Dissertation Report

At

Vipulmedcorp TPA

Noida

Role of TPA in Insurance company with cost containment using Incurred Claim Ratio

By

Dr Sankalp Swaroop(PT)

Under the guidance of

Dr A.K Khokkar

Post Graduate Diploma In Hospital And health Management

2013-15

International Institute Of Health Management Research

New Delhi

Completion of Dissertation from Vipul MedCorp TPA Pvt. Ltd.

The certificate is awarded to

Dr. Sankalp Swaroop

In recognition of having successfully completed her
Internship in the department of

Buisness Development Trainee

And has successfully completed his Project on

Role of TPA in insurance company with cost containment using ICR

From

2nd Feb - 30th April 2015

At Vipul MedCorp TPA Pvt. Ltd. Noida

He comes across as a committed, sincere & diligent person who has a
strong drive & zeal for learning

We wish him all the best for future endeavors

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Zonal Head-Human Resources

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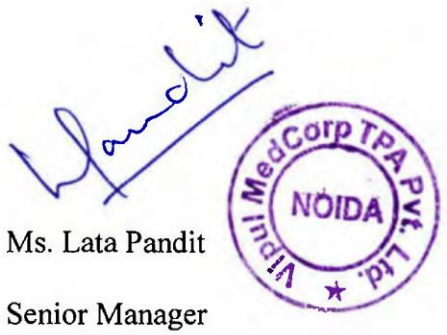

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Certificate of Approval

The following dissertation titled **"Role Of Third Party Administrator in Health insurance and Cost containment using Incurred Claim Ratio"** at **"VipulMedcorp TPA Noida "**is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

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FEEDBACK FORM

Name of the Student: Dr. Sankalp Swaroop

Dissertation Organization: Vipul Med Corp TPA Pvt. Ltd. - Noida

Area of Dissertation: Business Development

Attendance: Very Good.

Objectives achieved: Achieved all the objectives.

Deliverables: ① New Business Development
② Liasoning with Ins. Brokers & Ins. Co.
③ Liasoning with hospitals & other providers.

Strengths:
Positive attitude, enthusiasm to learn new things and hard working.

Suggestions for Improvement:
Need more practice for Corporate presentations

Signature of the Officer-in-Charge (Dissertation)

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Role of TPA in Insurance Company with cost containment using Incurred claim Ratio and submitted by (Name) Dr. Sandeep Swaroop Enrollment No. PG/13/062

under the supervision of Dr. A. K. KHOKKAR

for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 1/2/15 to 20/4/15

embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Sandeep

Signature

This is to certify that Dr Sankalp Swaroop(PT) student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at __1 Vipul medicorp from 1/2/15 to 30/4/15.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
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ACRONYMS/ ABBREVIATION

- TPA-Third Party Administrator
- SLA -Service Level Agreements
- IRDA- Insurance Regulatory and Development Authority
- ECG- Electrocardiogram
- IPD-In Patient Department
- HI – Health Insurance
- TAT -Turnaround time
- ICR- Incurred Claim Ratio

LIST OF ANNEXURES

INTRODUCTION

VipulMedCorp is currently managing over 5.4 Million lives across India and the rest of Asia. VipulMedCorpis engaged in the managed healthcare facilitation & has obtained a license from IRDA for TPA activities (Health) and offers its clients a wide array of services and products in the following areas:Third Party Administration (Health) services (TPA)

- Claims Handling, Management & Back office operations
- HealthCare Assistance Services
- Outpatient HealthCare facilitation & Management
- Tailor Made Insurance products
- Second Medical Opinion
- Cost Containment Services
- Preferred Service Provider (PSP) Networks
- Evacuation Services

ORGANIZATIONAL PROFILE

Headquartered in Gurgaon with branch offices in New Delhi, Noida, Faridabad, Vrindavan Jaipur, Mumbai, Kolkata, Bangalore, and Chennai & Cochin.

Wide Medical Network of over 2000 + hospitals, Diagnostic Center& Chemists. Operates a 24/7 Assistance Centre. Tailor-made software developed in-house with full web-based access for Claims Tracking, On-Line Access and Querying.

Professional manpower presenting our clients with benefits derived from our knowledge & experience of the medical network, TPA & Insurance fields. Dedicated Panel of Doctors, enabling us to render Second Medical Opinion, Case Management and Medical Procedure Audit.

SERVICES

- Claim processing & reimbursement, for non-network hospitals
- Computerized Medical History records
- Cost containment services for Insurance Companies & Insured with inadequate Insurance
- Online assistance to Insured during hospitalization & filing of claim documents
- 24hrs Ambulance/Doctor on call and Emergency services
- Priority admission in hospitals
- Hospitals/ nursing Homes all over India
- Tariff rationalization & Provider accreditation
- Evacuation Services i.e. Medical repatriation and medical escort

Service Level Agreements:

For deliverance of services the SLA (Service Level Agreements) are in place, which would be signed with various Insurance companies and the corporate groups.

1. ID Cards Printing and Dispatch
    - VipulMedCorp TPA TAT for the Delivery of cards is within seven (7) days of the receipt of the complete data of insured members and the details of the policy from the insurance company
2. Cashless Authorization / Rejection
    - Cashless authorization requests are to be scrutinized and the decision of acceptance or rejection is to be conveyed to the service provider within 24 hrs. of the receipt of the Pre Hospitalization Authorization Form.
3. Claims Settlement / Reimbursement
4. Customer Grievance Redressal
    - TAT for response is max. 2 working days, for any queries or grievance raised by the client.
5. Call Center Responses
    - VipulMedCorp TPA operates a 24 * 7 / 365 days Call center to provide instant accessibility to the clients for all information required for medical services facilitation and claims status.
6. MIS Reports
    - Weekly/ Monthly MIS are prepared

METHODOLOGY

This observational study will be carried out to study procedures and steps in Incurred claim ratio from various corporate.. ICR is the percentage of claim settled in return of premium paid .by corporate .

Studies is carried from 2/02/2014 to 30/04/2015 in which data of nine corporate was analyzed and studied from the corporate management information system (MIS) which taken from Vipul Medcorp TPA database.

DEPARTMENT AND SYSTEM COVERED DURING STUDY

Buisness Development

During course of Internship worked in Buisness Development trainee to understand key process of department mainly as how to pitch for new business and retaining the old one . in this networking with many players was involved as follows:

- Insurance companies
- Insurance Brokers
- Service providers such as hospitals etc

Third Party Administrators

The introduction of TPAs was made by Insurance Regulatory and Development Authority (IRDA) in order to infuse a new management system and to regulate the healthcare services and costs. In other words, the prologue of TPAs was made on the expectation to ensure better services to insurers as well as to insured. While introducing TPAs certain conditions, code of conduct/role defined by the IRDA for TPAs which they are expected to meet and follow. In this chapter an effort was made to examine all those conditions, code of conduct/role defined by IRDA and role in practice played by TPAs so as to come out with conclusive evidence as regards to parameters, where parity and deviation exist between these. Accordingly, this chapter is divided into three sections. Section A gives brief introduction. Section B examines all the conditions, code of conduct/role which is defined IRDA for TPAs and role in practice played by them. Section C deals with conclusive findings i.e. where parity and deviation exist between role defined by IRDA and role in practice played by TPAs.

Introduction

The Insurance Regulatory and Development Authority (IRDA), since its incorporation in April, 2000 have fastidiously stuck to its schedule of framing regulations and opening up the insurance sector for the development of insurance market. Moreover, in order to infuse a new management system and to regulate the health care services and costs, the introspection was made by the IRDA with the advent of TPAs (Third Party Administrator-Health Services) Regulation, 2001. The prologue of TPAs was made on the expectation to ensure better services to insurers as well as to insured. In other words, it was expected that introduction of TPAs will meet the cost and quality issues of health care providers as well as of receiver in the insurance market. The credit for the origination of concept of TPAs in India goes to US, where firstly the need for concept of managed care was felt and the system of managed health care financing and delivery was introduced in 1973. The system was introduced just to keep medical cost under control

and at an affordable level in US. By following the same line to control the cost, the concept of TPAs was introduced in India and more than 25 companies have been issued license to act as TPAs so far. Although, it was introduced on the same line of system launched in US, yet some difference exist between these two:

- The HMO in the US is allowed to underwrite the risk on its own books whereas TPAs in India are not allowed to do so.
- The HMO in the US is an independent organization, whereas TPAs in India are attached to one or more insurance companies and they can get business only through insurance companies.
- HMO services can be offered by any hospital in the US, whereas in India TPA services cannot be offered by a hospital.
- A HMO can have its own chain of hospitals, whereas a TPA is barred from entering into any other business activities.
- A HMO has the authority to admit its member at a hospital of its choice as per the risk covered to curtail the cost of treatment, whereas a TPA does not have such authority. The selection of the hospital is the privilege of the patient and the TPA can only monitor the hospitalization process and pay the claim on time to the hospital by liaising with the insurance companies – which gives the patient a cashless facility. The policyholder can still choose a hospital which is not on the network of the TPA and opt for the reimbursement procedure.
- TPAs are not allowed to do marketing and also not allowed to advertise without the permission of the insurance companies (Sureka, 2003, pp. 18-21).

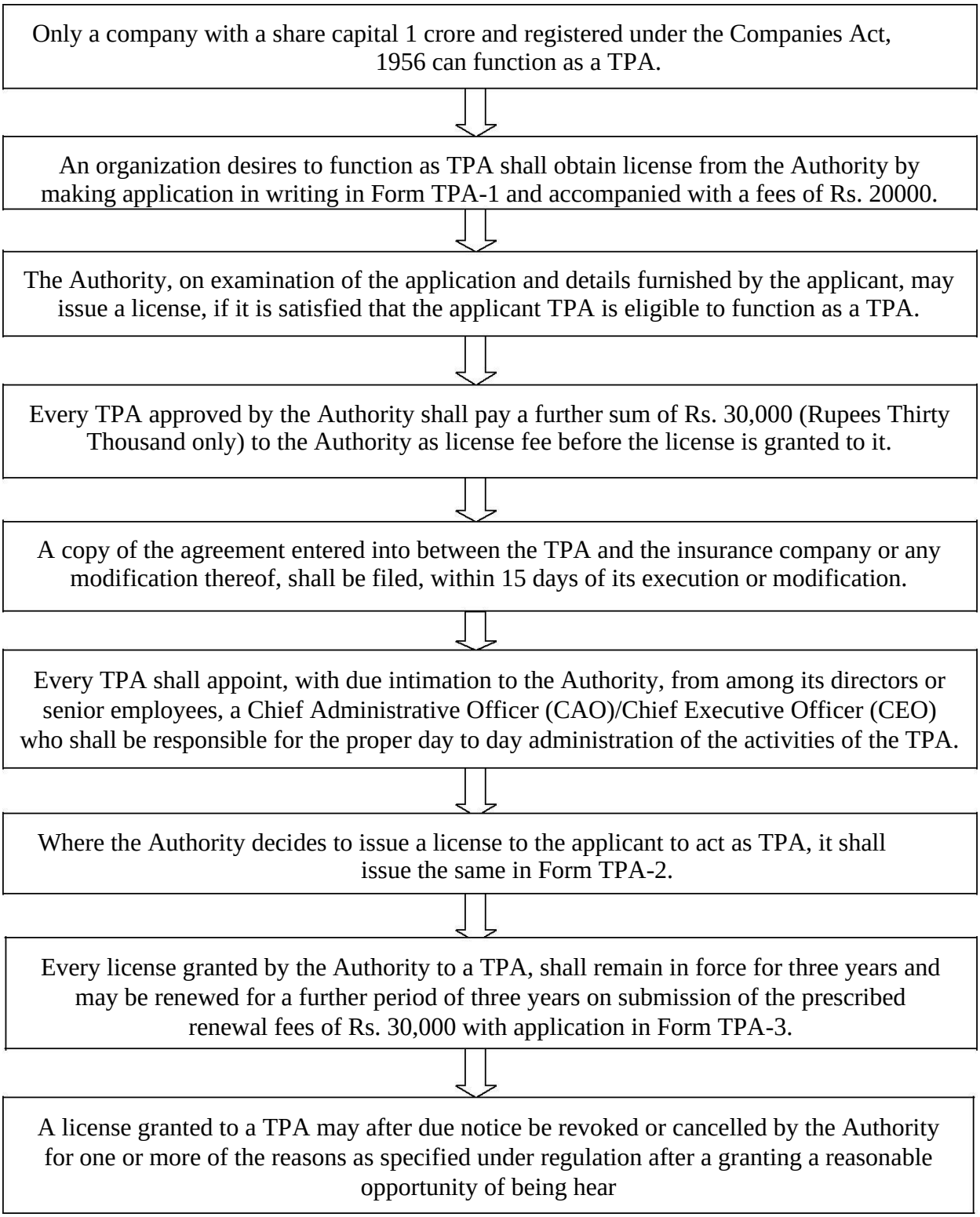
Conditions Defined by IRDA for TPAs

Before IRDA allowed the TPAs to formally enter into the insurance market, there were intermediaries who were acting on behalf of the corporate and playing a very similar role to that of present-day TPAs. Corporate were utilizing these agencies to help them to make the process of claim reimbursement easier and smoother for their employees. Also, these agencies were helping to market the insurance products available – mainly Mediclaim – to corporate.

As per IRDA (Third Party Administrator- Services) Regulation, 2001 the following are conditions, specified for TPAs. Figure 2 shows the detail conditions specified by IRDA for TPAs.

Figure 7.1

Conditions Defined by IRDA for TPAs



prejudice to the generality of the provisions contained above, it shall be the duty of every TPA, its Chief Administrative Officer or Chief Executive Officer and its employees or representatives to:-

Establish its or his or their identity to the public and the insured/policyholder and that of the insurance company with which it has entered into an agreement.

Disclose its license to the insured/policyholder/prospect.

- Disclose the details of the services it is authorized to render in respect of health insurance products under an agreement with an insurance company;
- Bring to the notice of the insurance company with whom it has an agreement, any adverse report or inconsistencies or any material fact that is relevant for the insurance company's business;
- Obtain all the requisite documents pertaining to the examination of an insurance claim arising out of insurance contract concluded by the insurance company with the insured/policyholder;
- Render necessary assistance specified under the agreement and advice to policyholders or claimants or beneficiaries in complying with the requirements for settlement of claims with the insurance company; Conduct itself /himself in a courteous and professional manner;
- Refrain from acting in a manner, which may influence directly or indirectly insured/policyholder of a particular insurance company to shift the insurance portfolio from the existing insurance company to another insurance company;

Refrain from trading on information and the records of its business;

Maintain the confidentiality of the data collected by it in the course of its agreement;

Refrain from resorting to advertisements of its business or the services carried out by it on behalf of a particular insurance company, without the prior written approval by the insurance company;

Refrain from inducing an insured/policyholder to omit any material information, or submit wrong information;

Refrain from demanding or receiving a share of the proceeds or indemnity from the claimant under an insurance contract;

Follow the guidelines/directions that may be issued down by the Authority from

time to time.

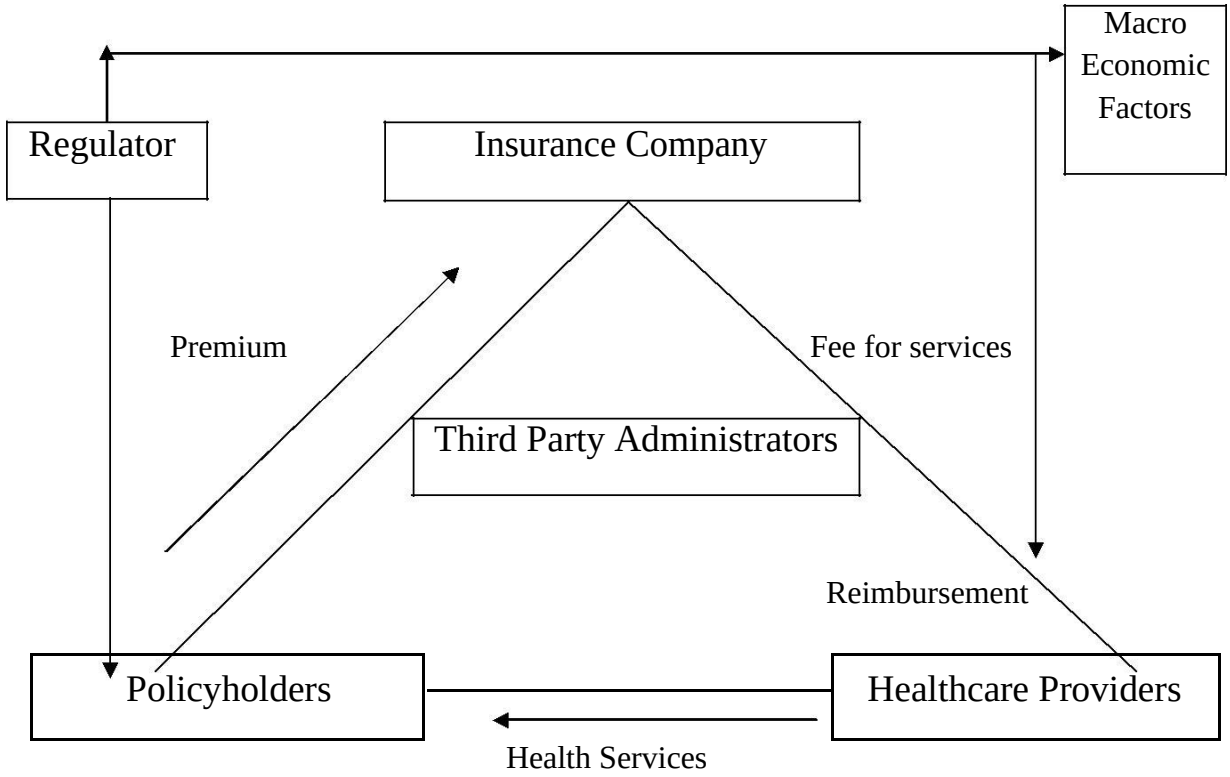
Role in Practice Played by TPAs

As per notification of IRDA, the basic role of the TPA is to function as an intermediary between the insurer and insured and facilitate cash less service to the insured. However as per practice the following is done by the TPAs or the following steps followed by TPAs from the initiation until settling the claims:

- All the records of medical insurance policies of an insurer will be transferred to the TPA once the insurance company has given the business to a TPA.
- The TPA will issue identity cards to all policyholders, which they have to show to the hospital authorities before availing any hospitalization services.
- In case of a claim, policyholder has to inform the TPA on a 24-hour toll-free line provided by the latter.
- On informing the TPA, policyholder will be directed to a hospital where the TPA has a tied up arrangement. However, the policyholder will have an option to join any other hospital of their choice, but in such case payment shall be on reimbursement basis.
- TPA issues an authorization letter to the hospital for treatment, and will pay for the treatment.
- TPA will track the case of the insured at the hospital and at the point of discharge; all the bills will be sent to TPA.
- TPA makes the payment to the hospital TPA sends all the documents necessary for consideration of claims, along with bills to the insurer

TPAs will receive a commission of 5.5% of premium amount from th insurance company for all the services rendered. Figure 7.2 provide the graphical representation of working environment of insurance industry and the role actually played by the TPA in this system. The core product or services of a TPA is ensuring cashless hospitalization to policyholders. Intermediation by TPAs ensures that the policyholders get the hassle-free services; insurance company pay for efficient and cost-efficient services and the health care get their reimbursement on time. It is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs, developing protocol to minimize unnecessary treatment/investigations, improve quality of services and ultimately leads to lower insurance premium. However, the system is currently going through teething troubles. Cash-less policies, where the insurers directly pays the hospital bills to healthcare providers, have not yet fully materialized (Kalyani, 2004, pp. 7-8).

Figure 3
Working Environment of TPAs



(Source: Kalyani, 2004, pp.7- 8).

Parity between Role Defined by IRDA and Role in Practice Played by TPAs

All organizations that got license from IRDA to act as TPA is required to follow the certain code of conducts and role as defined by it. Certainly when something is imposed, some goes with line defined, while some goes out of line defined. When TPAs carries out its activities and functions are per specific demarcation i.e. according to the framework set by IRDA, then it is called parity between role defined and role played. Followings will make us clear as regard the parity between role defined by IRDA and role in practice played by TPAs:

Providers of services as and when need: The primary job of the TPA is to provide services as and when needed by the insurers and insured. Here, the TPAs follow each case individually and arrange for specialized consultation and medical facilities for the insured. The insured will be provided with adequate services with minimum loss of time and effort to find out the healthcare providers. At the same time, TPAs maintain comprehensive records of communication between healthcare providers and families and evaluate the outcome of the treatment, thereby reduce the chance of moral hazards and provider induced demand.

Streamline and simplifies the claim process: TPAs were introduced as intermediaries to facilitate the claim settlement between insurers and insured. The agreement between TPAs and insurance companies provide for monitoring and collection of necessary information, documents and bills pertaining to the treatment of the insured. All these documents are examined by the TPAs and after processing sent to the insurance companies for reimbursement. Here, the TPAs play the role as defined by IRDA by fulfilling the responsibility of claims settlement, getting reimbursement from the insurance company and paying to the healthcare providers. This leads to achievement of simplicity in claim process and streamlining the claim process as mandated by the IRDA.

Automatic development of information system: TPAs job is to collect all the documents, processed them and send all these to the insurance company for consideration of claim and reimbursement. This will lead to the automatic design

and development of information system, which would allow TPAs to analyze data regarding hospital admissions, ascertain the health needs of a patient and check for the effective treatment protocols, tracking documents pertaining to each case and tracking shortfall of each claims. Accordingly, TPAs meet the parameters set by the IRDA.

Ensured services of qualified registered medical professional: One of the regulations of IRDA requires that at least one director of the TPA should be a qualified medical doctor registered with the medical council of India. Moreover, it is also require that the CEO/CAO of TPA should have successfully undergone a course in hospital management from an institution recognized by IRDA and passed the examination conducted by insurance institute of India, Mumbai. Apart from this he/she should have undergone practical training of at least three months in the field of health management. By following the above guidelines, TPAs generally have their own in-house medical doctors, hospitals managers, insurance consultants, legal experts, information technology professional and management consultant. Thereby meeting the requirement of the IRDA that envisages for effectiveness of work of TPAs, which will depend not only on their bargaining power rather on the services of health care providers that is imparted by qualified medical professionals of the TPAs

Value added services: IRDA regulation for TPAs aims at ensuring value added services to the consumers, which take diverse form and include arrangement of ambulance services, medicines and supplies, guide member for specialized consultation, provide information about health facilities, hospitals, bed availability, organization of lifestyle and well-being programmes and 24 hrs help-lines. By following the above specified, TPAs are providing the value added services to the customers. Moreover, the policyholders will be directed towards empanelled hospitals with which TPA has tie up arrangement for extension of quality and value added services to policyholders. However, policyholders have the choice to go to any hospital and will get reimbursed from TPAs.

No extra burden on insured: All the above mentioned services of the TPAs are provided to the insured without any extra cost; thereby the whole process does no

put any sort of burden on the insured. The TPAs are providing effective and efficient service to insured with regards to health insurance that too not at extra cost to insured and simply relying upon the fixed percentage received from the insurer. This shows that TPAs meet the service aspect for policyholders as defined by IRDA.

Deviation between Role Defined by IRDA and Role in Practice Played by TPAs

Likewise, examination of parity between role defined by IRDA and role played by TPAs, an effort was also made to examine the deviation between these two i.e. an effort was made to examine the second side of the same coin. When TPAs carries out its functions and activities not as per specific demarcation, rather goes beyond to the framework set by IRDA for role and code of conduct, then it is referred to as deviation between role defined and role played. The followings will make us clear as regard the deviation between role defined by IRDA and role in practice played by TPAs:

Failure to meet the service responsibility: TPAs are expected to provide valuable services and assistance at the time of admission and also during admission of patients to the hospitals. Their services include: to get enquire about duration of stay in hospital; enquiring about test/room rates; scrutinizing the bills; and also to enquire about treatment etiquette. However, the studies reveal that some of the TPAs are not even visiting their clients during their admission in the hospitals. They even do not arrange for specialized consultation on their patient conditions (Bhat et al. 2005).

Lack of knowledge about coverage and exclusion in policies: The regulations of IRDA for TPAs require that they should have adequate knowledge with regards to various inclusion and exclusion in health insurance policies issued by the insurance company. But the various studies on this area reveal that there is lack of adequate information on the part of TPAs which ultimately hinder the effective discharge of their obligations and also obstruct the achievement of basis objectives behind their introduction.

Failure to meet the expectations of parties involved: It is generally said that consumer is a king of the market, but the same is not true in case of insurance

market as it is heavily dominated by insurance agents and TPAs. Just because of the reason that the insurance market is heavily dominated by TPAs, so it is expected from them to carry out activities like issue identity card to policyholders; 24-hrs help-line for customers' services; informing the customers regarding empanelled hospitals; arranging for specialized consultation; and claim processing during admission of the policyholders with due care and diligence. All this require a strong communication skill on the part of TPAs and where they are lacking and ultimately proved fail to meet the expectation of parties involved like insurer, insured and healthcare providers.

Delay in settlement of claims: IRDA one of the objectives behind introduction of TPAs was to streamline and simply the claim settlement process. TPAs which were authorized by IRDA and appointed by insurance companies agree upon providing cashless facility to policyholders i.e. the policyholders are not required to make payment to hospital rater TPAs will make payment. Earlier for this hospitals were paid directly by the patient himself, but with the introduction of TPAs, now the hospitals are paid by them. But before paying to the hospitals they examine all the documents, duly process them and thereafter submit the same to insurance company for reimbursement. The time agreed for claim settlement with TPA is less than 1 month, whereas actual time taken for claim settlement varies from 2 to 3 months (Bhat et al. 2005). All this leads delay in settlement of claim and resulting dissatisfaction to the policyholders and hospitals.

Indirect cost to consumer: Although, the customers are not required to pay any extra charges for the services of TPAs, yet they are indirectly get paid in the form of higher premium charged by the insurance company. No doubt, the claims ratio is coming down and the insurance companies are getting freed from their workload both in the form of money and other administrative cost, still this savings are not passed to customers in the form of additional benefits rather charged with higher premium.

Cost of healthcare increase: TPAs are expected to provide cashless facilities, which will increases the capacity of policyholders to incur higher costs at the time of illness, and therefore has a tendency to inflate the demand for high-cost care.

This could be limited to a certain extent only with the presence of a system of co-payments. But this is ultimately defeating the vary purpose of introduction of TPAs i.e. to minimize the cost of healthcare.

Cost of management increases: Likewise cost of healthcare, cost of management also gets increases because of inability of the TPAs to make enough profits. Various studies reveal that TPAs are dissatisfied with the 5.5 per cent commission. Moreover there is lot of variation in calculating break-even among the TPAs on account of their in-built costs. As the breakeven in metro at Rs 20 crores of premium business will account for Rs 8 crores in non-metro. Some TPAs are out rightly admitting that they are incurring losses because of high management cost and lesser commission and would not be able to carry out activities and functions as per defined framework.

Role of TPA in Cost Containment

Cost of management increases: Likewise cost of healthcare, cost of management also gets increases because of inability of the TPAs to make enough profits. Various studies reveal that TPAs are dissatisfied with the 5.5 per cent commission. Moreover there is lot of variation in calculating break-even among the TPAs on account of their in-built costs. As the breakeven in metro at Rs 20 crores of premium business will account for Rs 8 crores in non-metro. Some TPAs are out rightly admitting that they are incurring losses because of high management cost and lesser commission and would not be able to carry out activities and functions as per defined framework.

Incurred Claim Ratios

Every insurer keeps the best foot forward when it comes to selling its insurance plans. But it is the settlement of claim that decides how good or bad an insurer really is.

Every policyholder pays the premium with a trust on his/her insurer that he'll be provided financial assistance in times of need, in a simple, smooth and timely manner. There are certain parameters to measure this trust. One such parameter is **Incurred Claim Ratio**.

Incurred Claim Ratio

It is the ratio of net claim settlement cost incurred by the insurer to the net premium earned for a given accounting period.

Incurred Claim Ratio = Net Claims Incurred / Net Earned Premium

So, a 90% incurred claim ratio implies that for every 100 rupees earned as premium, 90 rupees were spent on the claims settled by the insurer. Thus, 10 rupees is the net profit of the insurer. Unlike claim settlement ratio, incurred claim ratio can be above 100%. Obviously, that would imply that the insurer suffered a financial loss during that particular year.

Difference from Claim Settlement Ratio

Chances are thick that you stumbled upon this article while searching for Claim Settlement Ratio. These two are often confused but are quite different. Claim Settlement Ratio is the ratio of settled claims to the total claims filed in a given accounting period.

Claim Settlement Ratio = No. of Claims Settled / Total No. of Claims Filed

So, a 90% claim settlement ratio implies that of a total of 100 claims, 90 claims were settled by the insurer. The 10 claims, however, were outstanding or denied.

Importance of Incurred Claim Ratio for a Policyholder

Incurred Claim Ratio is a reflection of how much an insured can count on his insurer on getting his claim settlement amount, when he makes a claim. The thumb rule is, higher the ICR, higher level of trust an insured can put on his insurer. It's a way of rating insurance companies.

Also, as a policyholder you stand in a better position to negotiate with an insurer with a low incurred claim ratio.

ICR do not indicate

As can be seen in the formula, Incurred Claim Ratio doesn't take into account the time period taken by the insurer to process and settle a claim. So, there can be two insurers with the same 'incurred claim ratios' with one of them settling a claim within 3 months and the other one procrastinating the settlement up to 1 year.

The health insurance incurred claim ratio of the insurers for 2011-12 (in decreasing order) is given below:

Insurers	**Incurred Claim Ratio (%)**
Private	
L&T General	183.40
SBI General	122.82
Universal Sompo	102.59
ICICI Lombard	86.19
IFFCO Tokio	85.79
Reliance	85.77
Future Generali	85.58
Bharti AXA	80.44
Cholamandalam	76.51
HDFC Ergo	67.53
Bajaj Allianz	66.52
Royal Sundaram	50.86
TATA AIG	49.65
Public	
National	105.09
Oriental	102.83
United	97.68
New India	97.24
Grand Total	93.97

Source: IRDA

The health insurance incurred claim ratio of stand alone health insurers for 2011-12 (in decreasing order) is given below:

Stand Alone Health Insurer	Incurred Claim Ratio (%)
Star Health & Allied Insurance	95.76
Apollo Munich Health Insurance	58.20
Max Bupa Health Insurance	56.15

Source: IRDA

Result

I observed ICR of nine corporate and average ICR was 140% , this Rate of ICR is very high as ICr should be less than 100% so that Insurance company can have profit.

This signifies that premium paid by a corporate is less in comparison the amount of claims settled by Insurance company.

Recommendation

1. Apply GIPSA rates in every hospital
2. Apply co payment in elderly claims
3. Disease wise capping in policy
4. Claims investigation for suspected cases should increase
5. Preventive measure should be done like Health camps/ talks in each corporate

Conclusion

In nutshell, it is derived from the above discussion that the introduction of TPAs

was made by IRDA in order to infuse a new management system and to regulate the health care services and costs. The prologue of Third Party Administrators was made on the expectation to ensure better services to insurers as well as to insured. In other words, it was expected that introduction of TPAs will meet the cost and quality issues of health care providers as well as of receiver in the insurance market. While introducing TPAs certain conditions, code of conduct/role defined by the IRDA, which they are expected to follow. Thereby the study was conducted in order to examine the conditions, code of conduct/role defined IRDA and role in practice played by TPAs so as to come out with conclusive finding in relation to parameters where parity and deviation between exist in role defined and role played. The study provided that parity exist in case of followings: providers of services as and when need; streamline and simplifies the claim process; automatic development of information system; ensured services of qualified registered medical professional; value added services; and no extra burden on insured. Alternatively, deviation exist in case of: lack of knowledge about coverage and exclusion in policies; Failure to meet the expectations of parties involved; Delay in settlement of claims; Failure to meet the service responsibility; Indirect cost to consumer; Cost of healthcare increase; and Cost of management increases.

Refrences

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