CHAPTER ONE

INTRODUCTION
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Health is an important aspect of human resource development. Good health care facilities and services are essential for creating healthy citizens and society that can effectively contribute to social and economic development. With increased urbanization, industrialization and the changing environment, health related issues and problems are being emphasized and have become a great concern for the contemporary world. 'Health for All' is still a distant dream in India with a large proportion of the population still unable to access quality health care. The Tenth Five–year Plan document admits, “In all states, patients incur out-of-pocket expenses to meet the health care cost in public and privately-funded hospitals....the poorer segments of population have less access to both public and private sector curative services than the better off sections. The question whether the amount spent by different segments of the population results in their receiving the appropriate care remains unanswered as the country is yet to evolve and monitor appropriate treatment protocols and cost of care for specific illnesses in different settings”¹.

In the light of the fiscal crisis facing the government at both the Central and State level, the shrinking public health budgets, the escalating healthcare costs coupled with the demand for healthcare services and lack of easy access of people from the low income group to quality healthcare, health insurance is emerging as an alternative mechanism for financing of healthcare.

Health insurance is a mechanism of pooling resources and sharing risk or uncertainties among many people. Health insurance protects against the cost of illness, mobilizes funds for health services, increases the efficiency of mobilization of fund provision of health services and achieves certain equity
objectives. Currently, in India only 2 million persons out of total population of 1 billion are covered under Mediclaim, whereas in developed nations like USA, about 75 per cent of population are covered under some insurance scheme. The share of health insurance in India in health financing account for a mere 1.2 per cent of the total expenditure on health. The current size of the market, despite the high growth rate, is small at less than Rs. 2000 crore. The four established players have 82 per cent of the market. At 9 per cent of the total non-life market, the health portfolio now ranks as the third largest portfolio after motor at 40 per cent and fire at 20 per cent. Its growth has been truly phenomenal and future potential seems enormous.

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. Some of the key challenges faced by the industry are summarized below:

- An estimated one-third increase in claim amount due to the moral hazard, the adverse selection problem and/or the provider-induced demand;
- 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;
- Lack of actuarial data, lack of standardized billing and under reporting of information by private providers;
• High administrative cost of insurance companies;
• Slow claim processing. Insurance companies took on an average 121 days to settle the claim.

Under the existing private medical insurance scheme, which is indemnity based, policyholders, at the time of needing healthcare services, first pay for the expenses and are only later reimbursed depending on the sum insured and the coverage. 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 above problems of health insurance industry. Third Party Administrator (TPA) was introduced through the notification on TPA-Health Services Regulations, 2001 by the IRDA. Their basic role is to function as an intermediary between the insurer and the insured and facilitate the cash-less service of insurance. In the post liberalization era, and subsequent to the notification of TPA-Health Services Regulations-2001, few companies were licensed to act as TPA-Health Services to strengthen and encourage the health insurance and increase its penetration. The idea was to bring more professionalism in claims management, facilitate cashless services to the policyholders and to reduce the claims ratio.

Third Party Administrators (TPAs) are not technically managed care organizations, but play an important role in health insurance. TPAs provide an important link between insurance companies, healthcare providers and policyholders. Intermediations by TPA sensors that policyholders get hassle free services. Insurance companies pay for efficient and cost effective services, and policyholders get their reimbursements on time. They also provide services to the corporate sector in designing and managing health benefit packages for their employees. Based on the rate of growth of
insurance premiums in just one year, it is possible that health insurance will grow much more in coming years, giving more business to the TPAs\(^5\).

There is considerable confusion on the role and usefulness of third party administrators (TPAs) in India. Since the insurance companies pay the TPAs, it is argued that the policyholders should welcome such a move, since they receive enhanced facilities at no extra cost. The other benefit of the TPAs is that once the policy has been issued, the insurance companies have to pass on all the records to the TPA, and all the information regarding the insured will remain with the TPA. Finally, the new system is supposed to be based on a cashless mode, which is definitely an improvement over the previous system as far as consumers are concerned\(^6\).

1.1 REVIEW OF LITERATURE

An essential aspect of investigation is the review of related literature which is a general retrospective survey of previous writings pertaining to one to one's problem. It is obviously imprudent and wasteful to proceed in any study without knowing what has been done before. The review of related literature is an enacting task, calling for a deep insight and perspective of the overall field. It is a crucial step which invariably minimizes the risk of dead ends, rejected studies, wasted efforts, trials and errors actively oriented towards approaches, already decoded by previous investigations\(^7\). Keeping this in mind the related literature which directly or indirectly influences the study has been reviewed. The key findings of various studies have been classified into the following themes and arranged in chronological order:

1.1.1 Present Status of Healthcare system in India
1.1.2 Scenario of Health Insurance in India
1.1.3 Emergence of the System of Third Party Administrators
1.1.1 PRESENT STATUS OF HEALTHCARE SYSTEM IN INDIA:

Srinivas Krishna (2000)\(^8\) conclude in his study that the changing landscape of the healthcare sector is rapidly making the current business model irrelevant... The sector needs to find new ways of operating, if it has continued its relevance in the market place.

Dmytraczenko, Rao and Ashford (2003)\(^9\) identified that since the late 1980s, many developing countries have initiated efforts to improve their health systems. A number of factors prompted these efforts: the movement from state-controlled economies to market-oriented economies; insufficient funding for health in time of financial crisis; the lack of basic health services for many citizens; and the poor quality, low accountability and inefficiency of existing health services. To address these issues, many government launched health sector reforms, which are intensive long-term efforts to strengthen and improve the nations' health.

Barrett and Conlon (2003)\(^10\) observed that healthcare expenditure of the household may be another proxy of health status of the household.

Bhat and Babu (2004)\(^11\) pointed that the present healthcare system, characterized by mixed ownership patterns, both public and private facilities provide health services but the bulk of the curative services is skewed towards the urban areas and dominated by the private sector. He also mentioned that India spends 6 per cent of its GDP on health. The share of government is less than 2 per cent.

Devadasan, Manoharan, N Menon, S Menon, M Thekaekara, S Thekaekara and AMS Team (2004)\(^12\) mentioned that the health financing system in India is dependent on government's budgetary allocations and private financing. The role of the latter has increased significantly in recent years.
Ahuja (2004)\textsuperscript{13} suggested that the poor in India need to be protected from high out-of-pocket expenditure on health. A well-managed pre-payment system with risk pooling is effective in removing financial barriers at the time of illness. This can increase access to care-an important step towards improving the health status of households.

Varatharanjan, Godwin and Arun and Ritu Priya (2004)\textsuperscript{14} claimed that Government spending on health is poor in India. It is far less than the optimum for any economy; governments in India's social economy contribute only 17 per cent to the country's healthcare resources whereas those of European market economy allocate 75 per cent.

Gangolli (2005)\textsuperscript{15} stated, as the private sector remains outside the realm of regulation, the prices charged for treatment vary outrageously and the quality of service provided is uneven.

Bhat and Jain (2006)\textsuperscript{16} pointed out that public expenditure on health is less than 1 per cent of GDP. Also more than 80 per cent of total healthcare expenditure is out-of-pocket expenditure. They added that one important finding in earlier studies has been that the ratio of healthcare expenditure to GDP increased as countries developed economically and industrially.

Jagendra Kumar (2006)\textsuperscript{17} realized that the healthcare in India is in a state of enormous transition-increased income for the middle classes, price liberalization, reduction in bureaucracy and the introduction of private healthcare financing have all made a world of difference.

While average spending on health in India is Rs 202 for the poor-which is half their monthly income. This implies that the poor households bear a heavy burden on account of illness. They tend to spend a larger share of their income on health care.\textsuperscript{18}

It is expected that Changing demographics and disease profiles along with rising treatment cost will cause the spending on healthcare delivery over Rs. 2, 00,000 crore by 2012.\textsuperscript{19}
1.1.2 SCENARIO OF HEALTH INSURANCE IN INDIA:

Feldstein (1973) Cutler and Zeckhauser (1998)\textsuperscript{20} stated that recent research has documented that most of the secular change in health insurance coverage can be attributed to higher health care costs.

Wadhawan (1987), Ellis (2000), Bhat and Mavalankar (2001)\textsuperscript{21} stated in India knowledge and awareness about health insurance could be important factor for health insurance purchase decision.

Kronick and Gilmer (1999)\textsuperscript{22} revealed the relation of health insurance purchase decision and health expenditure is based on the premise that families which have higher chances of requiring hospitalization will have higher probability of buying health insurance.

Ahuja (2004)\textsuperscript{23} stated that health insurance is emerging as an important financing tool in meeting the health care needs of the poor. He added that lack of standards for disease and treatment procedures, absence of rating and credentialing of providers, non-existence of a centralized database, standardized billing, claims and proposal forms are some of the problems facing the health care industry.

Bhat and Babu (2004)\textsuperscript{24} stated that health insurance in India is at a nascent stage and contributes to a small proportion of the health expenditure. Various demand and supply - side imperfection, there are inherent problem in health insurance markets. Important constraints on insurance contracts are Moral hazard; Adverse selection; Covariate risks; and Information problems.

Matthies and Cahill (2004)\textsuperscript{25} described the various challenges the industry faces. These include lack of data to determine price of products and ability to negotiate payment rates with providers; a regulatory framework that
does not recognize the unique features of health insurance products; lack of quality assurance measures for health providers and lack of consumer awareness about the benefits of health insurance.

Sujata Rao (2004)\textsuperscript{26} found financing to be most important component to improve health system in India and advocated that health insurance should be given very high priority by the government as a financing mechanism. The government and the regulators have always recognized that health care needs greater focus and the health insurance is the significant driver for the improvement of health care.

Annual Report, IRDA (2004-05)\textsuperscript{27} pointed out, one of the reasons for low penetration of health insurance in India is the lack of regulations in the health sector, resulting in exposure of the beneficiaries to various wrong practices present in the system. The health insurance in the country presently covers only 1 per cent of the population. The share of health insurance in health financing accounts for a mere 1.2 per cent of total expenditure on health.

Jagendra Kumar (2006)\textsuperscript{28} stated that the cost of healthcare is only going to increase. Apart from, there are malpractices in the industry, which needs to be curbed. Unlike other countries, India can not afford to make health insurance mandatory as there is a cramp on infrastructure, with only about 0.7m beds available with the healthcare industry, according to estimates.

The Insurance Times (2006)\textsuperscript{29} reported the penetration of health insurance is currently woefully low at just one percent of the entire population.

1.1.3 EMERGENCE OF THE SYSTEM OF THIRD PARTY ADMINISTRATORS:

'Insurance industry in India has seen lot of changes since the opening of the sector for private participation. There has been a lot of innovation both
on the products front and also on service front. Innovation on the service front include providing call centre facilities, providing personalized financial planning tools and the best thing to happen on the service front is introduction of Third Party Administrators'.

'TPAs, which offer health insurance services, have failed to meet the expectations of IRDA. Absence of uniformity in rates among hospitals is one of the main reasons being cited by IRDA'.

'Third Party Administrators are the new breed of intermediaries in the sector, introduction of whom will benefit both the insured and the insurer. While the insured is benefited by better service, insurers are benefited by reduction in their administrative costs'.

To put in short, the job of the TPA's is to maintain databases of policyholders and issue them identity cards with unique identification numbers and handle all the post policy issues including claim settlements.

The Economic Times, May/ August (2004) states that General Insurance Public Sector Association (GIPSA) officials are planning to take hard decisions about TPAs. This is because of the growing complaints against TPAs on one hand and TPAs having complaints against insurers on the other hand.

Gupta, Roy and Trivedi (2004) deduced that in the scenario, privatization of the insurance sector and the subsequent creation of the system of TPAs meant that there was a possibility of more efficiency in the insurance market because of more competition as well as the creation of the professional cadre to look after speedy disposal of payments. Basically, a TPA acts as a service integrator between the insurer, the insured and the health service provider.
Bhat and Babu (2004)\textsuperscript{36} revealed that with the routing of reimbursement through TPAs, the system has undergone a change. Earlier, clients were handling everything themselves and there were risks of delay in reimbursements and non-payments of some expenses incurred. But it is providers who now face the risk of not getting reimbursements from TPAs.

Annual Report, IRDA (2004-05)\textsuperscript{37} stated that in the post liberalization era, and subsequent to the notification of TPA-Health Services Regulations-2001, few companies were licensed to act as TPA-services to strengthen and encourage the health insurance and increase its penetration. The idea was to bring in more professionalism in claims management, facilitate cashless services to the policy holders and to reduce the claims ratio. The cashless services to the consumer are an impetus to the growth of health insurance as it saves the consumer from the problems of reimbursement of medical claims. As on today there are 25 licensed Third Party Administrators.

Jagendra Kumar (2005)\textsuperscript{38} defined that Third Party Administrators are the middlemen in the healthcare delivery chain, which links physicians, hospitals, clinics, home health, long-term care facilities and pharmacies. He expected that based on the rate of growth of insurance premiums in just one year, it is possible that health insurance will grow much more in coming years, giving more business to the TPAs. He added that demand for hospital care has been increasing substantially with the new TPA system, and that is in the hospitals’ interest to move over to the TPA system. Claims under the health insurance are settled by the Third Party Administrator but the experience with the agency has not been satisfying to the policyholders.

Pratik Priyadarshi (2009)\textsuperscript{39} reported that with the advent of the Third Party Administrators, it was assumed that the solution of all the ills pervading the health sector in the insurance companies had arrived. He added that the healthcare providers and the TPAs could ensure that the standardization of
cost and prices is done, thereby eliminating the scope of variable pricing for the insured and non insured people. In fact we are now communicated that probably there is a process of this sort already in practice.

1.2 NEED OF THE STUDY:

In sum, it can be safely said that TPAs can potentially play an important role in making insured healthcare availability smoother. But it can not be seen a paracea for all the problems of the health sector, nor it can be blamed for these problems. Ultimately, of course, the role of TPAs in the country has to be measured against the basic parameters of the functional health sector. IRDA has defined the role of TPAs as one of managing claims and reimbursement. Their role in controlling costs of healthcare and ensuring appropriate quality of care is less well-defined. The introduction of TPAs will benefit both the insured and the insurer. While the insured is benefited by service, insurers are benefited by reduction in their administrative costs. But the questions in everybody's mind are—what does a TPA do? Who can be a TPA? What is his source of revenue? How does he benefit the insured? Whether the new system is an improvement over the previous one? Keeping all these in view the topic entitled, “A CRITICAL APPRAISAL OF THE THIRD PARTY ADMINISTRATOR SYSTEM” (with special reference to Health Insurance Industry) has been selected for the present study.

1.3 PLAN OF THE STUDY

The proposed study is an exploratory descriptive research and has been carried out in the following manner.

1.3.1 OBJECTIVES:

The main objective of the present study is to appraise the TPAs in Health Insurance Industry; the researcher has framed the following objectives to make the study more scientific and systematic:

1. To understand the role of Health Insurance in Healthcare System in India.
2. To understand the role and importance of TPAs in the emerging health insurance market in India.

3. To study the functions and procedures of TPAs in Health Insurance:

4. To study the benefits provided by TPAs to Indian Health Insurance Industry.

5. To analyze the problems generated in Indian Health Insurance Industry due to entry of TPAs from the perspectives of Insurance Companies, Hospitals and Insured Patients.

6. To examine issues and challenges faced by TPAs in Indian Health Insurance Industry.

7. To offer suggestions on the basis of the study for overcoming the problems in order to ensure smooth performance of TPAs in Health Insurance Industry.

1.3 RESEARCH METHODOLOGY:

To make the findings of this research more reliable and valid, the researcher has used both types of information i.e. primary as well as secondary. Being an exploratory research, the primary data has been collected from the purposively selected respondents.

The first hand information has been collected by administering self structure questionnaire and conducting structural interviews of the concerned respondents. Personal contacts and mail also utilized for the fulfillment of the research objectives. For administering the questionnaire, the following three categories of sampling units have been included in the study, which have been conveniently selected on the basis of their availability and reach: (1) Policyholders (2) Healthcare Providers (3) Insurance Companies
The present study examines the views of policyholders, insurance providers and healthcare providers about the different roles played by TPAs in standardizing treatment norms and cost of procedure assessment of the performance etc. The study used three questionnaires. One each for policyholders, healthcare providers, insurance providers. All the three instruments were pilot tested. The basic objective of pilot test was to examine the feasibility of obtaining unbiased responses to various questions. The results of the pilot gave useful insight into the final design of the questionnaire.

The secondary data has been collected from: magazines, newspapers, journals, reports and internet etc. The time taken for the study was restricted to the post IRDA (1999) to (March 2008). The present study is restricted to Agra District.

The findings of the research have been tabulated, analyzed and interpreted using different statistical tools like average, weighted average. The data has been analyze and processed with the help of computer packages.
REFERENCES


34. The Economic Times (2003): “Insurers May Get More Room to Invest” August p. 6..


37. IRDA- Annual Report (2004-05)
