Dissertation

In

ICICI Lombard General Insurance Company Private Limited

(February 2 – May 1, 2010)

Claim trend analysis of Bhai Ghanhya Sehat Sewa Scheme and developing claim control methods

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2008-10

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2010

Acknowledgement:

I would like to acknowledge and extend my heartfelt gratitude to the persons who have made the completion of this dissertation possible.

Mr. Anil Kumar, Area Manager, ICICI Lombard and Mr. Harish Sihare and Mr. Pawan Taneja (Faculty, IIHMR) for their constant inspiration and much needed motivation

The staff of the hospital and the TPA who extended their support in providing the accurate information for the research

Lastly, I would like to convey my thanks to those personnel who have imparted knowledge for my development and whose names could not be mentioned here.

Table of Contents:

1. **Introduction and objective of Internship**
2. **Organization Profile**
3. **Report on managerial task during Internship**
4. **Executive Summary**
5. **Introduction of Dissertation study**
6. **Background**
7. **Objective**
8. **Strategy**
9. **Methodology**
10. **Data analysis and findings**
11. **Recommendations**
12. **Limitations**
13. **Conclusion**
14. **Annexe- Questionnaire**
15. **References**
16. **Annexure- Time utilization schedule**

Acronyms and Abbreviations:

BGSSS – Bhai Ghanhya Sehat Sewa Scheme

TPA – Third Party Administrator

ICR – Incurred claims ratio

PSU – Public Sector Unit

IRDA – Insurance Regulatory and Development Authority

CGHS – Central Government Health Scheme

ESIS – Employee State Insurance scheme

PPO – Preferred Provider Organization

Introduction of Internship:

I did my internship and dissertation from ICICI Lombard General Insurance Company Limited from 2nd February- 1st May, 2010. It was an enriching experience and growth both from professional and personal point of view. This is carried out as a part of curriculum in the completion of 2 years PGDHHM programme.

Objectives of Internship:

1. To gain practical knowledge and skill from the organization
2. To handle managerial issues related to major departments of the organization.

I along with my other batch mates had exhaustive training session (theory + Practical) where the basic of Insurance and the Role of Insurance Company was introduced. We were introduced to various departments and their functioning in the process of claims management. A detailed comparison of various products of Insurance companies was also introduced. We were also given a fair idea about the schemes like BGSSS (Bhai Ganhya Sehat Sewa Scheme) in which the organization is doing fairly well and is the leading market player.

The various departments visited were:

1. Enrollment department
2. Network department
3. Cashless department
4. Finance department
5. HR department
6. I.T department
7. Claims department
8. Authorization department
9. Grievance department
10. Corporate department

Roles and Responsibilities:

I am working as **Customer Service Manager (Health)** in Customer Service Health and Accidents – Govt. and Rural team in **ICICI Lombard General Insurance Co. Ltd**

Responsibilities:

- Quality check of enrollment forms
- Claim investigation
- Coordination with Government officials
- Coordination with hospitals
- Coordination with TPA

Role:

- To coordinate with the TPA in case any cashless sent by the hospital for approval is stuck. To facilitate the settlement of reimbursement claims of non - network government hospitals. Also to check if the TPA is processing the claims within the stipulated TAT.
- To coordinate with the hospital by monitoring their TAT for sending the claim files to the TPA. To look if there is any malpractices being practiced by the hospital
- To handle the issues of the beneficiary, which is being filed by them due to non availability of mediclaim cards?
- To carry out investigation of the cases in case of any suspicious claim

Organization Profile:

ICICI Group offers a wide range of banking products and financial services to corporate and retail customers through a variety of delivery channels and through its specialized group companies, subsidiaries and affiliates in the areas of personal banking, investment banking, life and general insurance, venture capital and asset management. With a strong customer focus, the ICICI Group Companies have maintained and enhanced their leadership position in their respective sectors.

ICICI Bank is India's second-largest bank with total assets of Rs. 3,793.01 billion (US$ 75 billion) at March 31, 2009 and profit after tax Rs. 37.58 billion for the year ended March 31, 2009. The Bank has a network of 1,451 branches and about 4,721 ATMs in India and presence in 18 countries.

ICICI Prudential Life Insurance Company is a 74:26 joint venture with prudential plc (UK). It is the largest private sector life insurance company offering a comprehensive suite of life, health and pensions products. It is also the pioneer in launching innovative health care products like Diabetes Care Active and health Saver. The company operates on a multi-channel platform and has distribution strength of over 2,76,000 financial advisors operating from more than 2000 branches spread across 1800 locations across the country. In addition to the agency force, it also has tie-ups with various banks, corporate agents and brokers. In fiscal 2009, ICICI Prudential attained a market share of 10.9% based on retail weighted premium and garnered a total premium of Rs 153.56 billion registering a growth of 13% and held assets of Rs. 327.88 billion (31March,2009).

ICICI Lombard General Insurance Company, a joint venture with the Canada based Fairfax Financial Holdings, is the largest private sector general insurance company. It has a comprehensive product portfolio catering to all corporate and retail insurance needs and is present in over 300 locations across the country. ICICI Lombard General Insurance has achieved a market share of 27.2% among private sector general insurance companies and an overall market share of 11.2% during fiscal 2009. The gross return premium grew by 2.2% from

Rs.33.45 billion in fiscal year 2008 to Rs. 34.20 in fiscal year 2009.

ICICI Securities Ltd is the largest equity house in the country providing end-to-end solutions (including web-based services) through the largest non-banking distribution channel so as to fulfill all the diverse needs of retail and corporate customers. ICICI Securities (I-Sec) has a dominant position in its core segments of its operations - Corporate Finance including Equity Capital Markets Advisory Services, Institutional Equities, Retail and Financial Product Distribution.

ICICI Securities Primary Dealership Limited is the largest Primary Dealer in Government Securities. It is an acknowledged leader in the Indian fixed income and money markets, with a strong franchise across the spectrum of interest rate products and services - institutional sales and trading, resource mobilization, portfolio management services and research. One of the first entities to be granted Primary Dealership license by RBI, I-Sec PD has made pioneering contributions since inception to debt market development in India. I-Sec PD is also credited with pioneering debt market research in India. I-Sec PD has been recognized as the 'Best Domestic Bond House in India' by Asia money every year from 2002 to 2007 and selected as 'Best Bond House' by Financeasia.com for the years - 2001, 2004 to 2007 and 2009."

ICICI Prudential Asset Management is the third largest mutual fund with average asset under management of Rs. 514.33 billion and a market share of 10.43% as on March 31, 2009. The Company manages a comprehensive range of mutual fund schemes and portfolio management services to meet the varying investment needs of its investor’s through162 branches and 185 CAMS official point of transaction acceptance spread across the country.

ICICI Venture is one of the largest and most successful private equity firms in India with funds under management in excess of USD 2 billion. ICICI Venture, over the years has built an enviable portfolio of companies across sectors including Life Sciences, Information Technology, Media, Manufacturing, Retail, Financial Services, and Real Estate thereby building sustainable value. It has several “firsts” to its credit in the Indian Private Equity industry. Amongst them are India’s first leveraged buyout (Info media), the first real estate investment (Cyber Gateway).

Executive Summary:

With the Indian healthcare scenario of high out-of-pocket payment for curative care, both hospital and domiciliary, limited health insurance for the majority of the population, uncontrolled expansion of the private health sector and falling standards of government healthcare facility, it was clear that the health insurance sector needed to expand for greater coverage, at least for catastrophic illnesses.

For achieving this goal there were many schemes launched to cover majority of the population at a very subsidized premium so that health of the population could be taken well care of. Following a similar trend, the Bhai Ghanhya Sehat Sewa Scheme was launched by cooperatives of Punjab which is an earnest endeavor of concern for the health of farmers and others. The dawn of 21 st century is a witness to stagnating agriculture in Punjab leading to marginalization of farming and deterioration of health of farmers. The cooperatives which stood by the farmers during last one century are now geared up for meeting new challenges facing the farmers. The cooperatives as institutions of development play a proactive role related to matters concerning the community and there is no bigger concern than the one relating to the health of its members.

It was also quite obvious that the four public sector general insurance companies were unable to offer a product that was more useful or consumer-friendly than Mediclaim as it was designed in the beginning. Finally, the reimbursement process for even those few who had the policy was arduous and complicated enough to diminish the value of the benefits considerably in the eyes of the customer.

In this scenario, privatization of the insurance sector and the subsequent creation of the system of TPAs meant that there was a possibility of more efficiency in the insurance market because of more competition as well as the creation of a professional cadre to look after speedy disposal of payments. Thus, outsourcing of the service facility did make eminent sense, especially given the service quality of PSU companies. Average time for claim processing before the TPAs came into existence was apparently much longer than what it is now:

Secondly, the cashless system is definitely an improvement over the reimbursement scheme, and the choice set for such cashless transactions expanded when the TPAs succeeded in enlisting many more hospitals and nursing homes on the approved list eligible for cashless facility.

From the perspective of the insurance companies, the TPAs benefit them by bringing down the claims ratio, by reducing false claims as well as standardizing treatment costs. While the standardization has still not been completed, if it happens it would benefit the consumers immensely.

Though the claim settlement process is streamlined in today's era, the major challenge of claims control still lies ahead of any insurance company as increasing claims ratio is a concern for many schemes like this. Devising strategy for the control and implementing the model successfully would take them above their competitors in the market. The basic concept of claims control is fraud control, capping or excess clause on certain diseases and standardization of treatment rates.

This paper is an attempt to understand the diseases for which most of the hospitalization takes place in this scheme and the preferred hospital of the beneficiaries so that an initiative could be taken to establish a preferred provider network where a discounted and package rates for the treatment can be availed for the beneficiaries thereby decreasing the cost of healthcare. This would also reduce the risk of fraud claims. The claim pattern trend with respect to the terms and conditions of the group mediclaim policy of the members of Bhai Ganhya Sehat Sewa Scheme has also been studied so that the principle of excess clause or co payment can be brought into picture to bring down the claims ratio of beneficiaries by directly controlling the claims. On the basis of primary data collected through questionnaire and the interview with the personnel engaged in looking after the mediclaim policy and the secondary data from the MIS analysis was done and recommendations are suggested in the later part of the paper.

Bhai Ghanhya Sehat Sewa Scheme:

Introduction:

For the vast majority of rural population of Punjab, the cost of health care particularly in-patient care, is a significant barrier in accessing professional healthcare in time of need. Very often, the cost of treatment pushes the people to economic ill health. Normally, individuals when hospitalized borrow money or sell their assets to cover the cost of hospitalization which pushes them into debt trap. The Bhai Ghanhya Sehat Sewa Scheme aims to provide viable means of improving access to quality health services for rural community at affordable cost.

Objective:

To make equitable, affordable and quality health care accessible to the farmers and others comprising most vulnerable section of the society.

Policy Information:

Eligibility for coverage in the scheme:

- Any cooperative society registered under the Punjab Cooperative Societies Act, 1961
- Members and employees of Eligible Cooperative Societies/ Institutions, employees or retired employees of the Department of Cooperation/ office of the Registrar Cooperative Societies, Punjab or the Bhai Ghanhya Trust, and their families across the state of Punjab and Chandigarh, shall be covered under the scheme for a period of one year from the date of commencement of the Bhai Ghanhya Group Mediclaim Policy.

Main Member:

- Is a person who is a member or an employee of Eligible Cooperative Societies/ Institutions, employees or retired employees of the Department of Cooperation/ office of the Registrar Cooperative Societies, Punjab or the Bhai Ghanhya Trust
- Is not more than 75 years of age on the date of commencement of the policy plan period
- Fills up the Member Enrollment Form declaring his status as the Main Member and pays the insurance premium on behalf of his or her Family.

Beneficiary or Insured:

- Main Member + Dependants of the Main Member = Beneficiaries/ Insured
- Beneficiary/ Insured means members and employees of Eligible Cooperative Societies/ Institutions, employees or retired employees of the Department of Cooperation/ office of

the Registrar Cooperative Societies, Punjab or the Bhai Ghanhya Trust, and their families across the state of Punjab and Chandigarh, who have been named as dependants in the Member Enrollment Form for being covered under the scheme, provided no such persons is more than 75 years of age on the date of commencement of the policy plan period.

Family:

Family means the persons named in the Member Enrollment Form including the Main Member and any of his or her relatives irrespective of whether or not they are residing with the Main Member.

- Spouse of the Main member
- Parents of the Main Member
- Unmarried children of the Main Member
- Widow and divorcee daughters of the Main Member
- Minor children of divorcee and widow daughters of the Main Member
- Parents or Parents – in law in case of a lady Main member
- Age Limit – up to 75 years

Exclusions under the scheme:

- 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 necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
- Vaccination or inoculation or change of sex 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, contact lenses and hearing aids.
- Dental Treatment or surgery of any kind
- Convalescence, general debility, run down condition or rest cure, Congenital external disease or defect of anomalies, sterility, venereal disease, diseases directly attributable to alcoholic intake.
- Self inflicted injuries, HIV, AIDS.

- Charges incurred at Hospital or Nursing Home primarily for diagnostic, X- ray or laboratory examinations not leading to indoor treatment.
- Expenses on vitamins and 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/materials.
- Naturopathy Treatment, Ayurvedic and Homeopathic treatment
- Physiotherapy, psychiatric treatment, hospitalization only for giving traction, without any medical management/support. However, hospitalization exclusively for providing traction or for providing psychiatric treatment shall be covered only in Government hospitals.

Items not covered under the scheme and the Member has to pay to the hospital at the time of discharge:

- Ambulance charges
- Extra bed for Attendant, Attendant Pass, Food and Beverages for Attendants
- Bed retaining charges
- Expenses on luxury items like Radio, TV, AC, Laundry, Telephone
- Expenses on tonics, vitamins if not related to treatment
- Sanitary items
- Special duty nursing fee
- Xerox/ Certifying charges
- Vaccination/ Nutrition and Dietetics
- Expenses on spectacles and hearing aids

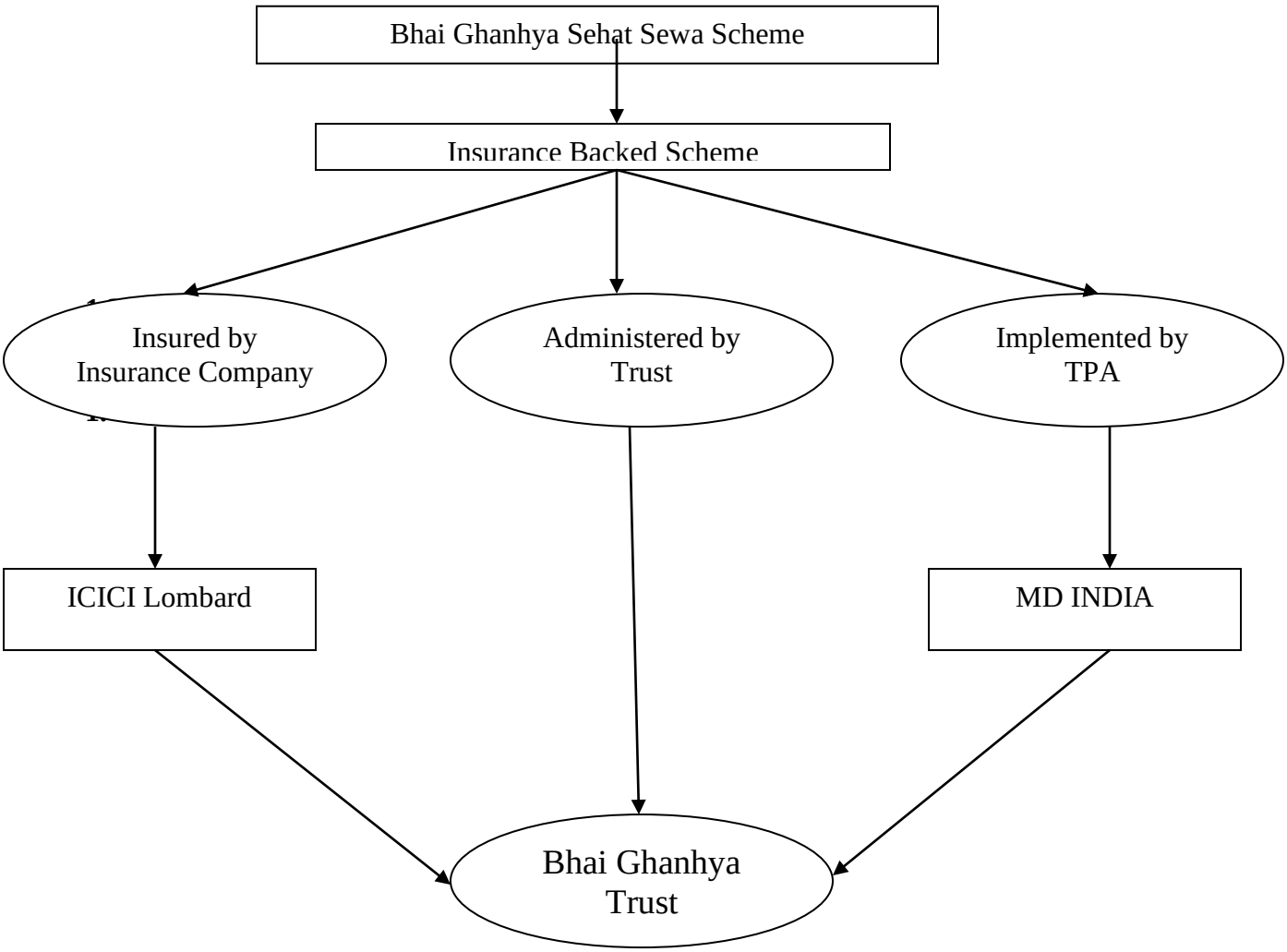
Insurance Premium:

Premium of the Main Member irrespective of the age of the Main Member (Inclusive of Service Tax (10.3 %) $ Subscription to Trust @ Rs. 10/-) is Rs. 2215. (The age cannot be more than 75 years.)

Premium of Dependants

Slab	Age group	Loading in % on premium of Main Member	Amount per dependant (in Rs.) (Inclusive of Service tax)
Slab 1	< 45 years	15%	331
Slab 2	45 – 65 years	30%	661
Slab 3	>65 – 75 years	40%	882

Scheme Tree:



Industry Background

The term Insurance, broadly defined, is that of an agreement in which both parties agree to the sharing of risk. Basically, the client pays a sum of money called the Premium and in turn the Insurance firm would commit to pay a predetermined sum of money to meet the customer's claims.

Health insurance will protect individual and his dependants against any financial constraints arising on account of a medical emergency.

It was during the late 17th century that the idea of health insurance germinated. In the year 1694 a member of the Peter Chamberlen family, Hugh proposed a scheme which was very similar to health insurance in the modern day world, but the idea of health insurance took a lot of time to develop. In late 19th century the accident insurance policies were introduced which resembles the disability insurance policies in the present world.

India has an extensive network of healthcare infrastructure. The system envisages availability and accessibility of publicly funded healthcare to all, regardless of their ability to pay. However, over a period of time due to expansion in size and shortfall in budgetary support, the public healthcare system has lagged behind in terms of its ability to meet the challenge of fulfilling the needs of large segment of population.

To meet this challenge partially private healthcare sector has grown in size and scope. Both public and private sector provide healthcare services, but the bulk of curative services are skewed towards the urban areas and dominated by private sector. Currently, less than 15 per cent of the Indian population has some kind of health insurance cover. This includes those covered under the Central Government Health Scheme (4 million beneficiaries), the Railways Health Scheme (1.2 million) and the Employees' State Insurance Scheme (0.3 million).According to the Human Development Report (2004) India ranks 171 out of 175 in public spending on healthcare while in terms of private spending it ranks 18^{th}. Private healthcare spending in nominal terms is growing at 18% per annum. With the proliferation of medical technology and new treatment protocols the health care costs are increasing and this justify the need for health insurance.

With the passage of IRDA Bill (1999), the industry has undergone a transformation. It has opened insurance sector for private players. The TPA was introduced through the notification on TPA-Health Services Regulations, 2001 by the IRDA. Their basic role is to function as an intermediary between the insurer and the insured and facilitate the cashless service of insurance. For this service they are paid a fixed commission of 5.6% of the insurance premium.

Insurance companies outsource their administrative activities, including settlement of claims, to TPAs who are prominent players in the managed care industry and have the expertise and capability to administer claims process and offer such services for a cost.

They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, enrollment and other administrative activities, the insurers remunerate the TPAs; hence, policyholders receive enhanced facilities at no extra cost.

Once the policy has been issued, all the records will be passed on to the TPAs and all further correspondence of the insured will be with the TPAs and not with the insurance companies

The core product or services of TPA is to ensure cashless hospitalization to policy holders. Intermediation by TPA ensures that policyholders get hassle free services, insurance companies pay for efficient and cost efficient services and healthcare providers to get their reimbursement on time. By doing this it is expected that TPAs would develop appropriate systems and management structures aiming at controlling cost developing protocols to minimize unnecessary treatment/investigation, improve quality of services and ultimately lead to lower insurance premiums

Apart from rendering basic core services the TPAs are expected to provide value-added services to the consumers, like arranging ambulance services, medicines and supplies, guiding policy holders for specialized consultation, and providing information about 24- hour help lines, health facilities, bed availability, organization of lifestyle management and well- being programs.

Therefore Third party administrators are intermediaries between insured and insurance company and benefit both the insured and the insurer, the insured is benefited by better service, and insurers are benefited by reduction in their administrative cost.

Given the potential size, India is one of the most promising countries in South East Asia for the development of its health insurance market. There is a limited network of health/social security schemes such as the Employee State Insurance Scheme (ESIS), the Central Government Health Scheme (CGHS) and some community-based schemes and employer-based schemes. However even here, access and availability of health services is likely to be less than satisfactory. When combined with the relatively small proportion of people with voluntary health insurance, the number of lives covered represents at best 100 million people, about 10% of the population.

The support of the IRDA will be crucial. It is keen to see health insurance coverage grow rapidly in the country and is likely to encourage insurers and service providers in their efforts to develop the market. The challenges should however not be underestimated. Delivering healthcare to the rural Indian population where the medical infrastructure is minimal will be a significant task in itself. Even in urban areas where services can be more readily established, little or no data for pricing products will remain an issue for insurers to resolve. And finally, the continuation of some less than ethical practices by some healthcare practitioners may cause concerns for the orderly development of the sector.

Research Objective

1. To establish a correlation between the number of claims and demographic profile (age, gender, relation) of the beneficiaries.

2. To understand the disease trend of the beneficiaries of Bhai Ghanhya Sehat Sewa Scheme through the MIS maintained by the organization.

3. To study frequency of cases in all the districts of Punjab under BGSS scheme.

4. To understand the top ten preferred hospital based on the frequency and the claim size.

5. To study the price deviation in claims of package treatment.

Strategies

1. To find the diseases that has incurred maximum claims in the Scheme of the beneficiaries of Punjab cooperative societies for first quarter of the policy period.

2. To understand the user preference for various hospitals and nursing home

3. To analyze if the network hospitals abide by or deviate from the Negotiated Tariff

4. To understand the relation between the diseases claim pattern and the inclusion and exclusion criteria of the Scheme

Methodology:

Study Design:

The study design shall be descriptive in nature.

Research Methods:

The research methods used would be quantitative analysis.

Type of data

Secondary data:

The secondary data on claim trend would be collected from the claims MIS maintained by the organization after the inception of Bhai Ganhya Sehat Sewa Scheme. The identity of the beneficiaries has been well protected and their names have not been depicted any where to maintain the privacy of the data.

Procedure:

A detailed MIS maintained by the organization for the BGSS scheme was acquired. The data was then analysed under different sub heads which would later be represented in the form of table and graphs in the project. The data was then analysed into various pieces of information to fulfill the objectives of the project and reach a conclusion for the recommendation of efficient running of the scheme.

Study time:

The study was carried out in three months (February 2- May1, 2010).

Data analysis:

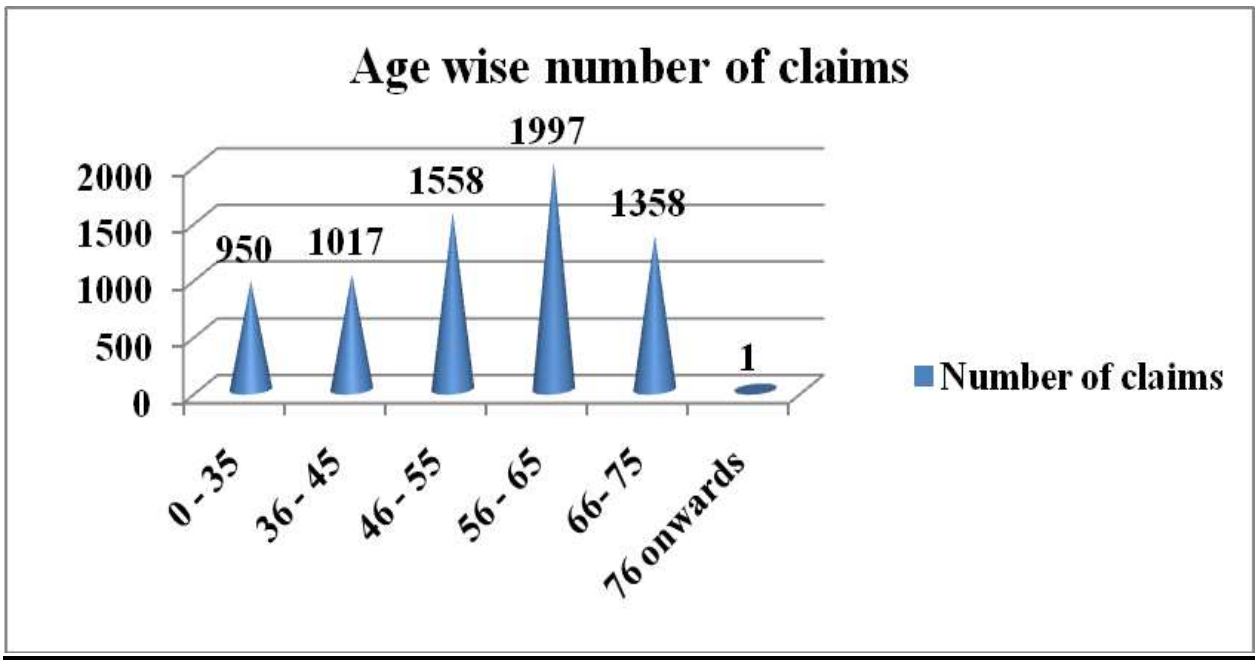
Data collected through MIS was assimilated and was analyzed further to draw a conclusion and infer the recommendation for the effective running of the scheme.

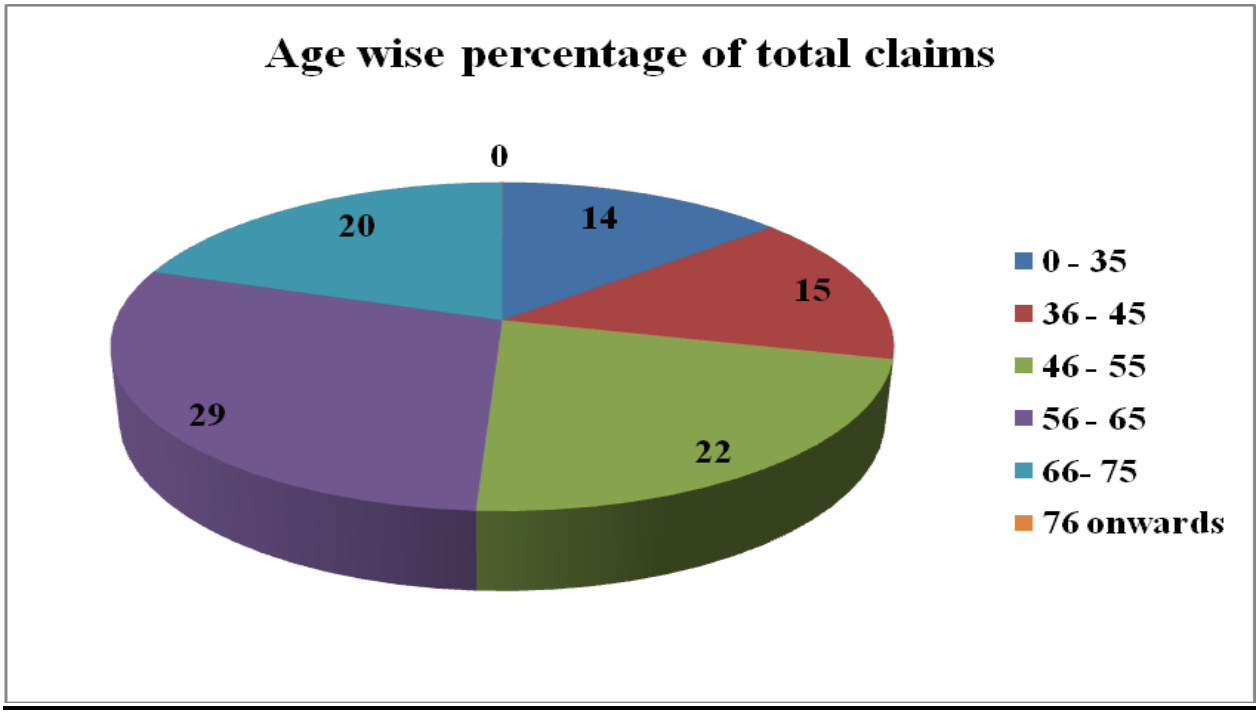
I. To establish a correlation between the number of claims and demographic profile (age, gender, relation) of the beneficiaries

The demographic study of the population is important as we know that there are some diseases which are related to age (E.g cardiac problems and cataract etc are commonly related to higher age groups). Some diseases are common to the gender of the population (e.g there are higher maternity claims if the population is mostly in the reproductive age group and mostly female). So the need of the demographic study arises in the prediction of the claims in the policy period of this scheme.

1. **Age wise analysis of the claims:**

Age band	Number of claims	Percentage of claims
0 – 35	950	14
36 – 45	1017	15
46 – 55	1558	22
56 – 65	1997	29
66 – 75	1358	20
76 – onwards	1	0



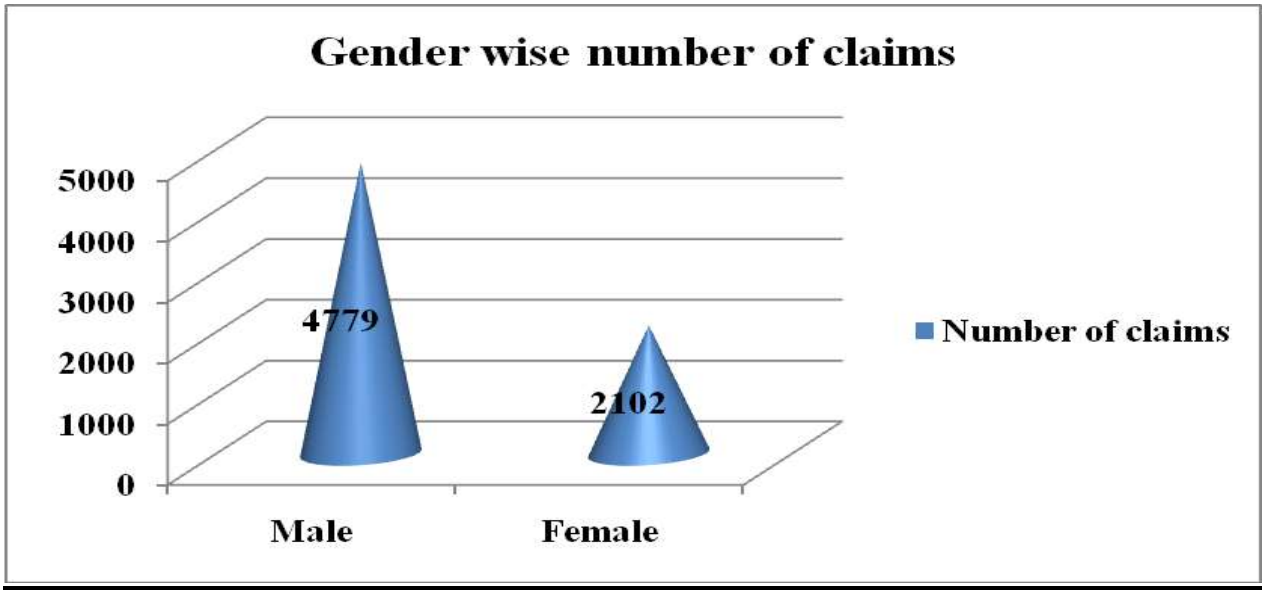


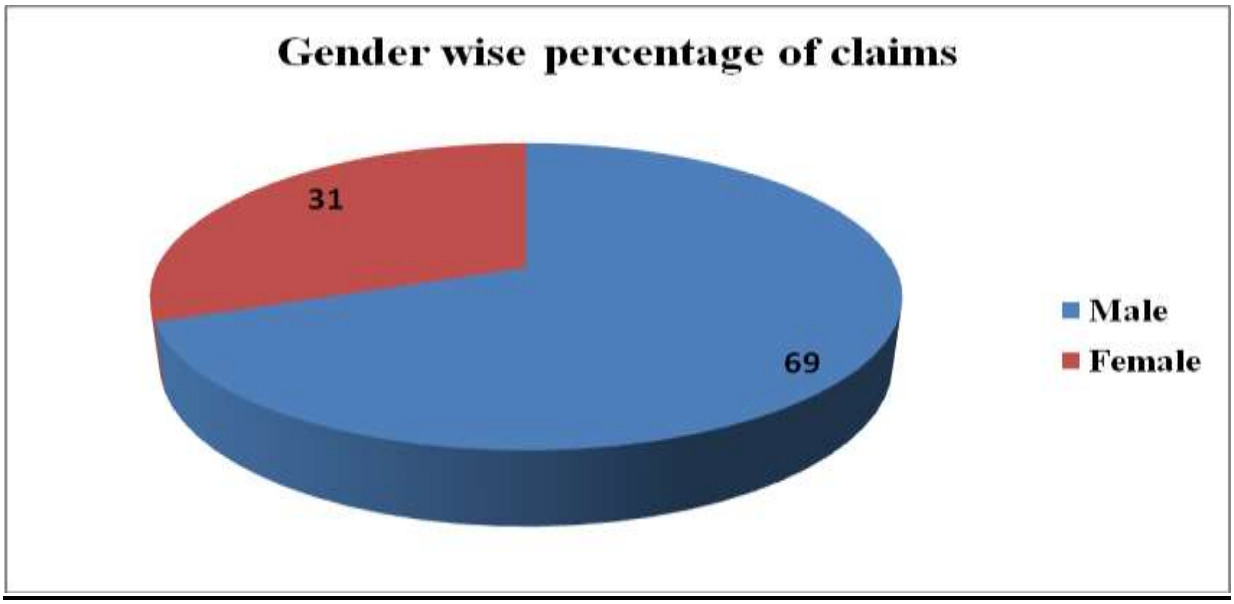
Analysing the data age wise we can draw a conclusion that the percentage of claims is maximum in the age group 56 – 65 years and subsequently 46 – 55 years. Diseases like cataract, osteoarthritis, neoplasm and cardiovascular ailment is common to this age group. Thereby if these cases can be investigated periodically on random basis there is a significant probability to

get hold of the deviated or over expensed claims. Moreover the beneficiaries should be encouraged to get these ailments treated in a network and packaged hospital to keep a track of the charges and drawing inferences on cost containment measures.

2. Gender wise analysis of the claim:

Gender	Number of claims	Percentage of claims
Male	4779	69
Female	2102	31

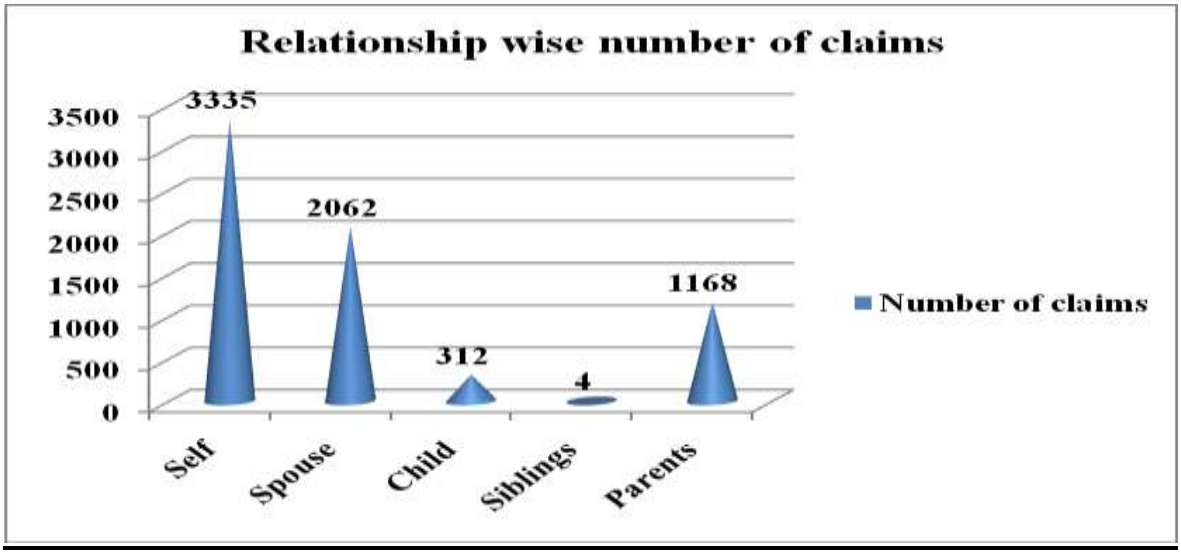


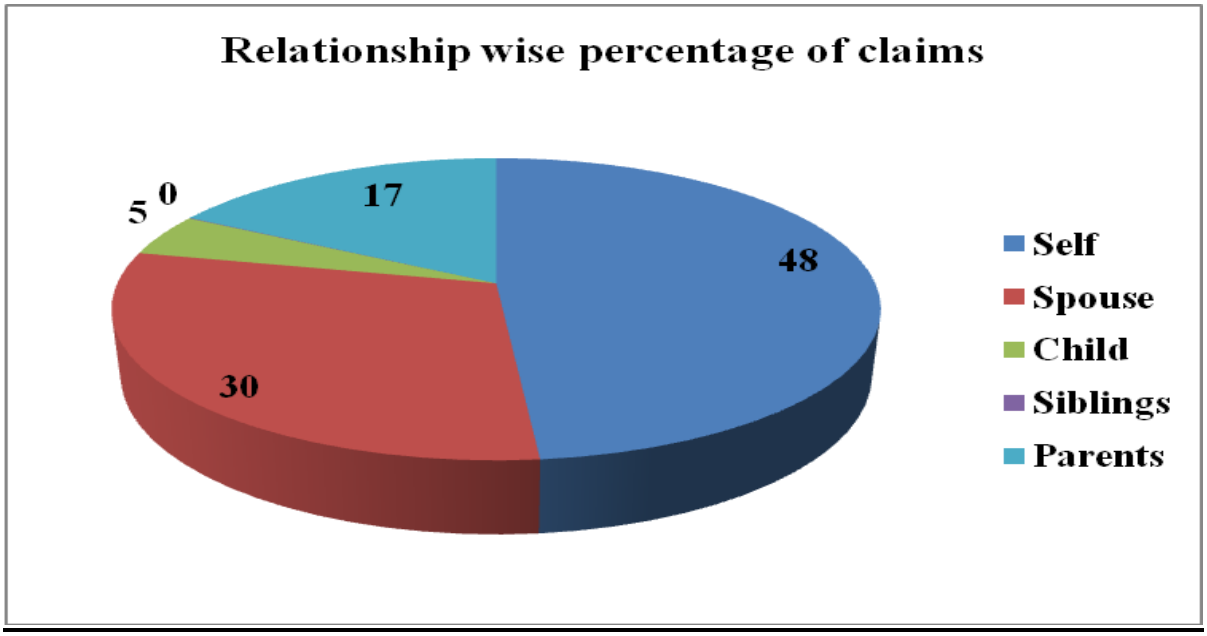


Further analyzing the data gender wise it was concluded that the claims of male were far ahead than those of females. Since the scheme is being run for the cooperative society of Punjab and mostly for the farmers, it is obvious that the females in this economic strata are not much aware of the benefits and moreover less concerned for their health. Awareness campaigns should be held for the beneficiaries so that the benefits provided can be used by them in a proper as well as they develop ownness towards the scheme and thus not abusing the health insurance scheme rather being more vigilant for the expenditure in the hospital.

3. Relationship wise analysis:

Relationship	Number of claims	Percentage of claims
Self	3335	48
Spouse	2062	30
Child	312	5
Siblings	4	0
Parents	1168	17





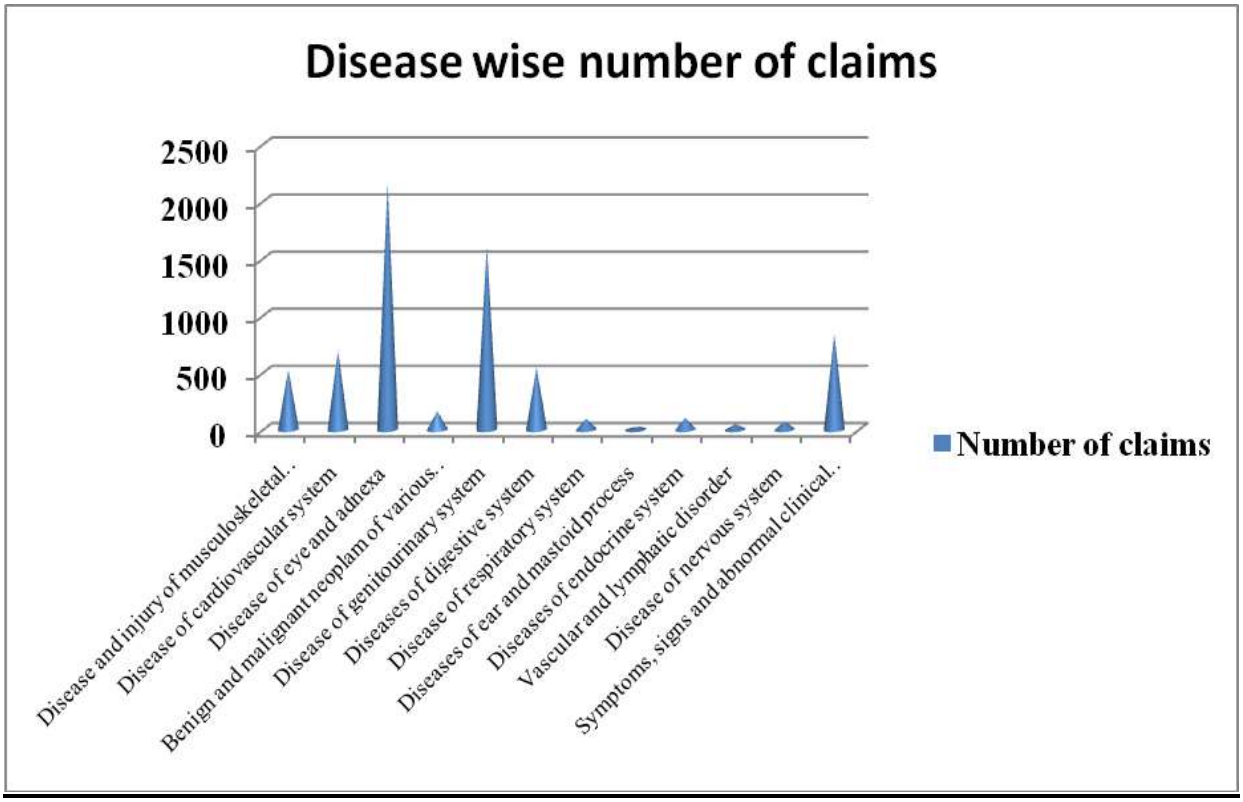
Self claims are significantly high than the others in the relation depicting that the claims of the main member should be scrutinized carefully. Though Health insurance is a blessing in present scenario but it comes along with moral and morale abuse which is difficult to curtail. These hazards can be partially controlled by educating the client as being ignorant is not at all a solution to any problem. They should be responsible for utilising the benefits effectively and efficiently.

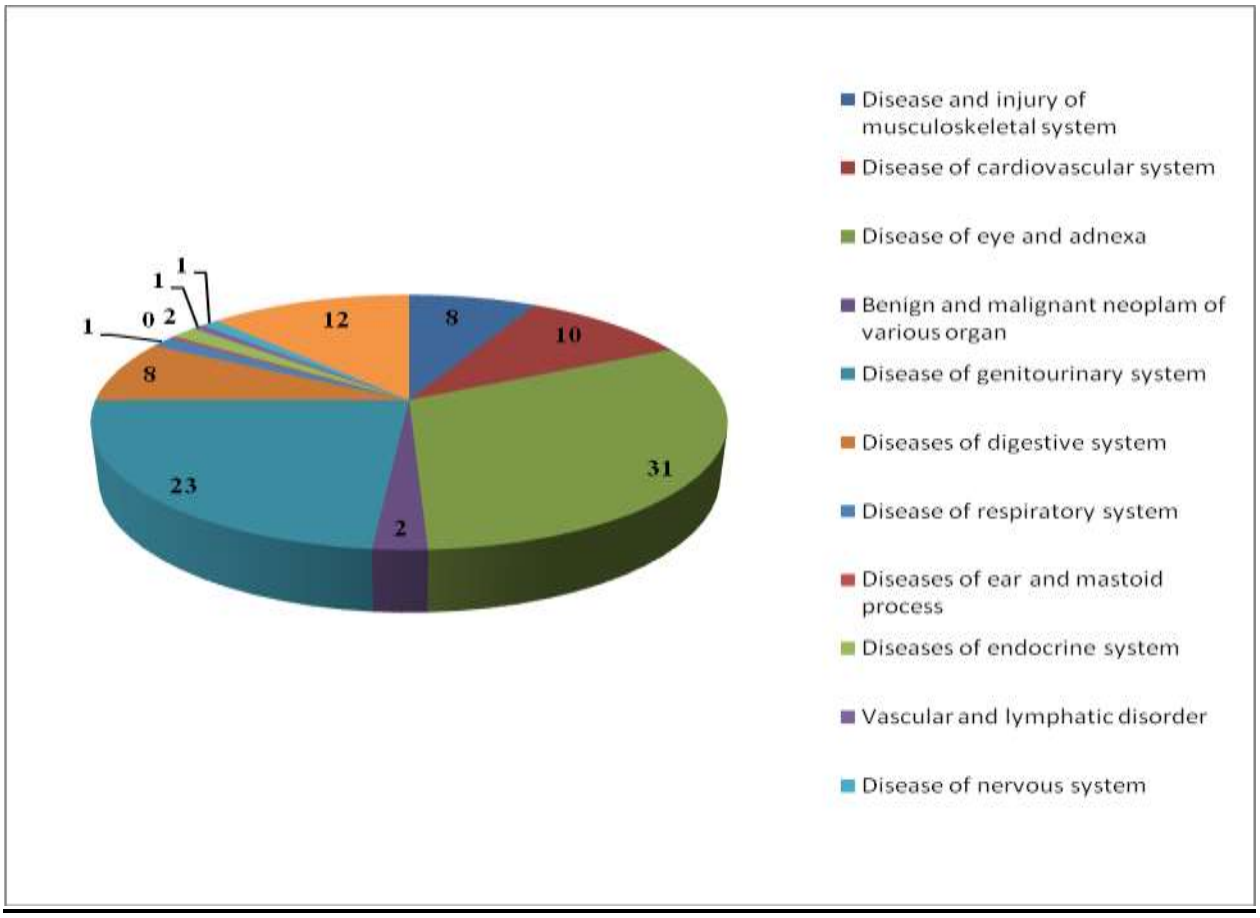
II. To understand the disease trend of the beneficiaries of Bhai Ghanhya Sehat Sewa Scheme through the MIS maintained by the organization.

The study of the disease trend is important as this would give a fair idea of the frequency of various diseases which would help in derivation of the disease which accounts for maximum claims. This would help in deciding the copayment pattern in various diseases so the claims ratio can be monitored. Also the negotiation for these diseases can be better done by the TPA.

4. <u>Disease wise analysis:</u>

Disease	Number of claims	Percentage of claims
Diseases of eye and adnexa	2163	31
Diseases of genitourinary system	1610	23
Symptoms, signs and abnormal clinical findings	838	12
Diseases of cardiovascular system	694	10
Diseases of digestive system	544	8
Disease and injury of musculoskeletal system	529	8
Benign and malignant neoplasm of various organ	162	2
Disease of endocrine system	105	2
Disease of respiratory system	97	1
Disease of nervous system	70	1
Vascular and lymphatic disorder	47	1
Disease of ear and mastoid process	22	0


Disease wise number of claims
2500
2000
1500
1000
500
0
Disease and injury of musculoskeletal..
Disease of cardiovascular system
Disease of eye and adnexa
Benign and malignant neoplam of various..
Disease of genitourinary system
Diseases of digestive system
Disease of respiratory system
Diseases of ear and mastoid process
Diseases of endocrine system
Vascular and lymphatic disorder
Disease of nervous system
Symptoms, signs and abnormal clinical..
Number of claims


8
10
31
2
23
8
1
0
2
1
1
12
Disease and injury of musculoskeletal system
Disease of cardiovascular system
Disease of eye and adnexa
Benign and malignant neoplam of various organ
Disease of genitourinary system
Diseases of digestive system
Disease of respiratory system
Diseases of ear and mastoid process
Diseases of endocrine system
Vascular and lymphatic disorder
Disease of nervous system

Analysing the disease, inference can be drawn that the percentage of claims of disease of eye and adnexa is significantly high as compared to disorders of rest other system. Most of the claims is of cataract and the treatment related to it. Vigilance on these claims is of utmost importance to curtail malpractices. The package deviated cases should be well investigated and measures to avoid such future issues should be implemented well in place. Diseases of genitourinary system, mostly of calculus are also significantly high. The procedure or treatment related to this should also be well capped and investigated.

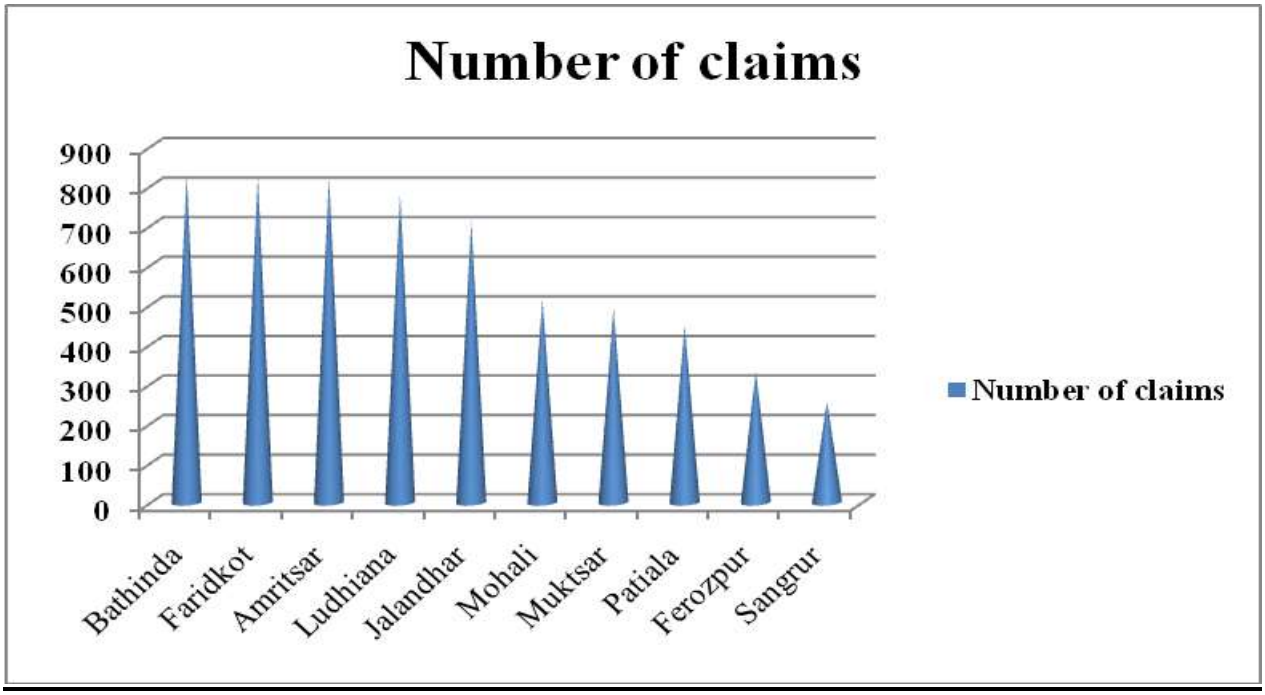
Investigation of suspicious claim and judicious capping of various treatment which bears maximum number of claims can only be the methods to curtail down the rising claims ratio.

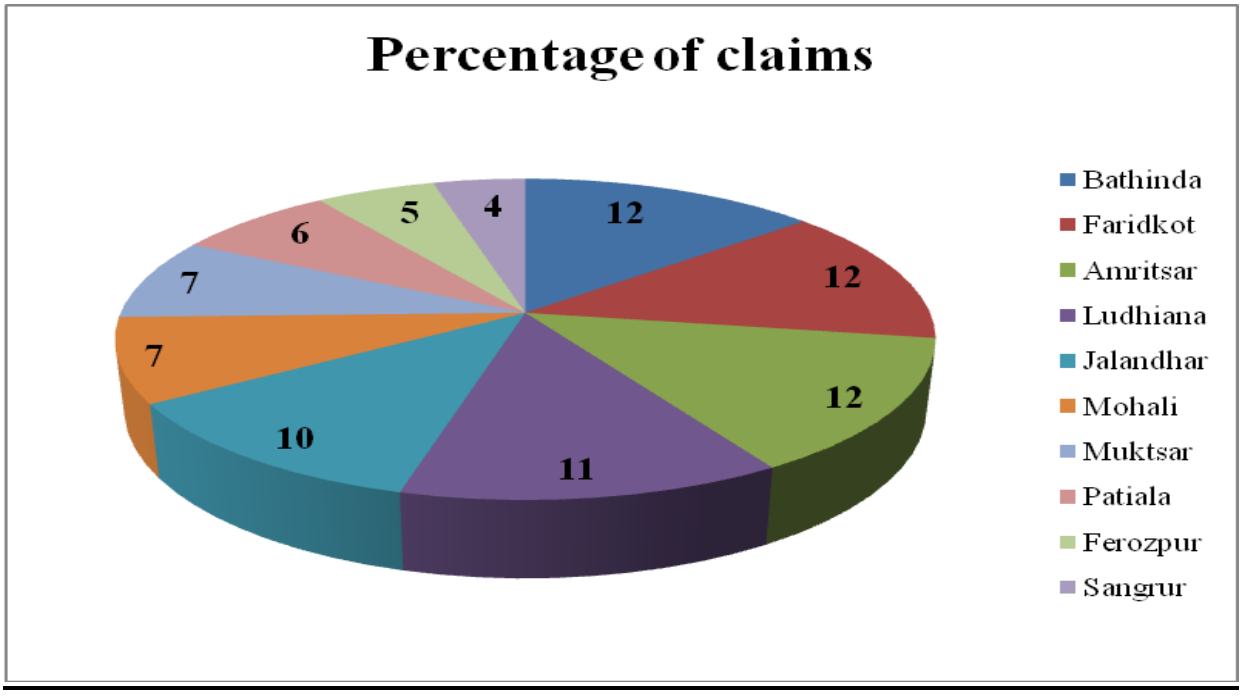
III. To study frequency of cases in all the districts of Punjab under BGSS scheme.

District wise analysis is important as this gives an idea of the districts of higher frequency of claims and hospitals of these districts can be negotiated further for various treatments.

5. District wise analysis of the claims:

Name of the district	Number of claims	Percentage of claims
Bathinda	828	12
Faridkot	824	12
Amritsar	823	12
Ludhaina	780	11
Jalandhar	711	10
Mohali	513	7
Muktsar	491	7
Patiala	447	6
Firozpur	333	5
Sangrur	256	4





The top 10 district as per the frequency of claims has been analysed. Out of this, Bathinda, Faridkot, Amritsar and Ludhiana accounts for 12 percent of the claims each. The number of claims reported in these districts has been mentioned in the table above. Even though the average

number of hospitals in each district is 20 to 25 probably the number of claims in these districts is high because of the preferred hospitals of the beneficiaries. So the TPA can negotiate further for the packages in these districts because of the huge influx of beneficiaries.

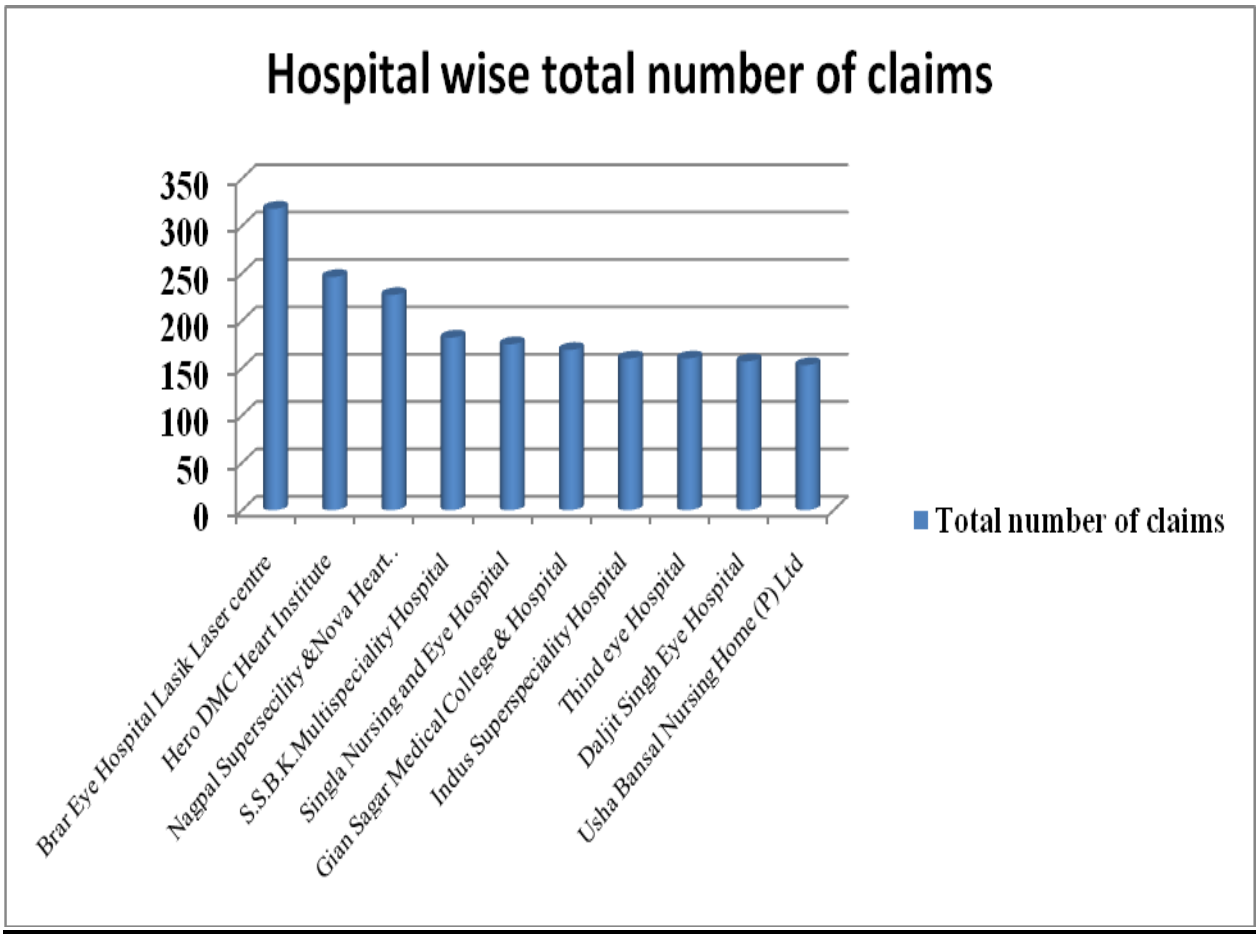
IV. To understand the top ten preferred hospital based on the frequency and the claim size

This analysis is important as this would help us to know the preferred hospitals of the beneficiaries in the districts of Punjab and could be a source for further negotiation.

6. Hospital wise analysis:

Case wise top 10 hospitals:

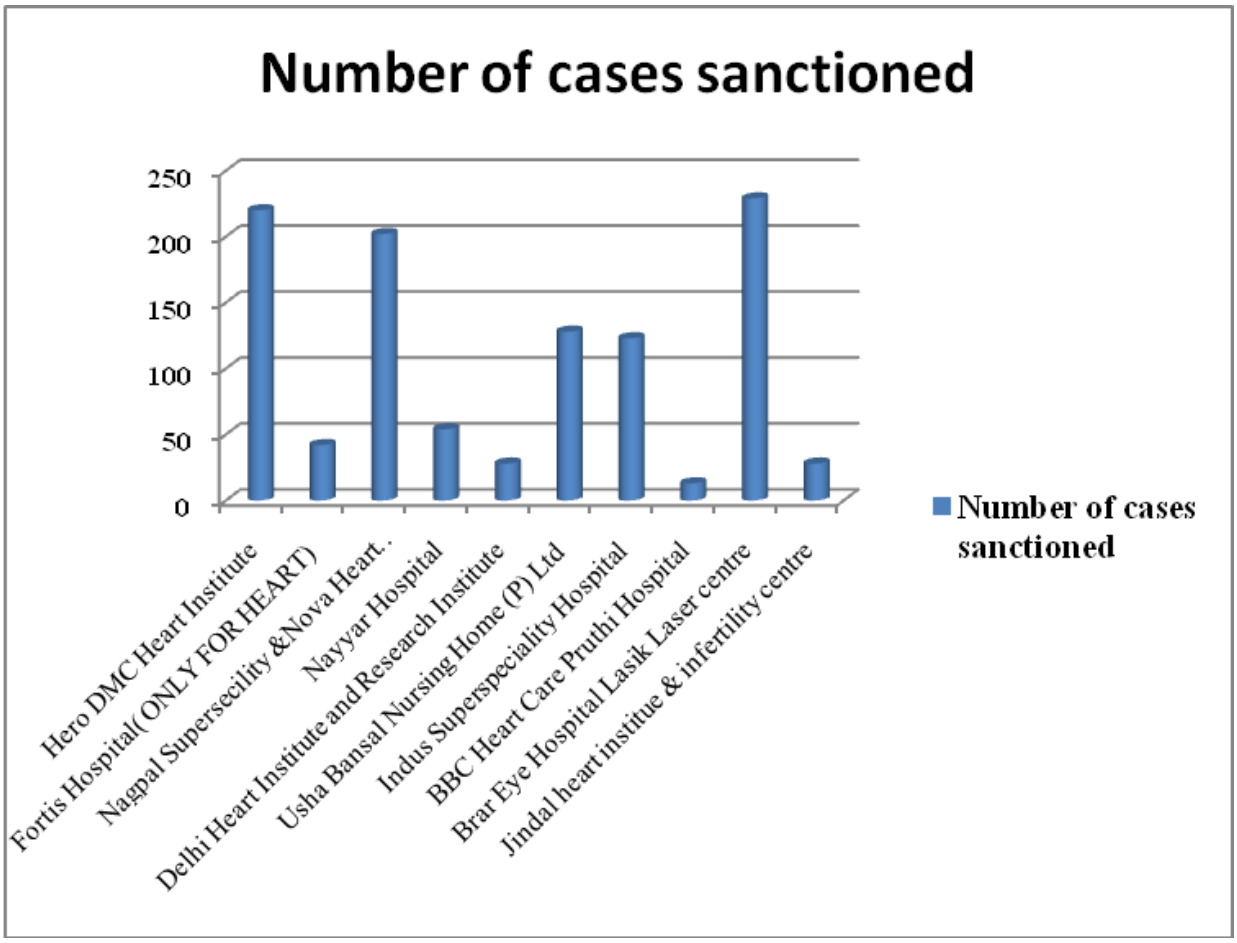
S.No	Name of the hospital	Number of claims	Percentage of claims	Total amount sanctioned	Percentage amount sanctioned
1	Brar Eye Hospital Lasik Laser centre	318	5	121,067	2
2	Hero DMC Heart Institute	246	4	14,761,596	23
3	Nagpal Superspecialty $ Nova heart & Kidney Hospital	227		2,064,691	3
4	S.S.B.K.Multispeciality Hospital	182	3	764,775	1
5	Singla Nursing and Eye Hospital	175	3	740,925	1
6	Gian Sagar Medical College & Hospital	169	2	456,277	1
7	Indus Superspeciality Hospital	160	2	1,409,669	2
8	Thind eye Hospital	160	2	390,300	1
9	Daljit Singh Eye Hospital	157	2	649,800	1
10	Usha Bansal Nursing Home (PLtd	153	2	1,562,586	2

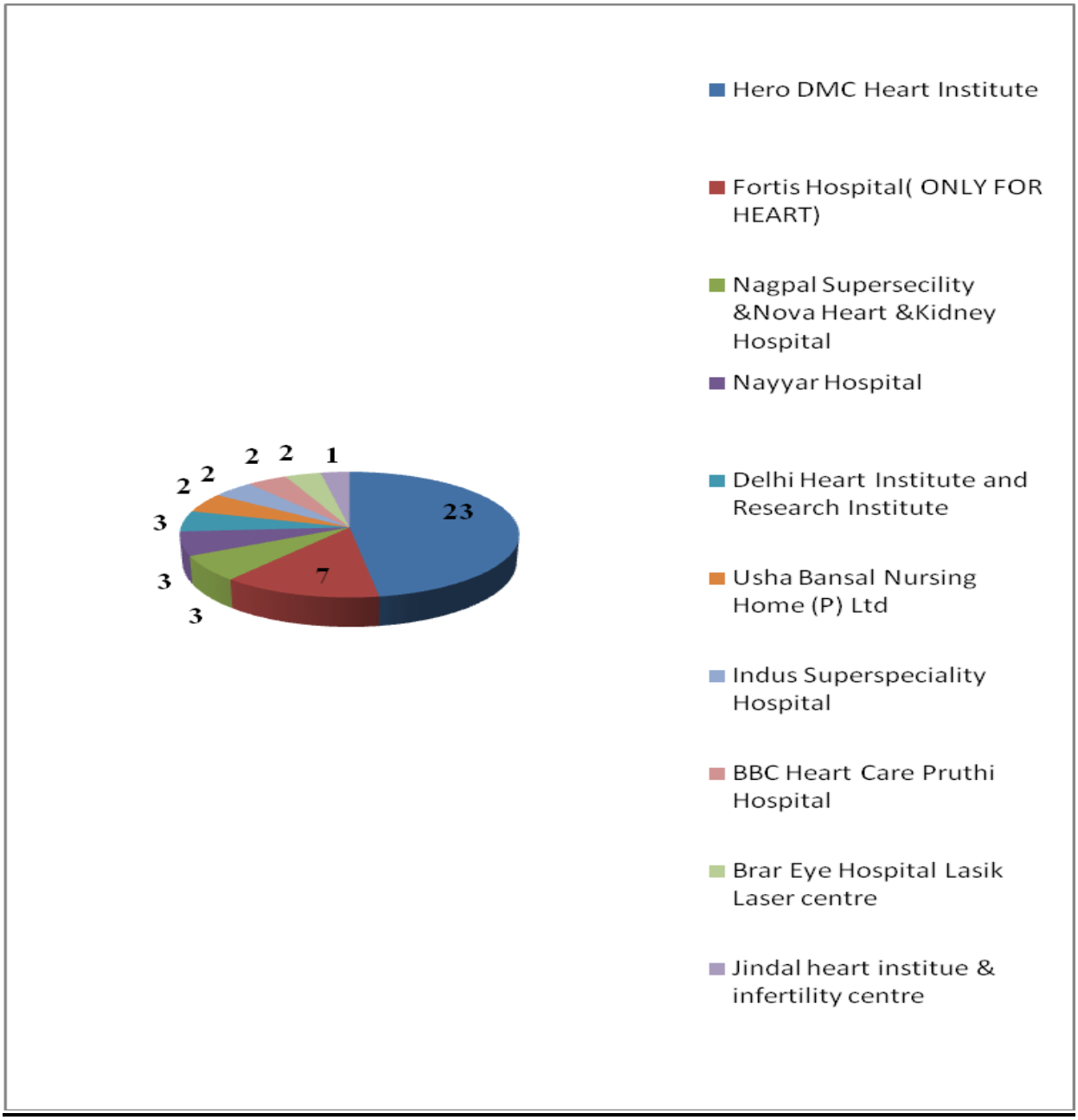


On analyzing the frequency of claims, conclusion on the most prefereed hospital by the beneficiaries is drawn. This analysis would be beneficial in determining if the the most preferred hospitals are abiding by the package rates negotiated by the TPA. Moreover periodic scrutiny of the claims in these hospitals can also help in minimizing the manipulated or overexpensed claims thus finally reducing the claims ratio.

Amount sanctioned wise top 10 claims:

S.No	Name of the hospital	Cases sanctioned	Amount sanctioned	Percentage sanctioned amount
1	Hero DMC Heart Institute	220	14,761,596	23
2	Fortis Hospital (only for heart)	42	4,237,200	7
3	Nagpal Superspecialty $ Nove Heart $ Kidney Hospital	202	2,064,691	3
4	Nayyar Hospital	54	1,923,302	3
5	Delhi Heart Institute and Research Institute	28	1,663,976	3
6	Usha bansal Nursing Home (P) Ltd	128	1,562,586	2
7	Indus supercialty Hospital	123	1,387,949	2
8	BBC Heart care Pruthi Hospital	13	1,332,288	2
9	Brar Eye Hospital Lasik Laser Center	229	1,200,675	2
10	Jindal Heart Institute and Infertility Center	28	952,843	1


Number of cases sanctioned
250
200
150
100
50
0
Hero DMC Heart Institute
Fortis Hospital(ONLY FOR HEART)
Nagpal Supersecility &Nova Heart.
Nayyar Hospital
Delhi Heart Institute and Research Institute
Usha Bansal Nursing Home (P) Ltd
Indus Superspeciality Hospital
BBC Heart Care Pruthi Hospital
Brar Eye Hospital Lasik Laser centre
Jindal heart institue & infertility centre
Number of cases sanctioned



This analysis would help in knowing the hospitals where the claim size is large so these hospitals needs to be negotiated well by the TPA as well as the network team need to investigate them regularly.

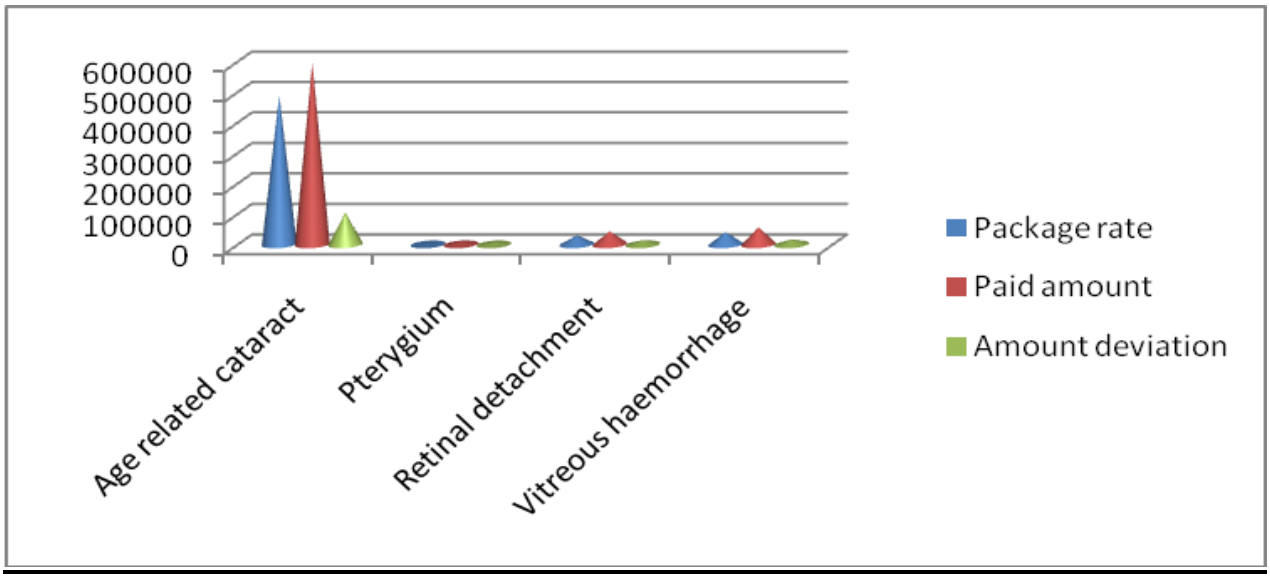
V. To study the price deviation in claims of package treatment.

Generally it has been observed that the TPA negotiates the package rate for various treatment with the hospital but even then the hospital deviates from the mentioned package rate. The deviation can be because of many reasons. To name a few it can be because of complications associated with the treatment, overbilling by the hospital, length of stay etc.

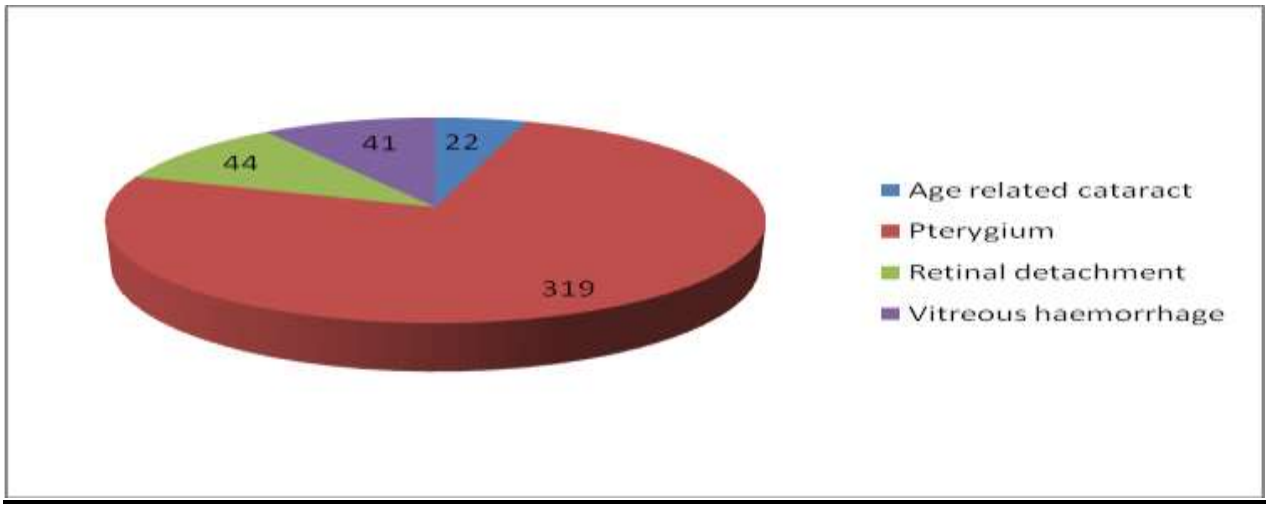
7. Package rate deviation analysis of the disease:

Diseases of eye and adnexa:

Disease of eye	Cataract	Pterygium	Retinal detachment	Vitreous haemorrhage
Package rate	490,000	2,400	30,000	40,000
Paid amount	595,600	10,050	43,150	56,411
Amount deviation	105,600	7,650	13,150	16,411
Number of deviation	98	3	3	4

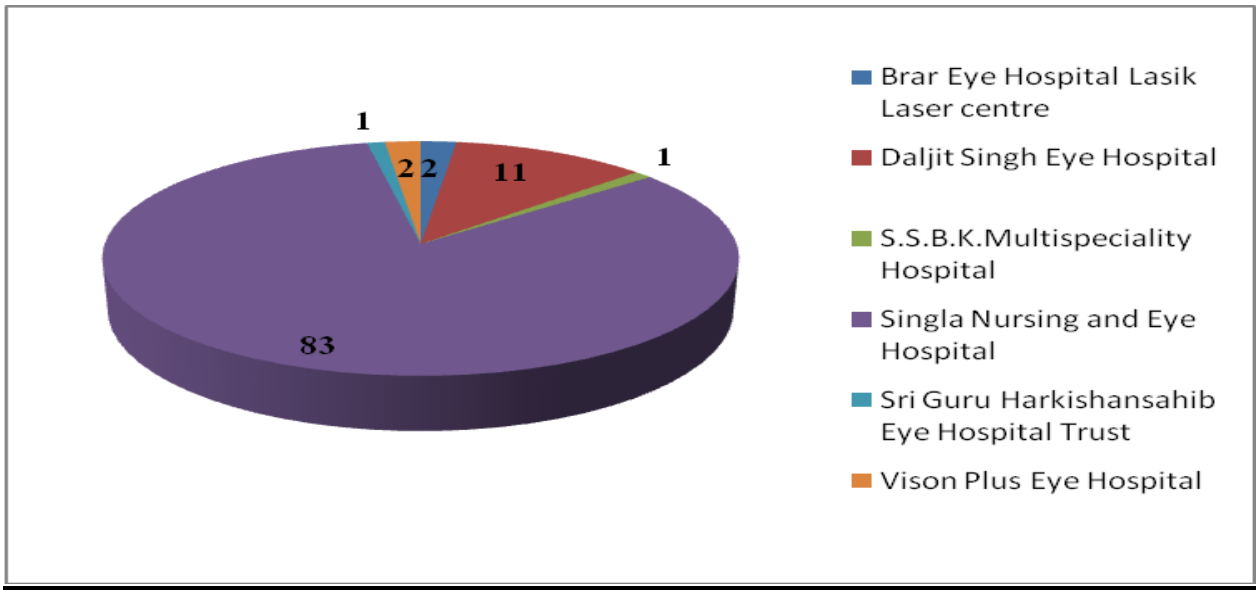


Percentage deviation from package rate:



Though the number of deviations in the pterygium claim is less but the amount deviated from the package rate of Rs. 800 per day is high so the percentage deviation is nearly 319 percent. The claim needs to be verified whether there were any related complication or the treatment was over expensed as such claims contribute to increased claims ratio.

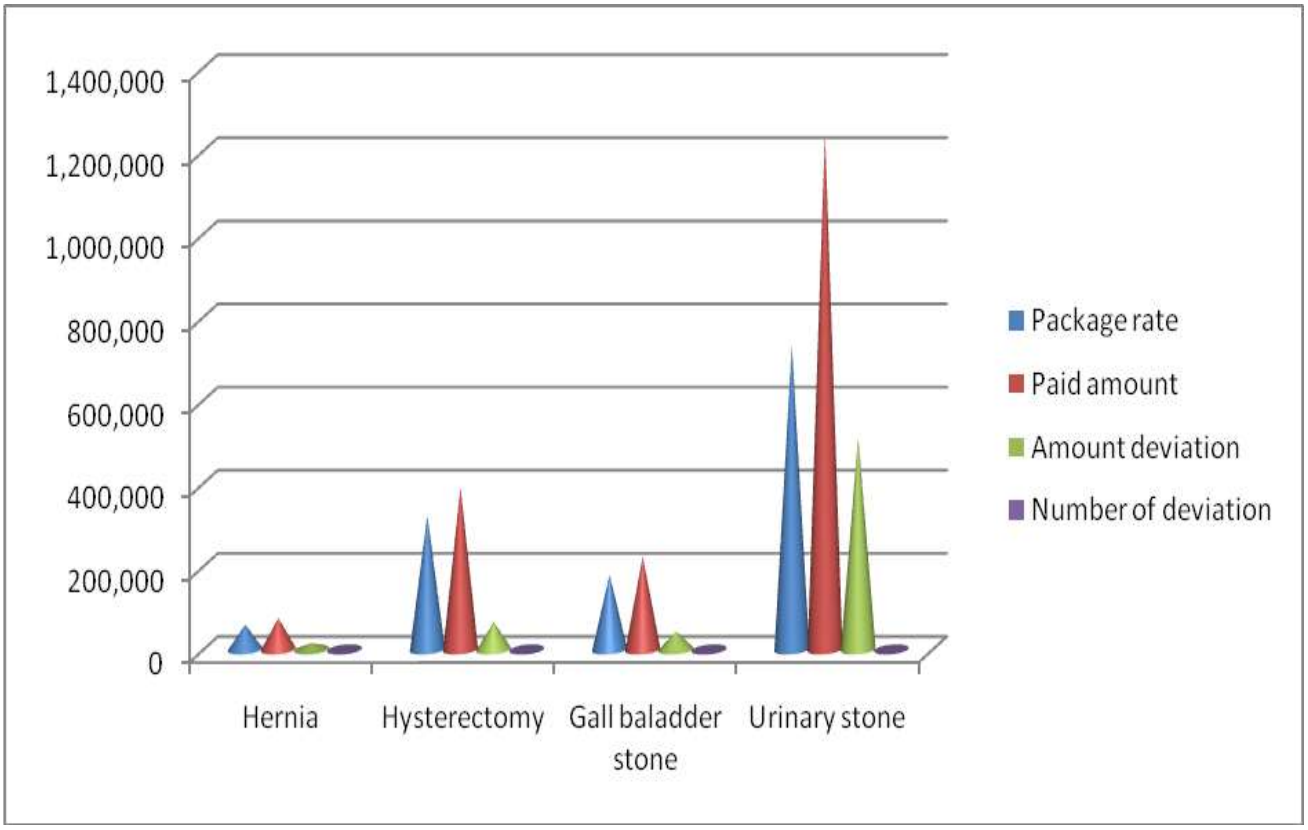
Percentage deviation by network hospitals treating eye disorders:



Out of 98 cases which have deviated from the package rate of Rs. 5000 for 1 day for the treament of cataract, 81 claims pertain to **Singla nursing and eye hospital of Faridkot** which accounts for about 83 percent of the total deviation. Following a similar trend is **Daljit Singh eye hospital** which accounts for about 11 percent deviation from the package rate. These and similar hospitals involved in overexpensing the treatment need to be investigated so that the malpractices can be curtailed thereby supporting the judicious running of the policy.

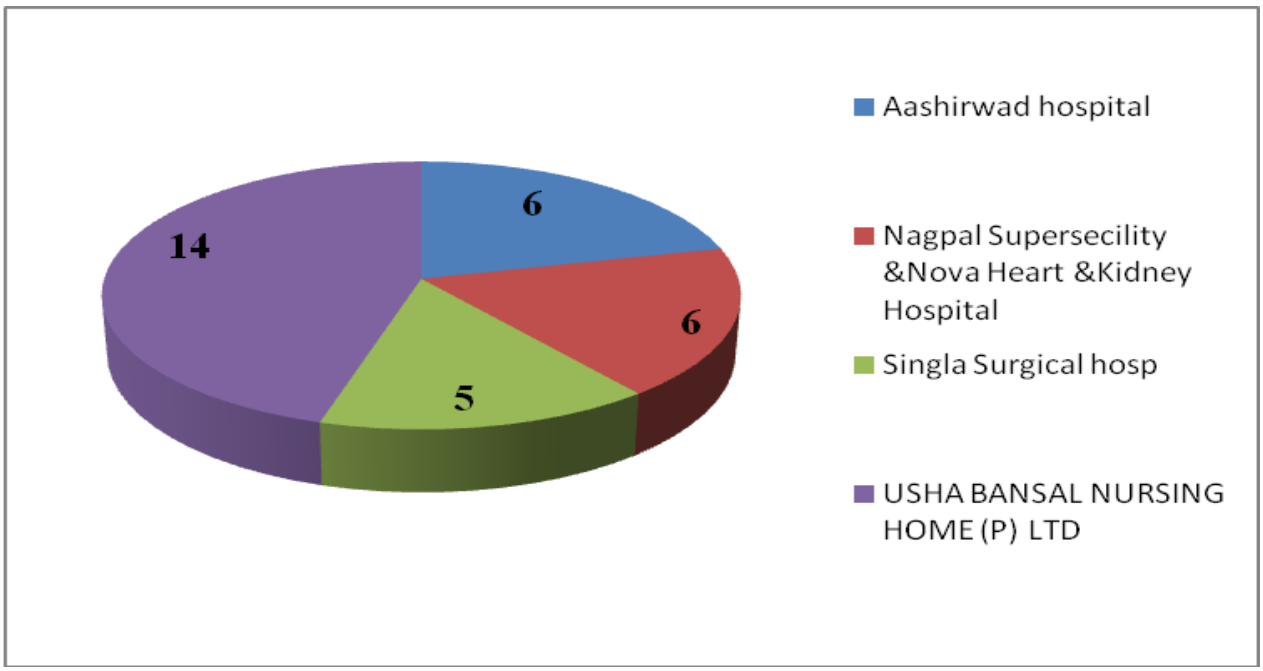
General surgery:

General Surgery	Hernia	Hysterectomy	Gall bladder	Urinary stone
Package rate	60,000	324000	180000	732000
Paid amount	75640	390045	223441	1242489
Amount deviation	15640	66045	43441	510489
Number of deviation	5	27	15	61



Percentage deviation from package rate:

Hospital Name	Percentage deviation
Aashirwad Hospital	6
Nagpal Superspecialty and Nova Heart and Kidney Hospital	6
Singla Surgical Hospital	5
Usha bansal Nursing Home (P) Ltd	14

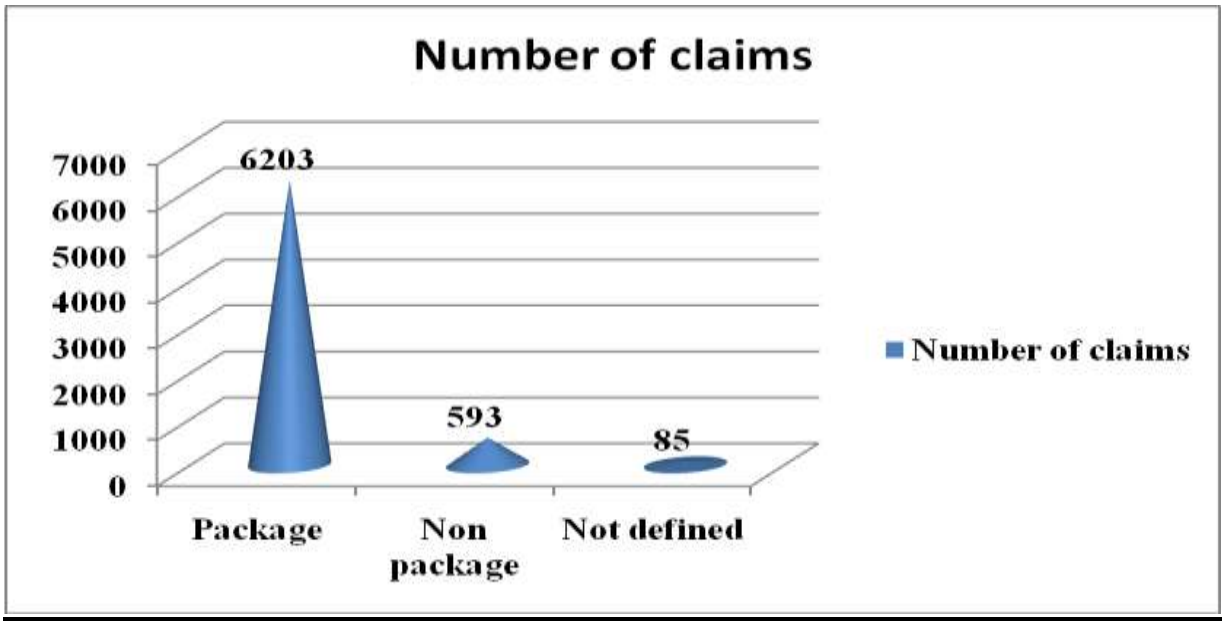


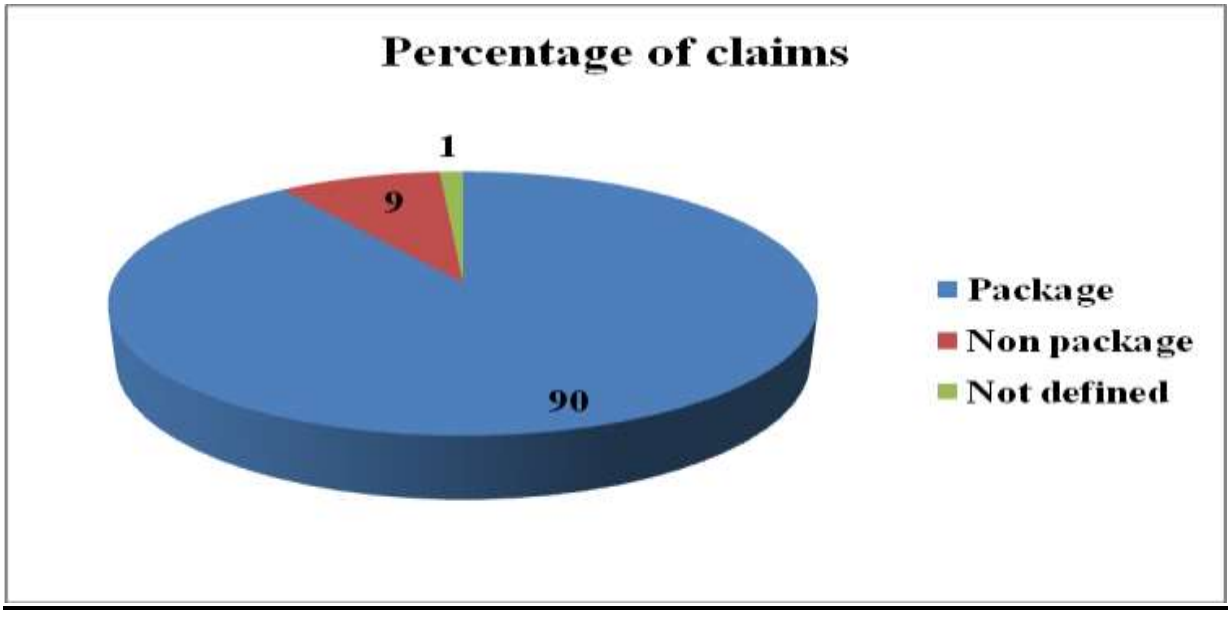
Analysing the data, its found that there are total 108 cases of general surgery which have deviated from the negotiated package rate. The percentage deviation in Usha Bansal Nursing Home is the highest. The hospital following the similar trend needs to be investigated for the reason of deviation to draw any further conclusion regarding whether the deviated cases were complicated or there is some malpractice happening which can be controlled.

Similarly, all the systemic treatment (conservative + surgical) needs to be analyzed as per the package rate of the TPA so that the abuse of the health Insurance policy can be controlled and it works out efficiently and effectively for the beneficiaries.

Package and non package treatment analysis:

Treatment	Number of claims	Percentage of claims
Package	6203	90
Non package	593	9
Not defined	85	1

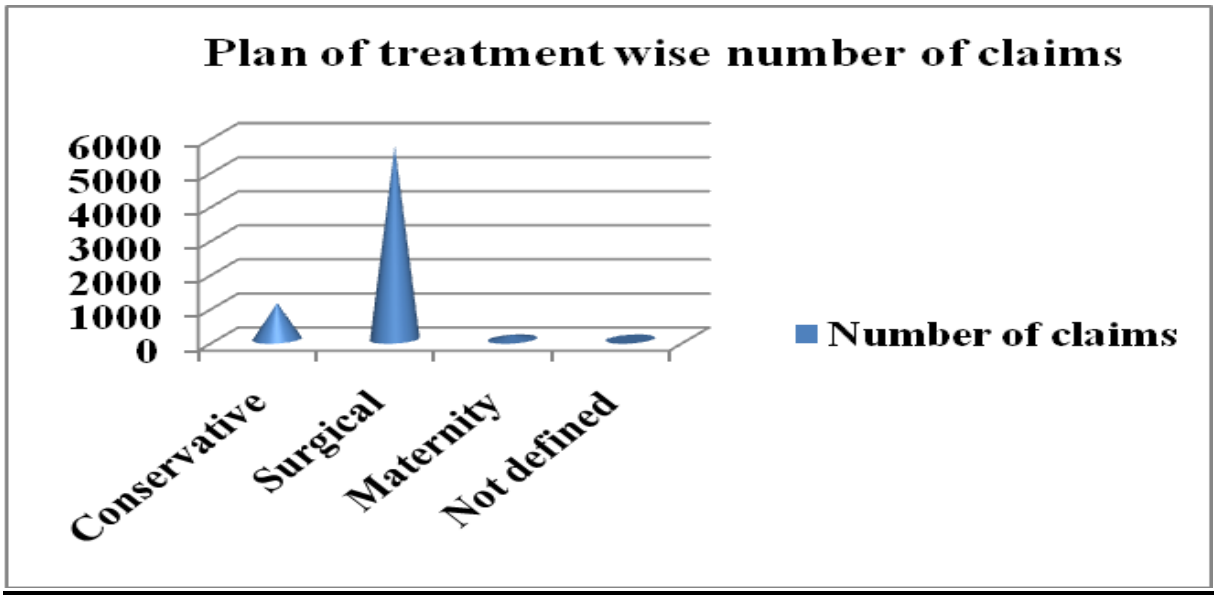


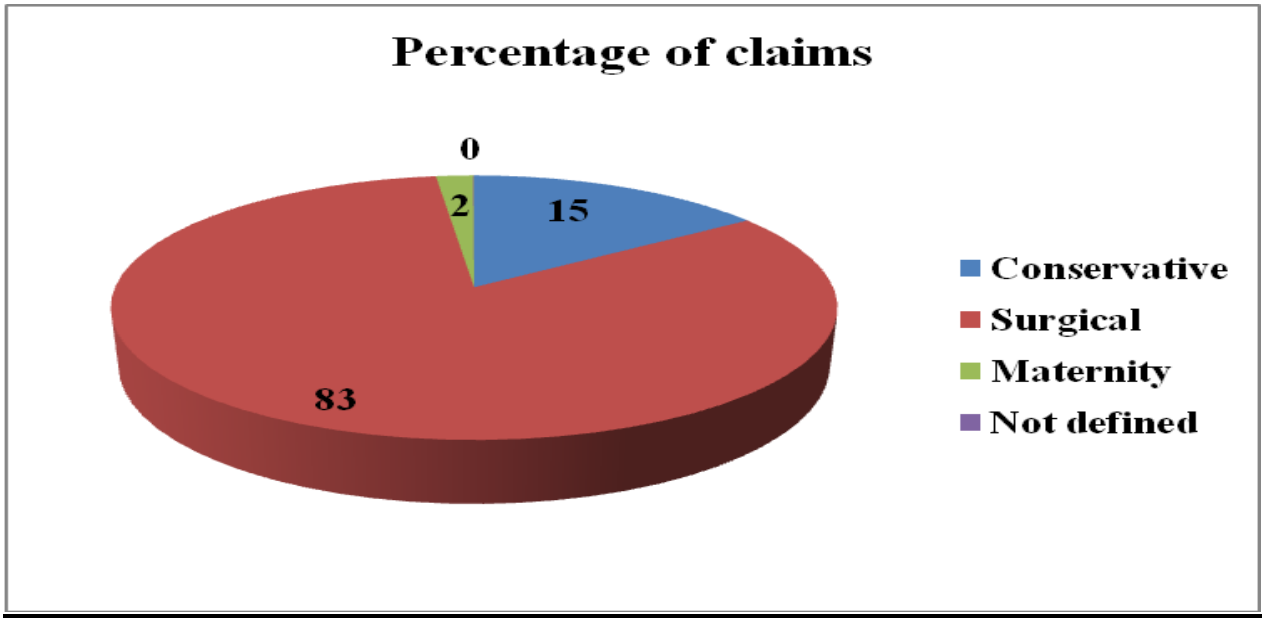


Though we have concluded that most of the claims fall in the package rate negotiated with the hospital but still the number of claims significantly fall in paying more than the negotiated package for any particular ailment. This is a significant flaw in the whole process. We need to question the hospital for over budgetting the expense and also educate the client to intimate any such billing to the networking team so that the malpractices can be controlled and investigated.

8. Treatment type analysis:

Treatment type	Number of claims	Percentage of claims
Conservative	1066	15
Surgical	5680	83
Maternity	132	2
Not defined	3	0





Eighty three percent of the claims are treated surgically. The team needs to focus more on the surgical treatment and negotiate fairly well with the hospital for all surgical procedure. This also should draw attention that the surgical procedure needs to be investigated thoroughly as compared to the conservative treatment because if these cases can be controlled for overexpensing the treatment cost it will significantly bring down the claims ratio of the Bhai Ganhya Sehat Sewa Scheme.

Recommendations:

1. Initiation in establishing a preferred provider network of the hospitals which are mostly visited by the beneficiaries of BGSS scheme so that in case of planned procedure the employee visits these network hospitals which will help minimize the fraud as well as health care cost thus curtailing the claims ratio.
2. Co- payment or an excess clause can be applied in diseases like cataract, genitourinary calculus, osteoarthritis etc. so that the beneficiaries are more vigilant towards the expenditure in the hospital.
3. No benefits of hospitalization should be given for diseases which can be treated on OPD basis unless it is life threatening and requires constant observation.
4. Discount + Standardized package rates negotiated with the network hospitals mostly for the diseases analyzed which accounts for higher number of claims should be investigated from time to time for malpractices or over expensing. Also to know whether the hospital is abiding by the SLA signed with the TPA..
5. Compulsory induction programme for mediclaim awareness should be held for the beneficiaries.
6. The preferred hospitals with huge influx of patients should be negotiated further for discounted package rates in the next year policy.

Conclusion:

The central message here is that managed care plans have succeeded in their primary mission to reduce the growth rate of health care costs in countries like California so this study can take an initiative in this direction. But the redesigning of health care delivery would evoke some resistance and on the other hand it is still unclear whether the health care system, as restructured to control costs will be able to provide acceptable access and quality. Fraud in health care can assume diverse forms; the most common is billing for health care services that were never rendered, either by adding charges to legitimate claims, or by using actual patient names and health insurance information to fabricate claims. Up coding is the second most common; third is the deliberate provision of medically unnecessary services, which include tests, surgeries, and other procedures. So to check the abuse, waste and mismanagement of claims a first step could be taken in the direction of preferred provider network. So it can be concluded that claims management and managed care can be achieved by identifying and managing potentially high value claims and choose PPO providers that help in minimizing the cost.

References:

- http://www.mdindiaonline.com/BGSSS/BGSMain.aspx - MDIndia Healthcare Services TPA (P) Ltd
- Ramesh Bhat, Sunil Maheshwari, Somen Shah – Third Party Administrators and Health Insurance in India: Perception of Providers and Policyholders- January, 2005
- Jack Zwanziger and Glenn A. Melnick – Can Managed Care Plans control Health care costs?- Summer, 1996
- Abhijit Nagendranath, Pallavi Chari – Health Insurance in India, the emerging paradigms- 6th September, 2002
- Ajit Sharan – Health Financing, Need for regulated development current experiences in India
- Gosford City Council- Fraud control Policy- 8th March, 2005
- Article on Audit of Health Plan Claims Administration- Plan Fiduciary, Trustee and Management issues
- American Medical association Proposal for Reform on Administrative costs of health care coverage
- Medindia (Health Insurance)- Focus on claims control hurts Health Insurance- 28.05.2008
- Applegate, Dennis - An overlooked risk: audits of self-funded health-care plans can apprise management not only of potential fraud, but also of compliance issues requiring remediation – February, 2007
- Gregory. J. Borca – Technology curtails health care fraud – April, 2001
- Helsman Management Services, a member of Liberty Mutual Group- An article on Claims Management and Managed Care
- http://www.comhealthins.org/publications/TPA%20Theory%20and%20practice.htm- Third Party Administrators Theory and Practice

Annexure: