Dissertation Title

A Survey Study on Third Party Administrators and Health Insurance in India-Perception of the Policyholders

A Dissertation Proposal for

Post Graduate Diploma in Health and Hospital Management

By

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Certificate of Approval

The following dissertation titled " **A Survey Study on Third Party Administrators and Health Insurance in India-Perception of the Policyholders** is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of Post- Graduate Diploma in Health and Hospital Management for which it has b" een 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.

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18 Jan 2014

Certificate from Dissertation Advisory Committee

This is to certify that **Ms. Ruchika Tuteja**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled **". A Survey Study on Third Party Administrators and Health Insurance in India-Perception of the Policyholders "** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor [MINAKSHI GAUTAM]

Designation

IIHMR

New Delhi

Date 16 JANUARY 2014

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LIST OF CONTENTS

CHAPTER 1 INTRODUCTION

Indian public healthcare infrastructure has not kept pace with economy's growth. The physical infrastructure is woefully inadequate to meet today's healthcare demands which are influenced by complexities emerging from the changing disease pattern.

The public healthcare system envisages availability and accessibility of health services regardless of their ability to pay. Now with time the expansion of the infrastructure and the shortfall in financial support the public healthcare system is lacking behind in its ability to cater needs of the ever-growing population of the country. The gap created between the demand and supply of healthcare has been narrowed to a certain limits by the private sector which has grown in size and scope in recent years.

At present both private and public healthcare facilities are providing the services; but the majority of services are of curative nature concentrated in the urban areas with private facilities forming the major workforce. As per WHO and Human Development Report India ranks at 171 of 175 countries in the amount of Public expenditure on healthcare and ranks 18 in the amount of Private expenditure on healthcare (WHO study 2007-08). For a country of one billion, India spends 5.2% of the GDP on healthcare. While 4.3% is spent by the private sector, the government continues to spend only 1.1% on public health (Human Development Report 2007-08); taking into consideration the out of pocket expenditure which is basically any direct payment made by households which include gratuities and other in-kind payments, to doctors and other practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services where the primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. This is a part of private expenditure oh healthcare; as of now India has 89.9% out of pocket expenditure.

Over the next few years the lifestyle diseases are expected to grow at a faster rate as compared to other infectious diseases, resulting in increase in cost per treatment. The increased advent of technology and the accompanied increase in cost of associated healthcare has resulted to explore health financing options to manage cost of treatment.

Healthcare financing involves the mobilization of funds for healthcare; allocations of funds and employing mechanisms for paying for healthcare (Hsiao, Liu 2001). The issues associated with health financing include:

a.) How and from where sufficient funds are generated for health.
b.) How to overcome financial barriers which prevents population to access healthcare services.
c.) How to provide an effective and efficient system of health services.

The health financing system in India involves government budgetary allocations and private financing. This expenditure pattern as previously described above has created serious equity issues; in such scenarios health insurance is proving to be an effective alternate for financing.

Health insurance protects the subscribers and their dependants against any financial constraints arising on account of a medical emergency. Here the subscriber pays a sum of money called the Premium and in turn the Insurance firm would commit to pay a predetermined sum of money to meet the customer's claims. The demand for health insurance has been high and the growth of the market has also been encouraging. With the passage of the IRDA act in 1999 the industry underwent a transformation where insurance sector was opened for private players as well.

With every development new opportunities and threats emerge; the expansion of the insurance sector with the increased privatization in the healthcare system resulted in number of issues within the insurance industry and the regulators. The key challenges that the industry has been facing in the past and few of them till now too are as follows:

a.) Limited influence over healthcare delivery mechanism.
b.) High claim ratio; as a result of insufficient data on consumers and disease patterns.
c.) Absence of standardization of healthcare cost and significant level of moral hazards leading to under-pricing of insurance products and subsequent higher claims.
d.) Limited funding support from the insurance company impacting the claim disbursement time.
e.) Delays and issues in the claim management leading to loss of goodwill amongst customer.

f.) High administrative cost of the insurance companies.

All the above issues led to the evolution of new body for cash-less claim processing in form of TPA (Third Party Administrators) which aimed at addressing the above prevalent problems related to health insurance.

- ✓ **Third Party Administrators: Role and Functions**

TPAs were issued licenses in September 2001 by IRDA, with the basic responsibility of functioning as an intermediary between insurer and the insured and facilitate the provision of CASHLESS health services to their customers, offering back-up services to the insurance companies. For these services they are paid a fixed percentage of the insurance premium as commission.

TPAs ensure that the policyholders get convenient hassle free services; for this they organize healthcare providers by establishing networks with hospitals, general practitioners, diagnostic centers, pharmacies, dental clinics, and physiotherapy clinics etc.

The agreement between the TPA and the healthcare providers implicates for monitoring and collection of documents and bills. Documents are audited, processed and sent to the insurance companies for reimbursements. For this purpose they have in-house medical doctors, hospital managers, insurance consultants, legal experts, IT professionals and other management consultants.

Thus it is expected from TPAs that they would develop an appropriate system and mechanism aiming at controlling of costs, developing a fixed protocol to minimize unnecessary treatment and investigations.

As of now there are 27 registered TPA health services in India licensed by IRDA.

All said and done but once the system of TPAs was brought into execution the clause of CASHLESS treatment went under a scrutiny and it resulted in a clash between the interests of the healthcare providers, the insurance companies and the TPAs.

The 4 major Public Sector Units (PSU) of the insurance industry namely New India Assurance, United India Insurance, National Insurance and Oriental Insurance suspended the provision of Cashless treatment in July of 2010 after they alleged over-billing by certain private hospitals. The crisis struck hard in metropolitan cities such as New Delhi, Kolkata, Chennai, Mumbai and Bangalore as well as few other cities with private corporate super-specialty hospitals. The PSU insurance firms made a call for a fixed rate structure to be employed by the TPA The restoration of services is took longer than expected because at first when negotiations started the hospitals were believed to have quoted rates quite higher than the tariffs under the current arrangement, called preferred provider network (PPN). The IRDA had refused to intervene in the impasse, saying that the regulator's role comes only when there is a breach of contract between the company and the insured person. The customers were left in a jiffy and the matter ran into judicial scrutiny where the New Delhi High Court issued the IRDA to take steps to restore the cashless facility provided by the four PSU general insurers to policyholders.

Later the representatives of private hospitals and TPAs, the two parties had agreed to categorise the hospitals on the basis of infrastructure availability and benchmark rates accordingly, those opting for treatment in super-specialty hospitals like Apollo, Escorts are likely to shell out more money for new premiums than those going for ordinary health centers.

For super-specialty hospitals in New Delhi where this study was conducted--Max, Fortis, Apollo and Medicity--the rates at Ganga Ram Hospital, New Delhi was used as benchmark for the new rate structure. The facility at another set of hospital like Rockland, St Stephens, Holy Family, Batra and Sitaram Bhartiya, however, would be based on lower premiums. The hospitals and TPAs later worked out package rates for 42 procedures, and they are now working out the rate structure, industry Chamber CII, which is mediating for a solution to the vexed issue.

Henceforth till now we have seen the development of TPAs, the teething problems which the industry has undergone after its implementation; through this study we tried to understand the

perception of policyholders of health insurance about the role and functions of TPA and to examine the issues and challenges faced by the healthcare industry with respect to the role played by the TPAs.

CHAPTER 2 LITERATURE REVIEW

The Economy of India is the eleventh largest in the world by nominal GDP and the fourth largest by purchasing power parity (PPP). The country's per capita GDP (PPP) is $3,290 (IMF, 127th) in 2010.

Government allocations in the health sector have declined from 1.3 per cent of GDP in 1990 to 0.9 per cent in 1999 (National Health Policy, 2001) which is again improved to 1.1% as per Human Development Report, 2010. The central government plays an important role in supporting national health programmes such as malaria, TB, HIV/AIDS, etc. Funds for these programmers are channelled through state governments. These schemes give priority to primary health care whereas state governments bear the major responsibility of recurrent costs, especially the cost of operating the hospitals. The significance of alternative sources of financing has increased significantly.

The role of private financing has increased significantly in recent years. It is estimated that people spend about 4.5% of the GDP on healthcare needs and this is about three- fourths of the health care expenditure (World Bank, 1998). Most of it is 'out-of- pocket' private expenditure, which has grown at the rate of 12.5%, and for each 1% increase in the per capita income it has increased by about 1.44% (Bhat 1999).

Insurance companies have to deal with unregulated healthcare providers who work in an environment where there are no standards, quality benchmarks and treatment protocols, and where highly variable billing systems and significant price variations across providers exist (reflected by the adverse claim ratios). It has also been observed that hospitals tend to charge the patients covered by insurance more, but in the absence of monitoring and control mechanisms; it is difficult to handle fraudulent claims.

It is to address such issues that insurance intermediaries such as Third Party Administrators (TPAs) become important and they are bound to play a key role in the growth and development of managed health care system.

TPAs are separate entities that coordinate between insurance companies, customers and healthcare providers; they arrange for cashless hospitalisation and closely monitor the use of resources and services.

Health insurance companies generally tie up with TPAs for the back office function of managing claims and reimbursements. IRDA has also come up with regulatory guidelines for TPAs and they have to fulfil certain requirements and observe a code of conduct.

Gupta, Roy and Trivedi (2004) mentioned that the current insurance sector requires a substantial makeover in terms of the amount of working capital invested and bank guarantees to finance operations of TPAs.

Mathew and Cahill (2004) described the challenges the industry at that point of time and the future challenges which included the lack of a centralized database, a effective and efficient pricing system acceptable to all parties involved in the process of insurance, the lack of quality assurance measures for healthcare providers.

Thus this study aims to find does the concept of introduction of TPAs has been able to reach the general masses and what they perceive out of the functions and the role assigned to a TPA.

CHAPTER 3

- **AIM OF THE STUDY**

To study the awareness level of health insurance policy holders regarding Third Party Administrators

OBJECTIVES OF THE STUDY

- To study the awareness amongst respondents regarding roles and functions of TPA.
- To study the satisfaction level amongst respondents with respect to TPAs.

STUDY DESIGN

A Quantitative study.

METHODOLOGY

STUDY AREA

The study was conducted in Delhi . Areas covered were West Delhi hospitals Medcity, Apollo, Max and Fortis.

SAMPLING

- . Sample Frame: IPD policyholder patients
- Sampling Method: Convenient sampling
- Size-150

DATA COLLECTION

For collection of primary data a questionnaire was designed.

DATA ANALYSIS

The data analysis was done using (SPSS Statistical Package for Social Sciences) and Microsoft Excel 2007.

CHAPTER 4 RESULTS

- **Total number of respondents**: 150
- **Demographic profile**:
- **Sex of the respondent**:
  - Males: 95(63.3%),
  - Females: 55(36.7%)

Gender of the respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	95	63.3	63.3	63.3
	Female	55	36.7	36.7	100.0
	Total	150	100.0	100.0	

- **Age of the respondents:**
- Maximum respondents were between 25-50 yrs of age.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	**Age of the respondent**	4	2.7	2.7	2.7
	18-25	29	19.3	19.3	22.0
	25-50	105	70.0	70.0	92.0
	>50	12	8.0	8.0	100.0
	Total	150	100.0	100.0	

- **Education level of the respondents:**
  - 40% of the respondents were graduates.
  - $2.7% of the respondents were post graduates.

Education level of the respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	5	3.3	3.3	3.3
	Secondary	2	1.3	1.3	4.7
	Higher secondary	19	12.7	12.7	17.3
	Graduate	60	40.0	40.0	57.3
	Post graduate	64	42.7	42.7	100.0
	Total	150	100.0	100.0	

- **Type of policy cover taken by individuals:**
- 38.7% of the respondents had Individual policy cover.
- 45.3% of the respondents had Family policy cover.
- 14% of the respondents had both individual as well as family policy covers.

Health insurance policy cover taken by the respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Individual policy cover	58	38.7	38.7	38.7
	Family policy cover	68	45.3	45.3	84.0
	Dont know	3	2.0	2.0	86.0
	both	21	14.0	14.0	100.0
	Total	150	100.0	100.0	

- **Number of Claims incurred since insured:**
- Out of 150 respondents only 56 had incurred any claims.

Claims incurred since insured

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-2	43	28.7	28.7	28.7
	3-4	6	4.0	4.0	32.7
	5 and above	7	4.7	4.7	37.3
	Nil	94	62.7	62.7	100.0
	Total	150	100.0	100.0	

- **Awareness about the existence of TPA**:

- Out of 150 respondents only 47 (31.3%) knew about TPA being an entity.

Awareness about existence of TPA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	47	31.3	31.3	31.3
	No	103	68.7	68.7	100.0
	Total	150	100.0	100.0	

- **Contacting point for claim settlement:**

- Most of the respondents contacted either the insurance agent or the insurance company for settling out their claims.
- This shows the disambiguate level of awareness amongst people regarding the role of TPAs.

Claim settlement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	TPA	29	19.3	19.3	19.3
	Agent	39	26.0	26.0	45.3
	Insurance company	46	30.7	30.7	76.0
	Don't know	23	15.3	15.3	91.3
	other	13	8.7	8.7	100.0
	Total	150	100.0	100.0	

- **Awareness about information to be provided by TPA:**

- From the data obtained it clearly visible that the respondents those who have the knowledge about the existence of TPA have appropriate knowledge about the information that the TPA has to provide to the subscriber except the information regarding whether coverage of illness occurring outside the city is permissible or not.

- Conversely a total lack of knowledge about the services of TPA was seen where people were unaware about TPA being a entity in their health insurance contract.

- The mean here is calculated on a 3 point scale with the standard deviations mentioned along.

Awareness about information to be provided by TPA

Awareness about existence of TPA		Knowledge about diseases covered	Knowledge about diseases not covered	Info about cashless service	list of network hospital	Illness outside city permissible
Yes	Mean	1.13	1.19	1.13	1.19	1.53
	N	47	47	47	47	47
	Std. Deviation	.337	.398	.494	.398	.747
No	Mean	1.83	2.09	1.83	1.75	2.08
	N	103	103	103	103	103
	Std. Deviation	.909	.793	.912	.894	.788
Total	Mean	1.61	1.81	1.61	1.57	1.91
	N	150	150	150	150	150
	Std. Deviation	.842	.808	.866	.814	.814

- **Awareness regarding the services provided by your TPA:**

This part of the questionnaire was analysed based upon the responses given by those respondents who have incurred claims against their health insurance. During hospitalization the services of TPA come into play, from this data it was observed that the maximum subscribers who used their health insurance for their treatment were unaware about the services that their TPA has to provide them as per their functions and responsibilities.

- **Arrangement of Specialised Consultation:**

Claims incurred since insured * Arrangement of specialised consultation Cross tabulation

		Arrangement of specialised consultation			
		Yes	No	Don't know	Total
Claims incurred since insured yes	Count	16	9	33	58
	% within Claims incurred since insured	27.6%	15.5%	56.9%	100.0%
Total	Count	16	9	33	58
	% within Claims incurred since insured	27.6%	15.5%	56.9%	100.0%

- **Auditing and scrutinizing of bills Cross tabulation**

Claims incurred since insured * Auditing and scrutinizing of bills Cross tabulation

		Auditing and scrutinizing of bills			
		Yes	No	Don't know	Total
Claims incurred since insured yes	Count	23	2	33	58
	% within Claims incurred since insured	39.7%	3.4%	56.9%	100.0%
Total	Count	23	2	33	58
	% within Claims incurred since insured	39.7%	3.4%	56.9%	100.0%

- **Enquiry about test room rates:**

Claims incurred since insured * Enquiry about test room rates Cross tabulation

		Enquiry about test room rates			
		Yes	No	Don't know	Total
Claims incurred since insured yes	Count	14	8	36	58
	% within Claims incurred since insured	24.1%	13.8%	62.1%	100.0%
Total	Count	14	8	36	58
	% within Claims incurred since insured	24.1%	13.8%	62.1%	100.0%

- **Assistance at the time of hospitalisation:**

Claims incurred since insured * Assistance at the time of hospitalisation Cross tabulation

		Assistance at the time of hospitalisation			
		Yes	No	Don't know	Total
Claims incurred since insured yes	Count	14	14	30	58
	% within Claims incurred since insured	24.1%	24.1%	51.7%	100.0%
Total	Count	14	14	30	58
	% within Claims incurred since insured	24.1%	24.1%	51.7%	100.0%

- **Enquiry about length of stay**:

Claims incurred since insured * Enquiry about length of stay Cross tabulation

		Enquiry about length of stay			
		Yes	No	Don't know	Total
Claims incurred since insured yes	Count	19	6	33	58
	% within Claims incurred since insured	32.8%	10.3%	56.9%	100.0%
Total	Count	19	6	33	58
	% within Claims incurred since insured	32.8%	10.3%	56.9%	100.0%

- **Assistance at the time of hospitalisation**

Claims incurred since insured * Assistance at the time of hospitalisation Crosstabulation

		Assistance at the time of hospitalisation			
		Yes	No	Don't know	Total
Claims incurred since insured yes	Count	14	14	30	58
	% within Claims incurred since insured	24.1%	24.1%	51.7%	100.0%
Total	Count	14	14	30	58
	% within Claims incurred since insured	24.1%	24.1%	51.7%	100.0%

- **Satisfaction level of respondent's w.r.t TPA:**

During the primary data collection the respondents after being asked the questions regarding the roles and functions of TPA were made aware about the role the TPA is supposed to play in as a part of their insurance contract; with that imparted knowledge they were asked to assess the satisfaction level they perceive about their respective TPAs; a majority of the respondents nearly 75% were neither satisfied nor dissatisfied clearly depicting a complete lack of previous knowledge about the services they are supposed to get from their TPAs.

Satisfaction level of TPA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Somewhat dissatisfied	5	3.3	3.3	3.3
	Neither	113	75.3	75.3	78.7
	Somewhat satisfied	15	10.0	10.0	88.7
	Satisfied	13	8.7	8.7	97.3
	Highly satisfied	4	2.7	2.7	100.0
	Total	150	100.0	100.0	

CHAPTER 5 DISCUSSIONS and CONCLUSION

As it has been previously discussed that India's changing disease profile has increased the need of development of an effective and efficient healthcare infrastructure along with increasing the capability of the population to afford the healthcare services hence the need of healthcare financing has also emerged.

The health insurance industry came up as an essential tool for arranging finances for their subscribers for their health related disorders and any other unfortunate incidents. The introduction of TPAs was a significant step towards designing a mechanism for unbiased and quality ensured healthcare delivery but after approximate 10 years since the TPAs came into existence still the general public is unaware about the roles and functions a TPA is supposed to perform, this raises questions on the working of the TPAs. The TPAs are meant to act as an interface between the insurer and the insured and they are in position to educate people about their health insurance policy.

A large chunk of the respondents of this study perpetuated the TPAs as traditional insurance agents and were unaware that their respective TPAs are responsible for provision of services ranging from details about network hospitals, cashless services, the continued stay and concurrent review of the patient during hospitalisation, arranging for specialised medical opinion etc. Thus a asymmetry in the information flow still remains a alarming issue which has to be dealt with in the coming years.

As of now there is no mechanism for appraise the performance of TPAs, the IRDA should design a mechanism to judge their performance and direct the TPAs to take corrective measures to ensure that the customer is made well aware of what he deserves to know.

Another striking feature found during the course of this study was that the education level of the respondent had no effect on their knowledge about TPAs, since a majority of the respondents were qualified graduates and post graduates still they faced a void in terms of having the complete knowledge about their policy and role of TPAs.

Moreover the subscribers who have a health insurance policy from their employer mentioned that they are not aware of these services because the insurance company or the respective TPA is in

contact with the employer's administration not directly to the employee of that organisation, there is a need for the TPAs to treat each customer as an individual entity even in the case of a group insurance taken by an organisation for its employees.

Henceforth the whole system of TPA is in need of scrutiny in terms of imparting the knowledge about the services they ought to provide to the subscriber so that the customer gets quality services worth the money they spend on health insurance premiums.

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ABSTRACT

The introduction of TPA in India's health insurance industry was a significant step towards addressing the need of a hassle free system for delivery of quality ensured healthcare for the policyholder. Their services were designed to address the cost and quality issues prevalent in the sector but still till date the implementation of TPA concept has not been as smooth and efficient as it was expected to be; a lot of work is still needed to be done in with respect to the current issues. This survey study was conducted to analyse the perception of the policyholders towards the TPAs; to know their knowledge about what roles and functions a TPA is supposed to perform. The study was conducted in New Delhi concentrating on the residents of West Delhi with a total sample size of 150.Convenience sampling was used to collect data and a questionnaire was designed for that purpose. The major findings of this study are as follows: a.) policyholders have low awareness regarding the existence of TPAs; b.) most of the policy holders rely on the insurance company or the insurance agent; c.) the policy holders are unaware of the services they can avail as a client of the respective TPA. This clearly shows that the regulatory body IRDA should take initiatives for designing an appraisal mechanism which keeps a check upon the performance of the TPAs.

Keywords: Third party administrators, Health insurance, policyholder's perception.