols, tracking documents pertaining to each case and tracking shortfalls in claims.

*** Time Taken To Settle Claims Of Providers Of Healthcare Services:**

TPAs were introduced as intermediaries to facilitate claim settlement between the insurer and the insured. The agreement between TPAs and healthcare facilities provides for monitoring and collection of necessary information, documents and bills pertaining to the treatment. Documents are examined and after processing sent to the insurance company for reimbursement. TPAs have the responsibility of managing claims, getting reimbursements from the insurance company and paying to the healthcare provider. It is expected that with the introduction of TPA services, the claim settlement process would be simplified. IRDA has suggested that all claims should be settled in seven days. Outsourcing claim-processing services may help in reducing the claim period, but settling claims in seven days looks very ambitious target in current scenario.

*** Impact Of Tpas On Hospital Administration And Cost:**

The introduction of TPA as claim settlement intermediaries in health insurance gives rise to certain concerns. For example, many hospital administrators feel that TPAs put additional burden on their administration. Hospitals have raised concerns about the cost of providing required data. TPAs also

influence their payment rates. There are also concerns of selective contracting by insurers with significant market penetration (Matthias and Cahill 2004).

*** Tpa Commitment:**

TPAs generally have in-house expertise of medical doctors, hospital managers, insurance consultants, legal experts, information technology professionals and management consultants. The effectiveness of TPAs in managing claims and reimbursements depends on their bargaining power vis-à-vis healthcare service providers. The IRDA regulations envisage at least one of the directors of the TPA should be a qualified medical doctor registered with the Medical Council of India. The CEO or CAO of the TPA should have successfully undergone a course in hospital management from an institution recognized by the IRDA and have passed the licentiate examination conducted by the Insurance Institute of India, Mumbai. Apart from this, he should have undergone practical training of at least three months in the field of health management. TPAs should have access to competent medical professionals to advise insurance companies and clients on various matters.

ii) From Health Consumer's Perspective

*** Awareness About TPA Services:**

With the introduction of TPA, insurers outsource their administrative activities to TPAs. Their activities include issuing identity cards to the policyholders, 24-hour help-line for customer services, informing the customers regarding empanelled hospitals, arranging for specialized consultation and claim processing during admission of the policyholders. Hence, it is expected from them to have strong communication skills in dealing with the policyholders. In a traditional insurance market, heavily dominated by insurance agent, knowledge and impact of TPA is a matter of determination. This survey of policyholders attempts to understand the level of awareness and knowledge among the policyholders about TPA services.

*** Knowledge About Coverage And Exclusion In Policies:**

Examination of exclusion clauses in the policy is imperative before authorizing admissibility and further treatment. There is a real lack of knowledge about health insurance and the role it can play in mitigating risks and preventing economic hardship.

*** Services And Consumer Education By The Tpas:**

TPAs are expected to provide value added services to the consumers which include arrangement of ambulance services, medicines and supplies, guide members for specialized consultation, provide information about health facilities, hospitals, and bed availability, organization of lifestyle management and well-being programs and 24-hour help-lines. Policyholders will be directed to an empanelled hospital with which TPA has a tie-up arrangement. However, policyholder has a choice to go to any hospital. But cashless facility will be available at only empanelled hospitals. To put in short, the jobs of TPAs is to maintain database of policyholders and issue them identity cards with unique identification numbers and handle all the insurance policy related issues including claim settlements.

*** Experiences Of Policyholders With Healthcare Providers:**

Hospitals empanelled with TPA appointed by insurance company agree on providing cashless facility to policyholders of the insurance. TPAs directly pay the healthcare providers. For this TPAs get reimbursements from the respective insurance company. However, after the introduction of TPA, many hospitals complain delay in getting their reimbursement of bills. Under earlier system the patient directly paid them.

VI. Service Demerits

Provider Perspective

***Agreement On Cost Of Procedure:**

TPAs insist on standardization in pricing of medical services and various procedures. Some of the major treatments excluded are congenital abnormalities, diabetes, hernia, HIV, pregnancy related care, ophthalmic treatment and cosmetic surgery.

***TPA Services At The Time Of Admission Of Patients:**

According to the hospital administrators, TPAs never visit their clients during admission in the hospital. Of the cases visited by TPA during admission, the key activities of the TPA are to enquire about duration of stay in hospital, enquiring about room rates, scrutinizing the bills and enquiring about treatment protocols. TPAs do not arrange for any specialized consultation on the patient condition. TPAs devote more attention on financial issues than on care management issues.

***Claim Settlement:**

Majority of the hospitals report that TPAs always delay in settling claims. While the agreed time for claim settlement with the TPA is less than 1 month, actual time for claim settlement varies from 2 to 3 months.

***Influence And Impact Of Tpas:**

There is no significant influence of TPAs in the routine hospital administrations and have minimal control on treatment procedure/protocols of the hospitals. There is also no marked increase in patient turnover after formalizing association with the TPA. However, this new partnership imposes significant burden on hospital expenditures as efforts in forming liaison with the insurance companies and TPA increase.

***Decision To Network With Tpas:**

Strategically the hospitals perceive the need for these types of intermediaries and perhaps it brings visibility to the hospital. But there are operational problems which impede the effective working of networked relationship.

Policyholders Perspective

***Knowledge About Policy And Tpas:**

It is quite evident that policyholders have little information about their insurance policy. They are not aware of TPA. Policyholders perceptually equate TPAs with traditional insurance agent. Generally policyholders avoid dealing directly with their insurance companies due to various procedural hassles. Insurance agents seem to have major influence on policyholders' decisions and policyholders have more trust and faith in them.

***Knowledge about Coverage And Exclusion In Policies:**

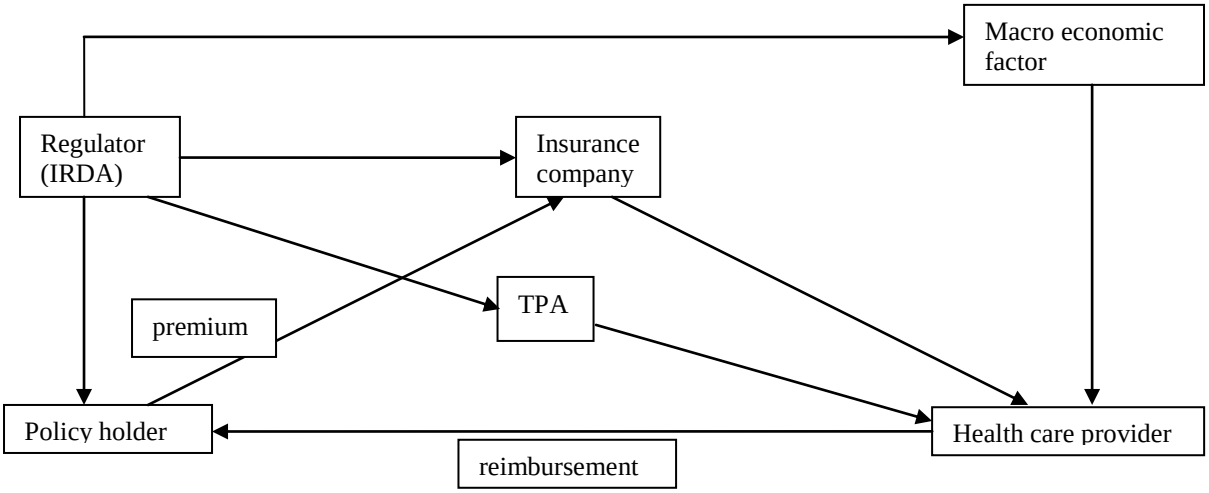
Policyholders have inadequate knowledge on illnesses covered in their policies, exclusion of illnesses in the policy, cashless reimbursement and the list of empanelled hospitals. Similarly policyholders are not aware of the fact that insurance companies charge extra premium for TPA services.

VII. Challenges Faced By Tpas

TPAs, in their current form in India are suffering from

1. Weak hospital networking,
2. Delay in issuing of identity cards to policyholders,
3. Poor standardization of billing procedures for hospitals (Viswanathan and Narayanan 2003). The industry is feared to be suffering from an informal nexus among corporate houses, corporate hospitals,
4. TPAs and insurance companies in ensuring high claim ratio on corporate insurance and low on individual insurance (Gupta, Roy and Trivedi 2004).
5. TPAs also face challenge of developing appropriate system of financing their operations.
6. General awareness among policyholders is low about the performance of TPAs.
7. The TPA services need to focus on developing their competencies and capacities and take care of various operational issues in provision of services.
8. There are no mechanisms to appraise the performance of the TPAs. The IRDA's present role of TPA appraisal is more based on their financial performance rather than consumer satisfaction.
9. There is a need to link incentive of TPAs with their performance rather than fixed percentage of policy premium.

Working environment of TPAs



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