Health Insurance - Marketing
CHAPTER – 3

HEALTH INSURANCE MARKETING

The preamble to the Constitution of the World Health Organization (WHO) as adopted by the International Health Conference, defines health “as a state of the absence of disease or infirmity.” It is an acknowledged fact that the real wealth of a nation is its people. So, ensuring their health and well-being becomes one of the primary duties of those governing the nation. Hospitals with adequate medical services including paramedics, ambulance services, etc., dissemination of information on various diseases, their causes and preventive measures, immunization initiatives, availability of medicines at a reasonable price, and an ongoing health education in general form is the part of a well-planned healthcare implementation.

There is need to analyze the current state of health insurance in India, the impact of regulations on this sector, privatization of the industry and the concomitant opportunities and challenges, the issues facing the industry, marketing strategies to be adopted, consumer’s awareness and attitude and suggestion for the future.

INSURANCE

All religions and the oldest of Holy Scriptures exhort man to help his fellowmen in distress. Saints and sages of the orient as well as the occident preach the eternal truth of giving relief to the sufferings and regard it as the best mode of prayer. “Under the Veil of Commerce, insurance performs these ecclesiastical functions through its manifold branches. It is, in fact, one of the manifestations of the noblest instinct and urge of man to bear each others burden and that too in a constructive manner.

Man has always been in search of security and protection from the early days and civilization. Human life and material possessions are continually exposed to loss or damage by numerous destructive forces. Thus there is a great deal of uncertainty in life in commerce, in industry. It is an undisputed fact that risk is inherent in the modern complex society; uncertainty is a fundamental fact of life. So human beings have a strong desire for security. That desire has created ways and means upon the principle of material co-operation to assure security.
The Random house dictionary of the English Language defines “insurance as the act, system or business of insuring property, life of one’s person etc against loss or harm in consideration of a payment proportionate to the risk involved coverable by contract in which one party agrees to indemnify or reimburse another for any loss that occurs under the terms of contracts”.

EVOLUTION OF INSURANCE

Insurance has been an institution of human society for thousands of years, having been practiced by Babylonian traders as long ago as the 2nd millennium BC. Babylonians as well as the ancient Hindus are familiar with the essentials of bottomry contracts (A system of using ship as a security against a loan to finance a voyage, the lender loses his or her money if the ship sinks.)

This system was in existence in Punjab till the middle of the 19th Century. Eventually it was given legal mention in the Code of Hammurabi, and practiced by early Mediterranean sailing merchants. The Greeks and Romans had "benevolent societies" which acted to care for the families and funeral expenses of members upon death. Guilds in the middle ages served a similar purpose. Insurance became much more sophisticated in post-Renaissance Europe, and specialized varieties were developed in 916 B.C.

Insurance was practiced by Rhodesians and in 14th century in Northern Italy a voyage in Mediterranean Sea was insured. The Greeks and Romans introduced the origins of health and life insurance 600 AD, when they organized guilds called "benevolent societies" which acted to care for the families and funeral expenses of members upon death. Guilds in the middle ages served a similar purpose. By the middle of the 14th century, as evidenced by the earliest known insurance contract (Genoa, 1347), marine insurance was practically universal among the maritime nations of Europe.

Towards the end of the seventeenth century, the growing importance of London as a centre for trade led to rising demand for marine insurance. In the late 1680s, Mr. Edward Lloyd opened a coffee house which became a popular haunt of ship owners, merchants and ships' captains, and thereby a reliable source of the latest shipping
news. It became the meeting place for parties wishing to insure cargoes and ships, and those willing to underwrite such ventures. Today, **Lloyds of London** remains the leading market for marine and other specialist types of insurance, but it works rather differently to the more familiar kinds of insurance. After the **Great Fire of London**, in 1666 Nicholas Barbon opened an office to insure buildings. In 1680 he established England's first fire insurance company, "**The Fire Office**", to insure brick and frame homes. The oldest documented insurance company today dates back to 1710. The first insurance company in the United States provided fire insurance and was formed in Charles Town (modern-day Charleston), South Carolina, in 1732.

After 1840, with the decline of religious prejudice against the practice, life insurance entered a boom period. In 1911 the Non-Marine Insurance and Electrical Insurance paved the way to insurance industry. The Aviation Insurance was started in 1909. The 19th century saw a rise in the government regulation of insurance, and the 20th century saw further specialization in insurance including health insurance.

**HISTORY AND EVOLUTION HEALTH INSURANCE**

The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, the early health insurance was actually disability insurance, in the sense that it covered only the cost of emergency care for injuries that could lead to a disability. This payment model continued until the start of the 20th century in some jurisdictions, where all laws regulating health insurance actually referred to disability insurance. Patients were expected to pay all other health care costs out of their own pockets, under what is known as the *fee-for-service* business model. During the middle to late 20th century, traditional disability insurance evolved into modern health insurance programs. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this was not always the case.

A Health insurance policy is an annually renewable contract between an insurance company and an individual. Some health care providers will agree to bill the insurance company if patients are willing to sign an agreement that they will be responsible for the
amount that the insurance company doesn't pay, as the insurance company pays according to "reasonable" or "customary" charges, which may be less than the provider's usual fee. The "reasonable" and "customary" charges can vary.

**HISTORY OF INSURANCE IN INDIA**

The early history of insurance in India is somewhat obscure. F.J. Mehean has mentioned in his book "**Human side of Insurance**" that the Aryan tribes in India practiced some type of insurance nearly 3000 years ago. The Sanskrit word "**Yogakshema**" which means well-being, found in **Rig-Veda** supports this idea. The word "**Yogashemam**" used by Vedic rishis also supports the idea of welfare state. Reference can be found regarding the welfare state in the Codes of Manu, the ancient clan maker in India. A few centuries after **Manu, Kautilya** in his "**Arthasastra**" has also laid down several rules and regulations of similar nature.

The Court of directors of India Company instructed **Sir John Child**, the then Governor of Bombay during 1681-1690 to form an insurance company in India. Indian soil saw the first Insurance in 1818 in Calcutta with the establishment of **Oriental Insurance Company**. It was mainly started to help the widows of Europeans.

The Government of India began to exercise control on business of insurance by passing the first insurance statute namely **Life Insurance Companies Act 1912**. To have a closer supervision and control in matters of investment of funds, expenditure and general management of insurance business the Government enacted the **Insurance Act in 1938**. This act provided for State control on both life and non-life offices of insurance. In the year 1956, 245 Indian and foreign insurers and provident societies were taken over by the central government and were nationalized and **LIC** was formed by an Act of Parliament.

The General insurance business in India, on the other hand, can trace its roots to the Triton Insurance Company Ltd., the first general insurance company established in the year 1850 in Calcutta by the British. In 1907 the Indian Mercantile Insurance Ltd. set up, the first company to transact all classes of general insurance business. In 1957, **General Insurance Council**, a wing of the Insurance Association of India, framed a code of conduct for ensuring fair conduct and sound business practices. In 1968, the **Insurance Act** was amended to regulate investments and set minimum solvency margins and the
Tariff Advisory Committee was set up. In 1972, the General Insurance Business (Nationalisation) Act, 1972, nationalized the general insurance business in India with effect from 1st January 1973. 107 insurers amalgamated and grouped into four companies viz. the National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd. and the United India Insurance Company Ltd. GIC was also incorporated as a company.

General Insurance Corporation (GIC) which was the holding company of the four public sector general insurance companies has since been delinked from the later and has been approved as the "Indian Reinsurer" since 3rd November 2000. The share capital of GIC and that of the four companies are held by the Government of India. All the five entities are Government companies registered under the Companies Act. The general insurance business has grown in spread and volume after nationalization.

ROLE OF INSURANCE IN ECONOMICS

Insurance is not merely characteristic of economic growth. It is a necessity for the great majority of today's economics. Insurance aids economic development in at least seven ways, which are given as follows:-

➢ Promotes Financial Stability
➢ Substitutes for government Security Program
➢ Facilitates Trade and Commerce
➢ Mobilizes National Saving
➢ Risk Management
➢ Reduce Losses
➢ Efficient Allocation of Country's Capital

Indian Insurance Industry plays the following role in Economic Development of the country. Insurance companies lead to economic development by mobilizing savings and investing them into productive activities. Indian Insurance Industry is able to mobilize long-term savings to support economic development by providing insurance cover to a large segment of our people as well as to business enterprise throughout India.
TYPES OF INSURANCE COMPANIES

- Life insurance companies, who sell life insurance, annuities and pensions products.
- Non-life or general insurance companies, who sell other types of insurance.
- Companies may sell both life and non life insurance, in which case they are sometimes known as composite insurance companies.
- Reinsurance companies sell insurance cover to other insurance companies. This helps insurance companies to spread their risks, and protects them from very large losses.

The reinsurance market is dominated by a few very large companies, with huge reserves.

HEALTH INSURANCE SCHEMES IN DIFFERENT COUNTRIES:

UNITED STATES OF AMERICA:

Healthcare provision is one of the biggest industries in the US. It is mainly financed through private health insurance. But nearly 40% of all personal healthcare expenditure comes from government sources via two safety net schemes – Medicare and Medicaid.

Medicare is aimed at providing healthcare for the poor over sixty-five years of age and the disabled, whereas Medicaid is a healthcare provider for the poor. Employers generally opt for the Blue Cross or the Blue Shield, the two leading non-profit insurance companies, and these two generally account for roughly fifty percent of the private health insurance market.

Americans also enjoy the privilege of joining managed care schemes such as Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) which provide a wide range of hospitals and services for a fixed prepaid annual sum.

GERMANY

German health care system is very comprehensive and known for its high quality service. It provides nearly 90% of the population with the healthcare via the statutory medical insurance institution. The statutory health insurance system is considered to be too expensive. Against the backdrop of rising costs, Germans are calling for new alternative forms of controlled and organized health insurance schemes, while the
German system of freedom to choose one's doctor has been one of the cardinal principles of the healthcare until now, in managed care programs, the patient is bound to his 'so-called' doctor.

The three principles organized healthcare-networking, therapy standards and risk distribution will continue to govern the health care system in Germany.

SWITZERLAND

Switzerland was the first European country to adopt 'Organized Health Care' of the managed care style on a broad scale. In Switzerland both the managed care and traditional care covers are in the operation but Swiss-managed care organization has gained considerable cost advantages from a reduction in the average duration of hospital stay.

FRANCE

France has the world's best performing health system according to a radical new analysis by the World Health Organization (WHO). Mail order pharmacies constitute an integral part of managed care system, which have to an extent already been tested and introduced in France and Holland.

Mail order pharmacies supply medicines required by patients via postal services and as a result, they stand to benefit from cost advantages due to direct procurement from manufacturers, reduced personal expenses and significant discount on bulk orders.

CENTRAL ASIA

The phenomenal economic growth in Asia has also witnessed a sea change in the attitude of the government and the people in the field of healthcare. Two board categories are noticed in the field of healthcare delivery.

Category A

Mainly state owned clinic and hospitals. These are in China, Vietnam, Laos, Cambodia and Myanmar.
Healthcare financing for this kind of clinics and hospitals is mainly through the government support via revenue collected in the form of taxes, levies and duties.

**Category B**

Mainly state owned hospitals, missionary hospitals and private operators. These are noticed in South Korea, Taiwan, Singapore, Malaysia, Thailand and the Philippines. Healthcare financing is done by the government for government hospitals; and by the church groups and donations in case of missionary hospitals. Private hospitals are run purely on profit motive and the patients pay their medical bills from out of their savings or through health insurance.

**CHINA**

The healthcare in China was previously the sole responsibility of the state supported by the traditional private medical insurance cover, but the situation has changed rapidly since the open policies were ushered in 1978.

The insurance industry was opened up to foreign participation in 1992 and a new insurance law came into effect in China from October 1995.

Homecare is different from managed care and is based on the premises of follow up care, as opposed to convalescent which is preferable both in terms of patient recovery time and cost. The reason for homecare is simply because of the rising cost of hospital-based health treatment.

It has been medically proved that a patient will recover from illness or surgery, more rapidly in a home environment than otherwise. In the long-term, reduced cost will be experienced by the insurers from this homecare concept.

**SINGAPORE**

Singapore has a number of hybrid forms of insurance. The government’s medi-shield policy is very popular in the country. Managed care in now available in the country, carrying strong cost containment features, but this is very recent development and its success has to be watched.
JAPAN

The liberalization of the Japanese non-life insurance industry will bring about many changes and transform the landscape in which the general insurance companies currently operate. The second phase of deregulation in Japanese insurance sector emanated from the US-Japan insurance talks and concepts of Japanese Big Bang.

The Japanese government has taken an interest in promoting the concept of Medicare and several operators are entering the fray. Private health insurance is also very popular in the country and new product lines are being introduced.

PRIVITASATION OF INSURANCE IN INDIA

After four decades of being under the purview of the public sector, the Insurance industry is now all set to bloom after the sector has been thrown open to private sector participation. There seems to be a lot of enthusiasm over the potential of the sector. This overview looks at the bright and the blight side of the Insurance sector.

However, penetration of insurance in the country has been low. Low level of awareness among the public and lack of affordability with certain classes of people are the main problems bogging the industry. For a new entrant, setting up of a sales and distribution network would entail huge investments.

Private players have introduced policies, which are similar to the ones, already existing in the market. Innovative products would be introduced once these players are sure of their sales and distribution network.

| What are the pros and cons of privitisation of health insurance? |
|---------------------------------|---------------------------------|
| **Pros** | **Cons** |
| Flexibility in health insurance products and prices | Supplier induced demand which would lead to increase in cost of care. |
| Comprehensive and cost effective packages | Risk selection practices where the disabled, poor, elderly would be ignored |
Medical plans will be tailored as per the requirement of an individual based on pre-negotiated rates
Exclusion of pre-existing conditions and diseases

Fewer age, disease and benefits restrictions
Monopoly of profit oriented insurance cartel with poor quality products.

Lower premium
Would benefit only a select target audience

Claim settlement would be smoother and faster

**INSURANCE SECTOR REFORMS**

In 1993, Malhotra Committee headed by former Finance Secretary and RBI Governor R.N. Malhotra, was formed to evaluate the Indian insurance industry and recommend its future direction. The reforms were aimed at “creating a more efficient and competitive financial system suitable for the requirements of the economy keeping in mind the structural changes currently underway and recognizing that insurance is an important part of the overall financial system where it was necessary to address the need for similar reforms...” In 1994, the committee submitted the report and some of the key recommendations included:

- Government stake in the insurance companies to be brought down to 50%
- Private Companies with a minimum paid up capital of Rs.1bn should be allowed to enter the industry.
- Foreign companies may be allowed to enter the industry in collaboration with the domestic companies.
- The Insurance Act should be changed.
- An Insurance Regulatory body should be set up. Controller of Insurance (Currently a part from the Finance Ministry) should be made independent.
- LIC should pay interest on delays in payments beyond 30 days.
- Insurance companies must be encouraged to set up unit linked pension plans.
- Computerization of operations and updating of technology to be carried out in the insurance industry.

The committee felt the need to provide greater autonomy to insurance companies in order to improve their performance and enable them to act as independent companies with economic motives. For this purpose, it had proposed setting up an independent regulatory body called the insurance regulatory and development authority. Reforms in the Insurance sector were initiated with the passage of the IRDA Bill in Parliament in
December 1999. The IRDA since its incorporation as a statutory body in April 2000 has fastidiously stuck to its schedule of framing regulations and registering the private sector insurance companies.

DUTIES, POWERS AND FUNCTIONS OF IRDA

Section 14 of IRDA Act, 1999 lays down the duties, some of the powers and functions of IRDA relating to consumers including, health insurance.

- Issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;
- Protection of the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;
- Specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;
- Specifying the code of conduct for surveyors and loss assessors;
- Promoting efficiency in the conduct of insurance business;
- Promoting and regulating professional organisations connected with the insurance and re-insurance business;

DETARIFFING

Finally, the Insurance Regulatory & Development Authority (IRDA) has laid down a road map for moving over to a detariffing regime in $ 5 billion Indian general insurance industry. The Insurance Regulatory & Development Authority would like to highlight the various steps to be taken by the Insurers to ensure that the shift from a tariffed market to a market where the insurers are free to fix the rates and determine the terms and conditions of the contract as smooth as possible.

HEALTH – DEFINITION AND MEANING:

- Health is viewed holistically as an interacting system with mental, emotional and physical components. We define health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1994).
We also consider health as a basic and dynamic force in our daily lives, influenced by our circumstances, beliefs, culture and social, economic and physical environments.

- Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.

- A dynamic state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity. (WHO'S New Proposed Definition. 101st Session of the WHO Executive Board, Geneva, January 1998. Resolution EB101.R2)

HEALTHCARE- DEFINITION AND MEANING:

- Healthcare includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term does not include vocational rehabilitation.

- Care, services or supplies related to the health of an individual. Healthcare includes, but is not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, mental health or palliative care and sale or dispensing of a drug, device, equipment or other item in accordance with a prescription.

HEALTH INSURANCE – DEFINITION AND MEANING:

- Health insurance is a type of insurance whereby the insurer pays the medical costs of the insured if the insured becomes sick due to covered causes, or due to accidents. The insurer may be a private organization or a government agency. Market-based healthcare systems such as that in the United States rely on private medical insurance.

- It is also called accident and sickness insurance, medical insurance. In general, any insurance program covering medical expenses and/or income lost owing to illness or accidental injury. Such insurance may cover some or all of the expense of hospitalization; surgery; physicians’ fees; drugs and medicines; laboratory tests, X-rays, and other diagnostic procedures; radiation therapy; maternity and nursing care; eyeglasses, crutches, prostheses, etc.

- The IRDA’s (Insurance Regulatory and Development Authority) definition of the Health insurance business or ‘health cover’ is “the effecting of contracts which provide sickness benefit or benefits, whether in-patient or out-patient, on a indemnity,
reimbursement, pre-paid, hospital or other plans basis, including assured benefits and long-term care. It covers both illness and injuries. Thus, health insurance could be

i) Either short term or ii) long term: and of the i) indemnity or reimbursement or ii) cashless or fixed benefit amount variety or both. The cashless type of insurance is administered by the IRDA – recognised Third Party Administrators (TPA).

Employee's state Insurance Scheme (ESIS)

A Enacted in 1948, the Employees' State Insurance (ESI) Act was the first major legislation on social security in India. The scheme applies to power-using factories employing 10 persons or more, and non-power and other specified establishments employing 20 persons or more, with employees earnings up to Rs 7500 per month being covered, along with their dependants. The current coverage stands at 84 lakh employees and 353 lakh beneficiaries across 22 States and Union Territories (expect-edly, the membership is higher for more industrialized States). The benefit package is quite comprehensive in its coverage of health-related expenses, going beyond the cost of medical care to include cash benefits (sickness, maternity, permanent disablement of self and dependant) as well as other benefits such as funeral expenses and rehabilitation allowance. However, the actual package of benefits available is determined more by the type of facility accessed rather than the type of cover. Medical care comprises outpatient care, hospitalization or specialist treatment as well as services of the Indian systems of medicines. These services are provided through a network of ESIS facilities, public care centres, non-governmental organizations (NGOs) and empanelled private practitioners.

Central Government Health Scheme (CGHS)

Established in 1954, the CGHS covers employees and retirees of the Central Government, and certain autonomous, semi-autonomous and semi-government organizations. It also covers Members of Parliament, governors, accredited journalists and members of the general public in some specified areas. The families of the employees are also covered under the scheme. Total beneficiaries stand at 43 lakh (10.4 lakh card holders, 2003) across 24 cities with membership in Delhi being the highest. Benefits under the scheme include medical care at all levels and home visits/care as well
as free medicines and diagnostic services. These services are provided through public facilities (including CGHS-exclusive allopathic, ayurvedic, homeopathic and unani dispensaries) with some specialized treatment (with reimbursement ceilings) being permissible at private facilities.

**CGHS-a mandatory social health insurance scheme for the Central Government Employees**

Six per cent of the combined budget of the department or 18% of the budget of the Department of Health was spent on 44 lakh beneficiaries or 0.5% of the country's population under the Central Government Health Scheme (CGHS). Since the introduction of contracting of private hospitals for providing health services and permitting beneficiary members to purchase drugs at pharmacy shops in 2000, there has been an escalation in expenditure under this programme. Over and above the Rs 503 crore incurred on the CGHS by the Department of Health, an additional Rs 200 crore was spent by the various administrative departments on medical reimbursements of their serving employees during 2001-02. All taken together, the outpatient expense under the CGHS per card is estimated to be about Rs 3478 per year and the inpatient expense per card issued to retired civil servants and dependents is Rs 6692 per year.

**Insurance offered by NGOs / community – based health insurance**

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk status. Expiations may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits.

Community-based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources (international Labour Office Universities Programme 2002 as quoted
in Ranson K & Acharya A, 2003). Such schemes are generally run by trust hospitals or non-governmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India CBHI schemes are negotiating with for the profit insures for the purchase of custom designed group insurance policies. However, the coverage of such schemes is low, covering about 30-50 million many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.

THE FOLLOWING IS A SWOT MATRIX OF INSURANCE BUSINESS IN INDIA

<table>
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<tr>
<th>SWOT ANALYSIS</th>
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<tr>
<td><strong>STRENGTHS</strong></td>
<td><strong>WEAKNESSES</strong></td>
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<tr>
<td>Huge potential market. Insurable population of 300 million networks</td>
<td>Players have to build their own distribution</td>
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<tr>
<td>Absence of specialised products and small product range of established players</td>
<td>Huge investments are required</td>
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<tr>
<th><strong>OPPORTUNITIES</strong></th>
<th><strong>THREATS</strong></th>
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<td>Existing players are slow and bureaucratic outmaneuvering them will be relatively easier</td>
<td>Repatriation of benefits not allowed in nature</td>
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<tr>
<td>Companies can concentrate on niche markets ensuring better returns</td>
<td>Joint ventures in insurance industry have a history of falling apart</td>
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<td></td>
<td>Market may not accept new products</td>
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MARKETING – DEFINITION AND MEANING:

- The process of organizing and directing all the company activities which relate to determining the market demand and converting the customers buying power into an effective demand for a service and bringing that service to the customer.

- The process of making customers aware of products and services, attracting new customers to a product or service, keeping existing customers interested in a product or service, building and maintaining a customer base for a product or service. Advertisements play a large part in marketing
SERVICES MARKETING

According to Kotler “A service is any act or the performance that one party can offer to another that is essentially intangible and does not result in the ownership of anything. Its production may or may not be tied to a physical product”. Service product may emerge from Government sectors, private non profit sectors, business sector or from a manufacturing factory.

ELEMENTS OF SERVICE MARKETING MIX APPLICABLE TO HEALTH INSURANCE

The service marketing mix comprises of the following seven variables.

- Product
- Price
- Promotion
- Place
- People
- Process
- Physical evidence

7. Ps of Insurance Market

a) Product b) Price c) Place d) Promotion e) People f) Physical Evidence d) Process

a) Product

b) Price
Premium - tariff - tariff regulations - rate of death - rate of accidents - interest calculation - bonus - expenses incurred.

c) Place
Physical distribution of the product: Head office - branch office - agents-development officers - professional brokers - bank assurance - tele sales - door to door selling.

d) People
Brokers - company staffs - agents - surveyor - institutions - policy holders - actuarial scientists - regulatory authority

e) Process
Application - verification - under writing - sanction - issue of policy - application for claim - claim processing - settlement of claim - prevention of loss

g) Promotion
Advertising - publicity - sales promotion - word of mouth - promotion-personal selling - tele-marketing - public relation - broadcasting

e) Physical Evidence
Brochures - Leaflets - Environment - people - currency - client - interior decoration - policy copies - contracts

CHARACTERISTICS OF HEALTH INSURANCE AS A SERVICE PRODUCT:
1. INTANGIBLE
When a product is purchased, something is acquired that can be seen. When a service such as travel, entertainment or education is purchased, there is nothing tangible to show for it. (After a day of buying services, the customer still has an empty market basket.) What the consumer is buying is a performance provided by the seller. The intangibility of services makes advertising and promotions more difficult than for products because the marketer must communicate an idea or concept rather than a physical object.
2. SERVICE VARIABILITY

Service industries tend to be labour intensive, whereas manufacturing is more capital intensive. As a result services are much less standardized than products. High service variability means the consumer faces greater uncertainty and risk in purchasing services and the service provider must control quality to ensure adequate service.

3. SIMULTANEOUS PRODUCTION AND CONSUMPTION/INSEPARABILITY

Products are generally produced, sold and then consumed. Services are usually sold first, then produced and consumed at the same time. Services for health care, hotels, beauty care, entertainment and education are reserved in advance and then consumed as they are offered. The simultaneous production and consumption of services means that

- Distribution of services must be simple
- Services must be delivered close to the consumer and
- The image of the service producer becomes more important.

4. SERVICE PERISHABILITY:

If services are not consumed when offered they go waste. Shifts in demand for products can be accommodated for the most part by taking goods from inventory. But there is no inventory of services. As a result, services have a much more difficult time regulating supply to meet demand, because it is rarely steady or predictable enough to avoid service perishability. The service marketer can try to overcome the problems of perishability by trying to match supply and demand by

- Varying supply in accordance with demand
- Keeping supply fairly constant but trying to smooth out demand to avoid excess capacity.

HEALTH INSURANCE MARKETING – THE CONCEPT

The term health insurance marketing refers to the marketing of health insurance services with the motto of customer-orientation and profit-generation.
In the Indian perspective where rural-orientation needs prime attention, the insurance marketing may prove to be a device for combating regional imbalance by maintaining the sectoral balance.

The marketing concept in the Health Insurance business is concerned with the expansion of insurance business in the best interest of society vis-à-vis the insurance organizations.

The selection of risks (product planning), Policy writing (customer service) rating or actuarial (pricing) and agency management (distribution)-all marketing activities make up an integrated marketing strategy.

➢ It is a managerial process.
➢ It is conceptualization of marketing principles.
➢ It is a process of formulating the marketing mix.
➢ It is a device to make possible customer-orientation.
➢ It is an attempt to help profit maximization.
➢ It is another name for marketing professionally.
➢ It is even a social process that paves avenues for social transformation.
➢ It is to make possible product attractiveness.
➢ It is to energize the process of quality upgradation.

PLAYERS IN HEALTH INSURANCE MARKET

The health insurance market can be characterized by three main players who are closely associated with each other. They are:

➢ The insured person and policyholder / patient
➢ The insurance company
➢ The medical provider (doctor, dentist, hospital etc.)
FACTORS INFLUENCING COSTS IN THE HEALTHCARE SECTOR

Not or Less Controllable
- Medical Inflation
- Tax Regulation
- Legislation
- Demographics

Controllable
- Increased Utilization
- New Technology
- Cost Shifting
- Increasing Cost of Medical Service

DATA IN THE LIFE CYCLE OF HEALTH INSURANCE PRODUCTS

Needs, motives, perception and attitudes known as the internal factors and the external influences like family, social groups, culture, economic and business conditions are found instrumental in guiding the behavioral profile of an individual.
The insurance organizations are supposed to study their behavioral profile so that they succeed in fulfilling their expectations. The marketing information system is well managed by the new generation of sophisticated information technologies which helps them in identifying the level of expectations. This makes their insurance decisions proactive.

The needs and requirements of rural and urban segments, teens and youths segments, affluent and weaker segments, individual and institutional segments cannot be identical.

MARKET SEGMENTATION IN THE HEALTH INSURANCE ORGANISATIONS

Before the adoption of mass production, the markets were automatically segmented because each product or service was tailored to the needs of buyers or users who had ordered for supply. With an increase in the scale of operation, the segmentation occupied a place of significance. ‘Know thy market’ was made a difficult process and the consumption processes were found complicated. To get a success, it was essential that the health insurance companies know the different segments availing policies.

In the insurance organizations, the task of formulating the overall marketing strategies cannot be performed efficiently unless we segment the market. It was against this background that marketing studies engineered a sound foundation for segmenting the markets of insurance business. The market for the insurance business is vast, the potential policyholders are in a very good number and their needs and requirements are not identical. Segmentation helps the insurance organizations in dividing and subdividing the market into small segments in which the needs and requirements are found by and large identical.

PRODUCT DEMAND IN THE CASE OF HEALTH INSURANCE – DRIVERS FOR THE GROWTH

With the liberalization of the economy, the demand for insurance is growing. Drivers for this growth are:
Investments in industries and infrastructure development due to:
- Increase in demand for goods and services
- Increase in exports with the globalization of the economy.

Growth in retail consumption due to:
- Increase in per capita income
- Growth of retail financing at 35 per cent annually
- Paradigm shift in distribution with multiple channel options
- Upward mobility of the population leading to higher asset ownership

Increasing awareness and penetration of certain product categories such as liability insurance, health insurance, and overseas travel insurance.

Innovative product offerings in the market such as weather insurance offering practical solutions to insurance needs.

PROFILE OF HEALTH INSURANCE COMPANIES SELECTED FOR THE STUDY:
PUBLIC SECTOR INSURANCE COMPANIES
NEW INDIA ASSURANCE COMPANY LIMITED

The New India Assurance Company was incorporated on 23rd July, 1919 and commenced business from 14th October, 1919. In 1972, the year of its nationalization, Government of India took over the management of the company along with all other non-life insurers in the country. NEW INDIA ASSURANCE (NIA) was subsequently reconstituted taking over 23 companies under the Scheme of Merger, following the nationalization of General Insurance Business in 1973. Later on in 2002, with the passage of Insurance amendment Bill (2002), New India Assurance Co. Ltd has been delinked from GIC and has been functioning as an independent company.
New India Assurance is an Indian non-life insurance company owned by the Government of India. Since commencing operations in 1919, we have gained credibility and strong results for more than 80 years. Till date, NIA remains the largest and leading non-life insurance company in India, which has now been open to the private sector.

THE UNITED INDIA INSURANCE COMPANY LIMITED

United India Insurance is one of the four subsidiaries of the General Insurance Company carrying on general insurance business with its head office at Chennai. Later in 2002, with the passage of Insurance amendment Bill (2002), United India Insurance has been delinked from GIC and has been functioning as an independent company. UI spans the country with a network of 1123 offices and manpower of over 21,000 employees.

THE ORIENTAL INSURANCE COMPANY LIMITED

The Oriental Insurance Company Ltd. is a public sector company and is one of the four subsidiary companies of the General Insurance Corporation of India.

After nationalisation of general insurance business, it commenced its operations from 1st January 1975. Later in 2002, with the passage of Insurance amendment Bill (2002), The Oriental Insurance Company Ltd. has been delinked from GIC and has been functioning as an independent company. The Company headquartered in New Delhi transacts all kinds of general insurance business ranging from very big projects to small rural insurance covers. The Company has 21 Regional Offices, 311 Divisional Offices and 635 Branch offices.
THE NATIONAL INSURANCE COMPANY LIMITED

Since its incorporation in the year 1906, National Insurance Company has been carrying out general insurance business under private management until 1972, the year of its nationalisation. Later in 2002, with the passage of Insurance amendment Bill (2002), National Insurance Company has been delinked from GIC and has been functioning as an independent company. Headquartered in Calcutta it has an organisational network of over 964 offices with around 20,077 trained workforces. The company also has operations in Hongkong and Nepal and ranks among the top global business insurers.

PRIVATE SECTOR INSURANCE COMPANIES

BAJAJ ALLIANZ GIC LIMITED

Bajaj Auto Ltd.

Bajaj Auto Ltd the flagship company of Bajaj Group was incorporated in 1945 as Bachraj Trading Corporation. Initially it started by assembling two and three wheelers in collaboration with Piaggio of Italy.

Allianz AG

Allianz group was founded in 1890 and is one of the world’s leading insurance companies with over 100 years’ experience in insurance and related services. It is also the largest insurer in Europe. Allianz group has multi-local structure and presence in over 70 countries.

The Joint Venture

Allianz Bajaj Life Insurance Co. Ltd. is a joint venture between Allianz AG and Bajaj Auto Limited. Characterized by global presence with a local focus and driven by customer orientation to establish high earnings potential and financial strength, Allianz Bajaj Life Insurance Co. Ltd. was incorporated on 12th March 2001. The company received the Insurance Regulatory and Development Authority (IRDA) Certificate of Registration (R3) No 116 on 3rd August 2001 to conduct Life Insurance business in India.
ICICI LOMBARD GIC LIMITED

ICICI Lombard is a joint venture between ICICI Bank – the second largest bank in India — and Lombard General Insurance — Canada’s oldest insurance provider. With over 50 products and sales of 3,000 policies per day, the company offers a host of insurance solutions to corporate, small and medium enterprises (SME), and retail customers. The insurance business is information-driven and competitive. In an emerging market where both private and government players vie for a huge customer pie, ICICI Lombard understands the value of fast, efficient and centralized information access.

ROYAL SUNDARAM INSURANCE COMPANY LIMITED

Sundaram Finance

Sundaram Finance Limited (SF) was established in 1954 with a paid-up capital of Rs 0.02 million, primarily to assist the development of Road Transport Industry.

Royal & Sun Alliance

Royal & Sun Alliance is one of the world’s leading international insurance company. The Sun was established in 1710 and is the oldest insurance company in existence still trading under its original name.

The Joint Venture

The joint venture bringing together Royal & Sun Alliance Insurance and Sundaram Finance Limited started its operations from March 2001. The company is Head Quartered at Chennai, and has two Regional Offices, one at Mumbai and the other at New Delhi.
RELIANCE GENERAL INSURANCE COMPANY

Reliance Group

Reliance Group is India’s largest business house which has an annual sales turnover of Rs. 41,280 crore (US$ 9,003 million) Reliance Industries Limited, India's largest private sector enterprise, is a major player in the Indian petrochemicals sector.

Reliance General Insurance Company Limited

Reliance group has announced its plans to enter the Indian insurance sector - both in the life and general insurance businesses. Reliance Industries plans to bring in around Rs. 300 Crores into its insurance venture through its financial arm Reliance Capital Ltd. This is the first application from an Indian company without a foreign insurance tie-up. However, Reliance will associate with international insurance consultants to bring the best practices in the business to India.

CHOLAMANDALAM GIC LIMITED

Cholamandalam Investment & Finance Co. Ltd

Cholamandalam Investment & Finance Co. Ltd. is the financial services arm of Murugappa Group, which commenced its operations in 1978, initially concentrating on asset finance through leasing and hire purchase to corporate and then to retail customers.

Cholamandalam General Insurance Company Limited

Cholamandalam General Insurance Company Limited is promoted by Chennai based Murugappa Group. The company is planning to garner a premium income of Rs.100 crore in the first year of its operation, and expects to break even by the fourth year of its operation with a premium income of Rs.500 crore. The general insurer plans to be in 30 cities in 18 months and would offer its customers about 50 products.
HDFC CHUBB GIC

HDFC

Incorporated in 1977 with a share capital of Rs. 10 crores, HDFC has since emerged as the largest residential mortgage finance institution in the country.

Chubb Corporation

The Chubb Corporation is one of the world's largest, financially strongest, non-life insurance companies. The Chubb Corporation was formed in 1967 and was listed on the New York Stock Exchange in 1984.

The Joint Venture

HDFC Chubb General Insurance Company Limited, a joint venture between HDFC, India's premier financial services company, and The Chubb Corporation, leading global non-life insurer, formally launched its operations on October 17, 2002 in Mumbai. Offices in New Delhi, Bangalore and Hyderabad have also been opened simultaneously.

IFFCO TOKIO GIC LIMITED

IFFCO

Indian Farmers Fertilizer Co-operative Limited (IFFCO) was created on November 3, 1967 as a multi-unit co-operative society engaged in production and distribution of fertilizers. The byelaws of the Society provide a broad framework for the activities of IFFCO as a Cooperative Society. The main emphasis is on production and distribution of fertilizers.

The Tokio Marine & Fire Insurance

The Tokio Marine & Fire Insurance (Tokio Marine) Company holds a leading position in Japan's property and casualty insurance industry.
The Joint Venture

IFFCO TOKIO General Insurance Company is a joint venture promoted by India Farmers Fertiliser Co-operative, Tokio Marine and Fire Insurance Company, Japan, the fifth largest insurance company in the world, Krishak Bharathi Cooperative Ltd. (KRIBHCO), and Indian Potash. Their contribution to the Rs. 100 crore equity capitals is 49 percent, 26 percent, 20 percent and 5 percent respectively. The Head Office is in Delhi and the other operating Offices are in about 20 cities.

TATA AIG GIC LIMITED

Tata-AIG General Insurance Company is a joint venture between the Tata Group and American International Group, Inc (AIG), the leading US-based international insurance and financial services organisation and the largest underwriter of commercial and industrial insurance in America.

Its member companies write a wide range of commercial, personal and life insurance products through a variety of distribution channels in approximately 130 countries and jurisdictions throughout the world. The Tata-AIG General Insurance Company offers a complete range of insurance solutions ranging from motor vehicle, homeowners, personal accident, travel, energy, marine, property and casualty to several specialised financial lines of insurance.
MARKET SHARE OF VARIOUS INSURANCE COMPANIES TOWARD HEALTH INSURANCE BUSINESS

Exhibit 3.1

Segment-wise gross direct premium within India

Insurance Companies

0.53 9.15 13.56 19.69 5.89 16.37 1.33 2.61 1.39 1.61 0.11 0.71
Sundaram TATA AIG Reliance HDFC Life ICICI Lombard Bajaj Allianz HDFC Genmed

255.65 202.84 288.47 252.17 273.53 230.05 232.85
National United India Oriental

2002-03 2003-04
Exhibit 3.2 (a)
Segment-wise gross direct premium within India
Market Share - 2002 - 2003

Exhibit 3.2 (b)
Segment-wise gross direct premium within India
Market Share - 2003 - 2004
The Types of Health Insurance

Group insurance:

Group medical insurance offers insurance cover to a group with a common trait – it may be employees of a company, members of a club or an association or members of a co-operative society etc. Many employers now provide medical insurance as a perquisite to their employees.

Individual insurance:

Individual insurance caters to the specific needs of an individual. Premium for an individual insurance is higher than group insurance.

Floater:

A floater is a unique plan wherein the value of sum insured opted can be used by all the members of the family or by a single-family member. Basically, the sum insured amount floats over all the members covered. For example: if the policy is bought for 3 lacs, then either all three members of the family can use Rs 1 lac each or one member can use the entire cover of 3 lacs.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Name of the company</th>
<th>Name of the policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sector</td>
<td>Life Insurance Corporation of India.</td>
<td>1) Asha Deep,</td>
</tr>
<tr>
<td></td>
<td>SBI Life Insurance Co. Ltd.</td>
<td>2) Jeevan Asha-I &amp; II</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3) Setubandhan</td>
</tr>
<tr>
<td>Private sector</td>
<td>ICICI Prudential Life Insurance Co. Ltd.</td>
<td>1) ICICI Prudential Life Time Medicare</td>
</tr>
<tr>
<td></td>
<td>Birla Sun Life Insurance CO. Ltd.</td>
<td>2) Personal accident Benefit rider,</td>
</tr>
<tr>
<td></td>
<td>Max New York Life Insurance Co. Ltd.</td>
<td>3) Dread Disease rider (these are add-ons to the newly launched life Maker policy, which has yet come into effect.</td>
</tr>
</tbody>
</table>

Some of the companies offering medical/health insurance

Life insurance companies
<table>
<thead>
<tr>
<th>Sector</th>
<th>Name of the company</th>
<th>Name of the policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>The National Insurance Co.Ltd.</td>
<td>1) Mediclaim, 2) Overseas Mediclaim, 3) Personal accident</td>
</tr>
<tr>
<td></td>
<td>The NewIndia Assurance Co.Ltd</td>
<td></td>
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<tr>
<td></td>
<td>The Oriental Insurance Co. Ltd</td>
<td>4) Universal health insurance</td>
</tr>
<tr>
<td></td>
<td>United India Insurance Co. Ltd</td>
<td>5) Jan arogya bima</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6) Bhaisha Arogya Bima</td>
</tr>
<tr>
<td></td>
<td>ICICI Lombard General Insurance CO.Ltd</td>
<td>1) Family floater health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) Health first</td>
</tr>
<tr>
<td></td>
<td>TATA AIG General Insurance Co.Ltd.,</td>
<td>1) Critical Illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) Group medishield</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3) Group/individual accident,</td>
</tr>
<tr>
<td></td>
<td>Iffco Tokio General Insurance Co.Ltd</td>
<td>1) Lok Swasthya</td>
</tr>
<tr>
<td>Private</td>
<td>Bajaj Aliianz General Insurance Co.Ltd.</td>
<td>1) Hospital Cash Daily Allowance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) Critical Illness</td>
</tr>
<tr>
<td></td>
<td>Royal Sundaram Insurance Co.Ltd.</td>
<td>1) Health guard / Health shield.</td>
</tr>
</tbody>
</table>

**MEDICLAIM POLICY FEATURES:**

**Highlights**

This policy provides for cashless hospitalization in India for the treatment of any illness or disease or accidental injury (not specifically excluded) suffered during the policy period. The payment of claim is made through Third Party Administrators who have been empanelled by the Company to provide hassle free admission and discharge from the Network hospital without making any payment. The reimbursement of domiciliary hospitalization claims will also be made through the TPA.

For obtaining Mediclaim policy the proposer has to fill up the proposal form and Insured Person details form and submit two latest stamp- sized colour photograph of each family member to be insured.
A family package cover can be taken covering the proposer, spouse, dependent parents and two dependent children with a 10% discount in premium.

Group policies can be issued to specified groups and group discount can be availed provided group size is more than 100 members.

Premium up to Rs.10,000/- paid by cheque for this policy is entitled for tax rebate under section 80D of the Income Tax Act.

**BENEFITS OF MEDICLAIM**

Mediclaim Insurance, like any other insurance, helps to insure against any uncertainty which may arise due to deterioration health of a person. However the longer one delays deciding to take a Mediclaim policy, the tougher it gets to make it one will end up paying a higher premium; get a lower coverage. The diseases, a person currently suffering from get excluded as pre-existing. The procedure gets cumbersome as he should undergo tests reserved for the higher age groups.

Mediclaim insurance for a person and his family will put him at ease emotionally as well as financially. Moreover, the individuals as paying premium by cheque (and credit card) get rebate in income-tax for premium paid for self and eligible dependants.

**An Analysis of Mediclaim Coverage Throws Some Interesting Facts:**

- 55 per cent of premium comes from group policies.
- Metros account for 75 per cent of the group premiums and 42 per cent of individual premiums.
- Other than the metros, 58 per cent account for individual premiums.
- Northern and western states account for over 60 per cent of the total premiums.

**Health Insurance:**

**Hospitalisation is Expensive, get it insured.**

The worst nightmare that anyone can have is the one when a family member is hospitalized. Today, when everything is uncertain nobody can be sure what will happen. A seemingly small ailment can turn into major one. And what happens when the earning member of your family is hospitalized? But with a policy from Bajaj Allianz you and your family can rest assured.
Health Guard

Bajaj Allianz covers you and your family against expensive medical care including pre & post hospitalisation expenses. Sum assured up to 5 lacs per insured.

Hospital Cash

A policy that provides a daily allowance for each day of hospitalization. Benefits is doubled in case of ICU admission. Income tax exemption under SEC 80 D.

Critical Illness

Protection against the 10 major life threatening illness like Cancer, Heart Attack, Paralysis, Kidney failure, Stroke, etc. In transplant surgery donor expense are covered. Sum assured up to 50 lacs per insured.

Personal Guard

This policy covers against accidental death and comes with several additional benefits like hospital confinement allowance, children's education bonus.

Silver Health

Bajaj Allianz's Silver Health is a health insurance plan specifically for people aged between 46-75yrs which protects you and your spouse in case you need expensive medical care.

e-opinion

Bajaj Allianz launches e-opinion rider, which will cover the expenses of 2nd opinion e-consultation services for serious illness in India.
Managed Care: An Explanation

The term "managed care" is used quite a lot in the United States. It is a way for insurers to help control costs. Managed care influences how much health care you use. Almost all plans have some sort of managed care program to help control costs. For example, if one needs to go to the hospital, the form of managed care requires that he should receive approval from his insurance company before he is admitted to make sure that the hospitalization is needed. If one goes to the hospital without this approval, he may not be covered for the hospital bill.

Health Maintenance Organizations (HMOs)

Health maintenance organizations are prepaid health plans. As an HMO member, one pays a monthly premium. In exchange, the HMO provides comprehensive care for him and his family, including doctors' visits, hospital stays, emergency care, surgery, laboratory (lab) tests, x-rays, and therapy.

The HMO arranges for this care either directly in its own group practice and/or through doctors and other health care professionals under contract. Usually, his choice of doctors and hospitals are limited to those that have agreements with the HMO to provide care. However, exceptions are made in emergencies or when medically necessary.

Such a HMO typically provides preventive care, such as office visits, immunizations, well-baby checkups, mammograms, and physicals. The range of services covered varies in HMOs, so it is important to compare available plans. Some services, such as outpatient mental health care, often are provided only on a limited basis.

Many people like HMOs because they do not require claim forms for office visits or hospital stays. Instead, members present a card, like a credit card, at the doctor's office or hospital. However, in an HMO one may have to wait longer for an appointment than one would with a fee-for-service health insurance plan.
Point-of-Service Plans (POS)

Many HMOs offer an indemnity-type option known as a POS plan. The primary care doctors in a POS plan usually make referrals to other providers in the plan. But in a POS plan, members can refer themselves outside the plan and still get some coverage.

If the doctor makes a referral out of the network, the plan pays all or most of the bill. If one refers himself to a provider outside the network and the service is covered by the plan, one will have to pay coinsurance.

Preferred Provider Organizations (PPOs)

The preferred provider organization is a combination of traditional fee-for-service and an HMO. Like an HMO, there are a limited number of doctors and hospitals to choose from. When you use those providers (sometimes called "preferred" providers, other times called "network" providers), most of your medical bills are covered.

When you go to doctors in the PPO, you present a card and do not have to fill out forms. Usually there is a small co-payment for each visit. For some services, you may have to pay a deductible and coinsurance.

As with an HMO, a PPO requires that you choose a primary care doctor to monitor your health care. Most PPOs cover preventive care. This usually includes visits to the doctor, well-baby care, immunizations, and mammograms.

Standalone Health Insurance Companies

Standalone health insurance company is a solution which IRDA is contemplating for the spread of health insurance. But will it be able to deliver the required and expect results. Any insurance company can only provide financial resources at a cost. Problems surrounding healthcare services are more complex since different stakeholders can appreciate only their personal interests. Unless they develop an integrated perspective and take a long-term view of the issue involved, there will not be any satisfactory solution for this problem.
TPAs

Third Party Administrators (TPAs) are the middlemen in the chain of integrated delivery systems that bring all the components of healthcare delivery – such as physicians, hospitals, clinics, household healthcare, long-term care facilities and pharmacies – into a single entity. They will provide quality healthcare and services at affordable costs, which hitherto were unheard of. The role of TPAs will particularly be beneficial to those sections of society for whom quality healthcare has always remained a dream.

WORK FLOW

- Customer/Policyholder takes insurance policy.
- TPA submits claim.
- Insurer reimburses TPA.
- TPA issues authorization letter for customer.
- Customer calls TPA for treatment.
- TPA pays the cost.
- Hospital sends discharge treatment cost.
- Member hospital.