3.1 Evolution of Third Party Administrators (TPAs) in Health Insurance Sector

After the nationalization of the insurance industry in the year 1956, it was considered as a landmark and a milestone on the way to the socialistic pattern of the society that India had chosen.1 The Insurance Regulatory and Development Authority (IRDA) bill, passed by the parliament in the year 2000, allowed the entry of various private insurance companies into the insurance industry, and thus, there have been significant efforts made by the public and the private health insurance companies to provide access to effective health insurance coverage. The multinational insurance company were also keenly interested in emerging insurance industry because their home markets were almost saturated while emerging countries had low insurance penetrations and high growth rates.

Before proper regulation, the insurance industry was uncontrolled, unmanaged and unorganized. In the absence of effective regulation, the healthcare costs were inevitably rising high and it was common people who were suffering the most as healthcare become almost unaffordable. There was inequitable distribution of healthcare delivery systems with low quality and high cost. And the policies launched by the insurance companies were also not so attractive.

Earlier, only the public sector insurance companies were dominating the entire health insurance industry. And the most popular, General Insurance Company (GIC) with its four subsidiaries, was offering Mediclaim policy, in which the policyholder
was required to make payments for hospital expenses and then submit the bill to the insurance company and wait to get reimbursed, which itself may take long time due to bureaucratic procedures involved in it.

As people expected hassle-free medical treatment and cashless services being provided by the insurance companies, but at the time of hospitalization, they first pay for the expenses and were only later reimbursed, depending on the sum insured and the coverage of diseases. Insurance companies have to deal with unregulated healthcare providers (hospitals) who work in an environment where there were no standards, quality benchmarks and treatment protocols, and where highly variable billing systems and significant price variations across the providers exists, reflected by the adverse claim ratios. It has also been observed that the hospitals tend to charge more from the patients covered by health insurance. And also in the absence of monitoring and control mechanisms, it was difficult to handle fraudulent claims.²

To implement effective and affordable services to the policyholders there were numerous challenges to overcome including the provision of a network of hospitals, access to general medication, administration of enrollment diagnosis, quality treatment, controlling fraud through claims process, providing an administration that would be capable of handling million of clients³ and settling the claims between the insurance companies and the hospitals.

It was to address such issues, the Third Party Administrator’s (TPAs) were introduced as an intermediaries to facilitate claims settlement between insurance companies and healthcare providers (hospitals), by Insurance Regulatory and Development Authority (IRDA) in the year 2001, through the notification on TPA health services regulations.
According to the Insurance Regulatory and Development Authority (IRDA) “TPA means a Third Party Administrator who, for the time being, is licensed by the Authority, and is engaged, for a fee or remuneration, by whatever name called as may be specified in the agreement with an insurance company for the provision of health services.”

Third Party Administrators (TPAs) are separate entities, licensed by Insurance Regulatory and Development Authority (IRDA) to undertake the implementation and administration of health insurance schemes. They act as a nodal agency, coordinating between insurance companies, insured members and the hospitals for rendering the services of cashless hospitalization, hassle-free claim-settlement and better services to the clients.

Figure 3.1.1 Relationship between the TPA, Insurer, Insured and the Hospital

Insurance Regulatory and Development Authority (IRDA) has also come up with Regulatory guidelines for Third Party Administrators (TPAs) to fulfill certain requirements and follow a code of conduct for best practices. Earlier, it were brokers
and agents playing a very similar role, but IRDA allowed TPAs to formally enter the market with set rules and regulations which was lacking for the agents and brokers, who charge the policyholders on their self-will with unfair trade practices and processing and creating false documents and claims against genuine member’s records.

In India, through the notification on TPA health services by Insurance Regulatory and Development Authority (IRDA) in the year 2001, around 23 TPAs were granted licence to operate in the country which increased to 29 in the year 2011-12. With their introduction, now the policyholders were not required to settle their hospital bills upfront and then make a claim with the insurer, instead, the insurers with the help of TPAs settles the hospital bills on behalf of the policyholders, who can leave for home without paying any charge.\(^6\)

### 3.2 Meaning/Characteristics of Third Party Administrators (TPAs)

The Third Party Administrators (TPAs) are the intermediaries between insurance companies, policyholders and the healthcare service providers (hospitals and nursing homes). They facilitate cashless services at the time of hospitalization for the policyholders, administers and settle claims for hospitals and policyholders on the behalf of the insurance companies and provide administrative support to the insurance companies for servicing their insurance policies. [Figure3.1.1]
The Insurance Regulatory and Development Authority (IRDA) has defined the Third Party Administrators as “an insurance intermediary licensed by the authority who, either directly and indirectly, solicits or effects coverage of, underwrite, collect charge premium from an insured, or adjust or settle claims in connection with health insurance, except as an agent or broker or an insurer.”

The arrival of Third Party Administrators (TPAs) as authorized entities in the Indian health insurance market dates back to 2001, when the Insurance Regulatory and Development Authority (IRDA) notified the regulations governing them. The regulation came into effect from the date of their notification i.e; 17th September 2001. The introduction of TPAs as intermediaries in the healthcare service chain was done with a view to ensure higher efficiency, standardization, providing cashless healthcare services to policyholders and increasing penetration of health insurance in the country. They are also potentially equipped to play a wider role in standardization of

Figure 3.2.1 Working Environment of TPAs
charges for various treatments and procedures, benefit management, medical management, provider network management, claim administration and maintaining a database of health insurance policies. \(^7\)

The basic role of TPAs is to function as an intermediary between the insurance company and the policyholder and facilitate the cashless-services. They are also responsible for providing an insurance company with highly specialized services to support the administration and management of their health insurance products. They also provide enrolment number, hospital network development and claim processing services to the policyholders on behalf of their insurers. For this service, they are paid a fee as a fixed percent of insurance premium as commission. This commission is currently fixed at minimum 6 percent of premium amount \(^8\) but the companies have the freedom to enhance the commission after negotiating with the Third Party Administrators (TPAs). [Figure3.2.1]

The idea behind bringing TPAs in health insurance sector was to reduce the high claim ratios by eliminating fraud cases. While TPAs network with hospitals and interactions with doctors is expected to reduce claims substantially and the insurance companies will also improve customer relationship through the TPAs.

Earlier the customers first incur expenditure on services provided by the hospitals and later submit their claims to the insurance company for reimbursement. With the introduction of TPAs, the customers could, avail the services on time by submitting proper documents. The claim is handled and settled by the TPAs, whereby the TPAs procure reimbursements from the insurance companies and directly pay the hospitals and settles the claim.

After the introduction of TPAs in 2002, the mediclaim policy became cashless
hospitalization benefit with payment made directly to healthcare providers. Prior to the coming of TPAs, it was the responsibility of patients claiming reimbursement, to submit bills directly to their insurer for payment. Cashless hospitalization allowed the TPA to prospectively guarantee payment to the hospital and thus, remove the burden of filing claims from the patients.

While call centre facilities and personalized financial planning tools are some of the innovative trends, experienced on the product front, the best thing to happen on the service front is the introduction of Third Party Administrators (TPAs) as they serve a vital link between insurance companies, policyholders and healthcare providers. The job of Third Party Administrators (TPAs) is to maintain a database of policyholders and issue identity cards with unique identification numbers to them. They also handle all the policy-related issues, including claim settlements for the policyholders.

A minimum capital requirement of Rs.10 million and a capping of 26% foreign equity are mandatory requirements for a Third Party Administrator as spelt by the Insurance Regulatory and Development Authority (IRDA). License is usually granted for a minimum period of three years. Ideally, The Third Party Administrators (TPAs) functions by collaborating with the hospitals, for the patients to enjoy hospitalization services on cashless basis. The introduction of Third Party Administrators (TPAs) is of great help and relief to the insurance companies, which have been searching for ways and means to get their management expenses in line with the specifications laid down by the Insurance Regulatory and Development Authority (IRDA).

Insurance companies outsource their administrative activities, including settlement of claims to Third Party Administrators (TPAs) who offer such services for
a cost. The insurers remunerate the Third Party Administrators (TPAs); hence, the policyholders receive enhanced facilities at no extra cost. Once the policy has been issued, all the records are passed on to the Third Party Administrators (TPAs) and all further correspondence of the insured is undertaken by the Third Party Administrators (TPAs) and not with the insurance companies.

The Third Party Administrators (TPAs) are expected to provide value-added services to the consumers, like arranging ambulance services, medicines and supplies, guiding policyholders for specialized consultation and providing information on 24 hour toll-free helpline numbers about the health facilities, hospitals, beds availability, organization of lifestyle management and well-being programmes.

With the arrival of Third Party Administrators (TPAs) in this arena, the insurance companies aim at ensuring higher efficiency, standardization of charges, greater awareness and penetration of health Insurance to a larger section of the people.

3.3 **Role of Third Party Administrators (TPAs)**

Third Party Administrators (TPAs) are the intermediaries who play an important role in health insurance market by bringing all components of healthcare such as physicians, hospitals, clinics, long-term facilities and pharmacies together. The creation of this new category of intermediary was the beginning of a new era in health insurance in India. These Third Party Administrators (TPAs) provide cashless services at hospitals, call centre support to policyholders, medical cost management and management of claims and reimbursements. Third Party Administrators (TPAs) develop network, manage finance and delivery of appropriate healthcare services to its clients.

Intermediation by Third Party Administrators (TPAs) ensures that
policyholders get hassle-free services; insurance companies pay for efficient and cost-effective services, and healthcare providers/policyholders get their reimbursements on time. By doing this, it is expected that Third Party Administrators (TPAs) would develop appropriate systems and management structures aiming at controlling cost, developing protocols to minimize unnecessary treatments/investigations, improve quality of services and ultimately lead to lower the insurance premiums.\(^\text{10}\)

**Following are the Primary Role of Third Party Administrators (TPAs):**

1. Enrolment and issuance of member ID Card.
2. 24 hours call centre services.
4. Claims-management.

**1. Enrolment and Issuance of Member ID card**

The Third Party Administrators (TPAs) receives the policies from the insurers along with the member details. They process this information and issue an ID card to the insured member in order to validate their identity at the time of admission.\(^\text{11}\)

**2. 24 Hours Call Centre Services**

Third Party Administrators (TPAs) provides assistance through its 24-hours call centre information regarding:-

a. The status of the claims on phone, fax or e-mail.
b. Information on coverage of treatments within the members benefit plan.
c. General questions regarding procedures and protocols.
d. Provide information related to network hospitals and their contact details.
e. Address grievances and complaints of customers.

3. **Pre-Authorization and Organizing Cashless Treatment**

Pre-authorization is a system of approval of treatment and guarantee of payment by Third Party Administrator (TPA) or an insurer to the treating healthcare provider for services rendered to the enrolled members of a pre-defined benefit plan.\(^{12}\)

The main objective of pre-authorization is cashless treatment for the enrolled member and ensuring quality of care within the parameters of cost containment to eliminate any potential risk to the patient. An attempt is made by the Third Party Administrators (TPAs) to control costs by examining whether services provided are medically necessary and at an appropriate level of care at a minimal cost.

Thus, the pre-authorization is an authorization issued by the insurance company or the Third Party Administrators (TPAs) specifying the value of the medical treatment that can be claimable under their insurance policy. To receive a pre-authorization, policyholder needs to submit duly filled-in pre-authorization form available at the hospital or Third party Administrators (TPAs).

Cashless treatment is a payment authorization or guarantee to the provider for cost of treatment rendered to the enrolled member. Cashless service relieves the members from upfront payment to the healthcare provider for the treatment which is covered in his/her benefit plan. The administrator settles the bill of the patient directly, once the authorization has been issued. The patient need not to pay for the hospital bills upfront in cash at the time of hospitalization, it will be paid by the Third Party Administrators (TPAs). The policyholder just needs to show the ID card at the hospital, if the policy is in force the Third Party Administrator (TPA) will arrange to make the payment directly to the hospital up to the amount of sum insured in the
policy. This is called Cashless hospitalization. After the amount is exhausted the policyholder must pay it from its own pocket.

4. **Claims-Management:-**

On the behalf of insurance companies, Third Party Administrator (TPAs) administers and settle-claims for hospitals and policyholders. Healthcare outsourcing and accuracy in health insurance claims processing are the key elements in improving turn-around time and claims throughput. This is achieved through high potential segments in healthcare outsourcing to the Third Party Administrators (TPAs) health insurance claims processing.

The target is to manage core processing cost drivers and generate significant financial improvements for the insurers overall plan performance. The health insurance claims processing services are driven by transactional efficiency. The Third Party Administrators (TPAs) helps in achieving maximum automation of claims resolution processes. They support new products and services by leveraging the existing legacy system.

The outsourcing of claims processing to the Third Party Administrators (TPAs) ensures cost and advanced process engineering savings that are critical to healthcare outsourcing and claims management functions and processes. The Third Party Administrators (TPAs) has a team of medical professionals and the technical staff to handle the claims management for the members enrolled with the insurance company.\(^{13}\) Largely the Third Party Administrators (TPAs) provide the following features in claims-management:-

a. Providing claims-management services that include complete evaluation of all claims, data entry and adjudication.
b. Facilitating better control and monitoring of claims funding processes.

c. All information on claim form captured in the software for complete reporting of information.

d. Access to claims, eligibility, enrolment, processing as desired by the insurance company.

e. Utilization and Case Management.

There are two methods for getting a claim under a health insurance policy:-

1. Cashless/Planned Hospitalization.


- **Cashless/Planned Hospitalization** -

1. In case of planned hospitalization, the policyholder initially informs the Third Party Administrators (TPAs) or insurance company about the date of admission in the hospital quoting their policy number and health ID Card at least 4-5 days in advance.

2. Obtaining pre-authorization for Cashless claims services and the form for intimation to Third Party Administrators (TPAs) is available with the admission counter of the hospitals.

3. The patient has to fill up the form carefully as any incorrect information may lead to rejection of pre-authorization.

4. The medical condition of the patient or the requirement of any surgical procedure is filled up by the doctor attending the patient. The doctor must be briefed correctly about the patients history otherwise it may again lead to the
rejection of pre-authorization by Third Party Administrators (TPAs).

5. In case of new policies, all pre-existing diseases are excluded. ‘Pre-existing diseases’ are the diseases/ailment/injury for which the policyholder had symptoms or were diagnosed and/or received medical advice/treatment within 48 months (4 years) prior to their first policy with the insurance company. These diseases are a consequence of any previous illness that has ever required or would require hospitalization/medical treatment and has been diagnosed prior to member’s enrolments. Pre-existing diseases are usually covered only after 3-4 continuous years of coverage with the same insurance company.

Therefore, at the time of signing pre-authorization form, the policyholder has to check that the doctor had not mentioned anything about condition which may lead to assume it for pre-existing.

6. The filled up form is then sent by the hospital authorities to the respective Third Party Administrators (TPAs) of the company for granting of pre-authorization of claim amount for hospitalization.

7. The Third Party Administrators (TPAs) carefully scrutinizes all the details such as: - policy number, validity of policy, sum assured, waiting period, pre-existing diseases etc, and after being satisfied sends the authorization of amount directly to the hospital.

8. After satisfying itself the Third Party Administrators (TPAs) will issue a pre-authorization letter/guarantee of payment letter to the hospital/nursing home mentioning the sum guaranteed as payable and also the ailment for which the person is seeking to be admitted as a patient.

9. And then, Ultimately the doctor treats the customer or policyholder till
discharge and after the completion of the treatment sends the treatment bill and discharge voucher to the Third Party Administrators (TPAs) stating the cost. The Third Party Administrator (TPA) then submits the claim to the insurance company and the insurer reimburses the amount. This is called Cashless Hospitalization or Cashless Services.

10. The Third Party Administrators (TPAs) has the right to deny the pre-authorization, if he is not satisfied with the documentation.

11. Unless, the Third Party Administrators (TPAs) gives the pre-authorization letter to hospital, the hospital will not treat as Cashless claim. So, the insured must vigorously follow up with the Third Party Administrators (TPAs) for giving the authorization letter.

12. If the letter from Third Party Administrators (TPAs) is not received or if they deny then the insured must first pay for the expenses from his pocket and then lodge a claim to the Third Party Administrator (TPA)/insurance company.

13. In case of planned hospitalization, it is easier to get pre-authorization since the insured has ample time to follow-up with the Third Party Administrators (TPAs). The problem comes in emergency hospitalization. Here, time is of essence. The hospital will not start treatment unless he receives authorization from Third Party Administrators (TPAs) or cash from the insured.

14. This creates a panic situation and many times the insured are forced to pay from their pocket and thereafter claim the amount from Third Party Administrators (TPAs)/insurance company in normal course due to emergency. In many cases, it has been seen that Third Party Administrators (TPAs) delay the process of authorization so that the customer pays from his
pocket and then claims reimbursements.

15. Generally the Third Party Administrators (TPAs) grant authorization for a particular amount. If the cost of treatment exceeds that amount the patient must give it from his own pocket and then claim reimbursement from the insurance company if it is within the policy limits.¹⁴

If the hospital where hospitalization is planned is on approved list then the Third Party Administrators (TPAs)/insurance company will give the authorization, which means that the hospital is getting the instructions to provide treatment and send the bills for payment to them. This is a case of Cashless Settlement.

If the hospital where hospitalization is planned but is not on approved list then they will give the authorization to go ahead with treatment at that hospital. In this case, insured makes the payment and then submits the bills to the Third Party Administrators (TPAs) for reimbursements. It means that the treatment is approved but it is not a case of Cashless Settlement.

❖ **Non-Cashless/Emergency Hospitalization:-**

   In an emergency, the insured should be taken for treatment to any hospital, at the earliest, to save his life. It is the duty of the insured or his relatives/friends to contact the insurance company/Third Party Administrators (TPAs) on phone/writing about the claim within the seven days of hospitalization. The notice should include the following:-

   a. Name of the patient

   b. Policy number

   c. Health ID card number
d. Address of patient

e. Name of the attending doctor

f. Name of hospital

g. Nature of illness/injury

As and when permitted by doctors the patient may have to be moved to appropriate Third Party Administrators (TPAs) approved hospital. The general opinion of Third Party Administrators (TPAs) is that the treatment should not be in a very small hospital (less than 15 beds) as the facilities may not be up to the mark.

So, in this case the Third Party Administrators (TPAs) may make direct payment to the hospital, where the patient was taken in emergency or they may ask the insured to make the payment to the hospital and submit the bills for reimbursements. If after few days patient is moved to Third Party Administrators (TPAs) approved hospital then bill of that hospital will be paid by the Third Party Administrators (TPAs) directly. And after the insured is discharged the final claim must be submitted to the company within 30 days from the date of discharge.

The following documents must be attached along with the prescribed claim form of the company:-

1. Original prescription of doctor.

2. Prescription of doctor advising for hospitalization/tests.

3. Original reports of all diagnostic tests along with the original bills like X-rays, ECG, Scan, MRI, Pathology etc.

4. Detailed itemized bill from the hospital for bed charges, OT charges (Operation Theatre), Medicines and details of any other charges that the
hospitals have levied.

5. Surgeons certificate stating nature of operation along with bill.

6. All bills for medicine purchased during the previous 30 days before hospitalization and after discharge.

7. Hospital/Receipts/Bills/Cash memos in Original (Copies of charge slips if payment is made by credit card) duly stamped.

8. Discharge certificate from hospital.

9. Certificate from the doctor that the patient is fully cured and is able to resume his work.

10. In case of domiciliary hospitalization a report from qualified nurse who attended the patient in his residence supported by a certificate from medical practitioner.

11. Copy of current insurance policy and previous policy.


13. The claim form must be filled correctly and these should not be any overlapping of information otherwise it may lead to rejection of claim.

14. Since all the original documents are submitted along with the claim form the policyholder must keep a copy of the claim form and all the original documents submitted along with the claim form. At the time of submitting the claim form he must obtain an acknowledgement from the insurance copy about the receipt of the documents to serve as a proof of submission.
15. The policyholder must follow up with the insurance company about the status of the claim after some time as the insurance company may require some other documents or clarifications from the hospital about the charges.

16. The insurance company if finds everything in order shall make payment for claim. Many times it deducts some amounts from the bill which are not authorized under the policy or which may seem to be in excess.¹⁵

Recently in 2006, some Third Party Administrators (TPAs) have introduced 5% concept under which insured pays 5% of the hospital bill and 95% of the bill is to be paid by the Third Party Administrators (TPAs). This has been done as hospital bill may be having some expenses which are ultimately not payable by the insurance company. If during finalization of the claim, it is found that 100% of hospital bill is payable then this amount of 5% which is being paid by insured will be paid by the Third Party Administrators (TPAs) to the insured.¹⁶

The insured pays for the services of Third Party Administrators (TPAs) and it is included in the premium charged by the insurance company. Some insurance companies offers discount of 5-6% on premium if the policyholder does not require Cashless facility through Third Party Administrators (TPAs) and agree to submit claim bills directly to the insurance company.¹⁷

✦ The other specialized activities of Third Party Administrators (TPAs) include:-

  a. Provision of MIS (Management Information System) reports to insurance companies and regulators.

  b. Grievance Redressal Mechanism.
c. Providing services to health schemes of government organizations.

d. Pre-insurance medical examination for health and life companies.

e. Any value-added health services bundled by the insurer to the policyholder including health-check, Doctor on call, health talks and discussions, preventive programmes.

f. Claim-processing of life insurance companies health policies (where pre-insurance medical examination is not done by the same Third Party Administrator (TPA).

g. Administration of emergency medical assistance.

h. Personal accident policies for medical component.

i. Critical illness policy claim processing for life insurance companies.

j. Verification, Investigation, Fraud Mitigation for health claims.

The Third Party Administrator (TPA) undoubtedly aims to give the health insurance industry the required boost in India. And the policyholders have the privilege of expressing their grievances to the concerned insurance company or at the consumers court if they are not satisfied with the services of a Third Party Administrator (TPA). But the policyholders are in a clear advantageous position when they abide by the guidelines. Here are certain checklists for the policyholders for availing cashless services from the Third Party Administrator (TPA):

1. The policyholder should contact the Third Party Administrators (TPAs) if they have not received the health insurance ID cards from them and the ID card and related documents must be kept in a safe place.

2. Before getting hospitalized, the insured must check the name of the
concerned Third Party Administrator after receiving the ID cards.

3. In case of a fresh policy/renewed policy, the policyholder must check the policy enrolment with the Third Party Administrator, failure of which can result in the rejection of cashless authorization request.

4. The policyholders must keep the number of Third Party Administrators (TPAs) in a prominent place to contact them easily and immediately.

5. The policyholders should always take their health card and list of network hospitals along with them while traveling for any medical emergencies.

6. The policyholder must lodge an F.I.R. in case of an accident.

7. Obtain pre-authorization form from insurance helpdesk/treating hospital, three to four days prior to the admission for planned hospitalization.

8. Pre-authorization form must be filled in by the treating doctor.

9. After receiving the written authorization receipt from Third Party Administrator, the insured can avail cashless treatment at the hospital.

10. The policyholder must fill the claim form very carefully. Any wrong information ignorantly may lead to rejection of claim or reduction in claim amount.

11. Generally the Out-Patient Department (OPD) consultation and investigations done before hospitalization are not covered by the medical insurance.

12. The insured should leave back all the original documents and sign the claim form with the hospital at the time of discharge. All claims of the
discharge from the hospitals will be processed by the Third Party Administrator (TPA) directly. The policyholders must directly file all original documents, bills and prescription for reimbursements of all their post discharge expenses.  

❖ **Pre and Post Hospitalization Expenses:**

Pre-hospitalization expenses means relevant medical expenses incurred during a period up to 30 days prior to hospitalization/domiciliary hospitalization for a disease/illness/injury, for which the hospitalization is required for more than 24 hours.

Post-hospitalization expenses means relevant medical expenses incurred during the period up to 60 days after the date of discharge from the hospital, due to a disease/illness/injury by an accident.

13. If the policyholder is suffering from any critical disease or condition while taking a health policy, it will not be covered under the scheme for medical treatment. Certain major surgical procedures are not covered during the first year of the health insurance policy.

14. The policyholders must make payments to the hospital for the expenditure over and above the Third Party Administrators (TPAs) approved limit.

15. While getting admitted into a non-network hospital, the insured must check that it fulfills the requirement criteria. Generally a hospital/ nursing home must have 15 in-patient beds, fully equipped operation theatre and fully qualified staff.
Network/Non-Network Hospitals:-

Network hospitals are those with which the insurance companies/ Third Party Administrators (TPAs) have a tie-up arrangement for cashless claim processes. When the insured avail the cashless treatment in any of these network hospitals, the insurance company/TPA settles the claim directly with them.

Non-network hospitals are the ones with which the insurance company/TPA do not have a cashless tie-up arrangement. When an insured, avail treatment in non-network hospitals, they then have to settle the bills themselves and then submit the relevant documents and bills to the insurance companies/ Third Party Administrators (TPAs). After the completion of the procedure the claim amount is subsequently reimbursed based on policy terms and conditions.

16. Large claims are rejected due to pre-existing disease whether known or unknown to the insured. The insured should be careful while giving details to their consulting doctor about their previous health history. If the doctor writes anything about the pre-existing disease simply pre-existing conditions, the claim may be rejected.

17. The policyholder should always give the notice of claim to the insurance company/Third Party Administrators and for any query contact local Third Party Administrator (TPA).

18. The policyholders are protected by Insurance Regulatory and Development Authority (IRDA) policyholder protection regulation 2002. After submitting the complete documents as required by the insurance company, they are bound to settle the claim or reject the claim within a period of 30 days.
19. The policyholders may complain the insurance ombudsman if the insurance company delays the payment of claim or can approach the grievance cell of Insurance Regulatory and Development Authority (IRDA).

20. The policyholders should not insist upon admission at the hospital merely for investigation, evaluation or health check-ups, as these are not approved by Third Party Administrators (TPAs).

3.4 Exclusions in Health Insurance Policies

The health insurance exclusions which are not payable under most health insurance policies and for which the health insurance companies do not make any payment as per the policy, in respect of any expenses incurred by the insured person for the treatment are as follows:

1. **Pre-existing diseases:** A pre-existing disease is a medical condition under which the health insurance companies do not pay for the treatment. However, many companies have specific waiting periods after which pre-existing diseases get covered, provided the policy renewals have been continuous and without any break.

2. **Certain Diseases:** The expenses on the treatment of diseases such as Cataract, Benign Prostatic Hyperthrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal Disease, Fistula in anus, Piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout and Rheumatism, Calculus diseases, Joint replacement due to Degenerative Condition and age related Osteoarthritis and Osteoporosis are generally not payable until a
specific period of time, which differs from company to company. The specific diseases may also differ with the company.

3. **Resulting from War**: - Treatment for injuries or diseases directly or indirectly arising from invasion of a foreign enemy, or due to war like operations, will not be payable by the health insurance company.

4. **Dental Care, Hearing and Vision care**: - For most of the parts in the country, these are not covered as these do not require hospitalization, and in India, health insurance is mainly associated with the charges for treatment in a hospital. So unless, hospitalization is required, these are not payable.

5. **Cosmetic surgery**: - Cosmetic surgery does not affect the life of an individual. It’s main role and benefit lies only in external looks and beauty, which are not life threatening. Hence, cosmetic surgery of any kind, including botox, liposuction etc. are not payable by the health insurance company. And now circumcision surgery is considered cosmetic surgery under most health insurance care plans and is not covered. Circumcision, plastic surgery will be payable only if it forms a part of the treatment of an illness.

6. **Abortion**: - As there is still a debate going on, as to whether to legalize abortion or not and if it should be payable, abortion is excluded from reimbursement, until a consensus is reached and a law is made legalizing abortion in India.

7. **Alternative therapies**: - These include acupressure, acupuncture, yoga, massage, aromatherapy, reflexology, naturopathy and all those...
therapies that do not form a part of conventional medicine. These are not covered under health insurance care.

8. **Diagnostic Charges**: - Charges incurred at a hospital or at a nursing home primarily for diagnosis; including x-rays or laboratory examinations, which does not lead to the conclusion of the existence or presence of any ailment, sickness or injury, for which confinement is required at a hospital or a nursing home, will not be payable.

9. **Treatment for pregnancy**: - Any treatment arising from or traceable to pregnancy including Caesarean section, is not payable under health insurance policy.

10. **The additional charges**: - Any kind of service charge, surcharge, admission fees or registration charges levied by the hospital is not reimbursed under health insurance policy.

11. **Additional Supplements**: - Expenses on vitamins and tonics that do not form a part of treatment for injury or disease, will not be paid by the health insurance company. But if these supplements do form a part of the treatment for a specific illness for which the person has been admitted into the hospital, and if it is certified by the attending physician, then it will be payable.

Thus, it is important to understand the exclusions mentioned in the health insurance policy carefully, especially the small wordings that may be disguising the exclusions. It is important to always keep a note of those ailments that are not covered under the health insurance policy so as to claim for it in the near future.
**Critical Illness Insurance:** - Critical illness insurance or critical illness cover is an insurance product, where the insurer is contracted to typically make a lump sum cash payment if the policyholder is diagnosed with one of the critical illnesses listed in the insurance policy. There are 37 critical illnesses mentioned below:

1. Major Cancers
2. Heart Attack
3. Stroke
4. Coronary Artery By-pass Surgery
5. Kidney Failure
6. Aplastic Anaemia
7. Blindness (Loss of Sight)
8. End Stage Lung Disease
9. End Stage Liver Failure
10. Coma
11. Deafness (Loss of Hearing)
12. Heart Valve Surgery
13. Loss of Speech
14. Major Burns
15. Major Organ / Bone Marrow Transplantation
16. Multiple Sclerosis
17. Muscular Dystrophy
18. Paralysis (Loss of Use of Limbs)
19. Parkinson’s Disease
20. Surgery to Aorta
21. Alzheimer's Disease / Severe Dementia

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22. Fulminant Hepatitis
23. Motor Neurone Disease
24. Primary Pulmonary Hypertension
25. Terminal Illness
26. HIV Due to Blood Transfusion and Occupationally Acquired HIV
27. Benign Brain Tumour
28. Encephalitis
29. Poliomyelitis
30. Bacterial Meningitis
31. Major Head Trauma
32. Apallic Syndrome
33. Other Serious Coronary Artery Disease
34. Angioplasty & Other Invasive Treatment For Coronary Artery
35. Progressive Scleroderma
36. Systemic Lupus Erythematosus with Lupus Nephritis
37. Loss of Independent Existence

Out of these 37 critical illnesses only 20 are covered by some of the health insurance companies. The 20 critical illnesses covered are as follows:

1. Cancer
2. First Heart Attack
3. Coronary Artery Disease
4. Coronary Artery bypass surgery
5. Heart Valve Surgery
6. Surgery to Aorta
7. Stroke
8. Kidney Failure
9. Aplastic Anemia
10. End Stage Lung Disease
11. End Stage Liver Failure
12. Coma
13. Major Burns
14. Major Organ/Bone Marrow Transplantation
15. Multiple Sclerosis
16. Fulminant Hepatitis
17. Motor Neurone Disease
18. Primary Pulmonary Hypertension
19. Terminal Illness
20. Bacterial Meningitis

3.5 Specialized functions of Third Party Administrator’s

The Third Party Administrators (TPAs) keeps and maintains all the records of medical insurance policies of an insurer, issues identity cards to all the policyholders, which they have to show to the hospital authorities before availing any services from them. In case of a claim, policyholders have to inform the Third Party Administrators (TPAs) on a 24 hour toll-free number and after informing the Third Party Administrators, the policyholder will be directed to a hospital where the Third Party Administrators has a tied-up arrangement. However, policyholders have the option to be admitted at any other hospital of their choice, in which, payment will be on reimbursement basis.

The Third Party Administrators (TPAs) pays for the treatment, and issue an
authorization letter to the hospital for the admission of the policyholder in the hospital. At the time of discharge, all the bills are sent to the Third Party Administrators (TPAs) while they are tracking the case of the insured at the hospital. Third Party Administrators makes the payment to the hospital and sends all the documents necessary for consideration of claims, along with the bills to the insurance company and the insurance company then reimburses the Third Party Administrators.

Third Party Administrators (TPAs) organize healthcare services by establishing networks with hospitals, general practitioners, diagnostic centers, pharmacies, dental clinics, physiotherapy clinics, etc. They sign a memorandum of understanding with insurance companies according to which they inform policyholders about the network of healthcare delivery facilities, various systems and processes for settling claims. Policyholders are enrolled and registered with TPAs for availing these services and in the event of hospitalization they are expected to inform the TPAs. The medical representative of TPA examines the admissibility of the case and accordingly informs the healthcare facility to proceed with the treatment.

The agreement between TPAs and healthcare facility provides for monitoring and collection of documents and bills pertaining to the treatment. Documents are audited and after processing sent to the insurance company for reimbursement. TPAs have the responsibility of managing claims and getting reimbursements from the insurance company and paying the healthcare provider. In some cases they pay the healthcare provider from the corpus amount without getting reimbursement from the insurance company.

With the routing of reimbursements 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, with the
passage of time, it is the providers who now face the risks of not getting reimbursements from TPAs. Besides, once patients are admitted and if treatment costs exceed the sum insured, providers may not get the difference in treatment cost and the sum-insured. As part of the agreement between healthcare providers and TPAs, some providers insist on getting a part of the expected costs as advance.

TPAs generally have in-house expertise of medical doctors, hospital managers, insurance consultants, legal experts, information technology professionals, and management consultants. The backbone of TPAs is management information system (MIS) whereby the TPAs provide management information reports to the insurer regarding the information on enrolment, pre authorization, claims-settlement & reimbursement and other information required by the insurer. Analysis of data regarding hospital admissions across the network (this also helps in identifying health need and effective treatment protocols), analysis of treatment, tracking documents pertaining to each case, and analyzing shortfalls in claims are essentials of claims management. TPAs also provide services to the corporate sector in designing and managing health benefit packages for their employees to suit the needs according to the nature of health risks which the employees face.

The major source of revenue for TPAs is fees charged for providing various services to the insurance companies and the companies pay the fee according to the volume and scope of services provided by them and is usually a fixed percentage of the premium collected from the enrolled. However, TPAs provide large number of services to the organizations for which the fee is paid by the organization directly. The services include:

1. **Benefit management:** TPAs help in designing appropriate health plans for
the corporate sector and insurance companies.

2. **Medical management:** This is basically disease management and involves the medical follow-up of the case. TPAs track the line of treatment and ensure genuine treatment.

3. **Provider network management:** This is the key task. TPAs need to negotiate with service providers regarding quality of case, credit facility, discounts, package pricing, priority appointments and admissions, etc. Periodic review and evaluation of the performance of service provider are also vital.

4. **Claims administration:** This involves the claim adjudication process. The task include: documentation, checking eligibility and coverage, claim submission and arranging payment for the service provider.

5. **Information and Data management:** TPAs can generate a lot of reports and database. This can be used as management tools for analysis and controlling costs and besides helping design new products.

The justification for introducing TPA services is that they help in minimizing moral hazard. For this purpose, TPAs follow each case in an individualized way. TPAs do comprehensive review of records and keep constant communication with 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.21

3.6 **Issues & Challenges before Third Party Administrators (TPAs)**

The Insurance Regulatory and Development Authority (IRDA) has paved the way for insurance intermediaries- The Third Party Administrators (TPAs), who are
expected to play a pivotal role in setting up managed care systems. Third Party Administrators have been set up to ensure better services to policyholders and to minimize the negative consequences of private health insurance. However, given the demand and supply side complexities of private health insurance and healthcare markets, Third Party Administrators face immense challenges. In the early stages of its development, Insurance Regulatory and Development Authority (IRDA) has defined the role of Third Party Administrators (TPAs) as one of managing claims and reimbursements; their role in controlling costs of healthcare and ensuring appropriate quality of care remains less defined.\(^2\)

The effectiveness of Third Party Administrators (TPAs) in managing claims and reimbursements depends on their bargaining power as compared with healthcare service providers. It is envisaged that Third Party Administrator’s (TPAs) can get better negotiated agreements with hospitals and medical practitioners and will introduce better monitoring system leading to lower claim ratios. However, in practice there are many challenges which Third Party Administrators face in achieving these goals. The management of claims and reimbursements in highly fragmented, unregulated markets and dealing with a large number of small sized healthcare service providers is bound to affect the revenue generation of Third Party Administrators (TPAs). Third Party Administrators (TPAs) will be required to employ medical management experts and managers who can negotiate deals with a large number of healthcare service providers. Since healthcare providers are not regulated and there is no information on various operational aspects of healthcare facilities such as occupancy rates, length of stay etc., negotiating rates and levels of quality of care will be a tough task.\(^3\)

There are certainly issues over operational aspects of the TPA system
including delays in pre-authorization approval and claim settlements.\textsuperscript{24} Third Party Administrators (TPAs) are bound to face a number of challenges such as maintaining a delicate balance between insurance company, healthcare providers and policyholders, serious pressure from the insurance companies to keep the claim ratio down, serious conflicts with healthcare service providers and to investigate and reduce the false claims.\textsuperscript{25}

According to IRDA guidelines, Third Party Administrators (TPAs) are not allowed to market health insurance policies, which will result in conflict of interest between the insurance company and TPA on one hand and between TPA and policyholders on the other. The system may create perverse incentives which give opportunities to healthcare providers, policyholders and TPAs to collude and TPAs may favor healthcare providers and policyholders in settling claims in order to attract more business. However, by not allowing TPAs to market insurance products, the health insurance sector will experience less participation of TPAs in areas such as consumer education and making them aware of differences in various policy options, which will discourage competition in the insurance sector and as a result the objectives of insurance reform will not be achieved.

Quality of healthcare is a critical issue in an unregulated private medical sector (Bhat 1999). Third Party Administrators (TPAs) are expected to develop a network of healthcare providers by following certain criteria such as minimum qualification of service provider, evidence that service providers follow basic minimum standards of care. However, TPAs face a number of challenges as the minimum standards of care are not defined, healthcare service providers have a much higher bargaining power and TPAs also have less influence on controlling the cost of care. Lack of standardization or accreditation system for hospitals also makes the concern of pricing
and billing serious. Billing systems differ from facility to facility. Most of the payments are cash based and less transparent. TPAs face difficulties in scrutinizing and processing claims and reimbursements using common standards as there are significant variations in charges across hospitals.26

Third Party Administrators (TPAs) face high operating risk of obtaining economies of scale necessary to break-even. Volumes are critical because the revenue generation of Third Party Administrators (TPAs) is linked to the number of policies they undertake to administer.

There occurs serious conflict of interest between the Third Party Administrators and the insurance companies because the insurance company demands less claims to be administered and processed by the Third Party Administrators but on the other hand (TPAs) try filing more claims in order to earn their commission, as their remuneration has been decided as fixed percentage of the policy premium.

It is also expected that with the introduction of TPA services, claim settlement process would be simplified. IRDA has suggested that all claims should get settled in seven days. In a case study done in Ahmedabad, it was observed that the insurance company takes on an average of 121 days to settle a claim (Bhat and Reuben, 2002). Outsourcing claim processing services may help in reducing the claim period but settling claims in seven days is a very ambitious target and Third Party Administrators (TPAs) will face major challenge in bringing down the settlement period to seven days. It has been observed that lack of proper documents related to treatment often results in deferred or non-payment of claims. Examination of exclusion clauses in the policy is imperative before authorizing admissibility and further treatment. Third Party Administrators (TPAs) have to sort these issues right at the time policyholder is seeking healthcare services. Winning the confidence of the policyholders and
maintaining the client-base is challenging for them. Attempts by insurance companies to tie-up with private hospitals through the system of TPAs in the past have yielded less success, as there is generally a mutual feeling of distrust. This will pose a major challenge for the Third Party Administrators (TPAs).\(^{27}\)

For the Third Party Administrators (TPAs) it is a challenging task to get an information on disease management and cost/pricing policy because there are large number of geographically dispersed healthcare providers and absence of uniform standards for them and without the involvement of healthcare providers the standards of care cannot be set.

It has been observed that a large section of consumers are unaware about the policy conditions and features that are incorporated in the policies. During medication they seek such claims for which they are not entitled leading to conflicts between the insurance companies and the policyholders. In order to avoid such situations and to protect the consumers, TPAs should provide such services so that the policyholder’s rights are protected with regards to claims.

Insurance Regulatory and Development Authority (IRDA) can revoke the license of Third Party Administrators (TPAs) if the financial performance of TPAs deteriorates at any point of time, as they stand as a guarantor of facilities and reimbursements between the insurer and the provider of healthcare services.

IRDA has the social responsibility aspect to make it mandatory for health Insurance Companies to have significant presence in rural areas. Hence, the Insurance Companies would require Third Party Administrator’s (TPAs) to set up infrastructures in rural areas and to handle the health needs of the rural people by providing them easy access to healthcare, medication and treatment of various diseases. Addressing
the rural segment will be a challenging task for the Third Party Administrators.

The growth and performance of TPAs in recent years indicate that the Third Party Administrators (TPAs) are going to influence the developments in the health sector and their influence would be determined by their activities and roles & responsibilities towards the Insurance Companies and customers. In spite of the services offered by the TPAs, the Insurance Sector still faces the challenges of institutionalizing the TPA service and there is substantial scope for improvements.  

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