CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS
The present healthcare system in India is characterized by mixed ownership patterns both public and private. Private households' contribution to healthcare is 75 per cent. Most of these costs are out-of-pocket costs. As there is no effective regulation of private health services, healthcare costs are inevitably high. Alternative healthcare financing mechanisms like health insurance protect people against catastrophic financial burden resulting from unexpected illness or injury.

Insurance companies have to deal with unregulated healthcare providers who work in an environment where there are no standards, quality benchmarks and treatment protocols; and where highly variable billing systems and significant price variations across providers exist. Because of various demand and supply-side imperfections, there are inherent problems in health insurance markets like moral hazards, adverse selection, covariate risks and information problems. It is to address such issues, the insurance intermediaries- Third Party Administrators (TPAs) become important and that are bound to play key role in the growth and development of a managed healthcare system. In the present study an assessment of TPA system has been made. The study has been organized into the following chapters:

Chapter one is 'Introductory' and deals with the general introduction of the topic, need and objectives of the study, research methodology etc. Chapter two describes 'Present Healthcare System in India', which concludes that healthcare system in India is inadequate, inefficient and inexpensive. The system consists of under funded and inefficient public sector along with expensive and unregulated private sector. Chapter three 'Health
Insurance in India’ concludes that health expenditure is a major outgo from the government revenue of individual’s income on financial capacity, which may not sufficient in the event of even minor hospitalization. Health insurance is the most ideal mechanism for transfer of individual health risk to the large community.

Governments, particularly in countries where public health systems are considered inadequate, look upon private health insurers as partners in achieving health policy goals. Private health insurance is an alternative source of health financing offered in the voluntary market and geared towards providing health coverage with customized benefits to a large portion of the population. While private health insurance is a potent tool to increase the capacity of a country's health system, government intervention is necessary to prevent market failures. Chapter four deals with the ‘Legal Framework of Health Insurance’.

Insurance industry in India has lot of changes since the opening of the sector for private participation. There has been a lot of innovations, both products’ front and also on service front. The best thing to happen on service front is the introduction of Third Party Administrators. Their presence is aimed at ensuring higher efficiency, standardization and improving penetration of health insurance in the country. Third Party Administrators 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. Chapter five analyses the ‘Role, Functions and Procedures’ of TPAs, while chapter six measures the Effectiveness and Problems of TPA System from the viewpoint of policyholders, healthcare providers and insurers. The
effectiveness of TPA System in the present study has been measured in the form of measurement of (a) Service Quality (b) Perceived Benefits (c) Perceived Problems.

The present study focuses on the experiences of the stakeholders. Some of the experiences have been described below:

The justification for introducing the TPA services as is evident from the findings is that they help minimize moral hazard. For this purpose, TPAs follow each case in an individualized way. TPAs do comprehensive review of records and maintain content communication with the healthcare providers and families. They also evaluate the outcome of treatment and have adequate data to compare it across different service providers. This knowledge base helps them to be more effective in handling future cases. Value added services provided by TPAs may include arrangement of ambulance services, medicines and supplies, guide members for specialized consultation, provide information about health facilities, hospitals, bed availability and 24 hour help lines.

The study reveals the expected benefits of TPA system and empanelled hospitals/healthcare providers, under which they can afford quality healthcare, cashless hospitalization, specialized consultation and value added services. A significant number of respondents expected that TPAs will follow each case in individualized way and may control the treatment cost, minimize unnecessary investigations and lead to lower premiums.

The study also reveals that standardization and categorization will affect hospital's competitive position and marked increase in patient's turnover. It brings visibility to the hospitals, claim settlement process would be
simplified as well as quick. Claim processing is outsourced in TPA System. This may help in reducing the claim period. The pricing of medical services and procedures is standardized, billing system is proper. This will motivate the controlled and regulated expansion of private healthcare sector. It can be concluded that healthcare provider see tremendous benefits under the TPA System.

Regarding the advantages of TPA System to insurance companies, standardization of treatment cost, reduction of claims ratio and false claims, availability of data for actuarial calculations, speedy disposal of payment by professional cadre, more efficiency in insurance market, simplified reimbursement process and quick claim settlement were the benefits of TPA System as reported by the respondents.

The description above presents a shiny picture of TPA System. However, the stakeholders perceive many problems which may be confronted by them.

• Almost all the stakeholders, except the policyholders, have a business angle. Given that the total market is limited, each one is trying to grab a major share. Among the TPAs, some hold a major share of the total business, while the smaller players are trying to stay afloat. One sure way of ensuring a greater share of the insurance market, administration of the insurance and hospital services is by collusions and mergers, a natural phenomenon of imperfect markets. One method of collusion is informal payment or bribes.

• Corruption has been mentioned by everyone with whom discussions were held, clearly indicating that the TPA is not functioning as a competitive system with efficient outcomes. Corruption or non-market
methods of allocation of business result in distortions and unnecessary system costs, which are then passed on to consumers as higher prices or premiums. Ultimately, in such a system, the policyholders have the most to lose.

- In many situations, policyholders are not aware of various conditions and exclusion clauses in insurance policies. As a result, disputes between policyholders and insurance companies have increased and both parties have resorted to litigation. Problems arise because of lack of information and awareness, as also inadequate understanding of various nuances of insurance. It is expected that TPAs can play an important role in educating consumers and creating awareness. TPAs are the interface between the insurer and the insured and they are in a position to educate the insurer on the health insurance.

- Customers are paying for the extra service being provided by TPAs through a higher premium. If, in fact, the claims ratio is coming down and the insurance companies are being freed of their workload, then the savings in terms of both money and other administrative costs should be passed on to the consumers. This is currently not happening. Insurance companies are not passing on the saving, made in outsourcing administrative work being done by the TPAs. Of course, the claims ratio may not be coming down as significantly as it seems due to the presence of family floaters that are now being offered by insurance companies.

- There is very little information and documentation on approaches that can be used to influence consumer behavior, provider practices and restructuring the market, in both health and insurance. The minimum
standards of care are not defined, healthcare service providers have a much higher bargaining power in the system and will not be persuaded to follow standards and quality guidelines.

- However, discussions with hospitals revealed that demand for hospital care has been increasing substantially with the new TPA system, and that it is in the hospitals’ interests to move over to the TPA system. Nevertheless, it probably continues to be true that demand for insurance-linked hospital care is mostly centered around the upper end of the tertiary care sector, with more expensive and super specialty hospitals benefiting the most from the new system.

- For hospitals that are not offering TPA or insurance services, there does not seem to be a great incentive to move over to the TPA system with delayed payment in contrast to the earlier system of on-the-spot payment. The discussions did indicate that some hospitals were not getting their payments on time and were reluctant to work with some of the current TPAs. However, as more and more health insurance policies are issued, even leading hospitals have to deal with TPAs.

- Lack of standardization or accreditation system for hospitals also causes concern over pricing and billing. Billing systems differ from facility to facility. Most of the payments are cash based and less transparent. TPAs would face difficulties in scrutinizing and processing claims and reimbursements using common standards across facilities.

- The system may create perverse incentives which give opportunities to healthcare providers, policyholders and TPAs to collude; and TPAs may favour healthcare providers and policyholders in setting claims in order to attract more business. However, TPAs feel that by not allowing
them to market insurance products, the health insurance sector will see less participation of TPAs in areas such as consumer education and creating awareness about various policy options, which will discourage competition in the insurance sector. As a result, the objectives of insurance reform will not be achieved.

- There is already evidence that a couple of hospital chains have got TPA license. This is certainly unethical and against the basic guidelines laid down by IRDA. This system will ensure that the TPA/hospital will work towards its own system, and there is always a possibility of playing favorites, that is, smooth claim settlement towards this hospital, and not to the other hospitals. This kind of system is, therefore, likely to bring in malpractices. Similarly, there are instances where insurance brokers have also ventured into the TPA business through a sister concern. There are implications of conflict of interest in this situation.

- Discussions with many TPAs revealed that there is dissatisfaction with the 5.5 per cent commission. There is a lot of variation in calculating break-even among the TPAs on account of their in-built costs. One player estimated the break-even in metros at Rs 10 crore of premium business and for non-metros at Rs 4 crore, while another estimated the break-even premium at Rs 100 crore for the TPA. Some TPAs frankly admitted that they were making losses as of now, and hoped to turn things around in a few more years. The public sector general insurance companies should be bringing down their total management costs from about 30 per cent to about 20 per cent (as per the Insurance Act).

- At present, TPAs are not allowed to market health insurance policies due to a conflict of interest. However, it cannot be denied that a TPA that sells the policy will probably have an incentive to offer better
services. Legally, it is difficult not to allow promoters to enter allied businesses as suitable equity structuring can always be done. But, due to the possibility of unethical practices, the IRDA/insurance companies need to ensure that a strict separation is maintained between these businesses.

- There are also instances of some TPAs working on behalf of corporate, which is another area of collusion that is fraught with inefficient outcomes. In fact, a notice from the IRDA to TPAs and general insurers says that “it has been observed of late by the authority that the offices of various insurance companies and licensed third party administrators—health services are entering into agreements at the insistence of their clients for the sake of business considerations allowing TPAs to charge separate fees in addition to insurance premium.

- TPAs also do not have an incentive in controlling costs. The remuneration of the TPA has been decided as a fixed percentage of the policy premium and are not linked to the effort of controlling reimbursements.

- Insurance companies do not have any incentive to control the systemic costs. Since corporate clients are keeping the bulk of the business afloat, and also because of the influence they have with insurance companies, their claims are seldom rejected, though some TPAs argue that corporate claims have gone down because they have been able to reject wrong claims.

- Approaches such as standardization of treatment protocols as proposed by IRDA can be problematic. These efforts may imply proposing treatment practices that may be contrary to existing practices, and the regulators may face serious opposition from
powerful professional groups. The monitoring function is vital but difficult to sustain in the long term. Such efforts are highly resource intensive, especially when they involve working with a large number of geographically dispersed and small-sized service providers. The regulator has made careful judgments in developing appropriate strategies to deal with private healthcare service providers. It is also not clear how standards of care can be set without involving the service providers. Also, given the diversity of providers and absence of uniform standards, getting information on disease management and costs/pricing are going to be challenging tasks.

The above discussion indicates that the system of TPAs, while theoretically sound and useful, is in practice fraught with problems.

The real benefit of this system will come out in future provided TPA has improved their service standards. There are few recommendations as extended by the respondents during the survey and informal discussions.

- The inefficiency in terms of delay in services and poor quality customer care is a crucial issue which needs to be addressed to sustain TPA system. Overall organizational restructuring, provision of infrastructure and initiative of all parties is required.

- Customer must know the terms and conditions of the contracts clauses. Customers should be educated in simple language to explain the terms and conditions of the contract and clauses.

- A list of hospitals, its tariff rates for various ailments should be displayed on the website and such list can be provided to the insured along with the pre-authorization prior to the admission to any hospital.
This will facilitate the insuring people to select the hospital/nursing home of their choice to meet with their requirements.

- Hospitals should be given complete freedom in treatment, standardized rates, billing procedure, treatment protocols and categorization of hospitals. Regulatory mechanism should monitor hospitals inflated bills. All the documents must be send to TPA in time. The duly filled preauthorization form should be submitted as per the given instruction in guide books; Hospitals must submit all the documents as per the given list. Proper medical protocols have to be developed. Hospital should provide complete care but should not intentionally inflate bills if patients are backed by TPA.

- TPA must have renowned doctors in panel. TPA must not command on the treatment method. They must limit their investigation but hospitals should be left free. TPAs infrastructure and service standards should be improved. The TPA cannot utilize the float amount for any other purposes except settlement of claims. The amount of fees and applicable service charge should be paid separately. Auditing of TPA claims are to be done periodically once in six months by the respective insurance companies and their audit reports should be submitted to IRDA for their scrutiny.

- The payments to TPA for their services are not linked to the effort of controlling reimbursements. Hence, how TPAs are paid for their services should take into account the TPAs efforts and successes in controlling costs and reimbursements. TPAs can play an important role in educating consumers and creating awareness. TPAs are the interface between the insurer and the insured and they are in a position to educate the insured on the health insurance.
• TPAs have financial problem that affects their servicing ability. If adequate float is given, TPA’s financial position will be better. At initial stage, TPAs must limit the coverage.

• In any insurance system, focus on prevention and promotive services can cut down many costs. TPAs can play an important role in these areas. However, the mechanisms for these are not in place and their role is not clearly defined. TPAs are in a position to offer and organize these services, but this will come at a cost.

• There has been steep rise in medical care costs recently. The Government should devise some ways to make our health system less expensive and accessible to majority of the population especially to poor. There is also the need to remove rural-urban gaps that exist in most health care provision. Access to health services must be improved in quantity and quality.

• The system demand transparency and clear regulation. IRDA must intervene in this matter. Standardization and categorization will ensure fair, transparent and quick settlement of claims. It is must in Indian Scenario. IRDA is expected to take quick action.

• The regulation must have strict control over TPAs and customers should follow guidelines provided by TPAs. Any regulation on health insurance should ensure the patient is provided with the choice of provider and insurer while managing the cost environment.

• IRDA recognizes that future health insurance products should be customized focusing on clients’ demand. There has been no actuarial involvement in designing health insurance products. A past experience is important in calculating premiums. A centralized database containing
information on the costs of insurers and healthcare providers is, therefore, desirable. However there is lack of information on healthcare services and utilization. Recognizing this as a problem. IRDA has constituted a committee with representation from insurers, TPAs, the tariff advisory committee (TAC) and IRDA to suggest a framework for the collection of health-related data and advise on the use of this information in (a) building health insurance products by insurance companies, (b) establishing benchmarks for the services to the provided by TPAs, and (c) standardizing the service to be provided by hospitals to policyholders.

This study does not indicate significant influence of the presence of TPAs on the behavior and decision making of different actors in the healthcare sector. It shows that in the early phase after introduction of TPAs, asymmetry of information continues and different stakeholders fail to realize the impact of TPAs' presence in the sector. With the maturity of TPA mechanisms, we propose that the impact of TPAs will be experienced in the form of changes in the economic and service delivery behavior of stakeholders in health sector. This process of behavior change is likely to be slow owing to the benefits for the service providers and TPAs with asymmetry of information. There is a need to fully expand and develop this stream of literature which is extremely scanty in the context of developing nations at the moment. The study shows the need of further research to examine the impact of TPAs on health sector functioning.