Market Intelligence Study of Health Insurance Claims in India

By

Nida Taranum Arabi

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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IIHMR UNIVERSITY

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Dr. Nida Taranum, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Apollo Munich Health Insurance from 04th Feb 2019 to 04th May 2019.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfilment of the course requirements.

I wish her all success in all his future endeavours.

Dr:Ashok Kaushik
Dean, Academics and Student Affairs
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ApolloMunich
HEALTH INSURANCE

4th May, 2019

To whomsoever it may concern

This is to certify that Dr. Nida Arabi has successfully completed her Internship with us from 4th February to 4th May 2019. Her project was based on **Market Intelligence Study of "Health Insurance Claims in India"** in Health Care Management, Operations. During the tenure, she came across as sincere, committed and diligent person who has a strong drive and zeal for learning.

We wish her all the best for her future endeavors.

Prashant Sivaramakrishnan
Assistant Vice President – Claims

Nupur Kashyap
Manager – HR

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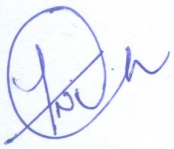
Best in Class in the Insurance Sector
This is an affirmation of our employees' faith in our Transparency, Fairness and Camaraderie

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled " Market Intelligence study of Health Insurance Claims in India" submitted by Dr. Nida Taranum Arabi Enrollment No 0608 under the supervision of Dr. Monika Chaudhary for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period from 04th Feb'19 to 04rd May'19 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.



Signature

Nida Taranum Arabi

ABSTRACT

In 2016 the private Health Insurance industry surpassed 1.3 trillion in global revenue a figure forecast to double by 2025.However it's an industry undergoing a substantial transformation and the business models of the future will be significantly different from those in existence today. Growth of the private Health Insurance industry is being fueled by a powerful combination of secular trends that are increasing Healthcare consumption and shifting more spending by private payors. Private payors seeking to intermediate more than roughly 30% of health expenditures that represent classic insurance risk need innovative products (and product markets) that go beyond traditional, underwritten indemnity insurance plans. Instead, they need products aligned with the contemporary risk burden. Advanced analytics and digitization have markedly increased the amount of information available to private payors, enabling them to draw conclusions that can help improve patient care. The rise of electronic healthcare data
e.g. Claims, Medical Records, and Clinical data combined with unbridled computing power and cheap data storage, makes measuring outcomes and costs feasible in timely, accurate fashion. The resulting transparency into care delivery performance makes possible very different payment and risk intermediation models. Examples include the expansion of episode – incentives based and bundled payment models, incentives based on population health, more complete capitated risk, and the transfer of increasing levels of financial risk to providers.

ACKNOWLEDGEMENT

I convey my heartfelt gratitude to Dr. Bhabatosh Mishra, COO, Apollo Munich Health Insurance, for providing me with the opportunity to work with Apollo Munich Health Insurance and allow me to conduct the project during dissertation period.

I would like to convey my thanks to Mr. Prashant Sivaramakrishnan, Assistant Vice President, Claims, Apollo Munich Health Insurance, for mentoring and guiding me and for his constant encouragement and continuous support when it came to guidance, suggestions and his expertise during my dissertation period at AMHI.

I would like to extend my heartfelt gratitude to the IIHMR University for giving me this opportunity to apply our theoretical knowledge in a practical setup, especially my guide, Monika Chaudhary for guiding me at every step

I express my sincere thanks to my guide at AMHI Mr. Adinath Gosh for his valuable guidance and timely suggestions as and when I was seeking them.

Key Highlights

1. Introduction

   AIM

   Objectives

   Limitations of the study performed

2. Methodology

   Study Methodology

   Data collection

3. Review of Literature

4. Results

   Methods in claim Benchmarking

   Competitor Assessment sheet

   Factors considered for Competitor Analysis of Claims

   Importance of factors in Competitor Analysis of Claims

   Stats of claims and claim pendency

   Constraints in settlement of claims

   Initiatives to settle the claims

   Accident and Emergency Claims

5. Conclusions
6. Recommendations

1. INTRODUCTION

Health insurance companies covers the whole or a part of the risk of a person incurring medical expenses by estimating, the overall risk of health care and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as monthly premium or payroll tax, to provide the money to pay for health care benefits specified in insurance agreement.

[e]dical claims provide the ability to concentrate on a specific service line by leveraging the agnosis or procedures codes within claims

When aggregated claims forms provide counts of patients, visits and surgeries by physicians, account for specified disease states, and provide insight across care settings.

CLAIMS PROCESS AT APOLLO MUNICH HEALTH INSURANCE

The health insurance policy can be claimed through two ways: Cashless settlement at the network hospital and Reimbursement after the treatment/hospitalization, however in both scenarios an early intimation to the insurance company is mandatory. A pre-approval needs to be in place for a planned hospitalization.

FOR CASHLESS SERVICE:

- At the time of hospitalization, submit the completed Pre-Authorization form at the TPA desk
- The TPA representative will then forward the form to Apollo Munich for an approval along with the concerned doctors report
- The request is then reviewed by the claim experts at the Apollo Munich and an approval is then issued, the insurance company can raise queries if required
- In case of rejection of the authorization, initiate the required treatment and claim for reimbursement later.

FOR REIMBURSEMENT OF CLAIM-

- Post hospitalization, the claim form is completed and submitted to the insurance company along with other documents like discharge summary issued by the hospital, prescriptions, bills and invoices for the medicines/treatments, etc
- In case insurance company needs any further classification/ information, it will be duly notified to the customer
- If the claim is rejected, a detailed rejection letter will be shared with the customer along with the reasons for denial, Apollo Munich takes pride in claim settlement process. Apollo claims to settle 95% of the claims within 30 days.

MARKET ASSESSMENT OF HEALTH INSURANCE CLAIMS

Market assessment on Health Insurance Claims is a continuous process done by an organization to compare its own process with those of organizations that are leaders in the particular area.

The purpose of assessment for claims in Apollo Munich Health Insurance is to improve efficiency, quality of service, reduce fraudulent, and improve patient satisfaction. The process involves looking at standards, best policies, their efficiency and identifying potential areas of improvement

AIM:

The aim of this study is to establish and compare the claim process of competitive organizations to improve product and service quality.

) ANALYZE THE ONGOING CLAIM PROCESSES, DOCUMENTS REQUIRED AND THE FASTEST MODE REQUIRED
) REACH THE CUSTOMERS OF HEALTH INSURANCE COMPANIES

The following objectives were kept in mind before conducting the study:

- To explore available Health insurance in the market and understand potential competitors in the study area
- To analyze the claim process gap in the proposed study.
- To propose an idea to provide the fastest claim for health insurance

OBJECTIVE

The objective of the project is to deliver seamless and transparent access to healthcare through dedication, integrity and excellence in process and services, the process should be

, ,

Outline of the Study Performed:

The study was performed using both primary and secondary research. For Primary research, standalone Health Insurance companies and other strong competitors were referred for their mode of claim process and claim settlement approval (only in case of health insurance).For secondary research online data base, AMHI database, reports of IRDAI and leading private aggregators were referred.

Limitations of the study:

- Financial feasibility has not been performed
- Consumer survey has not been performed
- The feasibility study is pertaining to only Health Insurance and cannot be applied in general.

2. METHODOLOGY

This study was conducted as a part of dissertation programme in APOLLO MUNICH HEALTH INSURANCE. The various methods and materials used are described under the following heads:

Study Methodology

Research Question: the following research question formed the basis of the study:

- Does Apollo Munich provide the fastest claims to the customers?
- What are the different modes of services that can be provided for claims that are fastest and hassle free

Research Design: A descriptive analytical study design was used for this study.

Duration: 3 months

- Understanding the project needs: 2 weeks
- Preparation of Competitor Assessment sheet: 3 weeks
- Secondary research: 3 weeks
- Primary data Collection: 1 weeks
- Data analysis: 2 weeks
- Report writing and presentation: 1 week

Data Collection

The study included collection of both primary and secondary data followed by a comprehensive analysis of the data.

Secondary Data: The sources for collection of secondary data included

- Online research
- Reports of the leading Market research organizations
- IRDA reports, and aggregators website
- AMHI database

Primary data: Claim assessment is done by comparing the overall claim process of competitors in the market, the survey included the modes through which the documents was submitted in respective organizations for the intimation of claims and the time taken to settle the claims.

The survey was conducted by calling the executives of eight respective organizations and open ended questions were asked.

Open ended questions reflecting the different modes involved in submitting the documents and the most approached method used by the customers to intimate the claims, as well as the total time taken for approval of claims.

Sample Size: sample size consist of eight Health Insurance companies, which are Apollo Munich, Bajaj Allianz, Religare, HDFC Ergo, Max Bhupa, Star Health Insurace, ICICI Lombard, and Axa

3. REVIEW OF LITERATURE

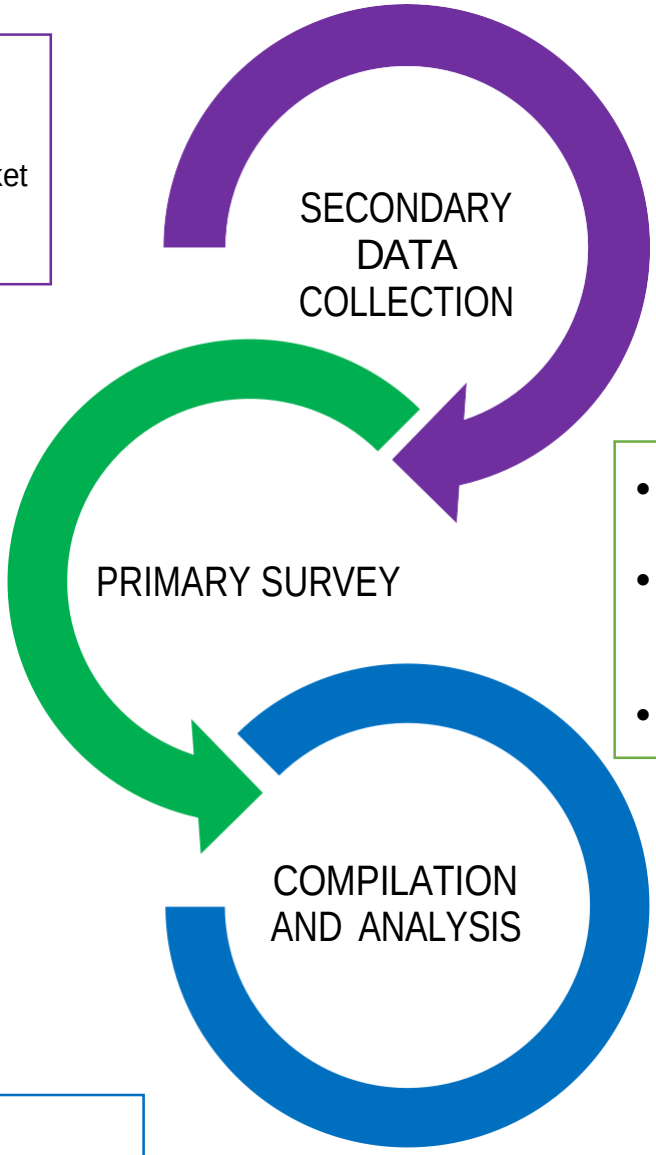
Amitabh Chaudhary ,2017 in his publication "The Changing Face of Indian Insurance" mentions how the global insurance industry is being challenged and to re think the ways of working, insurers are forced to adapt in an agile manner, become leaner and more efficient. Big data and digital are common mega trends that are causing transformations across all industries and are finding their way to the core of insurers strategy. Insurance excellence benchmark lays out the importance of insurance companies to assess their performance on a set of strategic priorities related to operation at efficiency and to compare it with that of relevant competitors in the market. Armed with insights gained from the tool companies can identify performance gaps and close them with targeted change initiatives that sharpen their competitive edge.

Joydeep. K. Roy in his report "India Insurance Prospective" explains how the connected world and the rise of digital technologies are ushering data driven era, creating huge opportunities for insurers to demonstrate their value and to reap the financial rewards of doing so

EY report 2016 "insurer of the future" explains how insurance industry is moving into the next phase of having public ownership. This phase will bring its own set of challenges due to greater transparency and compliance requirements, it will also provide an opportunity to easily assess and realize gains from efficient management. This phase will coincide with a period of transition globally in how business operates, due to changing customer behavior changing market dynamics and the increasingly important role of technology

4.RESULT

- Online research
- AMHI database
- Reports of leading market research organizations



- Survey conducted in February 2019
- Direct communication with the executives of competitor organizations over phone call
- Understanding the local dynamics

- Assembling data collected during primary survey
- Overall analysis of the report

METHODS IN CLAIMBENCHMARKING

Claimsbenchmarkingrequiresquantitativemeasurementofthesubjecton different parameters with respect to competitive organizations, the process or activity that are attempted to determine benchmarking are

- COMPETITOR ASSESMENT SHEET
- STATS OF CLAIMS AND CLAIMS PENDENCY
- CONSTRAINTS IN SETTLEMENT OF CLAIMS
- INITIATIVES TAKEN TO SETTLE CLAIMS
- INSTITUTIONAL FRAMEWORK TO REVIEW CLAIMS

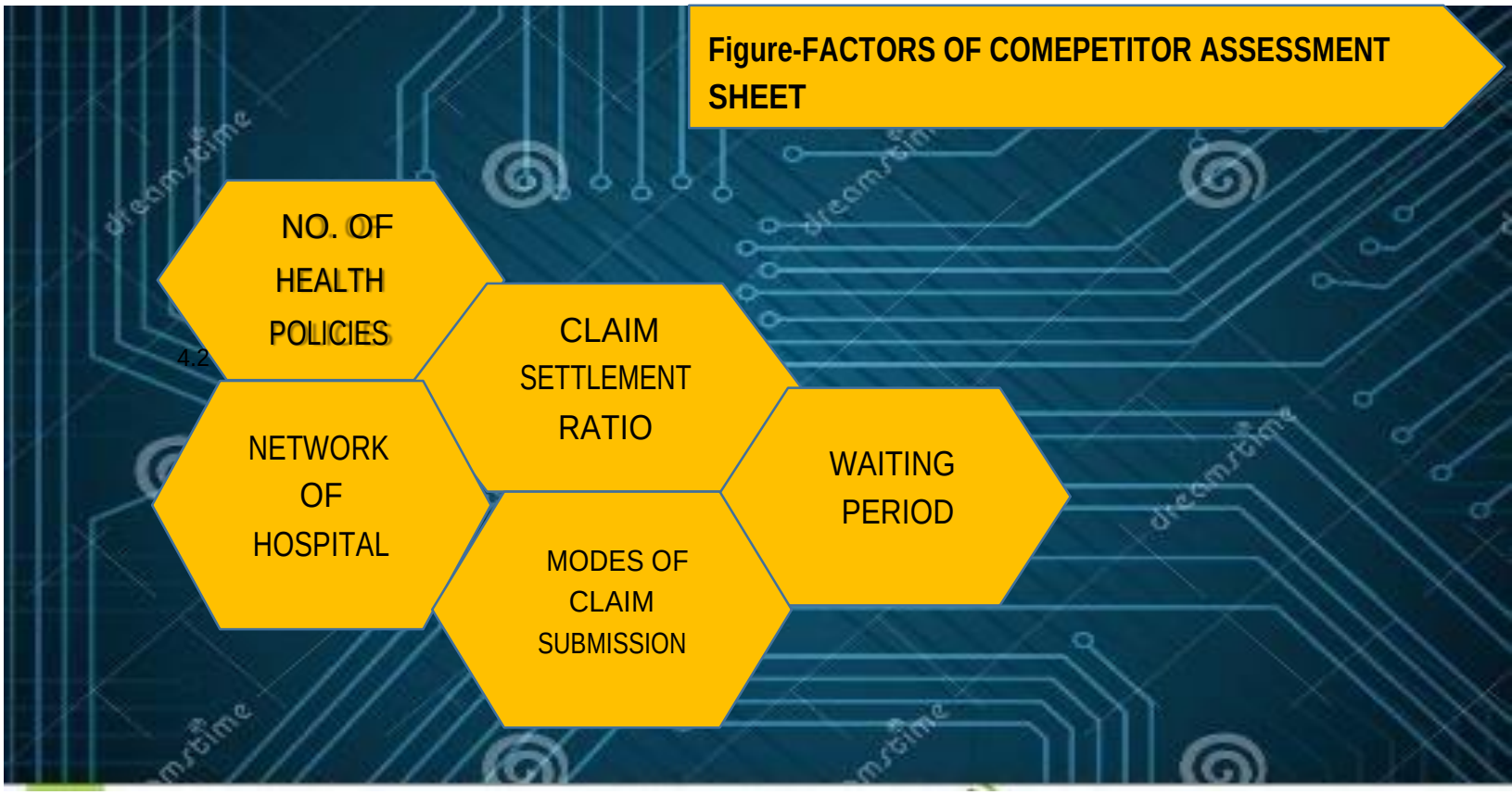


Figure-FACTORS OF COMEPETITOR ASSESSMENT SHEET

4.2

COMPETITOR ASSESSMENT SHEET

Competitor assessment is a powerful tool that enables the company to assess their performance on a set of strategic priorities related to claim efficiency – and compare it with that of relevant competitors in the market, and best in class companies armed with insights gained from the tool, companies can identify performance gaps and close them with targeted change initiatives that sharpen their 14etrics14ive edge.

- **Business profile**- performance on metrics such as number of health policies, net incurred ratios, hospitals.
- **FTE efficiency**- in activities including business lines core operations, claims, claims distributio
- **Digital readiness**- indicated by the existence of a digit offerings, use of digital platform for clai
- **Degree of customer centricity** –performance on 14etrics such as Net Promoter Score(NPS) and

This comprehensive tool built with extensive performance data from a wide array of insurance companies; covers different strategic priorities, offered as modules, from which AMHI can pick and choose for a personalized approach.

FOR AMHI FTE EFFICIENCY IS ALL ABOUT STEPPING UP THEIR DIGITAL INTERACTIONS WITH USTOMERS TO SPUR TOP LINE GROWTH WHILE ENHANCING CUSTOMER SATISFACTION THROUGH FASTER AND BETTER SERVICE.

KEY FACTS ABOUT INSURANCE CLAIM BENCHMARK

20+	• BENCH MARKING PROCESSES
2+	• YEARS OF DATA
8	• INSURANCE COMPANY INCLUDED IN BENCHMARKING PROCESSES

4.3 FACTORS CONSIDERED FOR COMPETITOR ANALYSIS OF CLAIMS-

- NO. OF HEALTH POLICIES
- MODES OF SUBMISSION OF DOCUMENTS
- WAITING PERIOD
- NETWORK OF HOSPITALS
- NET INCURRED CLAIM RATIO
- CLAIM SETTLEMENT
- CLAIM EXPERIENCE

IMPORTANCE OF FACTORS IN COMPETITOR ANALYSIS OF CLAIMS OF HEALTH INSURANCE COMPANIES-

Network of hospital– Health insurance policies clearly mentions the complete list of all the network hospitals they are associated with. It is a good idea to have the network hospitals list always handy for quick reference during emergencies. This turns out to be a blessing in the event of sudden hospitalization, as the policy holder can immediately approach any of the network hospitals and capitalize upon the health insurance plan.

More number of network hospitals will provide easy and hassle-free claim intimation to the customers with better customer satisfaction.

IS IS NOT A DEFINITE INDICATION BUT HELPS A POTENTIAL CUSTOMER JUDGE A COMPANY'S

:RVICE LEVELS.

Number of health policies- number of health policies helps to determine the market penetration of certain policies of the respective companies.

Waiting period- its defined as the period of time specified which must pass before some time or all of your healthcare coverage can begin. Hence this is the period during which claim is not admitted.

Modes of submission of claims- modes of submission of documents can be through, courier, physical submission of documents by the insurer or digitalized submission of documents on online portal or whatsapp.

ITAL MASTERY HAS BECOME THE NEW IMPERATIVE –DRIVEN BY CUSTOMER'S CHANGING ECTATIONS. TODAY; CUSTOMERS WANT THE SAM LEVELS OF SPEED, QUALITY AND TRANSPARENCY M THEIR INSURANCE PROVIDERS THAT THEY HAVE BEEN GETTING FROM DIGITAL- NATIVE GIANTS LIKE AMAZON, GOOGLE AND APPLE

Table 1: Number of Health policies, modes of documents submission, settlement ratio, waiting period and network of hospitals of seven organizations

FACTORS	APOLLO MUNICH							
NO. OF HEALTH POLICIC	11						7	6

IES								
MODES OF SUBMISSION OF DOCUMENTS FOR CLAIMS *	Health Jinn App						uhrit documents	nline submission
CLAIM SETTLEMENT RATIO	89%						90.69%	98%
WA	3						3	4

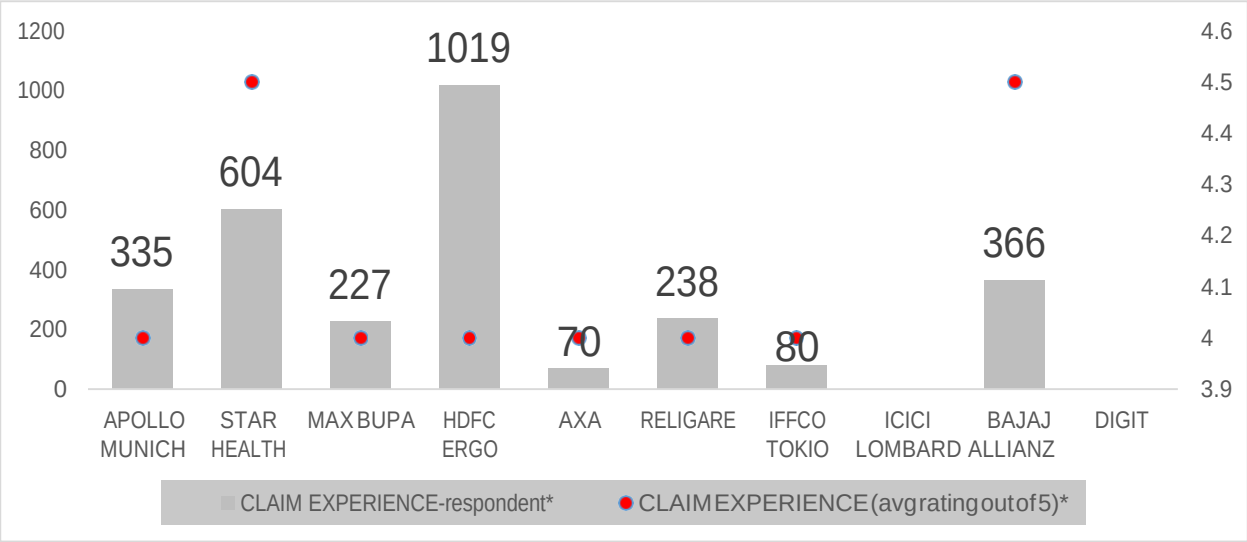
ITING PERIOD(preexisting)	yrs						yrs	yrs
NTWK OF HOSPITALS	4500						4000	3600

SOURCE: IRDA REPORT 2018 *Primary data obtained by calling executives of respective organization on call

Claim experience- Claim experience depends upon the experience owned by the customers in terms of claims i.e. how fast, effective and hasslefree the claim process is.

The rating is done ranging 1-5 where 1 is the least liked by the customers and 5 is most liked by the customers.

Figure 1- Number of respondents regarding experience in Claims of respective organizations and Rate of experience out of 5

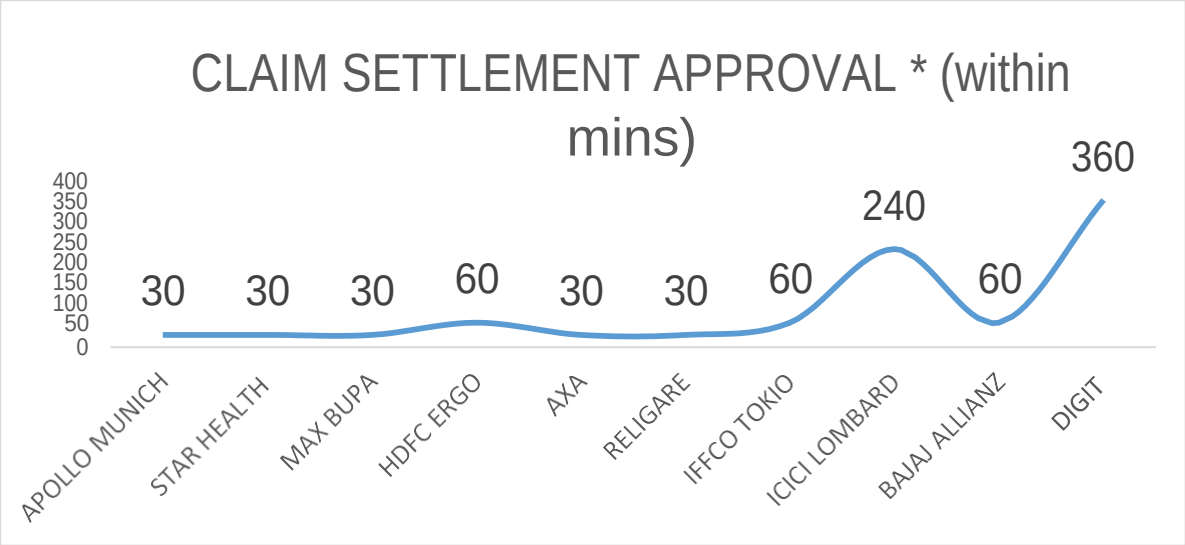


SOURCE: BANK BAZAR REPORT 2018

Claim settlement ratio-refers to the number of times an insurer successfully processes claims from admission to payout as against the number of times it rejects them or time taken to settle the claims intimated by the customer. Higher the settlement ratio and faster the settlement time means the organization is doing a good job

A positive ratio is one where the number of claims processed successfully are higher than those rejected

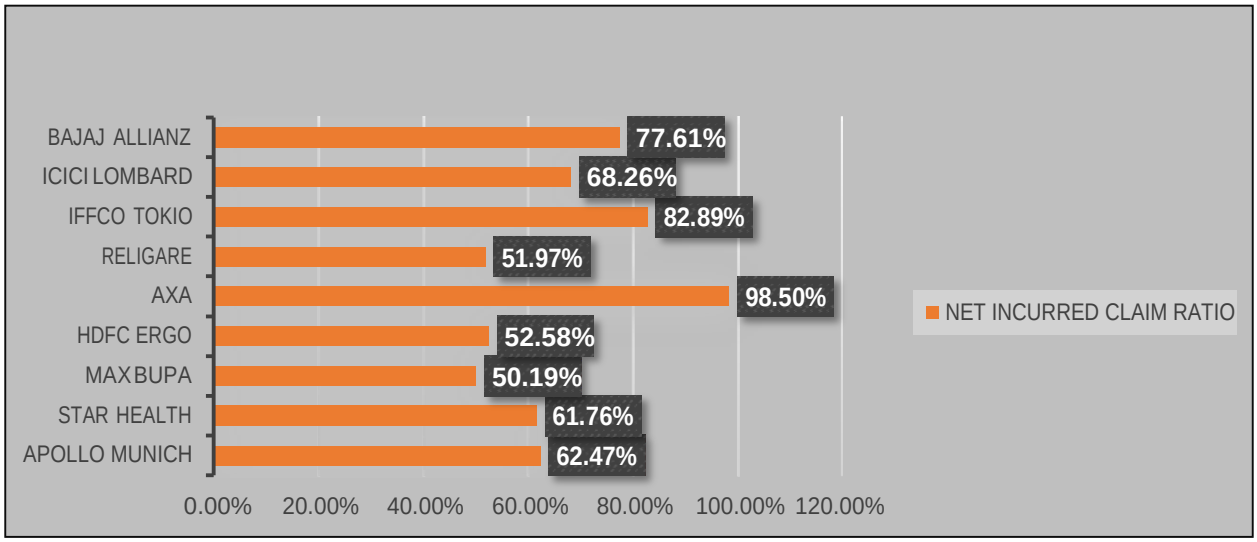
Figure 2- Claim settlement approval of respective organizations (within minutes)



Net incurred ratio-incurred claim ratio refers to the net claim paid by an insurance company as against the net premiums earned.

If the claim is less than 50% its means that the company is either hardly giving out claims or is making relatively large profit.

Figure 3- Net Incurred ratio



After analysis of competitor assesssment sheet, consolidated report of four strong competitors were prepared

Table 2-CONSOLIDATED REPORT OF STRONG COMPETITORS

ORGANISATION NAME	INCURRED CLAIM RATIO	GRIVENCES SOLVED	NETWORK OF HOSPITALS	P	NO OF PERSON COVERED	LAIM SETTLEMENT RA	WAITING PERIOD

						TIO	
APOLLOMUNICH	62.47%	96.73%	4500		34300000	89%	3yrs
ICICILOMBARD	68.26%	98.91%	3600+		10585000	98%	4yrs
HDFCERGO	52.58%	100%	8600+		23830000	52.58%	4yrs
BAJAJALLIANZ	77.61%	99.78%	6000+		11514000	83.94%	4yrs
R	51.	9	5		2	5	4

ELIGARE	97%	9.30%	400+		61700	1.97%	yrs

Note- the highlighted blue figures represent the desired result or benchmark of respective factors

Source: IRDA DATA 2018

STATS OF CLAIM AND CLAIMPENDENCY

A detailed report of claim process and claim pendency essential for bench marking was prepared, the following factors were determined in Apollo Munich, Religare, ICICI Lombard, HDFC Ergo and Bajaj Allianz

1) Claims Outstanding- The number of claims which are not settled and are in pipeline

2) Claims Reported- Number of claims reported in the financial year 2017-18

3) Claim Settled- Number of claims settled in the 2017-18

4) Claims Repudiated- Claims repudiated are the number of claims rejected due to pending documents, or some legal issues.

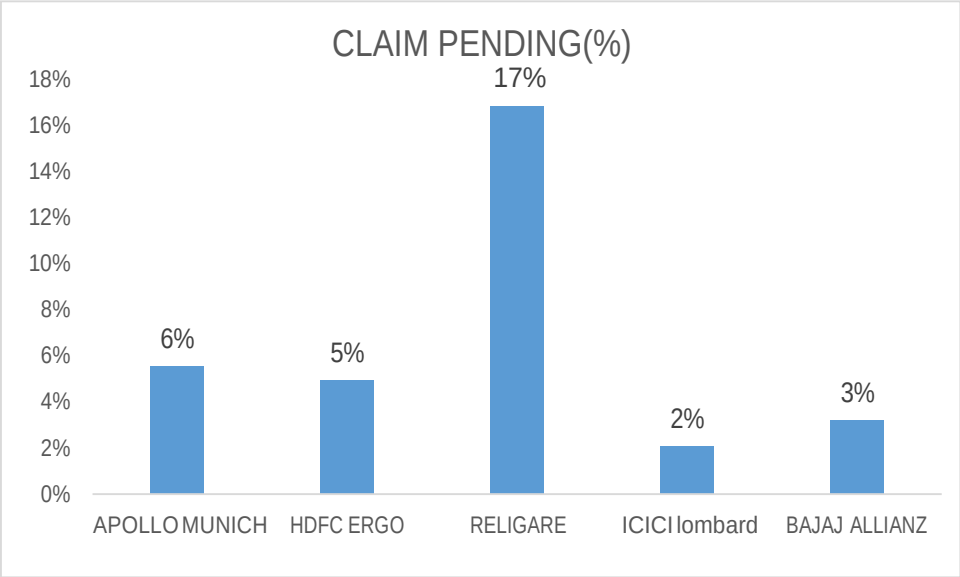
Table 3- Statistics of Claims and Claims Pendency*

FACTORS	APOLLO MUNICH	HDFC ERGO	RELIGARE	CICI LOMBARD	BAJAJ ALLIANZ
CLAIMS O/S	8438	4221	14661	513	225
CLAIMS REPORTED DURING THE PERIO	169,910	79434	136367	25606	4658

D					
CLAIMS SETTLED	150,039	75956	1103381	22921	40744
CLAIMS REPUDIATED	18866	37667	17724	86	660
CLAIMS PENDING	9443	3931	22966	538	149

CONSTRAINTS IN SETTLEMENT OF CLAIMS

Figure 4- <u>Percentage of Claims pending of respective organizations</u>



SOURCE: IRDA 2018 REPORT*IRDA CONSUMER BOOK

Depending upon the analysis of pending claims, the challenges or constraints each organization dealt with, for settlement of claims are as follows:

APOLLO MUNICH HEALTH INSURANCE-

- Fraud or suspected case requiring verification of the facts
- Delay in completing pending requirements at customer end

HDFC ERGO-

Delay in claim settlement is mainly due to delay in receiving related documents from the insured

BAJAJ ALLIANZ-

Deficiencies in claim documents

ICICI LOMBARD-

- Incomplete details provided by insured at the time of claim intimation
- Incomplete/wrong documents submitted
- Verification of pre- existing conditions/ ailments
- Non submission /delay in submission of required documents

INITIATIVES TO SETTLE THE CLAIMS

The initiatives taken by the following organizations to settle the claims are as follows-

APOLLO MUNICH HEALTH INSURANCE-

- Dedicated team for regular calling and reminder process for customers to submit pending documents
- Fast track verification to ensure timely process

HDFC ERGO-

Mail and SMS are sent to the customers requesting them to submit the documents at the earliest

BAJAJ ALLIANZ-

- Deficiency reminders are sent to the customers at an interval of 15 days from the date of information.
- Watsapp facility to submit documents, not required in original for settlement of claims
- SMS and email alerts to customers on each stage of the claim
- Dedicated email to solve queries.

ICICI LOMBARD

- Frequent email and SMS are sent to Insured explaining claim process
- In house team of claims surveyor is built for expeditious survey of claims, empaneled surveyors are assigned for location/situation where in house team is not available
- System triggered SMS to insured at various stages of the claim like- survey or assignment with surveyor details, post survey completion, post payment etc

INSTITUTIONAL FRAMEWORK FOR REVIEW OF REPUDIATED CLAIMS

Institutional framework for the review of repudiated or rejected claims of the organizations are as follows

APOLLO MUNICH HEALTH INSURANCE

- Customer can request for redressal of claims rejection on communication of decision

a) CRM/customer service team- reviewed by second doctor
b) Grievance –reviewed by grievance handling doctor/ medical team/ Head of claims

- Rejected claims are never redressed by the initial reviewer to avoid bias HDFC ERGO

Claim repudiation authority is given to very few senior managers in all line of business. All repudiations are reviewed by national managers of respective line of business. A quarterly report is sent to management for review.

BAJAJ ALLIANZ

- Claims Review Committee is with seven members

- Customer call/ mails/ enquiries received at our call centers/branches with regard to repudiated/rejected claims are automatically registered as Claim Review Committee requests for further processing
    - Representations from policy holders on repudiation are reviewed by the committee
- Claims Review Committee (CRC) works independent of claims processing team to review any referred claim and takes an independent view.

ICICI LOMBARD

- A senior level claims team is there to review any repudiated claim represented by the insured
    - Grievance redressal details available on website/policy documents RELIGARE

    - Corporate training
    - Broker/ agent training
    - Detailed claim procedure in company website
    - Proactive customer calling for claim deficiency resolution

5. ACCIDENT AND EMERGENCY CLAIMS

Accident and emergency claim is an additional vertical in Claims bench-marking, in which the competitors are compared on the basis of these three parameters

a) Claims provided to the list of network and non-network list of hospitals

b) Formalities to be fulfilled by TPA or for reimbursement claim settlement

c) Hospitalization process in case of accident and emergency claim, mandatory or not

Table 4- Accident and Emergency claims*

APOLLO MUNICH	BAJAJ ALLIANZ	ICICI LOMBARD	HDFC ERGO	RELIANCE HEALTH INSURANCE
Claims provided for provided list of network hospitals	Claims provided for provided list of network hospitals	Claims provided for provided list of network hospitals	Claims provided for provided list of network hospitals	On call cash less claims provided for network and non-network list of hospitals

list of network Hospitall		list of network hospitalls	list of network hospitalls	
Reimbursement provided for non-network	Reimbursement provided for non-network hospitals. Claims intimated within 7 days after discharge	Reimbursement provided for non-	Reimbursement provided for non-	TPA has to inform the company regarding the patient status and necessary treatme nt

network hospital within 15 days		network hospitals within 30 days	network hospitals within 15 days	
24hrs of hospitalization	24hrs of hospitalization is mandatory	24hrs of hospitalizatio	Company did not provide	Hospitalization not mandatory

n n o t m a n d a t o r y .		n i s m a n d a t o r y	 a n y d e t a i l s	

Note-the highlighted blue box represents the recommendations for AMHI in case of ACCIDENTS and EMERGENCY

6. CONCLUSIONS

Insurers have a unique opportunity to leverage multiple data sources to create deeper, customer relationship and to become more efficient. If we help our clients in this effort the sector will be well positioned to play a prime role in emerging ecosystems.

Future of Insurance will be determined by the net effort of multiple enablers like

a) Digit adoption- to enhance access to data and raise process efficiency through RPA/ AI
b) Big data Analysis- to make sense of the vast amount of data generated and consequently create value.

Source: Primary data obtained by asking open ended questions to the executives of respective organizations on call

7. RECOMMENDATIONS

Some recommendations that are made to AMHI after analyzing the results of the study are as follows

1) Cashless claim facility can be provided to the provider of non-network list of hospitals in case of Accidents and Emergency
2) In house team of claims surveyor can be incorporated for expeditious survey of claims, system triggered SMS to insured at various stages of the claims like survey or assignment with surveyor details, post survey completion post payment etc. can be provided to the customers
3) Technology being a core strength, AMHI can built whatsApp facility to submit documents for settlement of claims, which will reduce the average five days TAT

“

CASHLESS PROCESS FOR ACCIDENT AND EMERGENCY

1

Person met with an accident or emergency

2

3

TPA desk calls AMHI

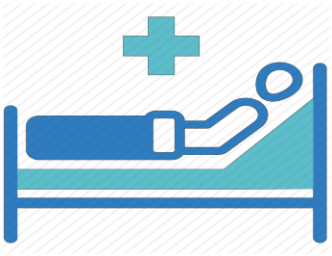
4

Details given to AMHI of the accident and treatment given to the patient by TPA

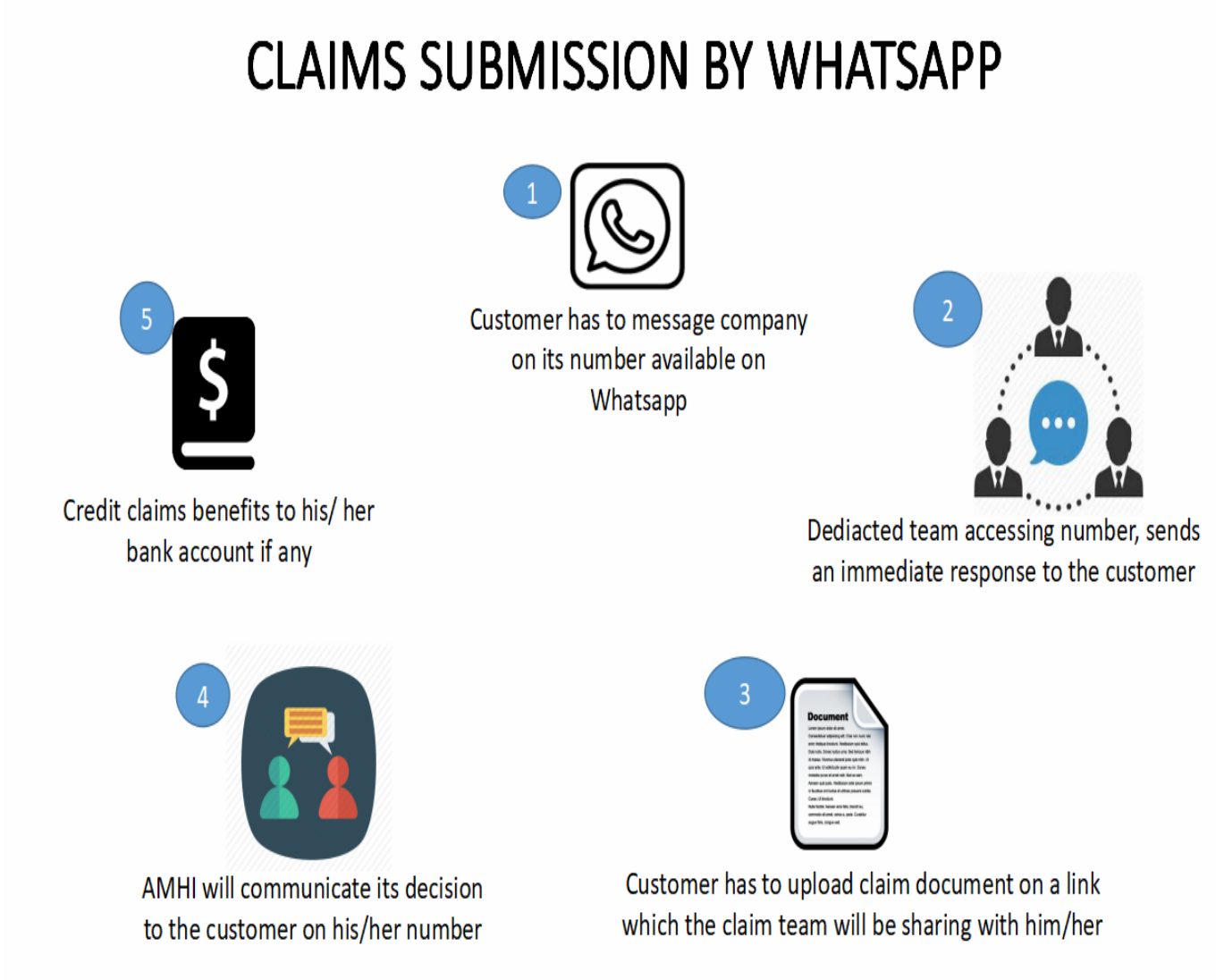
5

Taken to near by hospital

Cashless facility provided



The prime responsibility of any Health Insurance company is to honor a valid claim in the need of the hour. By embracing Mobile instant messaging platform like Whatsapp we can provide a prompt and afresh service option to enhance comfort and benefits to the customers.



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