"A STUDY ON CASHLESS INSURANCE PROCESS AND CLAIM SETTLEMENT IN TPA"

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

By

Dr. Kapil Joshi

International Institute of Health Management Research

New Delhi -110075 **May, 2012**

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Certificate of Internship Completion

Date: ……..

TO WHOM IT MAY CONCERN

This is to certify that **Dr.Kapil Joshi** has successfully completed his 3 months internship in our Organization from **January 10, 2012 to April 10, 2012** during this intern he has worked on Project named **"A study On Cashless Insurance Process and Claim Settlement In TPA"** under the guidance of me and my team at **Vasaneyecare Hospital, Hyderabad.**

His performance during the period in the department has been excellent. He is hardworking and sincere.

We wish his good luck for his future assignments

(Signature)

_____ (Name)

_____ (Designation)

Certificate of Approval

The following dissertation titled "**A Study on Cashless insurance process and Claim settlement in TPA**" 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 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.

Name	Signature
DR DHARMESH LAL	

Reporting Format

Final Dissertation and Internship Program
(IIHMR, New Delhi-Batch 2010-12)

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Enrolment No.: PG/10/082

Organization selected for Dissertation and Internship:
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Date of Joining: 10/01/2012

Name of Internal Advisor: Dr. Dharmesh lal

This is to confirm that I have reported to my internal advisor regarding my dissertation and internship placement. During my internship I will regularly keep in contact with my advisor and keep him updated about my progress. I will also carry out a special study (or, dissertation) on cashless insurance process and claim settlement in TPA in consultation with the concerned authority of the organization. I will prepare a brief study proposal on the agreed topic and send to my advisor before February 15, 2012 for approval. I understand that the general internship report and the special study report needs to be approved by my advisor before the presentation and subsequent submission of the final report before April 24, 2012.

Signature of the graduate student: _____ **Date:** _____

Signature of the Internal Advisor: _____ **Date:** _____

(Internal Advisor's Copy)
(PGDHM Office's Copy)
(Graduate student's Copy)

Abstract

A STUDY ON CASHLESS INSURANCE PROCESS AND CLAIM SETTLEMENT IN TPA

By

Dr. Kapil Joshi

The advent of Third Party Administrators (TPAs) is expected to play an important role in health insurance market in ensuring better services to policyholders. In addition, their presence is expected to address the cost and quality issues of the vast private healthcare providers in India. However, the insurance sector still faces challenge of effectively institutionalizing the services of the TPA. A lot needs to be done in this direction. Towards this the present paper describes the findings of a study, which was carried out with the objective to ascertain the experiences and challenges perceived by hospitals and policyholders in availing services of TPA in ICICI Lombard General Insurance company. The major findings are i) lack of sufficient professional staff leads to delay in claim process, ii) The deductions from the claim amount even though the documents were there is also the reason for delay in claim settlement. iii) Due to internal communication delay, improper work flow, improper file tracking are also reasons for delay in claim settlement process. (iv) healthcare providers do experience substantial delays in settling of their claims by the TPAs (v) The claim settlement delays also due to delay in updating the endorsements of policies in the fast track(a software using for claims process) (vi) In the addendum claims the amount paying excessively due to overlooking the documents, in some claims unnecessary deductions in the claimed amount leads to increase in processing cost of the claims. There is a clear indication from the study that the regulatory body need to focus on developing mechanisms, which would help TPAs to strengthen their human capital and ensure smooth delivery of TPA services in emerging health insurance market.

Keywords: Third Part Administrators, Health Insurance, Behaviour

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First and foremost, I express my heartiest thanks to **DR.Dhermesh Lal** Associate dean, IIHMR and**. Dr Divaker Dixit,** Manager Operation, **Vasaneyecare Hospital,** Hyderabad. for their grateful guidance and co-operation throughout the study of this project.

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I owe my sincere gratitude to my family members for their grateful encouragement and never ending support.

Last but not least, I want to give special thanks to my wife Dr. Mamta Pareek and daughter Lakshika for their support and encouragement.

STRUCTURE OF THE REPORT

LIST OF TABLES

LIST OF FIGURES

CHAPTER-1
INTRODUCTION

1.1) Topic area:

Processing of claims in Health Insurance Company.

1.2) Introduction to the title

A study of the claim settlement process in a third party administrator.

Cashless claims:

Insurers have tie-ups with a network of hospitals across the country. If the customer opts for cashless claims, he/she has the facility of cashless treatment at the networked hospitals. This list of the network is generally available in the policy kit and also on the website of the insurers.

In case of emergency hospitalization and admission, the TPA (third party administrator) needs to be intimated through a toll-free number within 24 hours. In case of a planned admission, however, the TPA is to be informed in advance. Also, the insured must remember to quote his/her health card membership number and/or policy number.

While getting admission, the cashless request form available with the hospital insurance help desk is to be filled and certified by the doctor. Having done that the form with supporting medical records is to be faxed by the hospital to the TPA's fax number. On scrutinizing the documents, the TPA conveys the decision to the hospital, the sanction of the cashless request or calls for additional documents if required. On approval of the cashless facility by the TPA, the hospital bills are settled directly by the insurer (subject to policy limits). However, inadmissible amounts such as telephone, food and attendant charges are to be borne by the customer. If the customer chooses to go to a hospital which is not part of the network, he/she can still get a reimbursement directly from the insurer.

Reimbursement of claims:

This facility is available at network hospitals as well as non-network hospitals. Under this facility, the insured can avail of treatment and settle all the bills with the hospital and file a claim for reimbursement. The insurer, however, has to be intimated immediately on admission not later than 30 days from the date of discharge. The policy certificate number should be quoted and the claim can also be intimated online through the website of the company. Generally claim documents (originals only) are to be submitted to the insurer within 30 days from the date of discharge:

1.3) Profile of Industry:

Insurance

Insurance is a promise of compensation for specific potential future losses in exchange for a periodic payment. Insurance is designed to protect the financial well-being of an individual, company or other entity in the case of unexpected loss. Some forms of insurance are required by law, while others are optional. Agreeing to the terms of an insurance policy creates a contract between the insured and the insurer. In exchange for payments from the insured (called premiums), the insurer agrees to pay the policy holder a sum of money upon the occurrence of a specific event. In most cases, the policy holder pays part of the loss (called the deductible), and the insurer pays the rest. Examples include car insurance, health insurance, disability insurance, life insurance, and business insurance.

Market drivers for Insurance is:

- Rise in GDP
- Demand For Terror Insurance
- Increasing Household Financial Savings
- Rising Urban Per Capita Income
- Rising Automobile Sales
- Health Insurance – the Fastest Growing Segment

- Population Growth

Insurance, in law and economics, is a form of risk management primarily used to hedge against the risk of a contingent loss. Insurance is defined as the equitable transfer of the risk of a loss, from one entity to another, in exchange for a premium. An insurer is a company selling the insurance. The insurance rate is a factor used to determine the amount, called the premium, to be charged for a certain amount of insurance coverage. Risk management, the practice of appraising and controlling risk, has evolved as a discrete field of study and practice.

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.

Health Insurance is against loss by illness or bodily injury. Health insurance provides coverage for medicine, visits to the doctor or emergency room, hospital stays and other medical expenses. Policies differ in what they cover, the size of the deductible and/or co-payment, limits of coverage and the options for treatment available to the policyholder. Health insurance can be directly purchased by an individual, or it may be provided through an employer.

The health insurance industry in India is expected to register robust growth rate in coming years and will see a CAGR of around 41% during FY 2010-2013. The industry future is promising despite the concern of lack of awareness in majority of the population. The health insurance industry growth will mainly be driven by rising healthcare costs and prospering middle class population, encouraging people to secure their health by taking medical coverage. Government initiatives, including the detariffing of general insurance industry and the rationalization of premium rates, will also give impetus to the industry.

Our research indicates that presently only 10% of Indian population is covered under health insurance, indicating that there is tremendous scope for growth in this area. Low penetration rate will be covered by a slew of innovative schemes and better coverage for urban as well as rural population. We have also evaluated various factors that will propel growth in the Indian health insurance market over the forecast period (FY 2010-FY 2013).

Besides, that there is an extensive research and prudent analysis of the Indian healthcare market in order to understand the factors that will continue to serve as market drivers in coming years. The factors that are identified as growing per capita healthcare spending, epidemiological transitions and change in the demographic profiles have supported the healthcare insurance industry to make strong headways and post healthy growth rate. The report also gives insight into the role of private players to popularize the concept of health insurance in the Indian populace.

As Insurance companies are becoming more mature in age and volumes, the number of claims arising is also increasing. Claims management is one of the key business processes which have a direct impact on Customer Satisfaction and overall relationship with the carrier. Claims management accounts for approximately 40% of an insurer's administrative overhead. Based on various survey results, average customer satisfaction is ‗Poor' after going through the claims process. This kind of resource-intensive function will result in such poor customer satisfaction.

While buying a health policy, the customer is required to opt for either cashless or reimbursement mode of settlement. In both the cases, however, it is important to understand the claim procedure laid down by the insurers.Simply because at the time of emergency, the understanding of the right procedure can help reduce unwarranted panic.

1.4) Profile HealthSprint Pvt. Ltd. Company:

Health Sprint networks is the healthcare IT services company founded in may 2006 by 3 promoters who possess desire and complementary skills from healthcare, technology and marketing domains.

Health Sprint has formulated clear business programs in healthcare, and implemented 1 revenue generating use scenario" web enabled in-patients insurance claims management network". This is one specific instantiation of company's larger program of "payer provider network".

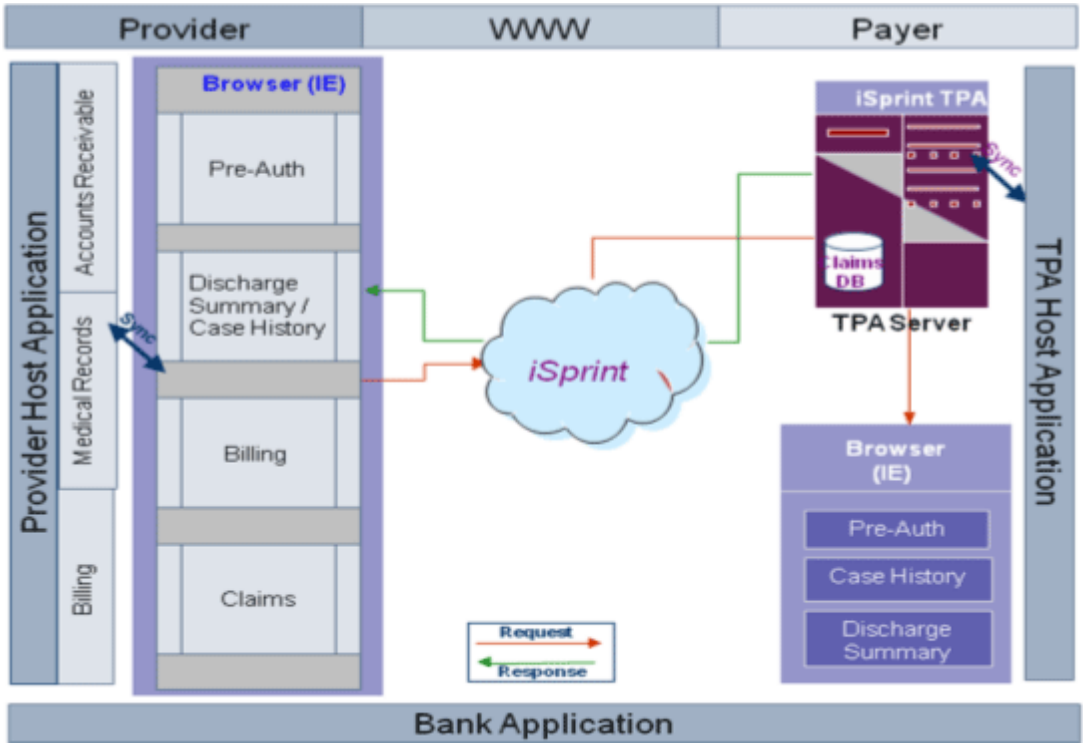
Health Sprint has growing customer base of providers and payers.Health Sprint has growing employee strength of 50+ who comes from healthcare, technical and business arena.

> Health Sprint believes in enabling green payer provider network by transforming paper based workflow into internet enabled workflows.
>
> **Vision**: We aim to connect healthcare ecosystem and its key players using web based technologies to enable valuable use scenarios, which bring value to our customers, investors and to the community we live in.

Mission: Enabling a web based information exchange platform, which enables reliable, speedy and transparent payer –provider workflow. HS details

I-Sprint Network Architecture

i Sprint electronic claims network is 1st of its kind of Network run in India run by a group of professionals which belongs to HealthSprint Networks Pvt.Ltd, Hyderabad.The aim of the network is to provide patient friendly health insurance transaction platform which smoothly enables transfer of Health Insurance related data with complete privacy and security



Computer System/Internet Requirement

Hardware Specification

Processor: Intel Pentium IV or Higher; Monitor: Min 14" Color Monitor RAM: 512 MB; Hard Disk: 40 GB; Keyboard: Any; Mouse: Any CD Drive: Any; Scanner: Document scanner and Printer.

Software Specification

Operating system: Windows 2000/XP professional with service pack.
Browser Internet Explorer 6.0 or higher. Others: Office XP, Any Antivirus software, Broadband stable Internet connection.

Commercials:

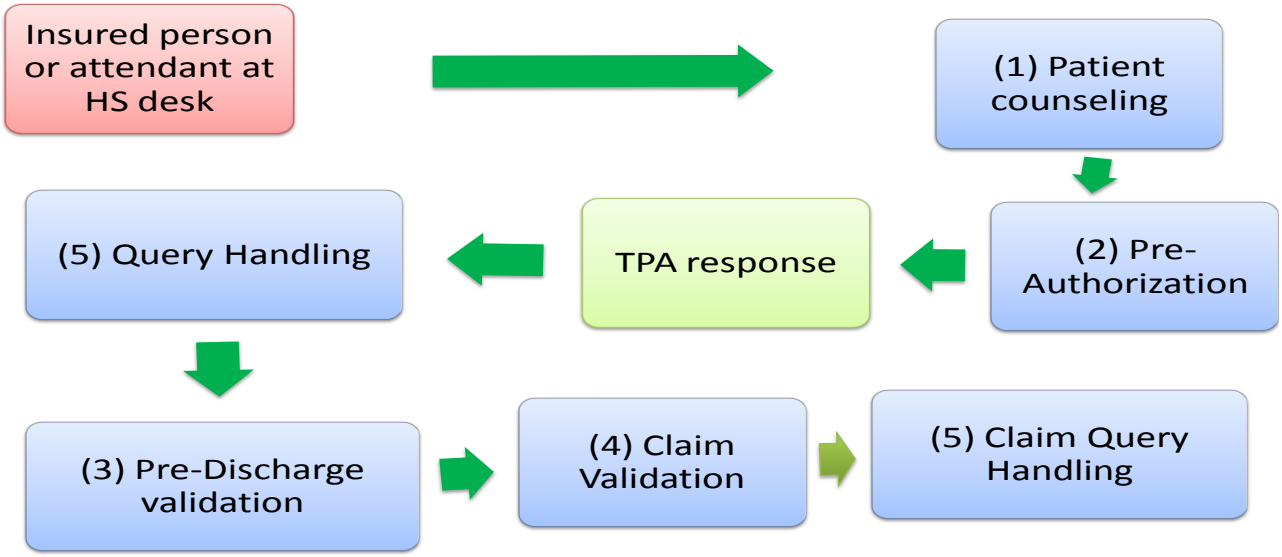
1. Training and Implementation Charges – Rs ------. (One time payment)

2. ISprint Software Module :(Preauth/Enhancements):License Fee: With Helpdesk – Rs -- / case (*Taxes will be extra as applicable)*Without Helpdesk – Rs -- / case (*Taxes will be extra as applicable)(Actual cost in figures is not revealed)*

Workflow and process by Healthsprint at Hospital end

Work flow at Vasan eye care Hospitals

Standard Operating Process (SOP)



Work flow of Vasan Eyecare Hospitals

HealthSprint Platform → Hospital Login → Process case

Online Preauth submission → Request response cycle → Approval of Claim → Case automatically gone to RCM Platform

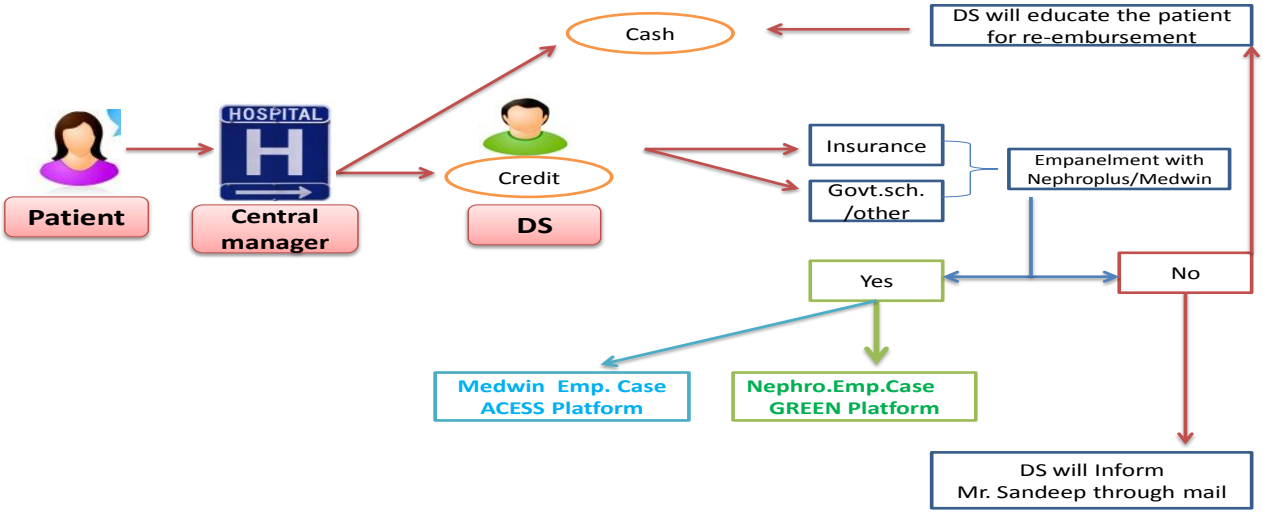
Offline Preauth submission through Mail or Fax → RR Cycle offline → Case upload on Platform in Offline Preauth → Approval of Claim → Offline Process step → Upload Approval letter on Offline Platform

shown as un-submitted status on RCM Platform

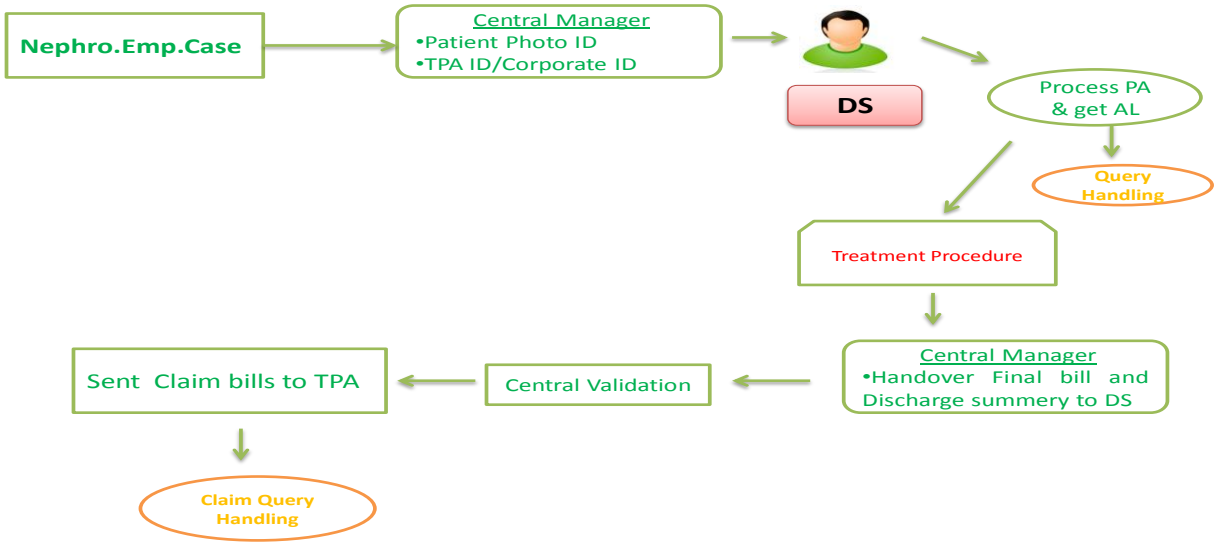
Manual claim validation done by DS at Hospital then soft copy of Claim documents uploaded on Platform for Central Claim Validation team → RR cycle between DS and Claim Validator → Validated → Courier dispatch to the respective TPA and dispatch no uploaded on Platform and hospital register.

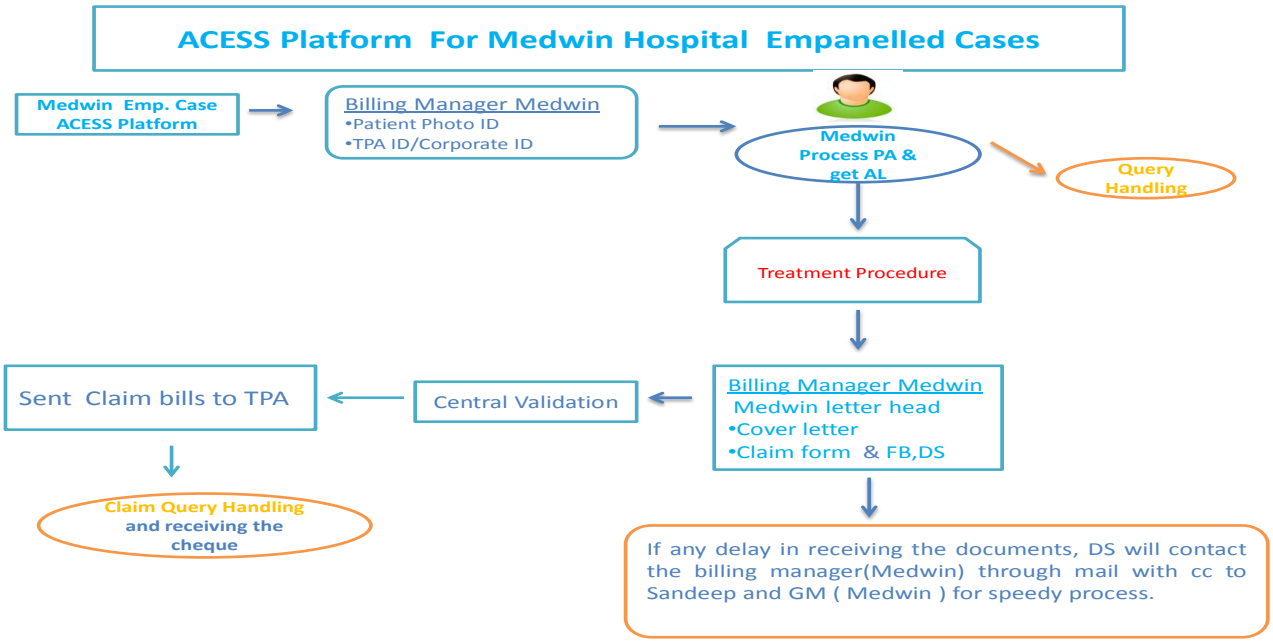
Insurance desk Workflow at NephroPlus Hospital

TPA DESK PROCESS



GREEN Platform For Nephroplus Empanelled Cases





Renewal of sessions :-

- DS has to intimate Nephroplus when 2 valid pre-auths are pending so that the renewal can be processed soon

- Nephroplus central manager will intimate DS when there is one valid pre-auth pending

Health Sprint Payer-Provider Web Services

- Real time Patient Information Exchange between Payer & provider for cashless authorization for health insured patients.
- Enabling speedy, transparent and traceable Information exchange between payer and provider.

1. Core Functionalities

The webpage allows checking the status of the submitted request (Processed/Unprocessed) as well to submit a fresh request (Compose New Request)

1. Processed Request: List of cases already processed can be viewed. A specific case can be located by entering the Name of the patient against Name Textbox and pressing Start Search option. Broadly cases under each TPA can be listed by selecting the option on TPA drop down list. The sort option enables the user to search the list of claims in Ascending/Descending order also the list can be sorted by options of Ref Id, Name, TPA and Status of the claim.
2. Compose New Request: A fresh request to be made has few mandatory fields to be filled marked with red asterisk under the following headings.

1.Patient Information (Basic patient info like Name, Age, Sex, TPA id etc)
2.Patient Medical Information (Patient Complaints, Diagnosis, Treatment etc)
3.Hospital Information (Admission date, Duration of Stay, Doctor name etc)
4.Reports/Files Upload (Additional info like reports, files can be attached)
5.Summary (to view the summary of request made before submitting)

iSprint Usage Report

- The list of all requests submitted to all the TPA for a period is displayed with Ref No, TPA, Patient Name, Patient Id, Submission time, Authorized time, Turn Around Time and Status .Further specific search can be made for particular TPA, Ref No, Request type, Status of the request, Duration From a date and To a date. The reports can be downloaded in MS Word, Adobe Page or MS Excel format and used.

2. Secondary Functionalities

- Alerts: *Work Load Alert:* This alert shows the no of PreAuth requests and Claims which are Unprocessed and Need more Info in two separate categories.

Non Activity Login Alert: This alert shows the non activit period

- Settings: *Personal:* This function allows the user to change the personal settings like Name, Email id, Security Question, Answer etc

Password: This function allows the user to change the password

- Audit Trail: *Login Trial :* The details of Login time and Logout time are shown

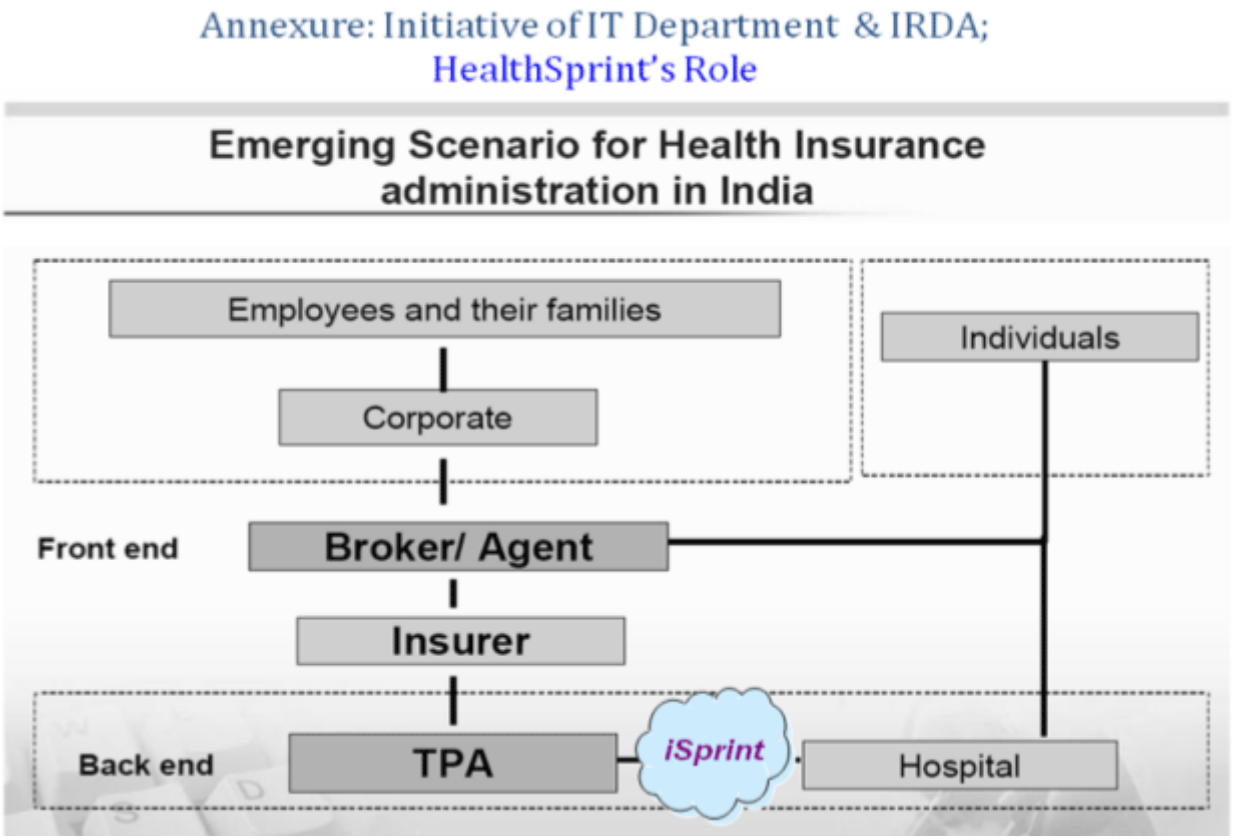
Transaction Trial: The details of all the claims between Hospital and TPA are shown

- Communication: *Mailbox:* to check the incoming messages, *Email:* to send a mail

- Search: Advanced search can be made to trace a Request/Claim.

- Logout : Selecting this will logout the user from iSprint web services

Health Sprint Role



i Sprint Software Features*:*

> Capture and Maintenance of Patient Health Information and Medical Billing Information

1. Registering the Patient (Capturing Patient Demographics and Insurance identification)
2. Obtaining Consent/Authorization for release of medical information
3. Creating the patient's medical record (Details on the Complaint, Diagnosis, Procedure, other information captured during the Patient Encounter)
4. Capturing Patient Insurance Information, Policies, services and prices.

> Pre-Authorization services

5. Providing Case History
6. Obtaining Authorization for providing service

> Submission of Enhancement

7. Providing Case Histories and Discharge Summary
8. Providing Bills with Break up

> Reporting Module

- Time Request submitted
- Time Request Processed
- Turnaround Time to process request

About ICICI Lombard General Insurance Company:

ICICI Lombard GIC Ltd. is a 74:26 joint venture between ICICI Bank Limited, India‘s second largest bank.

ICICI Lombard GIC Ltd. is the largest private sector general insurance company in India with a Gross Written Premium (GWP) of Rs. 3,694.7 crore for the year ended March 31, 2010. The company issued over 44 lakh policies and settled over 62 lakh claims and has a claim disposal ratio of 96% (percentage of claims settled against claims reported) as on March 31, 2010. The company has 4,201 employees and 315 branches as on October 31, 2010. The company has been assigned a domestic rating of ‗iAAA‘ by ICRA (an associate of Moody‘s Investors Service) for highest claim paying ability and a fundamentally strong position, for the fifth consecutive year.

The company has recently received ‗NASSCOM – CNBC TV18 IT User Award 2010‘ for Best Technology Implementation in the Insurance Sector. It has been awarded CNBC Awaaz Consumer Award 2010 for being the ‗most preferred brand‘ in the General Insurance category and Brand Loyalty award in the ‗Insurance Sector - Non-Life‘ at the 3rd Loyalty awards, 2010.

It was awarded the ‗General Insurance Company of the Year‘ at the 11th Asia Insurance Industry Awards. The company also won the NDTV Profit Business Leadership Award 2007 and was adjudged as the most Customer Responsive Company in the Insurance category at the Economic Times Avaya Global Connect Customer Responsiveness Award 2006. It has the Gold Shield for ‗Excellence in Financial Reporting‘ by the ICAI (Institute of Chartered Accountants of India) for the year ended March 31, 2006.

ICICI Lombard allows instant policy issuance and renewal through its website www.icicilombard.com f or all retail insurance products including Car Insurance, Health Insurance, Travel Insurance, Two Wheeler Insurance and Home Insurance. There are multiple payment options available including internet banking, credit card, debit card and cash card.

Ms. Chanda Kochhar, MD & CEO, ICICI Bank Ltd. added, –The Indian Healthcare industry needs to look at becoming six times it's current size by 2020 and that‘s exactly the scale and size that the industry needs to gear itself for. The Indian healthcare system needs to deliver the three A's to the Indian population, that is, increasing accessibility, affordability and assurance of quality of healthcare facilities in India. By providing Indians with basic healthcare and education

facilities, the healthcare industry as a whole will benefit entire growth in India become truly inclusive.

1.5) Insurance Backdrop:

Insurance appears simultaneously with the appearance of human society. We know of two types of economies in human societies: money economies (with markets, money, financial instruments and so on) and non-money or natural economies (without money, markets, financial instruments and so on). The second type is a more ancient form than the first. In such an economy and community, we can see insurance in the form of people helping each other. For example, if a house burns down, the members of the community help build a new one. Should the same thing happen to one's neighbor, the other neighbors must help. Otherwise, neighbors will not receive help in the future. This type of insurance has survived to the present day in some countries where modern money economy with its financial instruments is not widespread. Any risk that can be quantified can potentially be insured. Specific kinds of risk that may give rise to claims are known as "perils". An insurance policy will set out in detail which perils are covered by the policy and which are not.

When insured parties experience a loss for a specified peril, the coverage entitles the policyholder to make a 'claim' against the insurer for the covered amount of loss as specified by the policy. The fee paid by the insured to the insurer for assuming the risk is called the 'premium'. Insurance premiums from many insured‘s are used to fund accounts reserved for later payment of claims—in theory for a relatively few claimants—and for overhead costs. So long as an insurer maintains adequate funds set aside for anticipated losses (i.e., reserves), the remaining margin is an insurer's profit.

Insurer's Business Model

Profit = earned premium + investment income - incurred loss - underwriting expenses.

Insurers make money in two ways: (I) through underwriting, the process by which insurers select the risks to insure and decide how much in premiums to charge for accepting those risks and (2) by investing the premiums they collect from insured‘s

Insurance companies also earn investment profits on "float". "Float" or available reserve is the amount of money, at hand at any given moment that an insurer has collected in insurance premiums but has not been paid out in claims. Insurers star investing insurance premiums as soon as they are collected and continue to earn interest on them until claims are paid out.

The tendency to swing between profitable and unprofitable periods over time is commonly known as the "underwriting" or insurance cycle.

Create a New Business Model: Despite untapped opportunities, demand for insurance products still needs to be created. Amaze of challenges must be overcome to penetrate rural markets, including the creation of successful business models in rural insurance. FMCG and telecom companies have done an admirable job in penetrating rural markets by creating a need where one did not previously exist. For instance, telecom companies first built networks and tailored products for the rural markets, thereafter providing a distinct value to rural customers. Health Insurance providers could do likewise by first building an ‗accredited‘ network and then providing tailor-made policies for people at a price point they can afford. Learning‘s can be drawn from the much appreciated Rashtriya Swasthya Bima Yojana which is slowly expanding its reach. It has demonstrated an active, cooperative participation between Central Govt, State Govts, private and public insurers, Technology and NGOs/SHG etc.

Three-tier Model a Better Option:

Given India‘s broad division into three segments - those living below the poverty line, the middle class and the upper class - it would be better if India followed a three tier model, since a one-size-fits-all model won‘t work well in health insurance. Each of the three tiers- Government, private and public private partnerships (PPP) — are suited to meet the needs of different population segments. The poor would almost exclusively fall under a Government-subsidized

insurance scheme such as RSBY.Those in the middle may wish to opt for a PPP, which permits a mix of both systems, offering a combination of insurance benefits at a price point that the middle income population can afford. At the other extreme, upper-income groups would likely prefer to pay for additional benefits offered by individual private insurance companies. For the above, healthcare infrastructure needs to be improved dramatically.

1.6) Types Of Insurance:

- Health
- Disability
- Casualty
- Life
- Property
- Liability
- Credit

Other types Insurance companies:

Insurance companies may be classified into two groups:

- Life insurance companies, which sell life insurance, annuities and pensions products.
- Non-life. General, or Property/Casualty insurance companies, which sell other types of Insurance.

General insurance companies can be further divided into these sub categories.

- Standard Lines
- Excess Line

In most countries, life and non-life insurers are subject to different regulatory regimes and different tax and accounting rules. The main reason for the distinction between the two types of company is that life, annuity, and pension business is very long-term in nature — coverage for

life assurance or a pension can cover risks over many decades. By contrast, non-life insurance cover usually covers a shorter period, such as one year.

Reinsurance companies are insurance companies that sell policies to other insurance companies, allowing them to reduce their risks and protect themselves from very large losses. The reinsurance market is dominated by a few very large companies, with huge reserves. A reinsurer may also be a direct writer of insurance risks as well.

There are also companies known as 'insurance consultants'. Like a mortgage broker, these companies are paid a fee by the customer to shop around for the best insurance policy amongst many companies. Similar to an insurance consultant, an 'insurance broker' also shops around for the best insurance policy amongst many companies. However, with insurance brokers, the fee is usually paid in the form of commission from the insurer that is selected rather than directly from the client.

Third party administrators are companies that perform underwriting and sometimes claim handling services for insurance companies. These companies often have special expertise that the insurance companies do not have.

A Health insurance policy is a contract between an insurance company and an individual. The contract can be renewable annually or monthly. The type and amount of health care costs that will be covered by the health plan are specified in advance, in the member contract or Evidence of Coverage booklet.

Universal health care is health care coverage which is extended to all citizens, and sometimes permanent residents, of a governmental region. Universal health care programs vary widely in their structure and funding mechanisms, particularly the degree to which they are publicly funded. Typically, most health care costs are met by the population via compulsory health insurance or taxation, or a combination of both.

Universal health care systems require government involvement, typically in the forms of enacting legislation, mandates and regulation. In some cases, government involvement also

includes directly managing the health care system, but many countries use mixed public-private systems to deliver universal health care.

Social health insurance

Social health insurance (SHI) is a method for financing health care costs through a (government-mandated) social insurance program based on the collection of funds contributed by individuals, employers, and sometimes government subsidies. It is one of the five main ways that health care systems are funded.

How an efficient and ideal claims system should be. This document is most relevant for the Indian insurance industry.

Introduction

As Insurance companies are becoming more mature in age and volumes, the number of claims arising is also increasing. Claims management is one of the key business processes which have a direct impact on Customer Satisfaction and overall relationship with the carrier. Claims management accounts for approximately 40% of an insurer's administrative overhead. Based on various survey results, average customer satisfaction is ‗Poor' after going through the claims process. This kind of resource-intensive function will result in such poor customer satisfaction.

Requirements for a Claims Management System

In claims processing, the main goal of an organization is to decrease claim processing cost. The same can be achieved by reduction in the claims processing TAT (turnaround time) and improvement in their closure rate. This, in turn, will not only help the carriers reduce the operational claims expenses but also result in better customer satisfaction. However, this process is often dampened by several inefficiencies –

Error prone human intervention

Too many handshakes between the stake holders

Manually intensive paperwork

Couriering the documents

Quality checks on the manual claim processing

Time-sensitive dependencies on member signatures

An efficient Claims Management System should be able to resolve the above issues and improve the performance of the insurance companies by providing the following functionality:

- Claim Registration
- Pre-Authorization
- Assessment
- Requirement Management
- Investigation Management
- Opinions Management
- Post-Assessment
- Reminders, alerts, and notifications

1.7) Significance of the study:

The time required to pay claims is also a reflection of the efficiency of the Insurers' claims area in the processing of claims. Thus, a less efficient system will take longer, on average, to process a claim than will a more efficient one. This is a particularly important criterion in the selection of a health insurance company. The speed with which an insurer can efficiently process claims and remit payment may help to determine whether or not new business can be obtained. Obviously, there is need to monitor the whole claims payment process (as well as its constituent components) is crucial for insurers to know the performance of the company.

1.8) Research question:

How Cashless Insurance process at Hospital end and How Claim settle at TPA.

1.9) Objectives of the Study:

1) To identify the various steps in the claim settlement process.
2) To identify the functions of the Service Provider, the Insurer and the TPA in Claim settlement.
3) To find out the total time for settlement of claims.
4) To identify the bottlenecks in the settlement of claims.
5) To identify the reasons for non-payment or partial payment of claims.

1.10) Scope of the study:

The study analyses the claims made by policy holders and service providers to the patients in cash less facility. And also this study gives the factors which responsible to achieve smooth and quick discharge of claim from the complete processing .

In the TPA processing of the claims we can measure the key reasons responsible for the delayed claim processing and denial of claims by TPA. By study the TPA processing the identification of the fraud, overbilling, doubtful claims to reduce the claims ratio and losses to Insurance company. Based on the study the process regulations and modifications are made in the TPA process and Insurance company regulations with service providers and corporate customers.

1.11) Limitations:

1) The data collected pertains to few claims out of many claims received to claims processing centrer

2) The samples used in the study are confined to ICICI Lombard Health insurance company.

3) Since data has been collected for a short period of time, the validity of the data collected cannot be confirmed fully.

4) The period of the study is January-April 2012 i.e for 4 months only

CHAPTER - II

REVIEW OF LITERATURE

2.1) Preliminary work on this topic:

This study mainly reveals about the Third Party Administrators role in the health insurance claim settlement process of ICICI LOMBARD GENERAL INSURANCE COMPANY. The company has inhouse TPA services. I visited all the departments(claim inward, cashless reimbursement, member reimbursement) of the claim processing team in the company, I observed how the claims received to company & the processing of claims in the inward, cashless, reimbursement departments.

2.2) Existing knowledge:

TPA stands for Third Party Administrator. A TPA is a specialized health service provider rendering variety of services like networking with hospitals, arranging for hospitalization and claim processing and settlement. The concept of TPA has been introduced by the IRDA (Insurance Regulatory and Development Authority of India) for the benefit of both the insured and the insurer. While the insured is benefited by quicker & better health service, insurers are benefited by reduction in their administrative costs, fraudulent claims and ultimately bringing down the claim ratios. An insurance company can have more than one TPA and a TPA can serve more than one insurance company.

The scope of services of TPAs include:

- Maintain database of policyholders
- Issue of identity card to all policyholders
- Provide information to policyholders about hospitals
- Check various investigations
- Provide Cashless service

- Process claim

According to the Insurance Regulatory Development Authority (IRDA) regulation, A company with a share capital and registered under the Companies Act, 1956 can function as a TPA.The minimum paid up capital of the company shall be in equity shares amounting to Rs 1 crore. The working capital should not be less than Rs 1 crore at any point of time. At least one of the directors of the TPA shall be a qualified medical doctor registered with the Medical Council of India. The aggregate holdings of equity shares by a foreign company shall not exceed 26% of the paid up equity capital of a TPA.

2.3) Health Insurance - An Overview:

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance

covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groupsor individuals pay premiums or taxes to help protect themselves from high orunexpected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programs funded by the government. Health insurance works by estimating the overall risk of healthcare expenses and developing a routine finance structure (such as a monthly premium or annual tax) that will ensure that money is available to pay for the healthcare benefits specified in the insurance agreement. The benefit is administered by a central organization, most often either a government agency or a private or not-for-profit entity operating a health plan. History and evolutions The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance. Accident insurance was first offered in the United States

by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the US by 1866, but the industry consolidated rapidly soon thereafter. While there were earlier experiments, the origins of sickness coverage in the US effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911.Before the development of medical expense insurance, patients were expected to pay all other health care costs out of their own pockets, under what is known as the fee for service business model. During the middle to late 20th century, traditional disability insurance evolved into modern health insurance programs. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this was not always the case. Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organizations. The predecessors of today's Health Maintenance Organizations (HMOs) originated beginning in 1929, through the 1930s and on during World War II.

Otto von Bismarck was the first to make social health insurance mandatory on a national scale (in Germany), but social health insurance was already common for many centuries before among guilds mainly in continental Europe. Countries with SHI systems include Austria, Belgium, Germany, France, and Luxembourg. Generally, their per capita health expenditures is higher than in tax-based systems. Such predominantly tax-based systems tend to be called "National Health Systems" (or, "Beveridge systems", named after William Beveridge, who was in charge of writing the Beveridge report). Some see this label as inappropriate as the health care systems have been largely decentralized beyond the national level in these countries.

Universal health insurance in India:

India has partial universal health care system run by the local governments. The "government hospitals", some of which are among the best hospitals in India, provide treatment at taxpayer cost. Selected drugs are offered free of charge in some hospitals. In 1946 a Health Survey and

Development Committee in India put forward a plan for a universal health care system. According to India today, the country has not lived up to their outlined plan. As of 2007, the hospitals contain only a tenth of the recommended ratio of hospital beds; there are only 70 beds for every 100,000 people. According to the WHO. India's health care system is 83% privately funded, with 17% of health care expenditure corning from the government as of 2004.

Reason For Health Insurance

Every human being is exposed to various health hazards-

• Medical emergency can strike anyone without pre-warming.

• Inadequate facilities in government hospitals

• Private hospitals are too expensive

• Medicines have become quiet expensive

• Diagnostic charges are beyond common man's reach

• Specialists come at a price

• Tax benefit under section 80 D of the Income Tax Act.

• Health risk is a personal risk, which could arise from various factors viz.

a) Physical condition

b) Psychological condition

c) Accident related

d) Occupational related

e) Environment related

f) Life style related

g) Travel related

2.4) Insurance In India:

Insurance is a federal subject in India and has a history dating back to 1818. Life and general insurance in India is still a nascent sector with huge potential for various global players with the life insurance premiums accounting to 2.5% of the country's GDP while general insurance premiums to 0.65% of India's GDP. The Insurance sector in India has gone through a number of phases and changes, particularly in the recent years when the Govt. of India in 1999 opened up the insurance sector by allowing private companies to solicit insurance and also allowing FDI up to 26%. Ever since, the Indian insurance sector is considered as a booming market with every other global insurance company wanting to have a lion's share. Currently, the largest life insurance company in India is still owned by the government.

History of Insurance in India

Insurance in India has its history dating back till 1818. when Oriental Life Insurance Company was started by Europeans in Kolkata to cater to the needs of European community. Pre-independent era in India saw discrimination among the life of foreigners and Indians with higher premiums being charged for the latter. It was only in the year 1870. Bombay Mutual Life Assurance Society, the first Indian insurance company covered Indian lives at normal rates.

At the dawn of the twentieth century, insurance companies started mushrooming up. In the year 1912, the Life Insurance Companies Act, and the Provident Fund Act were passed to regulate the insurance business. The Life Insurance Companies Act, 1912 made it necessary that the premium rate tables and periodical valuations of companies should be certified by an actuary. However, the disparage still existed as discrimination between Indian and foreign companies. The oldest existing insurance company in India is National Insurance Company Ltd. which was founded in 1906 and is doing business even today. Insurance industry earlier comprised of only two state insurers. Life Insurers i.e. Life Insurance Corporation of India (LIC) and General Insurers i.e.

General Insurance Corporation of India (GIC). GIC had four subsidiary companies. With effect from December 2000, these subsidiaries have been de-linked from parent company and made as independent insurance companies: Oriental Insurance Company Limited, New India Assurance Company Limited, National Insurance Company Limited and United India Insurance Company Limited.

Related Acts

The insurance sector went through a full circle of phases from being unregulated to completely regulate and then currently being partly deregulated. It is governed by a number of acts, with the first one being the Insurance Act. 1938.

The Insurance Act, 1938

The Insurance Act. 1938 was the first legislation governing all forms of insurance to provide strict state control over insurance business.

Life Insurance Corporation Act, 1956

Even though the first legislation was enacted in 1938 it was only in 19 January 1956.that life insurance in India was completely nationalized, through a Government ordinance: the Life Insurance Corporation Act. 1956 effective from 1.9.1956 was enacted in the same year to, inter-alia, form LIFE INSURANCE CORPORATION after nationalization of the 245 companies into one entity. There were 245 insurance companies of both Indian and foreign origin in 1956. Nationalization was accomplished by the govt. acquisition of the management of the companies. The Life Insurance Corporation of India was created on 1 st September, 1956, as a result and has grown to be the largest insurance company in India as of 2006.

General Insurance Business (Nationalization) Act, 1972

The General Insurance Business (Nationalization) Act, 1972 was enacted to nationalize the 100 odd general insurance companies and subsequently merging them into four companies. All the

companies were amalgamated into National Insurance. New India Assurance, Oriental Insurance. United India Insurance which were headquartered in each of the four metropolitan cities. Insurance Regulatory and Development Authority (IRDA) Act, 1999 Till 1999, there were not any private insurance companies in Indian insurance sector. The Govt. of India then introduced the Insurance Regulatory and Development

Authority Act in 1999, thereby de-regulating the insurance sector and allowing private companies into the insurance. Further, foreign investment was also allowed and capped at 26% holding in the Indian insurance companies. In recent years many private players entered in the Insurance sector of India. Companies with equal strength competing in the Indian insurance market. Currently, in India only 2 million people (0.2 % of total population of 1 billion), are covered under Mediclaim, whereas in developed nations like USA about 75 % of the total population are covered under some insurance scheme. With more and more private players in the sector this scenario is changing at a rapid pace.

Composition of Authority As per the section 4 of IRDA Act' 1999. Insurance Regulatory and Development Authority (IRDA. which was constituted by an act of parliament) specify the Composition of Authority

The Authority is a ten member team consisting of

(a) A Chairman;

(b) Five whole-time members;

(c) Four part-time members,

(All appointed by the Government of India)

Insurance business

Insurance business is divided into four classes:

1) Life Insurance 2) Fire Insurance 3) Marine Insurance and 4) Miscellaneous Insurance.

Life Insurers transact life insurance business; General Insurers transact the rest.

No composites are permitted as per law.

Legislations

Insurance is a federal subject in India. The primary legislation that deals with Insurance business in India is: Insurance Act. 1938. And Insurance Regulatory & Development Authority Act, 1999.

Insurance products:

Life Insurance

Popular Products: Endowment Assurance (Participating) and Money Back

(Participating). More than 80% of the life insurance business is from these products.

General Insurance

Insurance offers security and so peace of mind to the individual. The concept of insurance is that the losses of a few are made good by contribution from many. It is based on the law of large numbers. It stemmed from the need of man to find a solution for mitigation of losses. It also reflects the nature of man to find a solution collectively.

Fire and Miscellaneous insurance businesses are predominant. Motor Vehicle

Insurance is compulsory. Tariff Advisory Committee (TAC) lays down tariff rates for some of the general insurance products.

Customer Protection

Insurance Industry has Ombudsmen in 12 cities. Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the insured amount is less than Rs. 20 lakhs, in accordance with the Ombudsman Scheme. Addresses can be obtained from the offices of LIC and other insurers.

General insurance Coverage

The general insurance penetration in India is among the lowest in the world. Th below figure shows the increase of premiums in theInsurance industry of India and to the life insurance penetration. The general insurance penetration (measured as a %of GDP) is also the lowest amongst the various financial services product categories in India and has remained largely stagnant over the last ten years.:

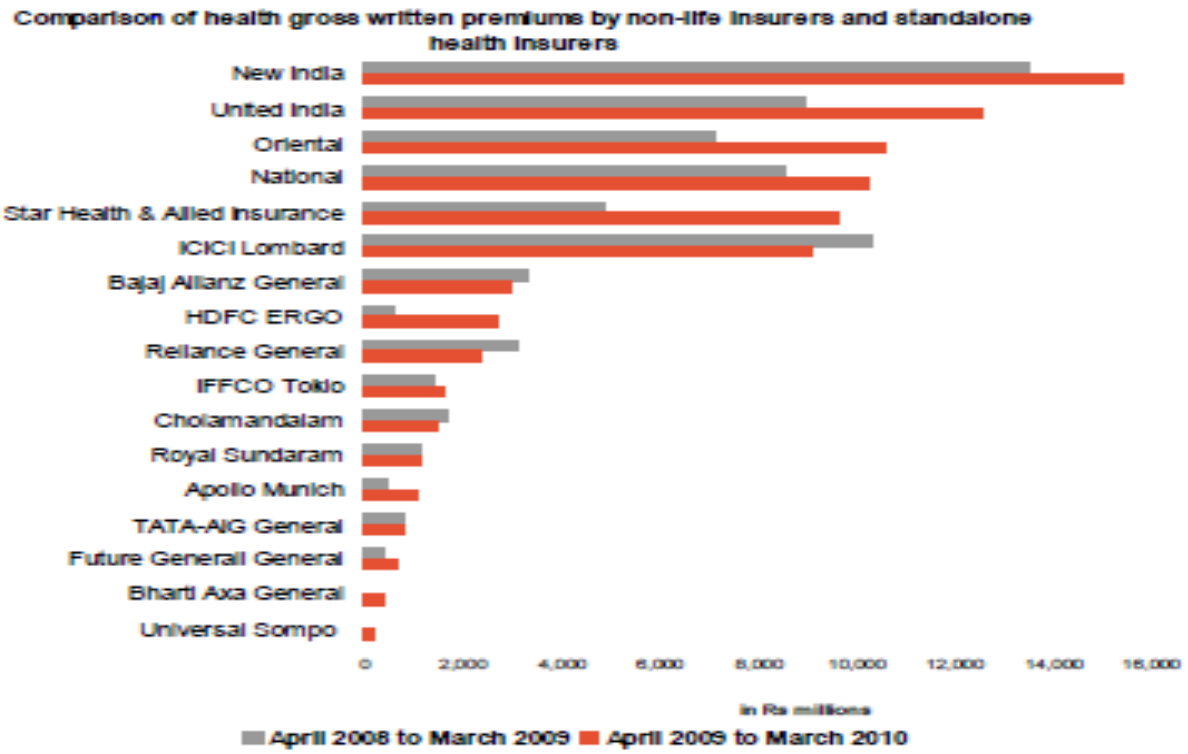


Figure.2.1 Comparison in premiums of various insurance companies

Potential for growth

The Indian economy has witnessed healthy growth in overall GDP in the recent years. The growth has been spurred by favorable demographic profile, growing literacy levels, robust investment climate and all-around infrastructure development in the country. With rising income levels, the country today boasts of a rapidly growing middle income group (upwards of 60 million households and growing). The higher disposable income and availability of organized credit has resulted in auto sector and goods sector growing rapidly. The financial services sector has seen significant growth backed on these favorable conditions. The future outlook for the economy continues to be very positive. While the general insurance industry has seen annual growth of about 15% over the last 10 years, the industry is today at an inflection point and poised to grow at a much faster pace.

The positive outlook is based on the following:

• Young population engaged in wealth creation - 60% of the population is aged below 30 years

• Rapidly growing middle class/high income segments

• Availability of organized credit in urban India

• Robust demand for motor cars and 2-wheelers

• Huge potential in health sector

• Untapped home insurance market

Healthcare consumption growth will be most rapid in India:

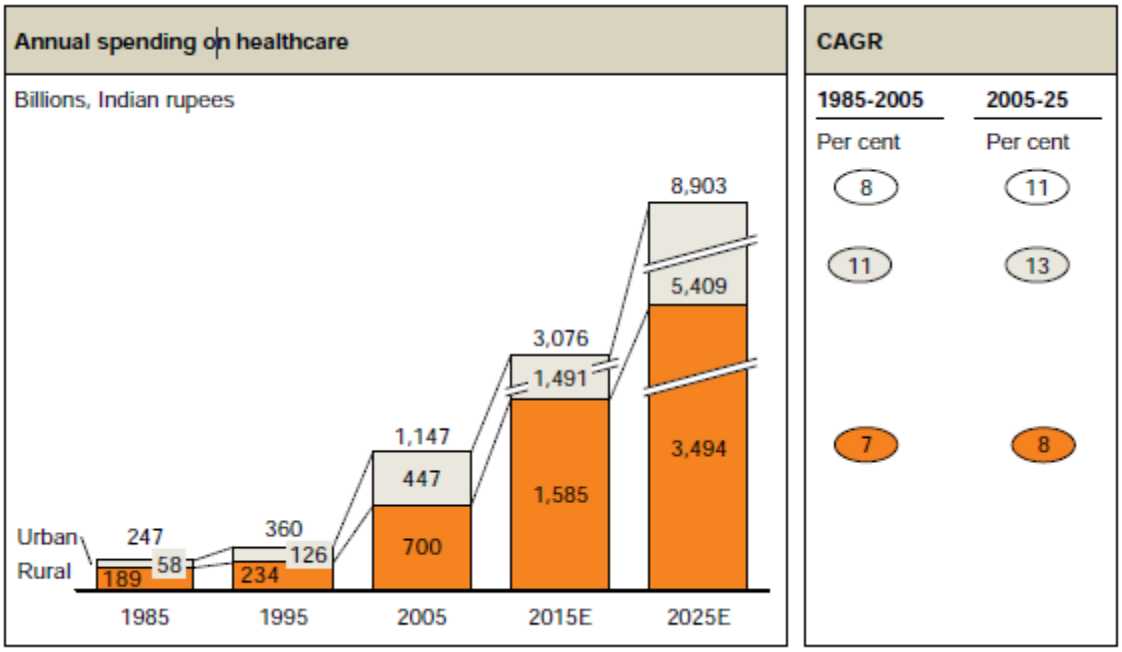


Figure.2.2 comparison of annual spending in Healthcare

Retail products

Retail products can be defined as risk categories such as health, travel, motor, home personal accident or any combination or any allied product. These products are rated on a class basis and can be pre-underwritten.

2.5 Third Party Administrators:

The concept of TPA or the THIRD PARTY ADMINISTRATOR has been introduced by IRDA (Insurance Regulatory and Development Authority) for the benefit of both

The insured and the insurer. While the insured is benefited by quicker & better service, insurers are benefited by reduction in their administrative costs, fraudulent claims and ultimately bringing down the claim ratios.

In brief, the job of the TPA is to maintain databases of policyholders and issue them identity cards with unique identification numbers and handle all the post policy issues including claim settlements. In terms of infrastructure, the TPA will need to run a 24- hour toll-free number, which can be accessed from anywhere in the country. And they will have full-time medical practitioners under their employment who will immediately take a decision on whether the ailment is covered under the policy or not.

The concept of TPA or the THIRD PARTY ADMINISTRATOR has been introduced by IRDA (Insurance Regulatory and Development Authority) for the benefit of both the insured and the insurer. While the insured is benefited by quicker & better service, insurers are benefited by reduction in their administrative costs, Fraudulent claims and ultimately bringing down the claim ratios. Third Party Administration (TPA) is a service given to a Mediclaim policyholder by providing cashless facility for all hospitalizations that come under the scope of his/her Mediclaim policy.

Products offered by a TPA

• Administering Mediclaim policies for Individuals and groups covered under Health insurance policies.

• Administering Tailor - made Mediclaim policies for Corporate and large groups covered under Health insurance policies.

• Designing and implementing Self Funded healthcare packages for large groups.

Services offered by a TPA:

• Liaison with insurance company

TPA works closely with all the leading insurance companies both public and private sector in designing the best suite of products to fulfill needs.

• Enrollment facility:

Beneficiaries enrolled with the TPA are issued photo ID cards with a Unique Health Identification Number (UHID) featuring the member details. This matter makes the member a bonafide member for availing all the services. UHID helps in the maintenance, updating and protection of the member's medical record.

• Network of Providers:

–Cashless hospitalization "a boon for the insurance products. To render truly customer centric services, entering into strategic tie up with provider hospitals, diagnostic centers across the country. These providers are dispersed across the length and breadth of the country to make the reach accessible.

• Claims management:

It is imperative for a payer organization to increase its health insurance claims processing automation and reduce administrative costs. TPA offers end-to-end world class health insurance claims processing solutions to help manage the claims

Effectively. Use of Information Technology in the insurance domain maximizes customer information and optimizes channels to serve the customer better. Employees undergo intensive training suitable for the insurance industry and its products and are trained to handle a high-pressure environment and understand the significance of real time monitoring and feedback.

TPA services strive towards complete implementation of automated end-to-end

process flows until the claims are successfully resolved with the following;

• Customer interaction services

• Application/claim processing

• Subscription service

• Finance and Billing services

• Medical and Healthcare Information Dispersal

• Troubleshooting for products and services

TPA provide high quality, value added services with emphasis on quality consistency along with timely, customized service.

Claims Audit Solutions

In an increasingly competitive market, health claims administrators must adjudicate claims accurately to control costs. TPA offers customized claims audit and consulting services that provide health insurers with qualified, unbiased third-party insight into claims processing and business office operations with the help of super specialist opinions. Audit team members edged with have extensive medical knowledge and experience in all facets of healthcare claims administration. Extensive claims processing experienced auditors are assigned to give a better possible result to customers.

Help Desk

A telephonic information resource is offered to all beneficiaries. This facility is operational for 24 hrs 365 days, for assisting the members with information of network hospitals, status of enrollment. Claims, payment details, General information, assistance in admission is the highlight of this desk.

Claims:

A request for payment of a loss which may come under the terms of an insurance contract.

Claims are broadly of two types:

• Reimbursement Claims

• Cashless claims.

Reimbursement Claims

In case, it is required to avail of hospitalization facilities at a non-network hospital, the medical expenses can still be claimed through the TPA. This is called Reimbursement.

Reimbursement claims may be filed in the following circumstances

1. Hospitalization at a non-network hospital

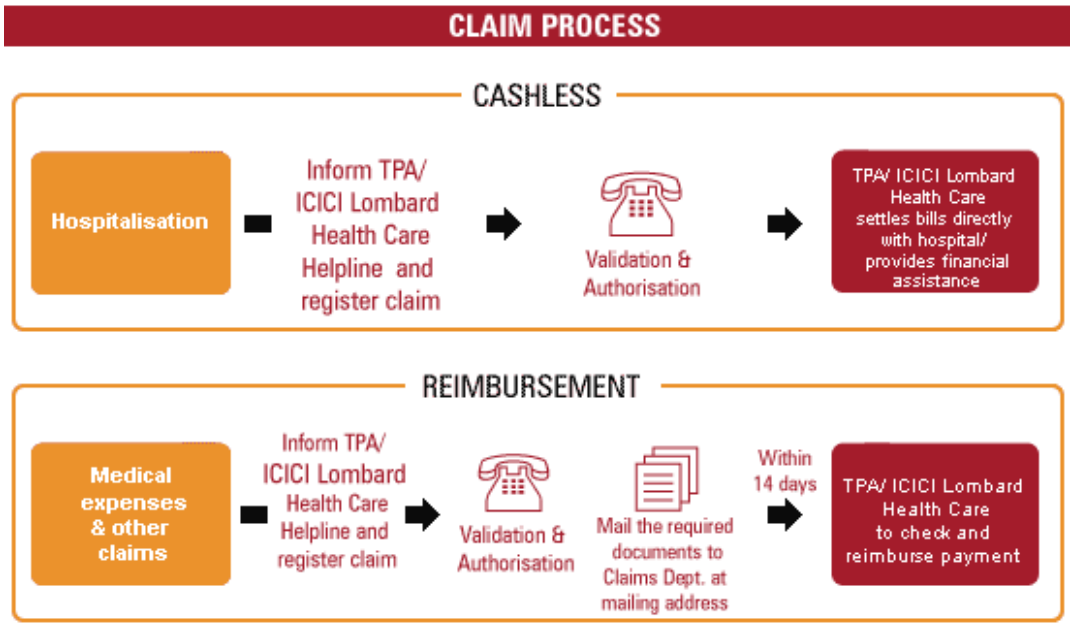
2. Post-hospitalization and pre-hospitalization expenses

3. Denial of preauthorization on application for cashless facility at a network hospital

Cashless Hospitalization

Cashless hospitalization can be availed only at the TPA network of hospitals. The essence of cashless hospitalization is that the insured individual need not make an upfront payment to the hospital at the time of admission.

Table 2.3 Claim settlement procedure



(Source ICICI Lombard Health insurance company website)

It involves service providers, insurers and third party administrators.

Proper and efficient claim settlement is very important to achieve professional Quality Claims Service.

• Fair & Time bound Disposal of a Claim.

• Customer Satisfaction with Empathy

• Loss Minimization

To settle the claims, it is essential that every policyholder go through a 3-step cycle

which is called-

(1) Claim Intimation/Notification;

(2) Claim document procurement; and

(3) Claim submission.

Advantages of TPA to policy holder

The policyholder will have full freedom to choose the hospitals from the empanelled network and utilize the services as per his/her choice For every hospitalization, the policyholder will be well aware whether the treatment he/she is to undergo is covered under his policy or not. If covered, then he/she can seek cashless facility without having to pay a single rupee at any of empanelled hospitals. During the time of Emergency Hospitalization, the policyholder or relative can flash the Photo ID Card of the policyholder and gain admission into any of our network hospitals. Priority treatment at hospital is given without any payment to be made at the any time of admission. So also at the time of discharge, no payments to be made. Thus, a complete CASHLESS TREATMENT facility is available to policy holder through TPA. Thus, the Individual does not run around for arranging cash for paying for the hospital expenses

Role and scope of TPA:

TPAs also undertake claims processing on behalf of insurers it should, however, be ensured that there is no conflict of interest between the work undertaken on behalf of the Central and State Governments and the work taken up on behalf of the Insurance Companies. It is also further clarified that the working capital requirements for attending to the work relating to the Central and State Governments shall be worked out separately and brought in additionally so as to ensure that the processing of claims on behalf of the Insurance Companies is in no way impaired.

The IRDA will not be responsible for administrative or financial transactions between the TPAs and the Central or State Governments. It. however, reserves its right to take appropriate action against the TPAs for serious acts of omission and commission brought to its notice by the Central or State Governments.

Total Claims Management (TCM)

Right from the moment of the intimation of claim to us, TPA take over entire process of informing the Insurance Company, arranging inspection / survey of loss, keeping a watch during survey for evaluating the loss correctly to derive the best to the client. Even after survey report is submitted to the Insurance Company, coordinating with them in processing the claim taking into account the coverage, so as not to suffer from aspects such as under insurance / exclusions and breach of warranties. It is also ensured that the claim cheque is delivered at the client's door step.

Total Customer Experience Management (TCEM)

Ever since the mandate is given to avail of our services we swing into action by collecting the existing policy copies if any, and also by collecting needs of the coverage afresh. Till the policy issuance and during the entire policy tenure for any changes to be incorporated, and with claims service.List of TPAs

• ICICI Lombard

• Max Bupa

• Parekh Health Management (Pvt.) Ltd.

• Medi Assist India Pvt. Ltd.

• MD India Healthcare Services (TPA) (Pvt.) Ltd.

• Paramount Health Services Pvt. Ltd.

• E Meditek Solutions Ltd.

• Heritage Health Services Pvt. Ltd.

• Universal Medi-Aid Services Ltd.

• Focus Healthcare Pvt. Ltd.

• Medicare TPA Services (I) Pvt. Ltd.

• Family Health Plan Ltd.

• Raksha TPA Pvt. Ltd.

• TTK Healthcare TPA Private Limited

• Anyuta Medinet Healthcare Pvt. Ltd.

• East West Assist TPA Pvt. Ltd.

• Med Save Health Care

• Genins India Ltd.

• Alankit Health Care Limited

• Health India TPA Services Private Limited

• Good Health plan Ltd.

• Vipul Med Corp TPA. Pvt. Ltd.

• Park Mediclaim Consultants Private Ltd.

. Safeway Mediclaim Services

• Anmol Medicare Ltd.

• Dedicated Healthcare Services (India) Private Limited,

• Grand Healthcare Services India Private Limited

• Rothshield Healthcare (TPA) Services Limited

• Sri Gokulam Health Services TPA (P) Ltd.

2.6 IRDA (Third Party Administrators - Health Services) Regulations, 2001:

In exercise of the powers conferred by sections 14 and 26 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) read with section 114A of the Insurance Act, 1938 (4 of 1938), the Authority, in consultation with the Insurance Advisory Committee hereby makes the following regulations, namely :-

1. Short title and commencement

(1) These regulations may be called the Insurance Regulatory and Development\ Authority (Third Party Administrators - Health Services) Regulations. 2001.

(2) They shall come into force from the date of their publication in the Official Gazette.

2. Definitions

In these regulations, under the context otherwise requires ,-

(a) "Act" means the Insurance Act 1938 (4 of 1938)

(b) "Agreement" means an agreement entered into between a TPA and an insurance company registered under section 3 of the Act, prescribing the terms and conditions of health services, which may be rendered to and/or received by each of the parties thereto:

(c) "Authority" means the Insurance Regulatory and Development Authority established under sub-section (1) of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999);

(d) "Health Services" means all the services to be rendered by a TPA under an agreement with an insurance company in connection with "health insurance business" or 'health cover' as defined in

regulation 2(f) of the IRDA (Registration of Indian Insurance Companies) Regulations, 2000, but does not include the business of an insurance company or the soliciting, directly or through an insurance intermediary including an insurance agent, of insurance business.

(e) "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.

(f) All words and expressions used herein but not defined in these regulations but defined in the Act, or the Insurance Regulatory and Development Authority Act. 1999 (4J of 1999), shall have the meanings respectively assigned to them in those Acts.

Third Party Administrator

3. Conditions of and Procedure for Licensing of TPA

(1) Only a company with a share capital and registered under the Companies Act, 1956 can function as a TPA.

(2) The main or primary object of the company shall be to carry on business in India as a TPA in the health services, and on being licensed by the Authority, the company shall not engage itself in any other business.

3. The minimum paid up capital of the company shall be in equity shares amounting to Rs. 1 crore (Rupees One crore only);

4. At no point of time of its functioning the TPA shall have a working capital of less than Rs. 1 crore.

5. At least one of the directors of the TPA shall be a qualified medical doctor registered with the Medical Council of India;

6. The aggregate holdings of equity shares by a foreign company shall not at any time exceed twenty-six percent of the paid up equity capital of a third party administrator.

7. Any transfer of shares exceeding 5% of the paid up share capital shall be intimated by the TPA to the Authority within 15 days of the transfer indicating the names and particulars of the transferor and transferee.

Explanation : For the purpose of this sub-regulation "working capital" means the difference between the aggregate of the current assets and current liabilities as on the date of reckoning.

4. (1) The TPA shall obtain from the Authority a license to function as a TPA for rendering health services.

2. The application for license shall be made in writing to the Authority in Form TPA-1 appended to these regulations and shall be accompanied by a nonrefundable processing fee of Rs. 20,000 (Rupees Twenty Thousand only) to the Authority by way of a crossed demand draft in favour of the Authority payable in Delhi.

3. The Authority may, in the course of examination of the application, call for such information or ask for production of such documents, as it may deem fit, and it shall be incumbent upon the applicant to furnish the same within the specified time.

4. The Authority, on examination of the application and details furnished by the applicant, may issue a license, if it is satisfied that the applicant TPA is eligible to function as a TPA.

5. Every TPA approved by the Authority shall pay a further sum of Rs. 30,000 (Rupees Thirty Thousand only) to the Authority as license fee before the license is granted to it and the same shall be paid to the Authority in the manner as stated in sub-regulation (2) of this regulation.

6. A TPA whose application has been rejected by the Authority shall not, for a period of two years from the date of such a rejection, apply once again to the Authority for a license.

7. Any transfer of shares exceeding 5% of the paid up share capital shall be intimated by the TPA to the Authority within 15 days of the transfer indicating the names and particulars of the transferor and transferee.

Explanation : For the purpose of this sub-regulation "working capital" means the difference between the aggregate of the current assets and current liabilities as on the date of reckoning

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4. The Authority, on examination of the application and details furnished by the applicant, may issue a license, if it is satisfied that the applicant TPA is eligible to function as a TPA.

5. Every TPA approved by the Authority shall pay a further sum of Rs. 30,000 (Rupees Thirty Thousand only) to the Authority as license fee before the license is granted to it and the same shall be paid to the Authority in the manner as stated in sub-regulation (2) of this regulation.

6. A TPA whose application has been rejected by the Authority shall not, for a period of two years from the date of such a rejection, apply once again to the Authority for a license.

5. A copy of the agreement entered into between the TPA and the insurance company or any modification thereof, shall be filed, within 15 days of its execution or modification, as the case may be, with the Authority.

6. More than one TPA may be engaged by an insurance company and. similarly, a TPA can serve more than one insurance company.

7. The parties to the agreement shall agree between themselves on the scope of the contract and the facilities that have to be provided. Such an agreement shall also prescribe the remuneration that may be payable to the TPA by the insurance company.

8. (1) Every TPA shall appoint, with due intimation to the Authority, from among its directors or senior employees, a Chief Administrative Officer (CAO) or Chief Executive Officer (CEO) who shall be responsible for the proper day to day administration of the activities of the TPA.

(2) Such a CAO or CEO shall possess the educational qualifications mentioned in sub-regulation (4) of this regulation and also undergo a specified period of training with any institution recognized by the Authority. (3) He shall not be :

i. A person of unsound mind:

ii. A person who had been subjected to a term of imprisonment for a period of three months by a court of competent jurisdiction on grounds of misconduct misfeasance, forgery etc.

(4) The qualifications referred to in sub-regulation(2) are -

1. a degree in arts, science or commerce or management or health or hospital administration or medicine; and

2. a pass in the Associate ship examination conducted by the Insurance Institute of India or such equivalent examination as may be recognized by the Authority and notified from time to time;

3. completion of practical training, as may be specified by the Authority, not exceeding one hundred hours with an institution recognized by the Authority, for these purposes, from time to time.

4. The Authority may grant, on an application made to it. by the CAO or CEO through the TPA, time not exceeding twenty four months from the date of the coming into force of these regulations for fulfilling the qualification, requirements as stated in sub-clauses (2) and (3) of this sub-regulation.

9. (1) Every application received by the Authority pursuant to these Regulations shall be considered by it within a reasonable time and its decision thereon communicated to the applicant.

2.) On an examination of the material placed before it and on the basis of enquiries made by it. where the Authority is of the opinion that the application does not deserve acceptance, it shall communicate its opinion to the applicant, who shall be given a reasonable opportunity to represent against the proposed rejection of the application.

3. Where on a complete examination of the materials, documents, information, etc.. available to it, the Authority finally comes to the conclusion that an application be rejected, it shall do so by making an order in writing, which shall be communicated to the applicant at the earliest.

4. Where the Authority decides to issue a license to the applicant to act as TPA, it shall issue the same in Form TPA-2.

10. Every license granted by the Authority to a TPA or any renewal thereof, in terms of these regulations, shall remain in force for three years, unless the Authority decides, either to revoke or cancel it earlier, as provided in these regulations.

11. (1) A license granted to a TPA may be renewed for a further period of three years on submission of the prescribed renewal application in Form TPA-3 along with a renewal fee of Rs. 30.000/-(Rupees Thirty Thousand only), at least thirty days prior to the date of expiry of the license.

2. Any failure on the part of the TPA to get its license renewed before its expiry has to be explained to the Authority. A delayed application shall state the reasons for the delay and be accompanied by a Sate fee of Rs. 100/- (Rupees One Hundred only).

3. The Authority after examining the reasons given in the application by the TPA may renew the license, if it is satisfied that the TPA was prevented by sufficient cause from applying for the renewal of its license at least 30 days (Thirty days) before the date on which the license ceased to remain in force.

4. The Authority may. if it is satisfied that undue hardship would be caused otherwise, accept any application after the license ceased to remain in force, on payment by the applicant of a payment of Rs. 750/- (Rupees Seven Hundred Fifty only).

12. Where a license granted by the Authority is lost or mutilated, the Authority may issue a duplicate license on payment of a fee of Rs. 1,000/-(Rupees One Thousand only) accompanied by an application in writing made by the TPA.

Revocation Or Cancellation of A Licence

13. A license granted to a TPA may after due notice be revoked or cancelled by the Authority for one or more of the reasons as provided in regulation 14.

14. The Authority may initiate action under regulation 13 for any of the following reasons:

1) the Authority, on the basis of information received by it, or on the basis of its own enquiry or investigation, is of the opinion that the TPA is functioning improperly and/or against the interests of the insured/policyholder or insurance company;

2) the Authority, on the basis of information in its possession, is of the opinion that the financial condition of the TPA has deteriorated and that the TPA cannot function effectively or that the TPA has committed a breach of regulations (3)r (4), (5) and (8) of these regulations:

3) the Authority, after enquiry or upon information, is of the opinion that the character and ownership of the TPA has changed significantly since the grant of license;

4) The Authority, finds that the license or any renewal thereof granted to the TPA was on the basis of fraud or misrepresentation of facts;

5) There is a breach on the part of the TPA in following the procedure or acquiring the qualifications laid down by regulation 8 of these regulations;

6) The TPA is subject to winding up proceedings made under Companies Act, 1956 or any statutory modification thereof.

7) There is a breach of code of conduct prescribed by regulation 21 of these regulations;

8) There is violation of any directions issued by the Authority under the Act orthese regulations.

15. Before proceeding under regulation 13 to revoke or cancel a licence granted to a TPA, the Authority shall grant a reasonable opportunity of being heard to the TPA.

16. (1) Every order made by the Authority under regulation 13 shall be in writing, stating clearly the reasons for the revocation or cancellation of the license and the order shall be served on the TPA as soon as same is made.

(2) The Authority shall also send copies thereof to the insurance company with whom the TPA has subsisting agreement(s).

17. The TPA on receipt of an order under regulation 13 shall forthwith cease to carry on its functions as TPA in relation to the insurance company and the insurance company shall immediately take such alternative steps including appointment of another TPA. as may be necessary to continue to cater to the insured/policyholders served by the TPA whose license has been revoked or cancelled.

18. A TPA whose license has been revoked or cancelled in terms of these regulations may file a review application with the Authority within 30 days of the receipt of the order cancelling or revoking the license.

19. Within reasonable period of the receipt of the application for review but not

later than 90 days thereof, the Authority shall dispose of the application after affording the applicant a reasonable opportunity of being heard.

20. Nothing contained in these regulations may be deemed to prevent or prohibit an insurance company in cancelling or modifying for good and sufficient reasons an agreement that has been entered into by it with a TPA.

21. Code of Conduct for TPA

1. A TPA licensed under these regulations shall as far as possible act in the best

professional manner.

2. In particular and without 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 :

(a) 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.

(b) Disclose its license to the insured/policyholder/prospect.

(c) Disclose the details of the services it is authorized to render in respect of health insurance products under an agreement with an insurance company;

(d) 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;

(e) 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:

(f) 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;

(g) Conduct itself/himself in a courteous and professional manner;

(h) 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;

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

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

(k) 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;

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

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

(n) Follow the guidelines/directions that may be issued down by the Authority from time to time.

22. Maintenance and Confidentiality of information -

(1) A TPA shall maintain proper records, documents, evidence and books of all transactions carried out by it on behalf of an insurance company in terms of its agreement. These books and

records shall be maintained by it in accordance with accepted professional standards of record keeping and for a period of not less than three years. Such records, documents, evidence, books, etc., and the information contained therein shall be available to the insurance company and the Authority and access to them shall not be denied by the TPA on any ground.

(2) Every TPA shall, in maintaining the records in terms of sub-regulation (1). follow strictly the professional confidentiality between the parties as required, but this does not prevent the TPA from parting with the relevant information to any Court of Law/Tribunal, the Government, or the Authority in the case of any investigation carried out or proposed to be carried out by the Authority against the insurance company, TPA or any other person or for any other reason.

(3) If the license granted to the TPA is either revoked or cancelled in terms of these regulations, the data collected by the TPA and all the books, records or documents, etc., relating to the business carried on by it with regard to an insurance company, shall be handed over to that insurance company by the TPA forthwith, complete in all respects.

Miscellaneous Provisions

23. The Authority may, from time to time, constitute Committees consisting of

members drawn from various sources including the TPAs, insurance companies, Authority, or any other persons as may be decided by the Authority to look into the proper and efficient performance of the TPAs.

24. (1) Every TPA shall furnish to the insurance company and the Authority an annual report and any other return, as may be, required by the Authority on its activities.

(2) The Annual Report, duly verified by a director of TPA and the Chief Administrative Officer or the Chief Executive Officer shall be submitted in Form TPA-4 (No. 1 to 7} within a period of sixty days of the end of its financial year or within such extended time as the Authority may grant.

(3) The TPA shall also make available to the Authority for inspection, copies of

all contracts with insurance company.

25. General:-

(1) Any changes made from time to time in the agreement entered into by an insurer and a TPA shall be filed with the Authority;

(2) A TPA shall not charge any separate fees from the policyholders which it serves under the terms of the agreement with the insurance company.

(3) If any person fails to furnish any document, statement, return, etc.. to the Authority, the same shall be construed as a non-compliance of the Act.

2.7 Terms Encountered In A Health Insurance Policy:

Inpatient Treatment

It indicated that the individual has been admitted to the Hospital for care, treatment and or observation.

Pre-Existing Diseases

A pre - existing disease is any ailment or disease that a person is already suffering from at the time of purchasing health insurance. A pre-existing condition is defined as any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that existed at the time of application or during the past duration(specified by each insurance plan) prior to the effective date of the insurance, including any subsequent, chronic or recurring complications or consequences related to thereto or arising there-from Out-patient insurance covers consultations and treatments provided by a specialist or medical practitioner when an overnight stay in hospital is not necessary. When applying for a group policy it may be possible to arrange a plan that covers all members of the group for all 'pre-existing conditions'. This option is generally only available to large groups but can be arranged if this is important to the

group.

Outpatient Treatment

A patient who is not an inpatient (not hospitalized) but instead is cared for elsewhere as in a doctor's office, clinic, or day surgery center is called an outpatient. Out-patient insurance covers consultations and treatments provided by a specialist or medical practitioner when an overnight stay in hospital is not necessary. The premium for out-patient cover will be roughly the same cost as the premium for in-patient cover. In general out-patient claims are frequent but the amount of the claim relatively small.

Pre-Hospitalisation Expenses

It covers all the expenses for treatment taken 30 days prior to hospitalization.

Post-Hospitalisation Expenses

It covers the expenses for the treatment taken for 60 days after hospitalization. Pre & Post Hospital Expenses:

• Medicines: Mandatory to provide doctor's prescription advising medicines and the relevant chemist bill.

• Doctor's Consultation Charges: Mandatory to provide the Doctor's prescription and the doctor's bill and receipt.

• Diagnostic Tests: Mandatory to provide the Doctor's prescription advising tests, the actual test reports and the bill and receipt from the diagnostic centre.

Coverage

The scope of protection provided under a contract of insurance; any of several risks covered by a policy, n general, the Policy covers reimbursement of Hospital / Nursing, Home expenses incurred by the insured as an inpatient for treatment of any disease or Bodily injury through an accident. The expense incurred in the policy period, covered

Up to a maximum of the sum insured in aggregate are:

Room, Boarding Expenses as provided by the Hospital / Nursing Home. Nursing Expenses, Surgeon, Anesthetist. Medical Practitioner, Consultants, Specialists fees Anesthesia, Blood, Oxygen, O.T.Charges, Surgical appliances, Medicine and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and Similar Expenses.

Day-Care Coverage

When treatment such as Dialysis, Chemotherapy, and Radiotherapy etc is taken in the Hospital/Nursing Home and the insured person-patient is discharged on the same day,the treatment will be considered to be taken under Hospitalization Benefit Scheme. Outpatient surgery allows a person to return home on the same day that a surgical procedure is performed. Outpatient surgery is also referred to as ambulatory surgery or same-day surgery or day- care surgery.

Domiciliary Coverage

Domiciliary Hospitalization is the treatment of the patient is carried out at home. This needs to be as per the doctor's recommendation. Most health insurance companies do cover domiciliary hospitalization subject to a certain limit depending on the sum insured. The policy provides for domiciliary hospitalization expenses when medical treatment is taken for a period exceeding 3 days for an illness/disease/injury (not specifically excluded) which normally would require treatment as an in-patient in a hospital/nursing home but is actually taken whilst confined at home in India.

Under the following circumstances: Either the condition of the patient is such that he/she cannot be removed to the hospital/nursing home OR the patient cannot be removed to the hospital/nursing home for lack of the accommodation therein.

This hospitalization will however not cover pre and post hospitalization and treatment for asthma , bronchitis, chronic nephritis and nephritic syndrome, diarrhea and all type of dysenteries including gastroenteritis, diabetes mellitus and insipidus . epilepsy, hypertension, influenza, cough and cold, pyrexia of unknown origin, all psychiatric or psychosomatic disorders, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis.

Maternity Cover

It covers maternity benefit i.e. expenses incurred in delivery. It is generally excluded in an individual policy but is provided as an add-on cover in group policies, provided the extension is taken for all the members covered in the group.

Normally maternity cover would include costs related to:

• Pre and Post-natal treatments & examinations

• Medically prescribed Caesarian

• Normal delivery

• Delivery with complications

• Delivery following fertility treatment

• Hospital or Home delivery costs

More comprehensive maternity plans will also cover:

• Care of newborn children

• Fertility treatments

• Congenital birth defects

Dental Cover:

Insufficient dental cover can prove to be very expensive as the cost of dental treatment in most countries is very high. Some employers do offer a dental cover plan to their employees, but this is usually at a very low level. Insurance Companies normally have a waiting period before they will accept any claims for treatments. This period can vary between individual insurance companies and it is important to check the specific conditions when considering dental coverage. Almost all Insurance Companies accept pre-existing dental problems. The majority of individuals is likely to have undergone treatments such as simple fillings, tooth cleaning and root

treatment. It is therefore extremely rare for the individual not to have any pre-existing conditions. This is why the insurance company will cover the preexisting conditions after a period of time.

Insurance companies normally offer two levels of dental cover to enable the client to select the most suitable plan.

Health Check-Up

Cost of health check up reimbursable at the end of 4 continuously claim free underwriting years limited to 1% of Average sum insured of 4 claim free years.

Floater

A floater is a unique plan wherein the value of sum insured opted can be used by all the members of the family or by a single-family member. Basically, the sum insured amount floats over all the members covered. For example: if the policy is bought for 3 lakhs, then either all three members of the family can use Rs 1 lakh each or one member can use the entire cover of 3 lakhs.

Rider

Insurance policies are usually written in a standard form, most of which is dictated by state insurance law. If you need additional coverage or if there are changes to the standard document, these changes can be made by way of a rider. The information to be conveyed in the rider is typed up on a separate piece of paper, which is attached to the standard policy. An endorsement can accomplish the same goal; the only difference is that an endorsement is actually incorporated into the body of the existing policy.

Some common health insurance riders are as follows.

Multiple indemnity

• Waiver of premium

• Exclusion

• Additional coverage

• Accelerated Death Benefit

• Free look period

• Guaranteed renewable

• Inflation protection

• Level premiums

• Longer waiting periods

Premium

Premium is the amount paid by the insured(the buyer) to the insurer for the policy.

Simply put. it is the cost of the insurance policy.

Tax Exemptions

There is a tax benefit available under Section 80C of the income tax act 1961. Every tax payer can avail an annual deduction of Rs. 15.000 from taxable income for payment of Health Insurance premium for self and dependants. For senior citizens, this deduction is Rs. 20,000. Please note that you will have to show the proof for Payment of premium. (Section SOD benefit is different from the Rs 1,00,000 exemption under Section 80 C)

Disablement Cover

(i) When an insured person sustains accidental injuries resulting in loss of limb and is certified by a medical specialist that the injury is of a permanent total or permanent partial nature, then only the insured shall deemed to be permanently totally/partially disabled.

(ii) Temporary total disablement arises when a person is not in a position to perform the duties that he performing immediately prior to the accident, which has to be certified by a medical

professional. In the event of an accidental injury resulting in temporary total disablement (to be confirmed by the attending physician) the insured shall be entitled to compensation @ 1% of sum insured per week subject to a maximum of 104 weeks. Such weekly compensation shall in no case exceed Rs.5,000/- per week.

Exclusions

Exclusions are diseases and conditions for which medical expenses are not covered by the health insurance policy. The common exclusions are:• All diseases/ injuries which are pre existing when the cover incepts for the first time.

• Any disease other than those stated in Point No. 3 below contracted by the insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however apply if in the opinion of the Panel of Medical Practitioners constituted by the Company for this purpose, the insured person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Insurance company. This condition shall not however apply in case of the insured person having been covered under this scheme or group insurance with any of the India Insurance companies for a continuous period of preceding 12 months without any break.

• During the first year of the operation of Insurance cover, the expenses on treatment of disease such as Cataract, Benign Prostate Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease/defect. Fistula in anus, piles. Sinusitis and related disorders are not payable. If these diseases (other than congenital internal diseases/defect) are pre existing at the time of proposal they will not be covered even during subsequent period of renewal. If insured is aware of the existence of congenital internal diseases/defect before inception of policy it will be treated as preexisting.

• Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign enemy, war like operations (whether war be declared or not).

• Circumcision unless for treatment of a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

• Cost of spectacles and contact lenses, hearing aids.

• Any dental treatment or surgery which is a corrective, cosmetic or aesthetic procedure, including wear and tear, unless arising from disease or injury and which requires hospitalization for treatment.

• Convalescence, general debility. "Run-down" condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs/ alcohol.

• All expenses arising out of condition directly or indirectly caused to or associated with human T cell lymphotropic virus type III (HTLB III) or lymphadenopathy associated virus (LAV) or the mutants derivative or Variations deficiency syndrome or any syndrome or condition of a similar kind commonly referred to as "AIDS".

• Charges incurred at hospital or nursing home primarily for diagnostic. X-Ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury for which confinement is required at a hospital/ nursing home.

• Expenses on vitamins or tonics unless forming part of treatment for injury or disease as certified by the attending physician.

• Injury or disease directly or indirectly caused by or contributed to by nuclear weapons or materials

• Treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of this, including caesarian section.

• Naturopathy treatment.

Death Benefits

A payment made to the nominee or the legal heir of the insured under a Personal Accident Insurance Policy in the event insured's death.

Benefits

An amount payable to the insured or his legal heir as a percent of the sum insured in case of accidental death to provide for education of the insured's children , etc.

Assignment

Assignment means that in the event of fatal accident of the insured person, the compensation is made to the assignee on the basis of his full and final discharge. In case the assignment is not made under Personal Accident Policy, the insurance company insists for succession certificate from the Court for settlement of claim compensation.

Coverage amount:

Coverage amount is the maximum amount payable in the event of a claim. It is also known as "sum insured" and "sum assured". The premium of the health insurance policy is dependent on the coverage amount chosen.

Coverage Limits

Some health plans only pay for health care up to a certain dollar amount. The policyholder may be expected to pay any charges in excess of the health plan's maximum payment for a specific service. In addition, some plans have annual or lifetime coverage maximums. In these cases, the

health plan will stop payment when they reach the benefit maximum and the policy-holder must pay all remaining costs.

Co - Insurance

After paying the deductible, percentage or amount of covered expenses that the insured pays.

Cumulative Bonus

Each claim free year ensures a benefit known as "cumulative bonus". The health insurance company adds more benefits for the same premium paid if the insured does not make any claim on his policy. If the insured person does not prefer any claim in the expiring policy, he is entitled to 5% cumulative bonus for every such claim free year subject to maximum of 50% cumulative bonus that means the sum insured under the renewed policy will be increased by 5% every year without charging any additional premium. In the even for a claim, the increased percentage will be reduced by 10% subject to minimum of the basic sum insured selected.

Deductible

The proportion of loss that the insured bears in respect of any claim. This will be in two forms, namely. Amount of excess, which will be mentioned either as a fixed amount or a percentage of the sum insured or the claim amount.Time excess by which the insured will not be entitled to the claim relatable to a Specific period (usually number of days) stated in the policy

Endorsement

Memorandum issued in connection with effecting some additions, alterations or deletions in the terms of coverage granted under the standard form of policies, either at the time of issue of the standard policy at the time of commencement of insurance or any time during its currency based on mutual agreements between insured and insurer. This will be signed by the authorized signatory of the insurer and once issued, the policy and the endorsement together will constitute the evidence of the contract.

Group Discount

Discount allowed in the premium arrived as per manual or prospectus rates depending upon the number of persons covered under a Group Personal Accident or Group Mediclaim Insurance Policy. Group Discounts are also allowed in the Industrial Policys. Householder's Comprehensive Insurance Policy. Shop Keeper's Package Policy also, where the discount depends upon the number of sections of coverage availed.

Hospitalisation

Admission of a patient in a hospital or a nursing home and treatment to him for injury, illness, sickness or disease.

Policy

A policy is a stamped document which is evidence of the contract of insurance between the insurer and the insured. The policy encapsulates the benefits and features of the policy.

Renewal

Health insurance policies are usually annual contracts. At the end of the policy period, the policy has to be renewed by the insurers. But renewing a contract of insurance is at the discretion of the insurer. There should be continuous renewal of the policies. If there is a break in insurance, the insured would lose the benefits of insurance in the event of any contingency.

Sum Insured

Sum insured is based on various factors namely:

(1) Income from gainful employment,

(2) Type of occupation,

(3) Age as on date of proposal.

(4) Period of insurance

(5) Conditions prevailing at the place from where the proposal is made etc.

(6) As regards the non-earning spouse of the insured the sum insured in respect of such spouse shall not exceed 50% of the eligibility of the insured, subject to a limit of Rs 1 Lakh under benefits available under Table III of the policy.

(7) Dependent children can be offered a sum insured not exceeding Rs.50000/- to Cover death and disablement only.

Waiting Period

This refers to a pre-specified time period during which you will not be covered by your insurance (for a particular Healthcare issue),the duration of waiting periods can be found in the policy conditions section of the insurance plan. Insurance companies enforce these periods in order to prevent policy holders making claims soon after the policy is in place.

The two types of treatment that usually have waiting periods are:

- Maternity
- Dental

MEMORANDUM OF UNDERSTANDING:

It is a legal understanding between the TPA and the service provider for providing

hospitalization and/or out-patient care to any individual enrolled in a plan.

The various clauses in an MOU are:

1. The agreement between _____TPA and _____provider.

2. Recital Clause

3. Provider Information:

4. Articles:

a) Inpatient i) Identification

ii) Admission and provision of identified services iii) Billing terms

iv) Payment terms v) Emergencies

b) Diagnostics Tests /Health Check-ups i) Identification

ii) Provision of identified services iii) Payment terms

5. General terms :

a) Confidential Information

b) Representations and warranties

c) Miscellaneous

6. Signatures of Authorities and witnesses - TPA and provider

7. Annexure and attachments

a) List of services offered

b) Package charges

c) Tariff for procedures and professionals

Service Level Agreement

This refers to the agreement according to the MOU regarding the quality of services to be provided to the policyholders availing cashless hospitalization.

The aspects to be highlighted in efficient provider management are:

a) Tiering of networks

b) Introducing guidelines

c) Document processing protocols

d) Standardization of contracting -

i) Ensuring full compliance with standard MOU

ii) Protocols for billing and claim form

iii) Negotiating discounts

iv)Deciding credit period

e) Provider reimbursement

i) Analyzing provider payment history

ii) Regular escalation of delayed payments

iii) Improve reimbursement process

f) Proper personnel training

g) Produce network savings

i) Discounts from pharmacy allied service network

ii) Savings from package rates

h) To assist in growth of pre-employment and annual health checkups

i) To increase awareness among customer retention team about package plans

j) To develop an effective claims tracking system for various statistical analysis.

Claim Procedure:

For Cashless / Reimbursement

Availing the facility of cashless hospitalization

Hospitalization happens under two circumstances – Planned and Emergency. Pre-authorization of the estimated hospital expense is a must to avail this facility.

Planned Hospitalization:

In the case of a planned admission, you would have first consulted a doctor who in turn would have advised you on the probable date of hospitalization. In such a case, you must have applied for an approval of the estimated hospital expenses directly with your TPA at least 4-5 days prior to the date of hospitalization.

In case you have not applied for a pre-authorization sufficiently in advance or if the doctor treating you advises you to get hospitalized immediately after the consultation, Corporate Help Desk will assist you through the pre-authorization procedure.

However, you will need to bear in mind that the Corporate Help Desk is only a facilitator and can in no way influence the decision on the approval. The approval can be turned down.

The pre-authorization procedure is detailed below:

Step 1: Establish contact with the Corporate Help Desk at the Hospital

Step 2: At the Corporate Help Desk, you need to present the original health Insurance card issued to you by your TPA

Step 3: Collect the pre-authorization will forms pertaining to your TPA

Step 4: Your pre-authorization will have two sections-

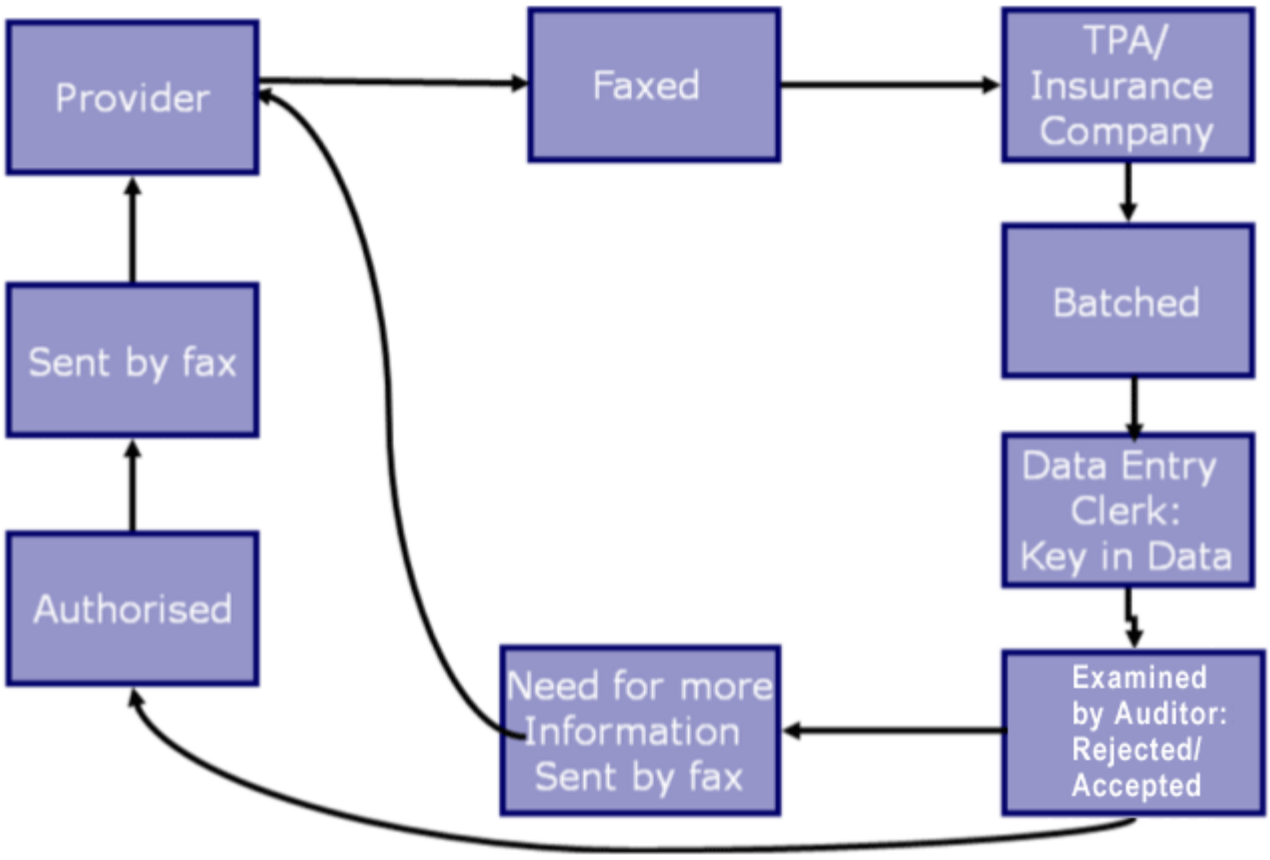
i. General details on the health Insurance policy – to be filled in by you (the Corporate desk will assist you in case you have any difficulty)
ii. Pertains to the treatment recommended for you-needs to be filled in and duly signed by the Doctor who is treating you (do not attempt to fill this section, contact the Corporate desk in case of any difficulty)

Step 5: Return the completed form to the Corporate Help Desk. The personnel at the desk will verify the form for its completeness and let you know in case of any discrepancy

Step 6: Once the form is complete in all respects, the Corporate Help Desk will fax the form to the office of your TPA.

Step 7: The Corporate Help Desk will revert to you on the approval status

Previous Cashless Process by Fax Method



- In this process a duely filled preauth form hospital will be faxed to the respective TPA.
- In TPA it will be stored in fax server and from this server they will take print out of the request sent.

- These printouts will be given to Batching dept. and here all the requests are batched according to area wise or zone wise.
- Then it will be given to data entry operator who feed the info from the request to TPA information system and makes first entry and PA no. will be generated.
- Then these requests are given to Approver/ Authorisor who refers to the policy conditions and the BSI and decides to approve the claim or reject or send for further info.
- If further info is required it will be faxed back to Provider.
- If the claim is approved it is sent to hospital via fax.
- In this process the major 3 steps which consumes lot of time for processing are taking print from server, batching it and data entry.

Pain points in current process

- Incomplete information
- Fax transmission errors and fax transmission losses
- Visual artifacts
- High Turnaround time
- No mapped flow of information
- Traceability & Accountability is absent

Online System of Preauth process

Health Sprint Networks , Health care IT company providing data exchange platform for various healthcare related processes has comeup with Online processing of preauth request addressing the pain points of the fax method.

- There are certain mandatory fields in the designed preauth form so that with out filling those info the request cannot be submitted so there is no problem of sending incomplete information.
- In online method the preauth request is sent to TPA by a click of submit button, correlation to sending e-mail a click of button it has to be reflecting the target mailbox, similarly once submitted from hospital it will be reflecting in respective TPA.
- As the information is punched in the system there is no problem of visual artifacts.
- As the data is entered at hospital end only and the request directly reflect on approvers system the TAT of Preauth process is drastically reduced.
- There is mapped flow of information as the request sent will be showing the type as submitted if its fresh request, info submitted if query answer is sent or enhance if the request is for enhancement, so that depending on the request type the priority will be given.
- As the access is given to the end user in their name as user name so that there will be transperancy and accountability who is sending the request from hospital and who is approving the same from TPA.

The step by step claim procedures, both cashless and reimbursement.

• Step 1: TPA will provide the list of network hospitals offering cashless facility for treatment.

• Step 2: The claimant needs to produce the TPA Health card / ID card at the hospital.

• Step 3: Hospital sends Pre-authorization Request with the treatment details; past history and clinical notes along with estimate of hospitalization expense to TPA branch office.

• Step 4: TPA issues a letter authorizing treatment to the Hospital the approved

Amount upto the Sum Insured limits.

Note: TPA can also reject the authorization in the following conditions

1. Incomplete information

2. Improper support of documentation

In such events, please pay the hospital and submit the claim for reimbursement.

• Step 5: In case the treatment is taken at other non network centers, the Insured

is reimbursed the cost of treatment, subject to the provisions of the Policy on

the basis of Admit Card/Discharge Card, Diagnostic Reports and Bills/Prescriptions.

Claim Reimbursement:

Some of the requirements to be complied with in the event of a claim are listed below:

• Step 1: Please immediately intimate TPA about the claim. Claim intimation can be done by the following methods-Inform the Call Centre at Toll Free No or send an e-mail at the company website.

• Step 2: At the time of intimation, the customer should provide the following

a. TPA ID card No. or Policy Number

b. Date of Hospitalization

c. Ailment

d. Approximate Date of Discharge

e. Approximate Date of Claim submission.

• Step 3: Download the Claim Form & Medical Certificate Form from website and fill all columns. The Medical Certificate Form will be filled by the treating doctor.

• Step 4: Send the filled and signed Claim and Medical Certificate Forms to closest TPA branch by courier / hand delivery, along with the following papers.

• Original Discharge Summary;

• All the Original Bills with break up.

• All Original Diagnostic Test Reports performed on patient during hospitalization

• Policy copy (if available)

• All Medical Bills must accompany the prescription

• Step 5: TPA will assess the validity of the claim based on the documents submitted, validate the policy, validate the treatment undergone and settle the claim within the claim settlement parameters. In case of claim is not adhering with parameters, the case would be rejected.

Step 6: TPA will correspond within 23 days of Claim receipt -

• If Claim settled. Discharge Voucher will be sent

• If Document Shortfall, request for the shortfall documents

• If Claim rejected. Rejection Letter will be sent

• If any bills and receipts are not supported by valid documents the claimed amount of that bill would be disallowed.

Step 7: Event of Settlement: Please sign the Discharge Voucher and send it back

• Event of Shortfall: Please forward the requested documents for settlement of claim

• Event of Rejection: In case of re-opening of the case, request supported by valid documents is forwarded.

• Event of Disallowance: Please forward the necessary documentation not submitted before to process disallowance and for addendum settlement.

CHAPTER- III

RESEARCH METHODOLOGY

METHODOLOGY Of THE STUDY:

3.1) Research question:

–A study on cashless claims, member reimbursement claims processing and Evaluation of claims discharge Turnaround time for member reimbursement/Hospitalization claims through TPA in Health Insurance Company.

3.2) Research design:

The design is the structure of any scientific work. It gives direction and systematizes the research. The method we choose will affect the results and how we conclude the findings. Most scientists are interested in getting reliable observations that can help the understanding of a phenomenon.

This study reveals about processing of the health insurance claim by Healthsprint Domain specialist at hospital and by processing team in the in- house TPA of ICICI Lombard Health insurance company. The processing team includes Inward team, cashless team, network reimbursement team and member reimbursement team of the TPA. This study also designed to find out the turn around time for the each claim from inward to cheque dispatch. which includes the documents received time, junior executive, senior executive and doctor processing time and quality check, payment request and final dispatch of cheque or electronic fund transfer.

By using my observations, and interaction with the processing team members I am getting thoroughness in the claims processing work, later on that I will use the tally sheet to find out the time taken for each claim settlement.

3.3) Data collection:

The total data used in this study is primary data about the way of processing of the claims and recording of the times for each step of claim process. The data collection is mainly by the observation and interaction with the processing team members.

3.4) Population:

The total population size is 200, the TPA of ICICI Lombard receives daily 200 claims for processing, which includes cashless claims, member reimbursement claims and additional payment required claims(addendums).

3.5) Sample design:

The sample size in this study is 200. The total samples collected in 84 days, 100 samples of member reimbursement/Hospitalization claims were collected in 50 days. Because the sample in this study is that observation of claim processing and recording the time for each step of claim process. So each claim need to observation and recording of time up to complete process of the claim for approval of claimed amount. Each member reimbursement/Hospitalization claim will take 24.5 days on average for completing the process for approval of claimed amount.

The sample of 100 addendums is also used in this study, these samples are collected in 34 days, on an average each addendum claim will take 17.72 days for approval of claimed amount.

3.6) Sampling method:

Simple random sampling technique was used while collecting the data. The methods used in this project were personal observation and a few interactions with the claims processing team.

3.7) Sample size:

The sample size is 200, out of this 100 claims are member reimbursement/Hospitalization claims and 100 are addendum/additional payment claims.

3.8) Sampling Unit:

Sampling unit is the claims which are observed to study the processing and to measure the turn around time for dispatch the cheque to providers or patients based on the type of claim.

The turn around time is the time taken for claim receiving, processing and dispatching cheque to service providers or hospitals.

3.9) Tools of analysis:

The tools used for this data analysis is central tendency, cause and effect diagram and histograms.

Designing of Tally Sheet:

A Well structured tally sheet was prepared to collect the data of time taken to process the member reimbursement claims by processing team in all levels.

CHAPTER-IV

DATA ANALYSIS & INTERPRETATION

Table 4.1 The time taken to process the Member reimbursement claims:

S.NO	TURN AROUND TIME FOR REIMBURSEMENT CLAIMS	DAYS	SATNDARD DEVIATION	MIN	MAX	MEDIAN	MODE
1	Time taken to complete inward	1.8	0.2	1	3	1.6	2.2
2	Time taken to jr.executive process	3.2	0.8	2	5	3.3	3
3	Time taken to sr.executive process	1.4	0.1	1	2	1.5	1.7
4	Time taken to doctor process	1.8	0.3	1	2	1.6	2.3
5	Time taken to quality check	6.2	1.8	2	7	6.9	5.9
6	Time taken to raise payment request	4.8	1.1	2	5	5.1	4.4
7	Time taken to dispatch cheque/fund transfer	5.3	1.4	3	8	5.2	5.6
	Total time taken	24.5	5.7	1	8	25.3	25.1
	Defined tat	23					
	Average deviation	1.5					
	Percentage of avg deviation	6.52					

4.1 Analysis & interpretation of claim process timings for member reimbursement claims:

1) The total number of claims studied for this TAT analysis is 100.
2) The actual turn around time to complete processing of each claim is 23 days.

3) According to this study the average time taken to complete processing of each claim is 24.5 days.
4) The average deviation time in a claim processing in member reimbursement process is 1.5 days.
5) The percentage of average deviation in a claim processing is 6.52 %.
6) The minimum time taken for claim inward process is 1 day.
7) The maximum time taken for claim inward process is 3 days.
8) The minimum time taken for junior executive process 2 days
9) The maximum time taken for junior executive process 5 days
10) The minimum time taken for senior executive process 1 days
11) The maximum time taken for senior executive process 2 days
12) The minimum time taken for doctor process is 1 day
13) The maximum time taken for doctor process is 2 days
14) The minimum time taken for quality check is 2 days
15) The maximum time taken for quality check is 7 days
16) The minimum time taken for raise payment request is 2 days
17) The maximum time taken to raise payment request is 5 days
18) The minimum time taken for cheque disoatch/ electronic fund transfer is 3 days
19) The maximum taime taken for cheque dispatch/electronic fund transfer is 8 days
20) The minimum time taken to process claim inward process and doctor process is 1.8 days.
21) The maximum time taken 6.2 days for quality cheque of the claim.

"**Median**" is the "middle" value in the list of times taken for claim processing in various steps.

The median of the complete inward process is 1.6 days

The median of the junior executive process is 3.3 days

The median of the senior executive process is 1.5 days.

The median of the doctor process is 1.6 days.

The median of the Quality check process is 6.9 days.

The median to raise payment request is 5.1 days.

The median to dispatch quality check or electornic fund transfer time is 5.2 days.

The **"mode"** is the value that occurs most often. The time which is repeatedly taken to process a claim at various steps is the mode for that process.

The mode of the inward process of a claim is 2.2 days.

The mode of the junior executive process of a claim is 3 days.

The mode of the senior executive process of a claim is 1.7 days.

The mode of the doctor process of a claim is 2.3 days.

The mode for the Quality check of a claim is 5.9 days.

The mode to raise a payment request for aclaim is 4.4 days.

The mode to dispatch cheque or electronic fund transfer is 5.6 days.

4.1.1 Standard deviation for each stage in claim process:

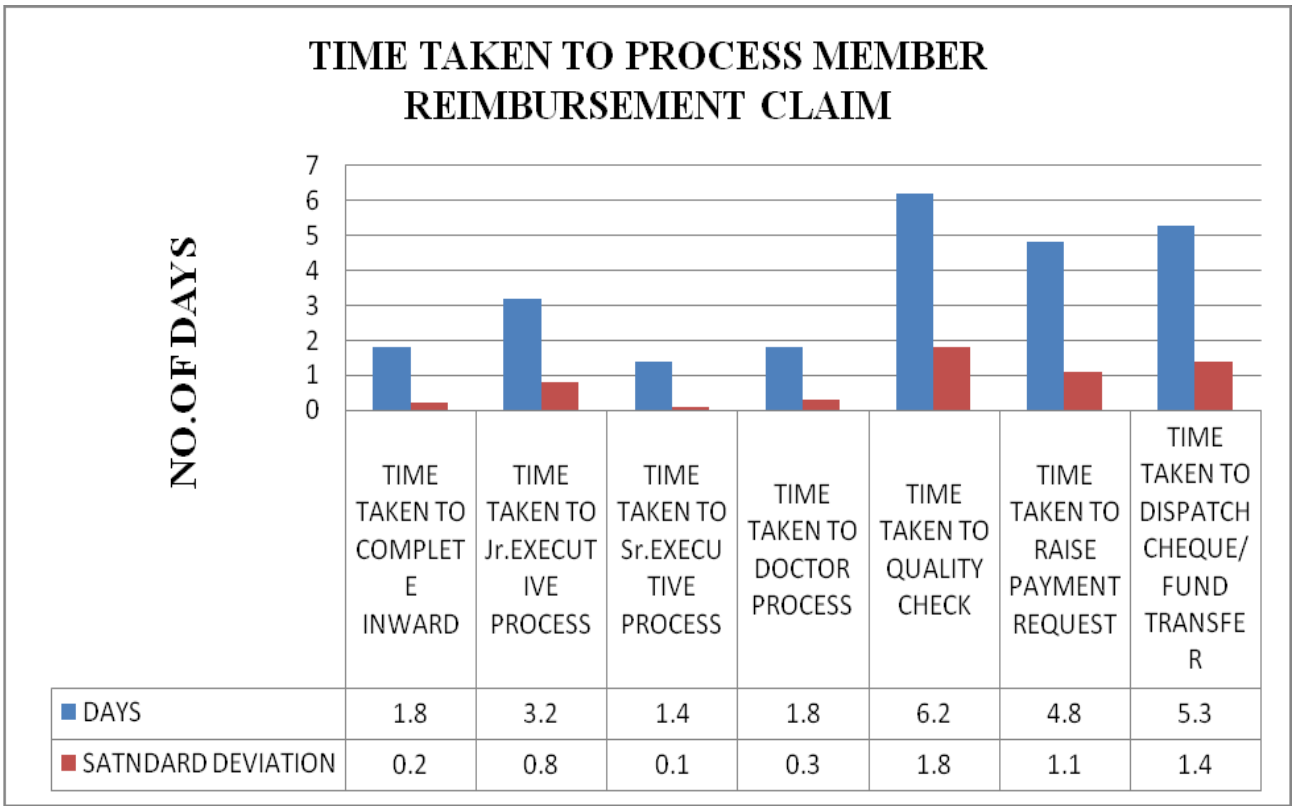


Figure.4.1 The time taken to process member reimbursement claims

INTERPRETATION:

1) The average time taken to complete claim inward process is 1.8 days.
2) The standard deviation for the claim inward process is 0.2 days
3) The time taken to complete junior executive process of a claim is 3.2 days.
4) The standard deviation for the junior executive process time is 0.8 days.
5) The time taken to complete senior executive process of a claim is 1.4 days.
6) The standard deviation for the senior executive process of a claim is 0.1 days.
7) The time taken to doctor process of a claim is 1.8 days.
8) The standard deviation for doctor process of a claim is 0.3 days.
9) The time taken to quality check of a claim is 6.2 days

10) The standard deviation for quality check of a claim is 1.8 days

11) The time taken to raise payment request for an approved claim is 4.8 days

12) The standard deviation to payment request for an approved claim is 1.1 days.

13) The time taken to dispatch cheque/electronic fund transfer is 5.3 days.

14) The standard deviation for cheque dispatch or electronic fund transfer is 1.4 days.

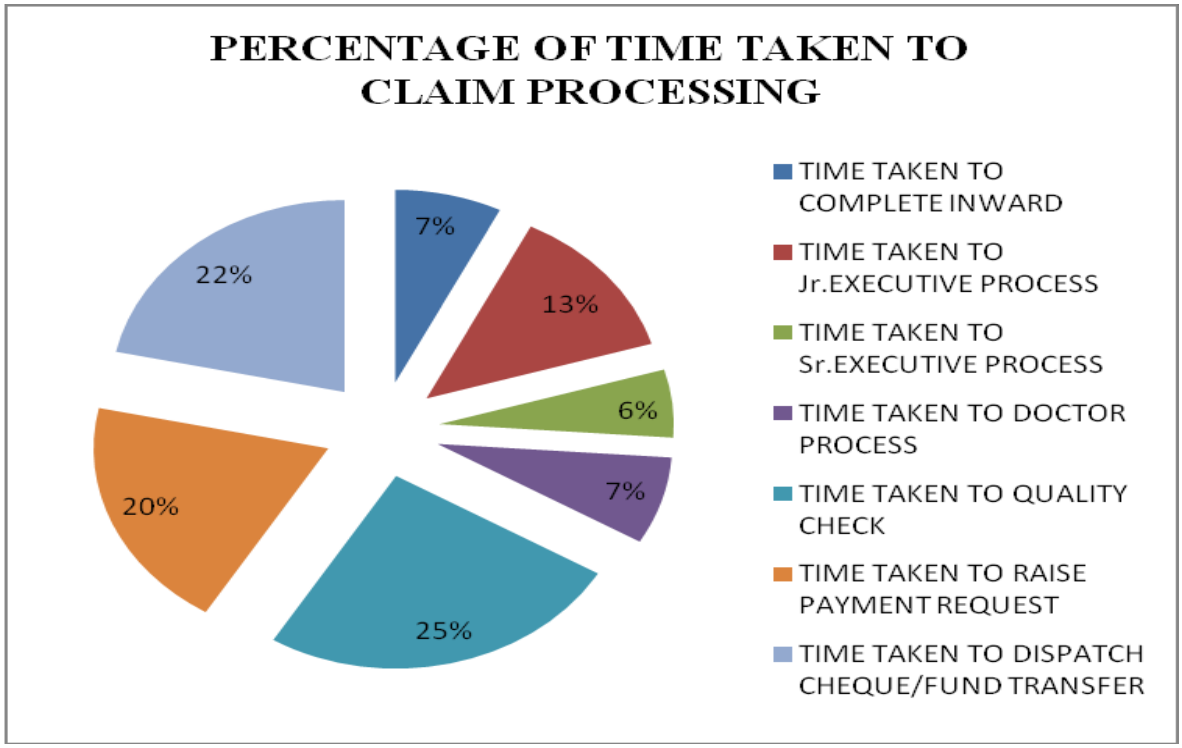


Figure.4.2 percentage of time taken to each step in claim process

Interpretation:

1) The percentage of time taken to complete inward process of a member reimbursement claim is 7%
2) The percentage of time taken to complete junior executive process of a claim 13%
3) The percentage of time taken to senior executive process of a claim is 6%
4) The percentage of time taken to doctor process of a claim is 7%.
5) The percentage of time taken to quality check of a claim is 25%.

6) The percentage of time taken to raise payment request for a claim is 20%.
7) The percentage of time taken to cheque dispatch or electronic fund transfer is 22%

Table 4.2 the time taken to process addendum claims

S.NO	TURN AROUND TIME FOR ADDITIONAL PAYMENTS	DAYS	SATNDARD DEVIATION	MIN	MAX	MEDIAN	MODE
1	TIME TAKEN TO COMPLETE INWARD	1.30	0.14	0.72	2.17	1.16	1.59
2	TIME TAKEN TO Jr.EXECUTIVE PROCESS	2.31	0.58	1.45	3.62	2.39	2.17
3	TIME TAKEN TO Sr.EXECUTIVE PROCESS	1.01	0.07	0.72	1.45	1.08	1.23
4	TIME TAKEN TO DOCTOR PROCESS	1.30	0.22	0.72	1.45	1.16	1.66
5	TIME TAKEN TO QUALITY CHECK	4.48	1.30	1.45	5.06	4.99	4.27
6	TIME TAKEN TO RAISE PAYMENT REQUEST	3.47	0.80	1.45	3.62	3.69	3.18
7	TIME TAKEN TO DISPATCH CHEQUE/FUND TRANSFER	3.83	1.01	2.17	5.78	3.76	4.05
	TOTAL TIME TAKEN	17.72	4.12	0.72	5.78	18.29	18.15
	DEFINED TAT	17.00					
	AVERAGE DEVIATION	0.72					
	PERCENTAGE OF AVG DEVIATION	4.24					

4.2) Analysis and interpretation of time taken to process addendum claims:

1) The total number of claims studied for this TAT analysis is 100.
2) The actual turn around time to complete processing of each claim is 17 days.
3) According to this study the average time taken to complete processing of each claim is 17.7 days.
4) The average deviation time in a claim processing for additional payments/addendum process is 0.72 days.
5) The percentage of average deviation in a claim processing is 4.24%.
6) The minimum time taken for claim inward process is 0.72day.

7) The maximum time taken for claim inward process is 2.17 days.
8) The minimum time taken for junior executive process 1.45 days
9) The maximum time taken for junior executive process 3.62 days
10) The minimum time taken for senior executive process 0.72 days
11) The maximum time taken for senior executive process 1.45days
12) The minimum time taken for doctor process is 0.72 day
13) The maximum time taken for doctor process is 1.45 days
14) The minimum time taken for quality check is 1.45 days
15) The maximum time taken for quality check is 5.06 days
16) The minimum time taken for raise payment request is 1.45 days
17) The maximum time taken to raise payment request is 3.62 days
18) The minimum time taken for cheque disoatch/ electronic fund transfer is 2.17 days
19) The maximum taime taken for cheque dispatch/electronic fund transfer is 5.78 days
20) The minimum average time taken in additional payments claim process is to senior executive proces ie 1.01 days.
21) The maximum time taken in additional payments claim process is to quality check of the claim afetr approval by the doctor is 4.48 days.

"**Median**" is the "middle" value in the list of times taken for claim processing in various steps.

The median of the complete inward process is 1.16 days

The median of the junior executive process is 2.39 days

The median of the senior executive process is 1.08 days.

The median of the doctor process is 1.16 days.

The median of the Quality check process is 4.99 days.

The median to raise payment request is 3.69 days.

The median to dispatch quality check or electornic fund transfer time is 3.78 days.

The "**mode**" is the value that occurs most often. The time which is repeatedly taken to process a claim at various steps is the mode for that process.

The mode of the inward process of a claim is 1.59 days.

The mode of the junior executive process of a claim is 2.17 days.

The mode of the senior executive process of a claim is 1.23 days.

The mode of the doctor process of a claim is 1.66 days.

The mode for the Quality check of a claim is 4.27 days.

The mode to raise a payment request for aclaim is 3.18 days.

The mode to dispatch cheque or electronic fund transfer is 4.05 days.

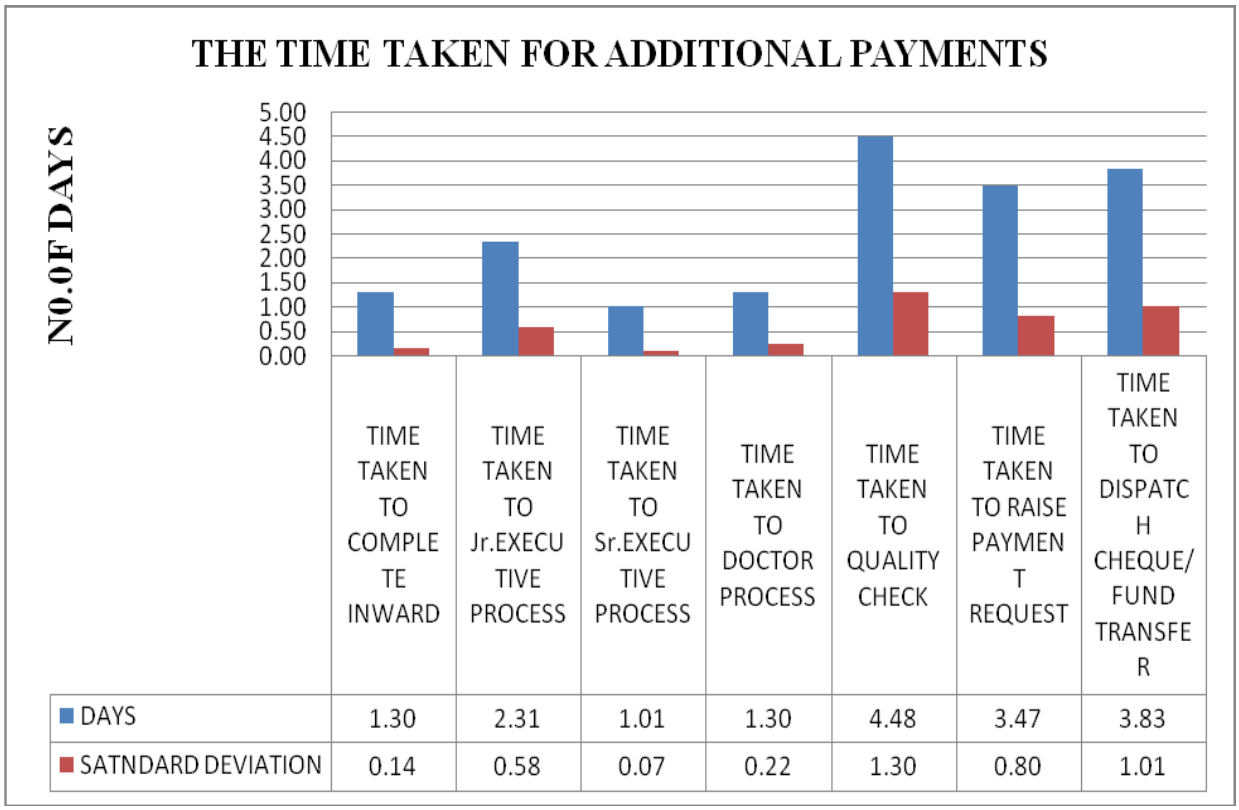


Figure.4.5 The standard deviation to each step of claim process

Interpretation:

1) The average time taken to complete claim inward process is 1.30days.

2) The standard deviation for the claim inward process is 0.14 days

3) The time taken to complete junior executive process of a claim is 2.31 days.

4) The standard deviation for the junior executive process time is 0.58 days.

5) The time taken to complete senior executive e process of a claim is 1.01 days.

6) The standard deviation for the senior executive process of a claim is 0.07 days.

7) The time taken to doctor process of a claim is 1.30 days.

8) The standard deviation for doctor process of a claim is 0.22 days.

9) The time taken to quality check of a claim is 4.48 days

10) The standard deviation for quality check of a claim is 1.30 days

11) The time taken to raise payment request for an approved claim is 3.47 days

12) The standard deviation to payment request for an approved claim is 0.80 days.

13) The time taken to dispatch cheque/electronic fund transfer is 3.83 days.

14) The standard deviation for cheque dispatch or electronic fund transfer is 1.01 days.

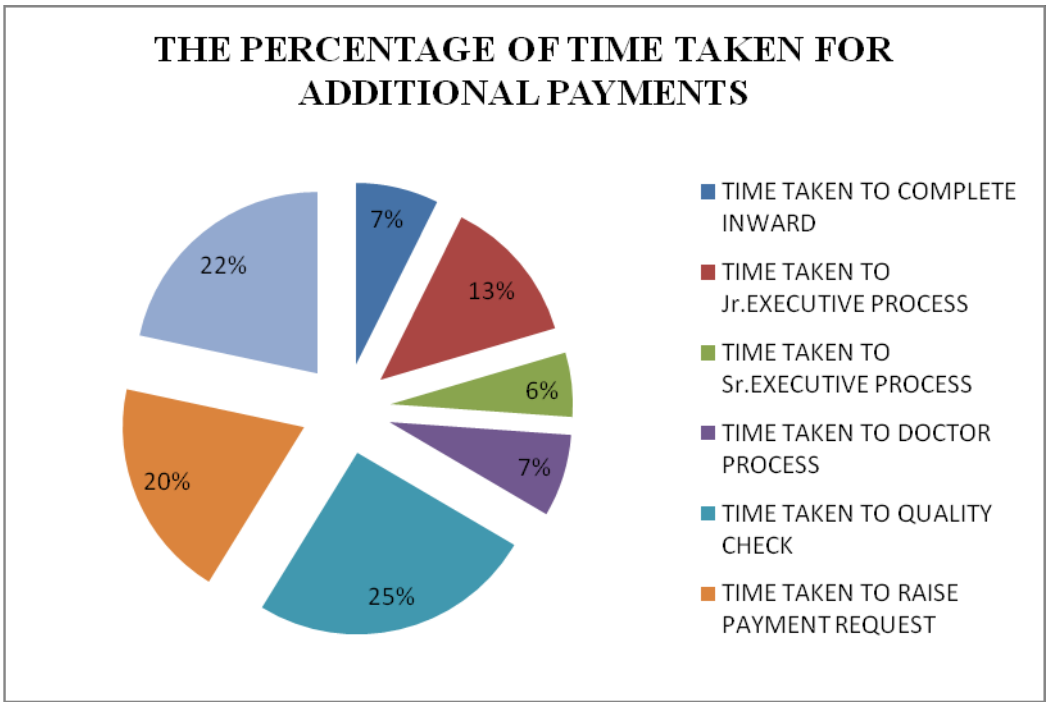


Figure.4.4 Percentage of time taken to each step of addendum claim process

Interpretation:

1) The percentage of time taken to complete inward process of additional payments reimbursement claim is 7%
2) The percentage of time taken to complete junior executive process of a claim 13%
3) The percentage of time taken to senior executive process of a claim is 6%
4) The percentage of time taken to doctor process of a claim is 7%.
5) The percentage of time taken to quality check of a claim is 25%.
6) The percentage of time taken to raise payment request for a claim is 20%.
7) The percentage of time taken to cheque dispatch or electronic fund transfer is 22%.

Data analysis explanation:

This study mainly dealt about the TPA processing of the claim and to measure the turnaround time for the member reimbursement claims and addendum/additional payment claims.

The claim processing time is the time starting from the documents received to TPA office to cheque dispatch or electronic fund transfer from the TPA office to providers or patients.

The various steps involved in the claim processing is:

1) The bills, reports & documents received to TPA office through courier.
2) The inward process of the claim based on the documents submitted by patient/service provider, the inward number generated separately to each claim.
3) Later the claims received to desk manager, from here the desk manager distributed the claims to all junior executives for processing.
4) The junior executive will enter all the bills, reports details into the fast track (software using for claim processing).
5) Now the senior executive verify the process of junior executive and modify any changes required, also the senior executives will do their process.
6) Finally the doctors did the medical scrutiny of the cases based on the type of disease and reports submitted by patient, if the claim is genuine the doctor will approve the amount, otherwise doctor will request further documents for clarification in case any doubt arises about treatment and disease.
7) If any claim seems to fraud then doctor will send that claim to investigation team for further clarification.
8) After approval of the claim by the doctor the claim is verified by quality check team.
9) Based on the quality check the payment request raised to approve amount.
10) And finally cheque dispatch to patients address or electronic fund transfer to patients bank accounts.

In this study The average time taken for the processing of member reimbursement claims is 24.5 days, but the actual time for processing is 23 days, out of all stages of claim process the steps which are taking more time are quality check-6.2 days, to raise payment request 4.8 days, and for dispatching cheque or electronic fund transfer taking 5.3 days. Out of 100 claims nearly 7 claims are delayed in processing.

The total standard deviation for the addendum or additional payments claim process is 4.12 days. The standard deviation for the member reimbursement claim process is 5.7 days.

4.3 FISH BONE ANALYSIS (CAUSE AND EFFECT DIAGRAM) to identify the delayed claim process causes:

Fish bone diagram was developed by prof. Ishikawa of Tokyo university in 1943.Fish-bone diagram enables to understand the linkage between the various causes and the end results. The effect or problem is stated on the right side of the chart, and the major influences or causes are listed on the left.

The fish bone diagram identifies many possible causes for an effect or problem. It can be used to structure a brainstorming session. It immediately sorts ideas into useful categories. The Fish bone diagram was used here because to identify possible causes for the problem i.e. Delay in claim processing.

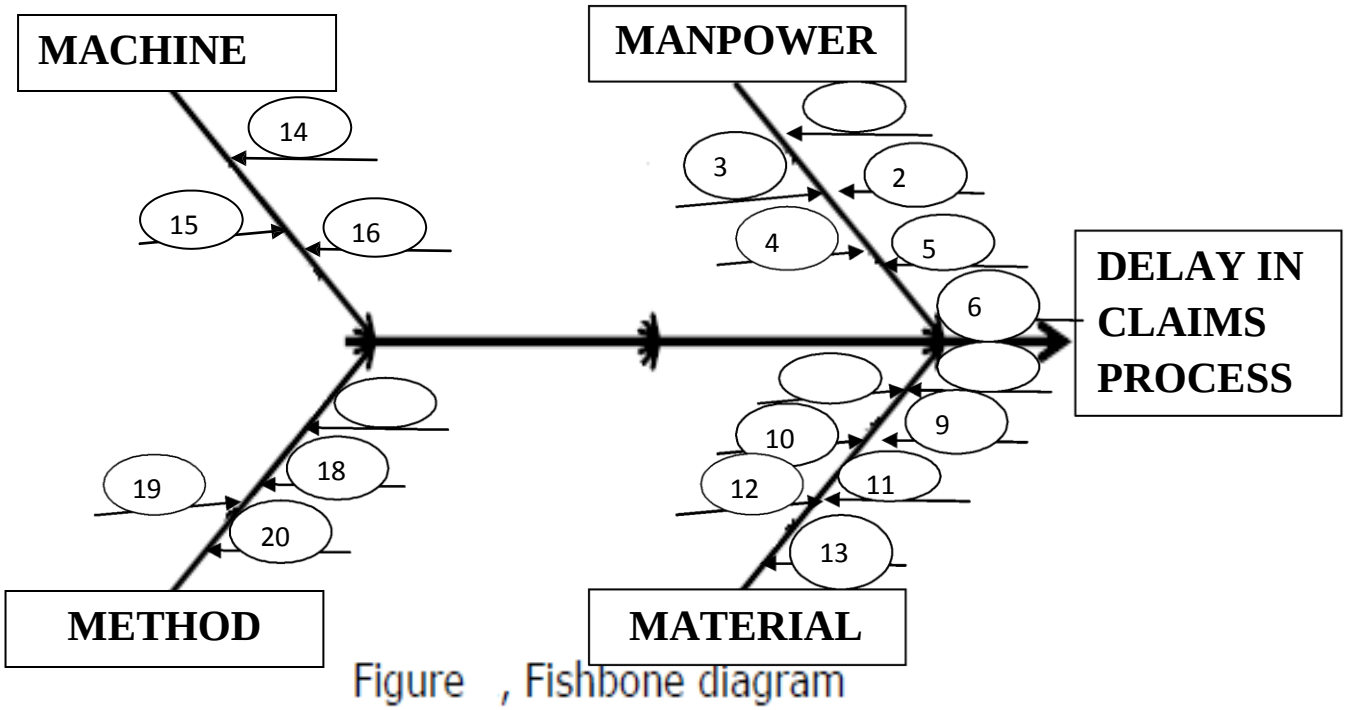


Figure , Fishbone diagram

Figure.4.5 Causes for delayed claim process

MANPOWER:

1) Lack of problem solving skills:

The employees with poor knowledge in problem handling situations, during that the employees will expecting advises from the colleagues and superiors.

2) Intercommunications:

If any doubt arises in the claims related policies, endorsements, medical reports the staff spending more time on unnecessary discussions.

3) Domain skills:

The people working in the processing area are poor domain knowledge about service providers, policy holders.

4) Inadequate professional skills
5) Inadequate knowledge of policy holders
6) Lack of sufficient staff:

The staff at the quality check, payment request and cheque dispatch areas are not sufficient, because of that the above steps of processing are taking more time.

MATERIALS:

7) Work environment
8) Incentive structure
9) Excess targets
10) Work pressure
11) Enrollment problems
12) Endorsement related issues
13) Lack of required documents

MACHINE:

14) Lack of problem knowledge base
15) Technical problems
16) Internet problems

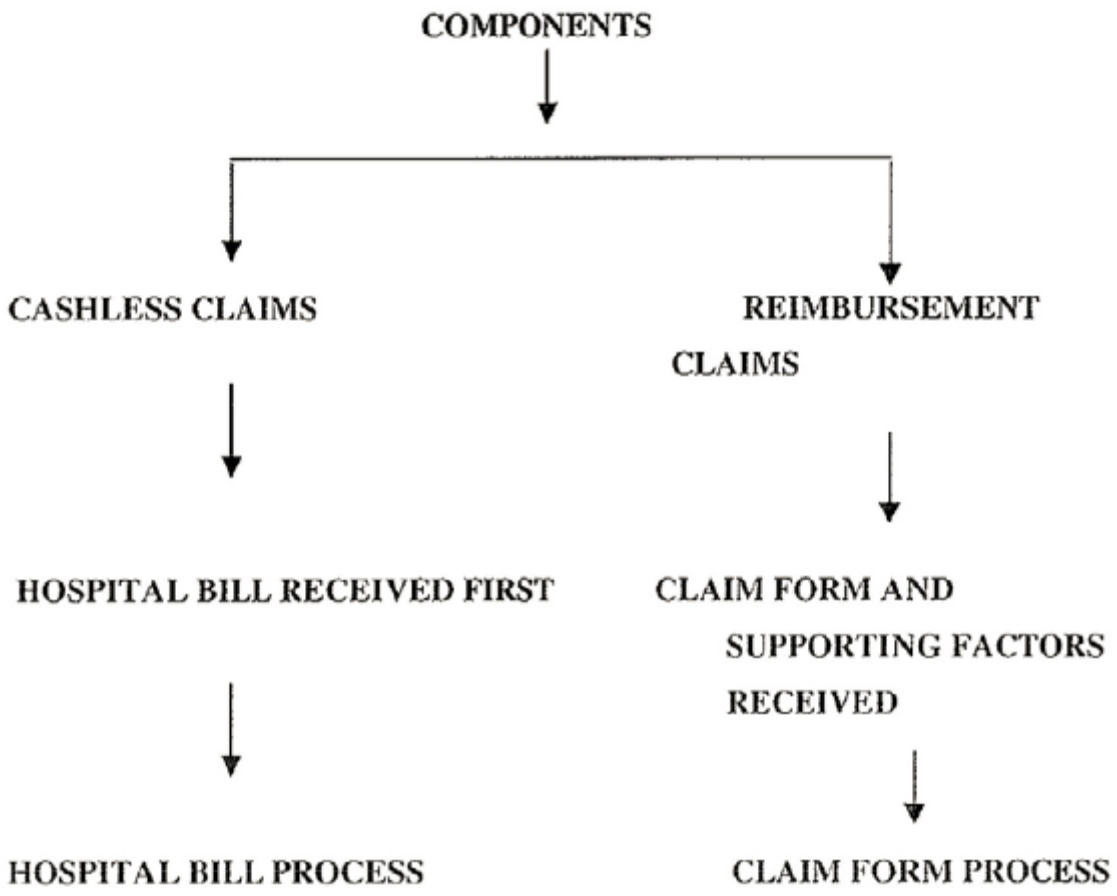
METHOD:

17) No proper file tracking system
18) Improper claim files movement
19) Work assignment
20) Work flow

Steps in the Claim Settlement Process:

Claim settlement process in the TPA:

Table .4.3 Claim settlement process in TPA



HOSPITAL BILL PROCESS:

Table 4.4 Claim settlement process to cashless claims

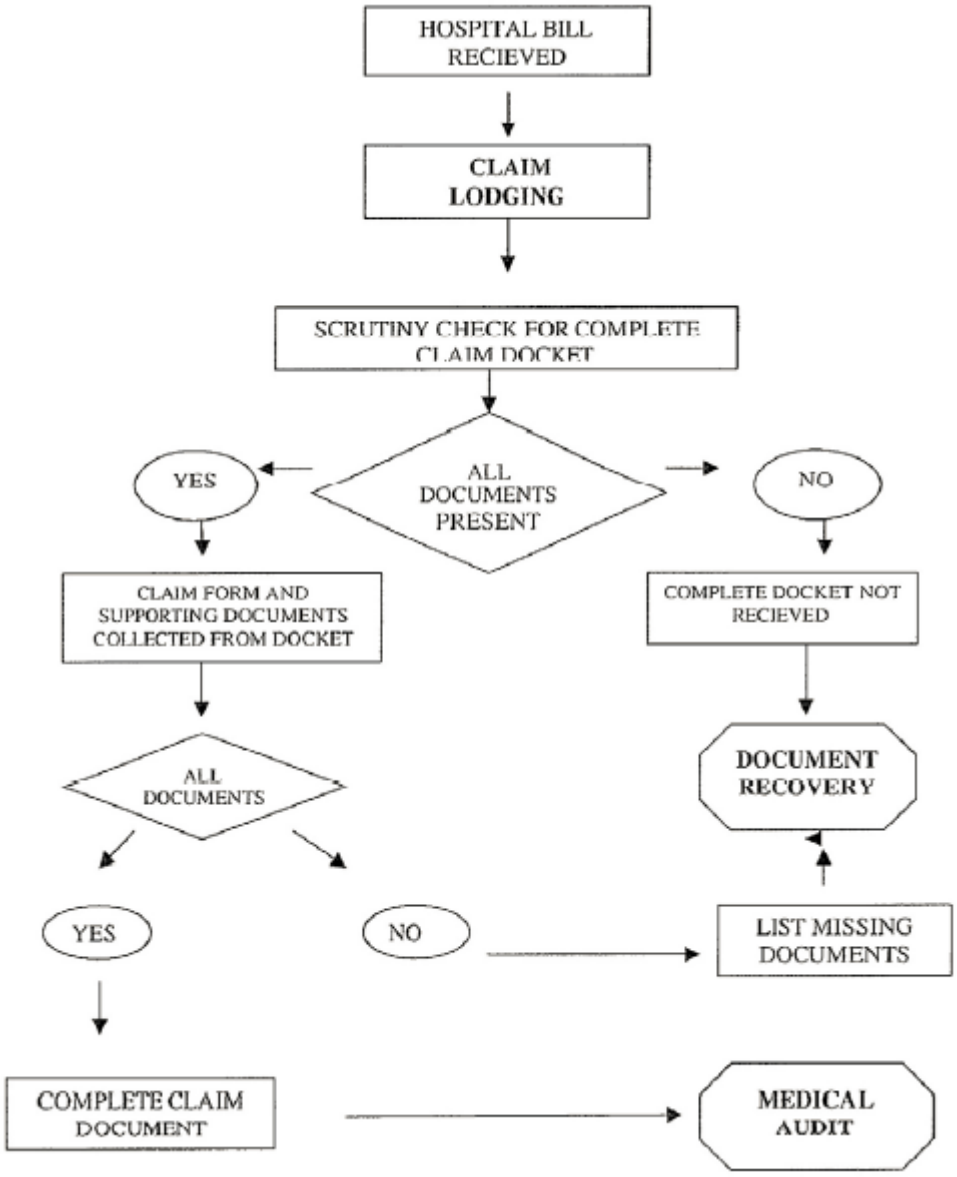


Table 4.5 Claim settlement process in document recovery process

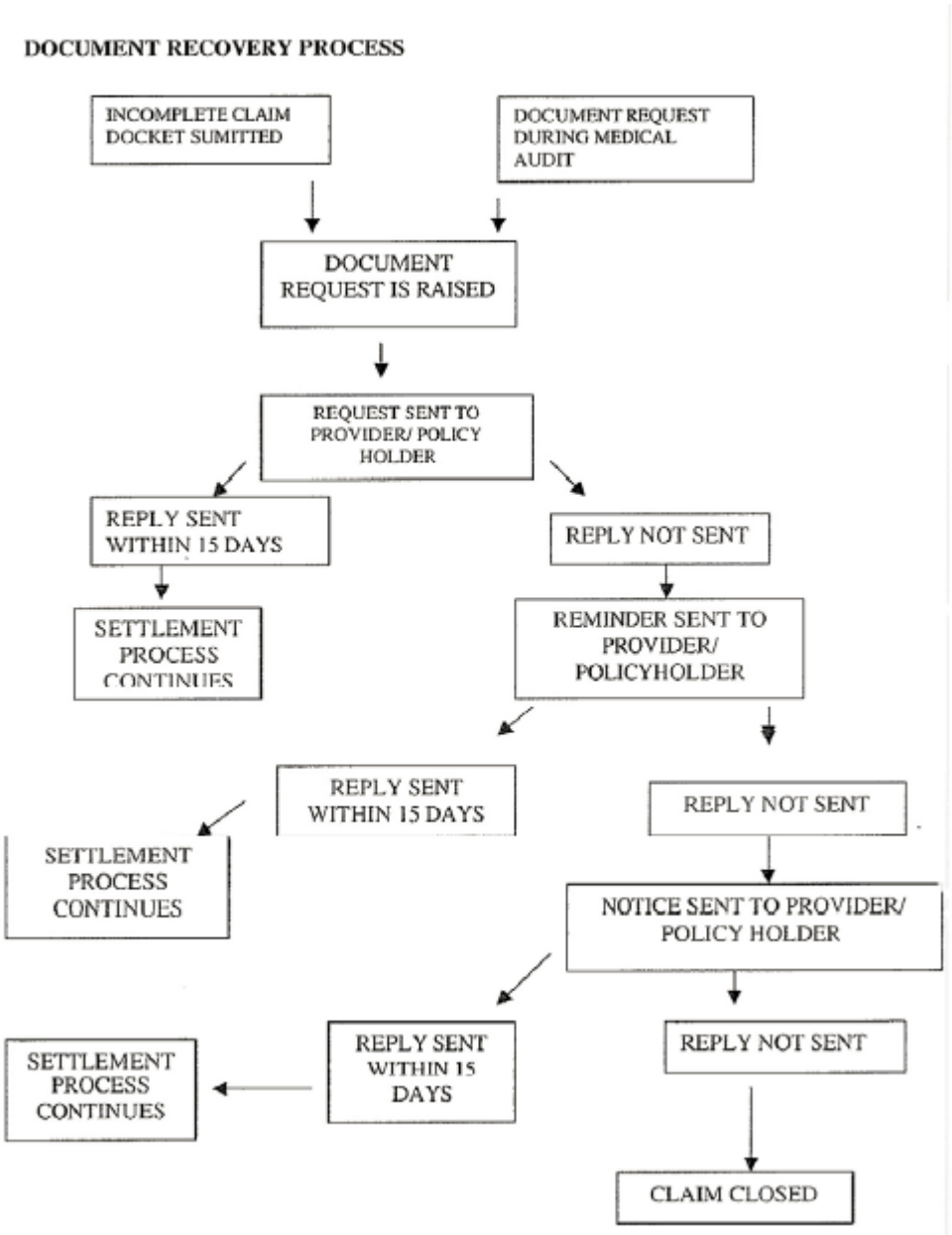


Table 4.6 Member reimbursement claim process

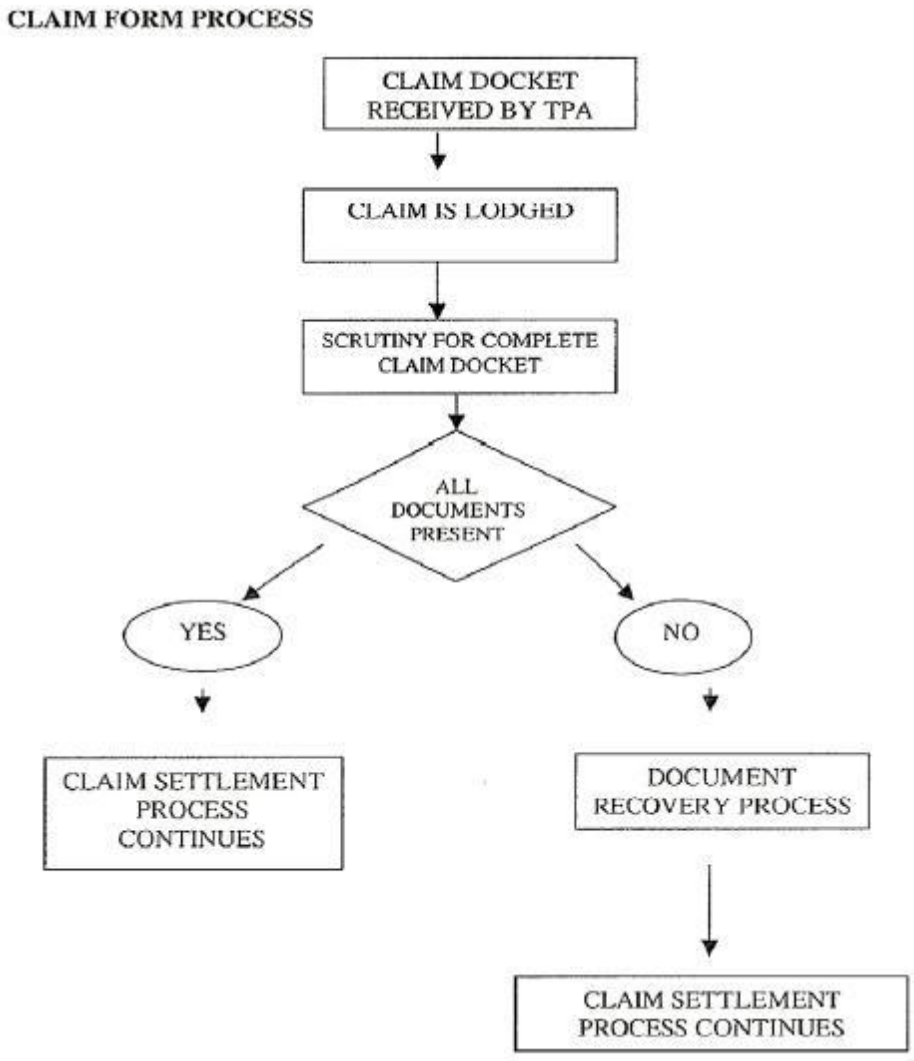
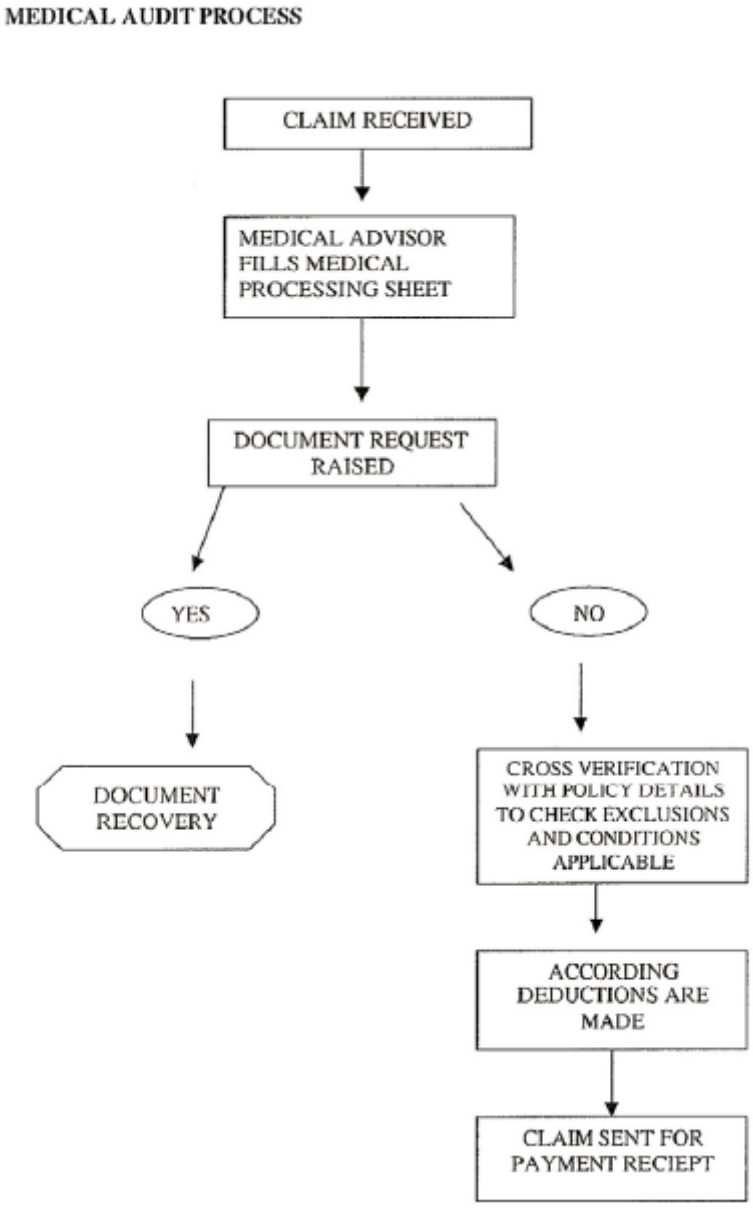


Table 4.7 Medical audit process in claims process



1.Obtaining Authorisation Letter:

A letter to the TPA mentioning the diagnosis, the treating doctors and hospital name, the proposed line of treatment and the estimated cost in order that the provider gets the approval from the TPA that it will be reimbursed for the cashless hospitalization provided.

2. Claim lodging:

Entry of the claim in the software through details of type of policy, patient name, hospital name, type of claim, sum insured, cumulative bonus applicable, duration of hospitalization. bill amount. Each claim is then given a unique identification number known as the CCN or the

CLAIM CONTROL NUMBER. With the help of the CCN, it is easy to track down the claim to ascertain its status and easy communication.

3. Claim Dispatch

The claims after being lodged are dispatched to the head office where the rest of the claim settlement process takes place.

4. Medical Audit

Analysis of the claim in terms of the nature of hospitalization, nature of disease, if the hospitalization was required and if there is any element of the claim being false in terms of unnecessary hospitalization, over- billing, unrelated diagnostic tests or procedures being done, if the ailment is related to a pre-existing disorder. Auditing is also done to verify the balance sum insured and the discounts and deductions applicable according to the Memorandum of understanding entered into with the hospital.Auditing is also done to find out if all the documents required for settlement of claim have been attached.

5. Document Recovery

In order to grant pre-authorization or to settle the claim, if any document is required then

a query or document request is raised.

These documents include:

• Copy of Member ID card with the member's details.

• Copy of the policy papers if any.

• Copy of pre-authorization letter

• Original detailed discharge summary.

• Original investigation reports

• Original Hospital Bill-consolidated and with detail breakup with the patients Signature on it.

• In case of surgical packages - detail breakup of the package.

• Pharmacy bills and breakup.

• Bed strength of hospital and its registration

• Policy coverage and other details

6. Payment Reciept

In case of complete compliance with all the requisitions, the claim is then settled after making the required deductions. The payment is received from the insurance company and is allotted to the claim.

7. Cheque Preparation

The cheque for the appropriate amount is prepared and dispatched accordingly.If these, the medical audit, payment receipts and cheque preparation occur at the head office whereas the

requests for documents recovery are communicated to the branch office and made from there. The rest of the process takes place at the branch offices of the TPA.

The various types of claims that are handled in a TPA are:

Cashless claims

Reimbursement claims

Claims for additional payments

Claims for deductions

Reconsideration claims

Health check up claims

Procedure For Settlement Of Cashless Claims

The claims sent by the provider of the network hospital are known as the cashless claims. When the policy holder is admitted into a network hospital, a request for authorization is sent by the hospital to the TPA . In case the request is approved,authorization is granted. If the authorization is denied, the patient has the right to submit the claim on reimbursement basis.

The steps in the claim settlement process of cashless claims are:

• Grant of authorization

• Claim receipt

• Claim Lodging

• Claim dispatch

• Medical Audit

• Document recovery

• Payment Receipt

• Cheque Preparation.

Reimbursement Claims

The claims submitted by the policy holder in case of admission into a non- network hospital or in case of denial of authorization are known as reimbursement claims.

These come under the category of non-cashless claims.

The steps in the settlement of reimbursement claims are:

• Claim receipt

• Claim Lodging

• Claim dispatch

• Medical Audit

• Document recovery

• Payment Receipt

• Cheque Preparation

4.4 Claims For Additional & Deduction Payments

In case the authorization is granted but the amount of authorization is far less than the cost of the treatment, after settlement of the claim made by the provider, the policyholder can claim the remainder of the treatment cost as an additional payment to a settled claim. This also comes

under the non-cashless category. Additional payments are also claimed in case the extension for authorization is not provided.

The steps in the settlement of Additional payment claims are:

• Claim receipt

• Claim Lodging

• Claim dispatch

• Medical Audit

• Document recovery

• Payment Receipt

• Cheque Preparation.

Pre- Hospitalisation And Post- Hospital1sation Expenses

The claims for the pre and post hospitalization expenses are submitted under the

additional payments claims and are settled accordingly.

Deduction Payments

In case of claims submitted for reimbursement by the provider or policy holder, due to the schedule of charge/ tariff agreed with the hospital in the MOU or if the policy holder has not submitted certain bills in the first case and submits them later, then the same is settled under the category of deduction payments. This is also considered under the category - non cashless.

The steps in the settlement of claims for deduction payments are:

• Claim receipt

• Claim Lodging

• Claim dispatch

• Medical Audit

• Document recovery

• Payment Receipt

• Cheque Preparation.

Investigation, Reconsideration & Indemnity Claims

Investigation claims:

In case the claim submitted is identified to be tampered with or some element of mischief has been introduced in the claim on the receipt of the authorization letter or during medical audit, the claim is sent for investigation at the respective branch office.Investigations may also be ordered to check and verify various documents submitted.

In order to prevent the element of moral hazard, investigations are carried out to verify:

• Fraud

• Over- billing

• Unnecessary Hospitalization

• Pre- existing disease

The investigation is done to find out and verify the indoor case papers, the duration of

hospitalization, cross verification of hospital records and pharmacy records

Reconsideration Claims

In case a claim has been repudiated earlier on the clause of non compliance with the document request, if the claim is under the first two years and the claims have been made under the exclusions applicable, if an element of fraud has been traced or if the hospitalization is due to a pre- existing illness.

In such cases, the claim is submitted for reconsideration by providing adequate proof against the basis of repudiation. The procedure for settlement of such claims is similar to that of the non cashless claims.

Indemnity Claims

In case the policy holder expires during the course of hospitalization, then in case of an assignee being present under the policy, the reimbursement and the balance sum insured after applying the short period scales are made available to the assignee. An appropriate endorsement to the effect is taken from the insurance company.

In case no assignee is present, then the legal heir of the policyholder is entitled to receive the amount by providing:

1. Necessary proof/ Evidence on a stamped paper stating that he/she is the legal heir

2 Two persons as witnesses to the same whose Income Tax returns are greater than the sum insured of the deceased person.

On receipt of the documents, the amounts are accordingly paid by the insurance company.

CHAPTER-5

FINDINGS AND SUGGESTIONS:

5.1) Findings:

• A lot of delay is observed in receiving the payments from the insurancers and hence the delay in cheque preparation.

The settlement of the claim is delayed due to insufficient staff members for quality check, raise payment request and cheque dispatch/electronic fund transfer process.

The process team deducting & approving the excess amounts in some claims due to overlooking the documents submitted for reimbursement of claim.

In some claims the the claimed amount is approved based on the mail approval by the higher management authority even after the claim intimation period is exceeded

In most of the claims the required documents are investigation reports, consumables breakup, medicines breakup, invoices, stickers of implants which are not submitted by patients along with main claim.

In some addendums the required investigation reports are not submitted by patient, but the amount has been paid for the reports that were not submitted.

In some claims the photocopy of reports were also paid (other than ICICI bank policies).eventhough photocopy reports are not payable.

In few claims, pre-post investigation reports and consultation papers were also paid even after the intimation period was exceeded.

In some cases the pre-post Hospitalization claims were wrongly tagged as addendums.

In few claims the amount was not being paid though all the required bills were attached since few bills were over looked and amount for these bills were paid in addendums.

The eligibility for claiming amount was not being mentioned clearly to the patients, when the remarks were sent.

In few cases the bills for the investigation reports that were paid in main claim, are also paid again in addendums.

• The providers take a lot of time to submit the cashless bills to the TPA

• Delay is also observed in receiving replies for the queries asked.

• The policyholder knowledge is insufficient regarding the policy exclusions and the

non medical expenses leading to an increase in the number of deductions for certain claims.

• A lot of documentation is required to settle the claim.

• Most of the hospitals still follow the previous policy terms and conditions and as such, re-submit the bills for deduction payments.

• According to the revised policy terms and conditions, the waiting period for several diseases has been increased and as such many claims are not granted authorization for cashless treatment.

• As most of the hospitals are not granted immediate extension, they collect the remainder of the amount from the patient. The policyholder has to re-submit the claim after settlement of the cashless claim which results in utter inconvenience to them.

• The original claim documents are required for the settlement of the claims for additional payments, deductions and reconsiderations: provisions should be made to retrieve the same immediately.

The endorsements passed by the corporate customers is not updated in the fast track(software using for claims processing), it leads to excess deductions of claimed amount. Because of this again the policy holder have to claim for that excess deduction amount,it leads to Increase the processing cost of claims to TPA.

5.2) Recommendations:

• There should be strict time limit framed to receive the bills from the providers. As such, it will help to settle the claim at the earliest because despite the TPA taking less time to settle, due to the delay in receiving the claim, the turn around time increases greatly.

• The time required to receive the documents as per the request made should be fixed to reduce the high turn around time.

• The TPA along with the agent should help promoting awareness among the policyholders to regulate the claims made for additional payments and deductions.

• The providers and the policyholders should be provided the checklist for bill submission to facilitate prompt settlement of claims.

• Online facilities for the patients to know the status of the claim should be made in order to reduce the load on the help desk of the TPA as well as to reduce the grievance.

• SMS and E-mail facilities to inform the patient about the authorization granted should be made in order to provide immediate information and to speed up the request for extensions and granting them accordingly.

Creating awareness in employee about the common causes in wrongly issued addendums, like

A) Deduction of amount for the reason that reports and break up of bills not furnished even though they exist in the main claim itself .

B) Approval of addendum even though the required documents were not submitted.

Making arrangements that an addendum file should go to the same employee who processed the main claim, to avoid errors and to reduce the processing time.

Educating the corporate clients on delayed settlements arise due to the non- submission of all required documents at a time.

Minimizing the pressure on the employee regarding the targets.

CHAPTER-6

Conclusion:

The TPA concept has evolved in order to provide better claims experience to the hospitals, insurance companies and the policyholders and thereby ensure customer satisfaction. The TPA depends on the hospitals and the policyholders to deliver the claims immediately in order to ensure prompt settlement. Similarly, it depends on the insurance company to issue funds for payments immediately so that the cheques can be dispatched immediately to the policyholders after the claim settlement.

As such the turnaround time for the claim settlement by the TPA reflects on the integrated operations of the hospital, the insurance company and the third party administrator. Similarly, the knowledge of the policyholders and the hospitals as well as the TPA employees themselves about the TPA and the insurer protocols proves to be insufficient and hence a lot of claims for additional payments, deductions and reconsiderations are re-submitted. Since the TPA is dependent on a lot of Factors for settlement of claims, it is not possible to frame strict guidelines for the same.

In this study of the TPA processing of claims the actual time taken is 23or less than 23 days, but the average time taken for member reimbursement claim claim is 24.5 days, the addendum claim have taken 17.72 days instead of 17 days or less than 17 days. The reasons for the dealy is due to the lack of sufficient staff at the quality check,payment request,and cheque dispatch or electronic fund transfer process areas. In the process of executive level and doctor level the claim processing is delayed due to technology problems, improper work flow,irregular tracking of files.So the organization has to provide the guidelines & process manual for clarifications about claim process to employees.By this way the turn around time for claim can be minimised, a part from this the organization has to create awreness to policy holders and hospitas regarding the delays in claim settlement process due to delayed submission of documents, partial submission of reports and also about the deductions and copayments in certain policies. So the tardy clearance of claims is impacts the organization ability and efficiency, by avoiding the factors

responsible to delay in claim settlement the organization can achieve good market share and customer loyalty.

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APPENDIX

Actuary: A mathematician who specializes in estimating risks, rates, premiums, and other factors for insurance companies.

Actuarial analysis: The technique of calculating the insurance premium and the reserves required, using actuarial methods. This involves mathematical modeling using the life expectancy of the population, the frequency of hospitalization, the costs of healthcare, etc. All insurance company premiums are usually based on actuarial analysis, but in India, because of the lack of adequate data, this analysis is based on a weak foundation.

Administrative costs: Costs related to the operations of the health insurance. This includes costs incurred in marketing the scheme, in premium collection, in claims processing, in quality assurance and underwriting fees. In India, the insurance companies load the premium by about 20% to cover these costs.

Agent: An insurance company representative, licensed by the regulator, who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Ambulatory care: Medical services that are provided on an outpatient (non-hospitalized) basis, services may include diagnosis, treatment, and rehabilitation.

Beneficiary: A person who is eligible to receive, or is receiving, benefits from an insurance policy. Beneficiaries usually include both people who have contracted for benefits for both themselves and their eligible dependents. (See also subscriber)

Benefits: Benefits are the sum of money received by an insured or an assignee (e.g. a hospital) as reimbursement for medical costs incurred due to illness. Benefits may also be in the form of health services received. These benefits are in lieu of a premium paid to an insurance provider.

Brochure (also called certificate of coverage): The booklet showing the complete details of a plan‘s benefits, limitations (or limited benefits), exclusions, and definitions. The brochure is a plan‘s contractual statement of benefits.

Cap: A limit of the benefit amount that an insurance company will pay

Claim: A request to an insurer by an insured person (or by the provider of a good or service on behalf of the insured individual) for payment of benefits according to the terms of an insurance policy.

Claim amount: It is the amount/benefit payable by the insurer under a policy on a claim occurrence.

Co-insurance: A cost-sharing provision of a health insurance policy that requires the insured beneficiary to pay a percentage of the cost of covered services. The rest is then paid by the insurance company, e.g. the beneficiary pays 10% of the bill, the rest 90% is reimbursed by the insurer

Co-payment: A type of cost-sharing arrangement whereby insured or covered persons pay a specific, flat amount per unit of service or time and the insurer pays the rest. The co-payment is incurred at the time that the service is rendered. Unlike coinsurance which involves payment of some percentage of the total cost, the co-payment does not vary according to the cost of a service.

Deductible: The amount of money an insured person must pay ‗at the front end' before the insurer will pay.

Exclusions: Specific conditions listed in an insurance or medical care policy that are not covered by benefit payments. Common exclusions include pre-existing conditions, such as heart disease, diabetes, hypertension, or asthma which began before the policy was in effect. Because of exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage either for a particular disease or in general. Sometimes conditions are excluded only for a defined period after coverage begins, such as nine months for pregnancy or one year for illnesses. Exclusions are often permanent in health insurance coverage for individuals and temporary (e.g., one year) for small group insurance. They are uncommon in large group plans that are capable of absorbing extra risk.

Health insurance: A financial instrument that, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of their contributions. These are primarily used to meet the costs of the benefits.

Health maintenance organization (HMO): An organisation that provides a wide range of healthcare services for a specified group at a fixed periodic payment (similar to a premium). The main advantage of an HMO is that it has an inherent interest in keeping costs low.

Long-term care: The range of maintenance and health services to the chronically ill or physically or mentally disabled. Services may be provided on an inpatient (for example, rehabilitation facility, nursing, etc.).

Managed care: Healthcare systems that integrate the financing and delivery of appropriate healthcare services to covered individuals by arrangements with selected providers to furnish a comprehensive set of healthcare services, explicit standards for selection of healthcare providers, formal programmes for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Premium: The amount of money or consideration paid by an insured person or policyholder (or on his or her behalf) to an insurer or third party for coverage under an insurance policy.

Underwriting: The process by which an insurer determines whether or not to accept an insurance application and on what basis/terms it will be accepted.

Waiting period: The period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overallcoverage has commenced (see exclusions). Some policies will not pay maternity benefits, for example, until nine months after the policy has been in force. Another common waiting period occurs in group insurance that is offered through a place of employment, whereby coverage may not start until an employee has been with a firm more than 30 days.

Drugs, dressings other consumables:

Drugs, dressings and other consumables are additional services to support hospital treatment. They include medications, bandages and crutches, prostheses (surgically implanted items such as hip replacements, artificial lenses and heart valves).

Intensive care

Intensive care is treatment for actual or potential life-threatening illnesses, injuries or complications.

Pre-existing ailment

A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health insurer, existed at any time during the 6 months prior to the member becoming insured under the policy.

Eligibility period: A specified length of time, frequently ninety days up to one year, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Group insurance: Any insurance plan under which a group of employees (and their dependents), or members of a similar homogeneous group, are insured under a single policy that is issued to an employer or the group itself. Group health insurance is usually rated based on experience (except for small groups, all of which are given the same rate by an insurance company). Group coverage is less expensive than comparable individual insurance, in part because an employed population tends to be healthier than the general population, and in part because of lower administrative costs, particularly in marketing and billing). Note that a policyholder or insured is the employer or group, not the individual employees or group members.

Lapse: Termination of a policy upon the policyholder‘s failure to pay the premium within the time required

Outpatient services: The care provided to you in the outpatient department of a hospital, in a

clinic or other medical facility, or in a doctor‘s office.

Policy: The legal document issued to the policyholder that outlines the conditions and terms of

the insurance; also called the ‗policy contract‘ or the ‗contract‘.