CONCLUSION

Health Insurance Industry witnessed a sea change in the post reform period due to the emergence of private & foreign participation, hence, the Health Insurance Sector emerged as the most dynamic and fast evolving constituents of the Indian Insurance Industry. Health insurance is a mechanism to finance the health care needs of the people. Health insurance provides a cushion against medical emergencies and it is closely concerned with security. India is having the second largest population in the world and having a vast scope for health insurance market due to the emerging economy. Health insurance is now the second biggest segment after motor which contributes nearly 40 per cent of the total premium. About 12-13% of the Indian population is covered by health insurance, where private insurance coverage is approximately 3-4%. IRDA opened up the market for private and foreign companies to enter the insurance industry and with the passing of IRDA Act, 17 private health insurance companies, along with four subsidiaries of general insurance companies and four stand-alone health insurance companies have also entered into the field focusing on health insurance. Some of the life insurance companies along with Life Insurance Corporation (L.I.C.) are also offering health insurance policies. With the growth of new health insurance companies in the country & the increase in the customer base of both urban and rural population the companies were facing problems in customer relationship management & claims-management. A mechanism was needed to be developed which could be able to tackle and address these issues. Third Party Administrators (TPAs) was the only ways which could be able to provide some relief to the Insurance companies and the customers. Hence, there was a birth of Third Party Administrators (TPAs) who were regarded as facilitators in the coordination process between the health insurance companies and the policyholders.
To manage the problems arising out of increasing health care costs, the health insurance industry had assumed a new dimension of professionalism with the Third Party Administrators (TPAs). The Third Party Administrators 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 policyholder’s, administers and settle claims for hospitals and policyholder’s on the behalf of the Insurance Companies and provide administrative support to the Insurance Companies for servicing their insurance policies. The core service of a TPA is to ensure better services to the policyholders. 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.” The idea behind bringing TPAs in health Insurance Sector was to reduce the high claim ratios and eliminating fraud cases. 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. 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 license to operate in the country which increased to 29 in the year 2011-12. Introduction of TPA benefits both the insured and the insurer in the healthcare industry. While the insured benefits from the 24 hour customer services, cashless hospitalization and claims-settlement, the insurer is
benefited by reduction in administration cost and bringing down claim ratio by reducing false claims as well as standardizing treatment cost. Policy holders welcome introduction of TPA since they receive enhanced facilities at same cost. Once the policy is issued, all the records are passed on to the TPAs and all the correspondence of the insured remains with the TPA. TPAs issues identity cards with unique identification numbers to policy holders and handles all issues related to their claim settlements. They run a 24-hour toll-free number, which can be accessed from anywhere in the country. They have full-time medical practitioners under their employment who take decision whether the ailment is covered under the policy or not. In case of a claim, policyholder has to inform the TPA on a 24-hour toll-free line about the treatment and hospital. In case of cashless, he will be directed to a hospital where the TPA has a tied up network. However, the policyholder will have the option to join any other hospital of their choice, but in such case payment shall be on reimbursement basis. The claim for health insurance is classified into 2 categories:

• Cashless Hospitalization

• Medical Reimbursement

a) Cashless Hospitalization

Cashless hospitalization is a specialized service provided by an insurer wherein an individual is not required to pay the hospitalization expenses at the time of discharge from the concerned hospital. The settlement is done directly by the Third Party Administrators (TPAs) and their prior approval for the treatment is taken before availing the benefits under this option. Cashless hospitalization can be of two types:

• Planned Hospitalization: In planned hospitalization, the insured is aware of the hospitalization in advance. The insured can make a claim without paying any cash up
At the time of treatment, the insured is admitted to the hospitals, with which the Third Party Administrators (TPAs) have a tie-up across the country. The insured can get themselves admitted in these specified network hospitals and take treatment for the disease contracted without any cash payment to the hospital at the time of discharge. Later the claim is settled by the TPAs between the hospitals and the insurance companies. These are basically the Cashless hospitalization. Before hospitalization, policyholder has to get pre-authorization from TPA for hospitalization expenses. Policyholder does not pay anything for hospitalization once pre-authorization has been received. Hospitalization expenses for policyholder or his/her dependants will be borne by Insurance Company. Payments are made by the TPAs within 1 or 2 months of hospitalization. (Pre-authorization is an approval of treatment and the maximum amount that can be paid by the TPA- on behalf of an Insurance Company for the purpose of hospitalization. If hospitalization expenses goes above the approval limit, rest of the amount has to be settled by the policyholder.)

- **Emergency Hospitalization**: It is a sudden hospitalization that may be either an emergency or due to unforeseen circumstances. In short, hospitalization is not anticipated in advance. Under this, the insured has to bear the entire expenses incurred during hospitalization. After getting discharged from hospital, the insured can claim reimbursement. For availing benefits under this option, the insured has to approach the concerned TPA, fill the requisite form and satisfy all the requirements as mentioned. This includes submission of TPA card, policy paper, discharge summary, prescriptions, diagnostic laboratory reports, OPD treatment details etc. A sum is granted as reimbursement for treatment expenses. This could either be cashless or a non-cashless hospitalization. To avail cashless facilities, the insured or his relatives/friends are required to contact the Insurance Company/ Third Party.
Administrators (TPAs) on phone/writing about the claim within the seven days of hospitalization. As and when permitted by doctors the patient can move to the appropriate TPAs approved hospital. 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 post liberalization scenario, witnessed the inception of private and public health insurance companies providing various products & services to their customers. The evolution of Third Party Administrators (TPAs) is considered to provide services as an intermediary to the insurance companies, policyholders and the health care providers, to act as a facilitator of health insurance services between them. But with the passage of time, it has been observed that the TPAs are not been able to justify their role and there arouse a conflict of interest between the insurance companies, the policyholders and the health care providers regarding their role and functioning. The TPAs in order to provide benefits to the Insurance companies are evoking dissatisfaction and loss to the policyholders. During the course of interviews from the employers and employees of insurance companies regarding the role of TPAs in health insurance, there were alarming views expressed by them. One of the common concerns was the unethical practices by TPAs regarding the enhancement of claims submitted by the policyholders. The intention was to inflate the hospitalization bills for a reasonable return from them, while the TPAs were of the opinion that they were
faithful to the companies and policyholders regarding the claims and other services. Hence, in order to know the transparency of their working, there is a need to study the role of TPAs in the health insurance sector.

Allahabad District has been selected for study on purposive basis because it is one of the major cities of Uttar-Pradesh. The penetration of health insurance in Uttar-Pradesh is 2-3% and in Allahabad District about 0.25%. Allahabad is a developing city and an emerging economy for the health insurance sector to grow, it is the seventh most populous city in Uttar-Pradesh, with an estimated population of 3.7 million, where the agglomerated towns are developing, which demands hospitals and advanced medical facilities and allows more penetration for health insurance sector. And for this, almost all the Third Party Administrators (TPAs) are actively working and rendering their services in the sample area to the policyholders.

After the analysis of the study the primary data revealed that from the total respondents, 41% represented MD India TPA, 33% Raksha TPA and 26% Medi Assist TPA Company. It was observed that from MD India TPA Company, 79.59% respondents were satisfied with their services in the areas of Enrolment number issuance, ID card facilities, Customer support services, Cashless hospitalization Facilities and claim-processing and settlement while 20.40% were dissatisfied. From Raksha TPA Company, 67.08% respondents were satisfied in the areas of Enrolment number issuance, ID card facilities, Customer support services, Cashless hospitalization Facilities and claim-processing and settlement while 32.91% were dissatisfied. From Medi Assist TPA Company, 49.20% respondents were satisfied in the areas of Enrolment number issuance, ID card facilities, Customer support services, Cashless hospitalization Facilities and claim-processing and settlement and 50.79% were dissatisfied. The analysis indicates that from MD India TPA Company the
majority of the respondents were satisfied with the services as compared to Raksha TPA Company and Medi Assist TPA Company. The respondent’s satisfaction provides sufficient grounds to state that after the inception of Third Party Administrators (TPAs) in the health insurance sector, the procedure of settling health insurance claims and providing medical services became systematic, organized and easier for the policyholders.

The primary information reveals that from MD India TPA Company majority of the respondents were satisfied in the area of Enrolment number issuance, while from Raksha TPA Company majority of the respondents were highly satisfied, whereas from Medi Assist TPA Company majority of the respondents were moderately satisfied in the area of Enrolment number Issuance. The primary information reveals that from MD India TPA Company majority of the respondents were highly satisfied in the area of ID card facilities, while from Raksha TPA & Medi Assist TPA Company majority of the respondents were moderately satisfied in the area of ID card facilities. The primary data findings indicate that from MD India TPA Company majority of the respondents were moderately satisfied in the area of 24 hour customer support services, from Raksha TPA Company majority of the respondents were highly satisfied, while from Medi Assist TPA Company majority of the respondents were satisfied in the area of 24 hour customer support services. The primary data reveals that from MD India TPA Company and Raksha TPA Company majority of the respondents were satisfied in the area of Cashless hospitalization facilities, while from Medi Assist TPA Company majority of the respondents were highly satisfied in Cashless hospitalization services. The primary data finding reveals that from sample MD India TPA Company and Raksha TPA Company majority of the respondents
were highly satisfied in the areas of claim-processing and settlement while from Medi
Assist TPA Company majority of the respondents were moderately satisfied.

The secondary data revealed that during 2011-12, the TPAs received total
37,83,261 claims, out of which 83.85% of the claims were settled within one month,
which is an improvement when compared to the previous years. In 2010-11, the TPAs
received total 36,41,584 claims and settled 75.39% of the claims within one month
while in 2009-10 they received total 33,65,940 claims and settled 69.76% of the
claims within one month.

The secondary data indicated that during 2011-12, the sample TPA company
MD India settled the maximum numbers of claims which stood at 101.05% within one
month, which reflects their work efficiency as compared to the other sample TPA
companies as Raksha TPA settled 93.49% of the claims within one month while Medi
Assist TPA settled 80.92% of the claims within one month.

Regarding claim-processing and settlement, the primary information indicates
that majority of the respondents were satisfied as the sample TPAs were able to settle
their health claims within 1 month, the secondary information too revealed that
majority of the claims were settled by the sample TPAs within 1 month in the year
2011-12. From MD India TPA Company, 83.67% of the respondents claims were
settled within 1 month while the secondary information revealed that in the year
2011-12, 101.05% of the claims were settled within 1 month by them. From Raksha
TPA Company, 78.48% of the respondents claims were settled within 1 month while
the secondary information revealed that in the year 2011-12, 93.49% of the claims
were settled within 1 month. From Medi Assist TPA Company, 76.19% of the
respondents claims were settled within 1 month while the secondary information

(197)
revealed that in the year 2011-12, 80.92% of the claims were settled within 1 month by them.

One of the important services provided by Third Party Administrators (TPAs) is the claim-processing and settlement to the policyholder’s. On the analysis of primary data regarding the sample TPA Companies (MD India TPA Company, Raksha TPA Company and Medi Assist TPA Company) it was observed that the sample companies were able to settle overall approximately 80% claims within 1 month, 11.66% claims between 1-3 months, 6.25% claims between 3-6 months while remaining 2.08% were settled in more than 6 months. Hence, the policyholder’s were satisfied with the services of claim-processing and settlement by the sample TPAs. This provides an ample evidence to state that the role of Third Party Administrators (TPAs) are justified in providing health care services to the policyholders.

**Improvements in Services Expected from the Third Party Administrators (TPAs):**

In spite of the policyholders being satisfied with the services of the Third Party Administrators (TPAs), there are areas where improvements were expected from them in order to enhance the quality of services in the areas of Enrolment number issuance, ID card facilities, Customer support services, Cashless hospitalization Facilities and claim-processing and settlement. From Medi Assist TPA Company majority of the respondents expect improvement in their services as compared to the other two sample TPA companies.

1) In enrolment number issuance and ID card Facilities, the policyholders expect quick and timely issue of the enrolment number and ID cards and demand online web access for E-cards and information on enrolment.
2) In customer support Services, it is expected from the Third Party Administrators (TPAs) to provide 24*7 toll-free helpline services, quick response for customer queries, Well-trained & experienced executives should handle the customer’s grievances, detailed information about the network and non-network hospitals to provide hassle-free hospitalization services at all locations of client operations, provide claims status (cashless, reimbursement and payments), provide call-centre service in English as well as Hindi languages to the insured, online assistance to the customers and timely redressal of customer’s grievances.

3) Regarding Cashless hospitalization facilities, the Third Party Administrators (TPAs) should provide easy access to the network hospitals for planned hospitalization; the network hospitals should be well maintained and should have latest and modern facilities for treatment of the insured, proper standardized documentation, quick approval of pre-authorization/guarantee of payment request, Online filling of forms, assistance in providing ambulance services during emergency, proper arrangement of medical services and experienced and qualified staff to ascertain the nature of ailment and verifying the eligibility of the insured person.

4) Regarding Claim-processing and settlement, it is expected that there should be less administrative procedures and delays, standardized billing patterns, Online assistance to the customers, the TPAs should monitor and co-ordinate the delivery of healthcare services in such a manner so that the unnecessary costs & irrelevant medical treatment is eliminated, there should be timely & speedy processing and settlement of the claims; whether a policyholder is treated from a network or a non-network hospital.
After the survey of policyholders it was necessary to seek the opinion of the health insurance companies, who are the appointing authority of Third Party Administrators (TPAs). The selected company consisted of public and private sector organisations, including two public sector and two private sector health insurance companies. The selected public sector health insurance companies were:- National Insurance Company Limited and The New India Assurance Company Limited while the selected private sector health insurance companies were:- Bajaj Allianz General Insurance Company Limited and Reliance General Insurance Company Limited. The health insurance companies were selected on the criteria of hiring the services of maximum number of TPAs, number of policyholder’s insured, claim-settlement and premium generated. The information was gathered from the top-level management through interviews and discussions during the survey. Besides the interviews, various conversations were being held with middle level management to know their opinion about the functioning of TPAs. The Third Party Administrators (TPAs) provides the services of premium collection, maintaining the records of the insured, data and information management, pre-authorization and organizing cashless treatment and claims management for the health insurance companies.

Claim-settlement is one of the important aspects in the services provided by the Third Party Administrators (TPAs). On the analysis of primary data, it was observed that in case of public sector health insurance companies, the claim-settlement ratios were high while in private sector health insurance companies the claims ratio were comparatively low. The analysis reveals that the public sector health insurance companies were somewhat satisfied with the claim-settlement services of the Third Party Administrators (TPAs), the reason attributed to it were the social welfare objective of the public sector health insurance companies and the high and
prompt claim-settlement by the TPAs thereby paying the huge claim amount to the policyholders. The policyholders were satisfied for they opined that their claims were duly met within time. While the private sector health insurance companies were moderately satisfied with respect to the claim-settlement services provided by the TPAs, because the companies objective of profit maximization and customer service were duly met but it was observed that the customers were less satisfied as they believed that their claim-settlement were not in conformity with the due claim amount. Thus, it can be concluded that the public sector health insurance companies expect improvements in the services of Third Party Administrators (TPAs) to enhance the scope of efficiency in their work performance for their prolong existence in the health insurance industry and high growth prospects in the future years to come.

Other Suggestions:-

From the interviews, discussions and observations made during the course of survey there were grievances by the respondents regarding the services provided by the Third Party Administrators (TPAs). In spite of the best efforts by the TPAs the following suggestions will assist in enhancing their efficiency:

1) The Third Party Administrators (TPAs) should make efforts to raise the awareness about their role and services amongst the policyholders. They should provide claims services to the policyholders who have not opted for cashless facilities and settle the claims of the policyholders who avail treatment from non-network hospitals.

2) They should abide by the rules and regulations, guidelines and notifications issued to them by the Insurance Regulatory and Development
Authority (IRDA) from time to time, and follow proper code of conduct in carrying out their activities.

3) A periodic review should be undertaken by the IRDA, in order to bring improvements in the working, performance and role of the Third Party Administrators (TPAs).

4) The Third Party Administrators (TPAs) should closely monitor and investigate the claims filed by the policyholders for cashless hospitalization and scrutinize the claim documents at the initial stage, in order to control fake & fraudulent claims. It may be suggested, that after treatment, the medical bills of the insured should be verified in order to detect the chances of frauds in cashless and reimbursement. A TPA representative should be appointed in all the network hospitals, to verify and investigate the medical bills and then forward it to the TPAs office. In case, if any fraudulent claims are discovered & proved, then it should be treated as criminal offence and subject to strict legal action. It should be the prime objective of the Third Party Administrators (TPAs) to minimize & control the health claims-ratio as much as possible.

5) IRDA should ensure mandatory trainings for the Third Party Administrators (TPAs), there should be monthly or quarterly meeting or seminars for all the professionals and representatives of TPAs, Insurance companies and Healthcare Service providers at a common platform so that they may interact with each other and discuss the drawbacks & relevant aspects of the services provided by them. IRDA shall consider facilitating the creation of a Formal association or body of Third Party Administrators
(TPAs), where all TPAs can be represented and which could take up various initiatives on behalf of the TPA industry.

One of the paradox that was raised regarding the services of Third Party Administrators (TPAs) was their loyalty towards the health insurance companies. They were appointed to serve the health insurance companies and the companies took their services in order to provide better health care facilities to the policyholder’s, though the policyholder’s are satisfied with their services but due to flexibility in their code of conduct they began to serve the policyholder’s rather than the company for their vested interests, thereby diluting their basic objective of serving the health insurance companies. Hence, it is suggested that the regulatory body IRDA should frame stringent measures to control their activities. It can be concluded that the Third Party Administrators (TPAs) have played a valuable role in the health insurance system of the country by making available professional expertise in handling health insurance claims, in terms of the wide availability of the cashless facility and increasing availability of health insurance data. The Third Party Administrators (TPAs) inherit wide scope for future business prospect in the health insurance sector in India.

The health insurance segment showed strong growth during the year and the premium serviced by TPAs also increased significantly. The TPAs expanded the reach of the hospitals across the country by adding new hospitals to their network. The physical presence of TPAs was also augmented by opening of new branches at new locations by many TPAs during the year. Further, the claim settlement performance of the TPAs witnessed improvement during the year 2011-12.

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(203)