Study to Develop Cost Negotiation Strategies for Hospitals Empaneled with Aditya Birla Health Insurance Co. Ltd. (ABHICL)

By

Shreya Saxena

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Shreya Saxena**, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **Aditya Birla Health Insurance Co. Ltd.** from **1st February 2019 to 30th April 2019.**

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

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dean, Academics and Student Affairs

The IIHMR University, Jaipur

17 May 2019

Associate Professor

The IIHMR University, Jaipur

May 10, 2019

Internship Completion Certificate
To Whom So Ever It May Concern

This is to certify that **Ms. Shreya Saxena** has completed her internship with **Aditya Birla Health Insurance Company Limited (ABHICL)** from **1st February 2019 to 30th April 2019.**

She has successfully completed her project **"A study to develop negotiation strategies for hospitals empanelled with Aditya Birla health insurance."**

Her performance was found to be as per the high standard required by ABHICL.

We wish her all the best in her future endeavours.

Thanking you,

Yours sincerely,

Anuradha Puranik
Head – Corporate HR

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **A study to Develop Cost Negotiating Strategies for Hospitals Empanelled with Aditya Birla Health Insurance Co. Ltd. (ABHICL)** and submitted by **Shreya Saxena** Enrollment No.: **IIHMR-U/01/2017-19/0671** under the supervision of **Dr. Neetu Purohit** for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period from **February 2019 to May 2019** 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.

Shreya Saxena

Acknowledgments

I owe immense appreciation to some people for their contribution towards this work. This study could not have been successful without the support of some concerned people. I extend my sincere gratitude to my mentor, **D. Santosh Mande**, Manager, and Dr. Shubhra Bawra, Senior Manager, Central Operations, Provider and Partner Management of Aditya Birla Health Insurance Company Limited. I am thankful to them for spending their valuable time with me and giving me insights to complete this work. I would never have been able to finish my dissertation without the help of my office colleagues for always been a helping hand to me.

The successful completion of this study owes much to Mr. **Gaurav Tripathi**, JVP, Provider Network, ABHI who has guided the research from its beginning to end. His comments and insights and the constant encouragement have been invaluable to this report.

Without the guidance and blessings of our director; **Dr. S.D. Gupta**, Director IIHMR University this project would not have been possible for us.

My Special Thanks to **Col. Dr. Ashok Kaushik**, Dean Academics and Students Affair, IIHMR University, Jaipur for being a continuous guiding source throughout the degree, I would also like to thanks **Dr. Neetu Purohit,** IIHMR University, my guide for providing me support in completing my project successfully as well as giving insight in to my operational issues which came across during the project.

Most importantly, for abundance mercy and providing me good health throughout the study; I thank my Almighty God.

(Shreya Saxena)

Abstract

A Study to Develop Cost Negotiation Strategies for Hospitals Empanelled with Aditya Birla Health Insurance Co. Ltd. (ABHICL)

By- Shreya Saxena

Background

Health insurance is an important mechanism to finance the health care needs of the people. ABHICL delivers health insurance services to its customers in collaboration with health care providers such as hospitals, doctors etc. by empanelling them on the ABHICL network. It is very important for ABHICL to keep a check on hospitals as to what cost they are delivering healthcare services to their patients.

Based on those facts, central operations team of ABHICL analyses the current and upcoming schedule of charges (SOCs) which hospital may implement in future and variation is accordingly identified. These variations gives a clear picture to ABHICL as to what discounts they must get against the upcoming SOCs explaining the inclusion and exclusion criteria to that discount being offered.

These inclusion/ exclusion criteria helps in calculating the saving that can be done by accepting that discount from the hospital. Through this saving, result is the final impact that will actually impact the claim ratio of ABHICL.

Objectives

- To build Cost Saving Strategies for ABHI from networked hospitals.
- To prepare hospital specific recommendations to negotiate with the hospitals through central operations team.

Methodology

Descriptive cross sectional study was performed with simple random sampling. Firstly the request for SOC comparison is received from hospital to the regional manager which is directed to central operations team. Old and new tariffs/ SOCs are compared and impacts such as Medical Impact, Surgical Impact, Overall Impact are calculated. While analysing impacts, current discounts which are going on with the hospital were also observed.

All this data is being sent to the regional managers for the respective hospital locations and they start negotiating with the hospitals to get the best discounts and deals possible for ABHICL. These discounts when agreed are studied as to on what conditions does this apply and accordingly average cost saving is calculated.

Total 50 hospitals were studied out of which 27 hospitals were closed with the agreed discounts. In this, 19 hospitals were tertiary care hospitals based on the bed strength and location and rest8 hospitals were secondary care according to the bed strength and location.

Results and Findings

Comparative study was done between proposed tariff lay down by the networked hospitals with that of list of old tariffs already present with central operations team, ABHICL. Based on the impacts studied individually or in groups, several Cost Saving/

Negotiating Strategies were formulated which were hospital specific. On the basis of the deals agreed, Cost Saving Scenario in the favour of ABHICL was calculated obtaining the final impact. This final impact will be helpful for ABHICL to estimate the projected business with those hospitals in the coming financial years and many more.

Conclusion

On the basis of the results obtained, it is very important for ABHICL to standardise the cost saving/ negotiation strategies, so that every time a hospital comes with a great hike in prices, regional teams and central operations team find it easy to bring in better deals and save as much as cost as possible to decrease the claim ratio. These strategies must be developed with some strict regulations mentioning the inclusion and exclusion guidelines as well. Through this study, there is saving of 3% of amount that ABHICL will save through these 27 hospitals otherwise it would have been a huge amount to pay.

Limitations

Before the implementation at a wider scale and at a commercialized level, the viability of this model needs to be checked through a pilot study.

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LIST OF ABBREVIATIONS

ABHICL	Aditya Birla Health Insurance Co. Ltd.
TPA	Third Party Administrators
TAT	Turn Around Time
OOP	Out of Pocket
ALOS	Average Length of Stay
ACS	Average Claim Size
SOC	Schedule of Charges
EPD	Early Payment Discount
DCI	Drugs, Consumables, Investigations

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1. INTRODUCTION

Heath Insurance is any health plan that pools resources up front by converting unpredictable medical expenses into a fixed health insurance premium. It also centralizes funding decisions on health needs of a policyholder. This covers private health plans as well as medi-claim policies.

The insurance industry in India has experienced a sea of change since the opening up of the sector for private participation. With a plethora of companies entering the foray in the near future, the health insurance sector is surging forward and is posed for a phenomenal growth.

Health insurance is an important mechanism to finance the health care needs of the people. To manage problems arising out of increasing health care costs, the health insurance industry had assumed a new dimension of professionalism with Third Party Administrators (TPAs). Further, the uncertainty related to a medical condition increases the need for a health insurance for all the citizens.

Ideally, the TPAs functions by collaborating with the hospitals in order for the patient to enjoy hospitalization services on a cashless basis.

Health Insurance basically covers either whole or part of the risk allowed for all the medical expenses by providing a financial backbone to the customers when they are in need of any healthcare process or intervention. The benefits are administered either by government insurance companies or by private sector like Aditya Birla Health Insurance Co. Ltd. (ABHICL) and other competitive companies like ICICI Lombard, Max Bupa, etc.

ABHICL reaches out to its customers using a mix of channels such as hospitals, diagnostic centres and some other third party vendors (agents, bancassurance, etc.). To maintain this network with healthcare providers, ABHICL has a Provider Network Team who is responsible for all the management of the healthcare providers including their rates at which they are offering services to the customers, types of services, basic TAT etc.

Health Insurance companies such as ABHI set up a department/ team known as Provider Network Team. This team help ABHI to set up a network with hospitals across country by taking them on their panel through empanellment process. After creating this network, ABHI enable Cashless Services to all the patients/ customers who buy ABHI policies and visit networked hospitals for diagnosis and treatment.

This cashless procedure helps the patients/ customers to reduce out of pocket (OOP) expense whenever they are in need to avail the services. When ABHI pay against any procedure for any patient on cashless basis, it is termed as Cashless Claims.

To enable cashless claims, ABHI tend to agree on some terms and conditions beforehand consisting of some tariff plans of the services offered by the hospital and sign an MOU agreeing all the decisions mutually.

If there is a planned admission of any patient, hospital sends a pre-authorization form including every detail about the type of treatment to be provided to the patient during the average length of stay (ALOS). This pre-authorization form is a tentative expense break-up which is to be claimed when the patient is discharged from the hospital. Once the patient is discharged, hospital sends a claim request to ABHI to pay the agreed amount for all the procedures.

Now to manage Risks and Loss Ratio from ABHI end, the Central Operations Team, a sub-team of Provider Network have to keep a check Year on Year inflation rates

which is currently 5%, and that can make a huge difference when analysed on a broader perspective, and keep Average Claim Size (ACS) in control.
To help ABHI in managing Risks, Loss Ratios and control on ACS, this project is taken up, where my team will analyse the ABHI tariff as per competitor's tariffs and during rate revision of the hospital. These tariffs will include:

1. Room Rent + Nursing Charges
2. Consultation and Investigation Fees
3. Most utilized surgeries etc.

This tariff is analysed by Central Operations Team, and understand the impact of the rate revision that shall have on the complete claims portfolio. Based upon the impact analyzed the central operations team along with the regional team negotiates with the hospitals to get better rates and discounts. Negotiation here means, as per the competition and inflation in the market, ABHI tries to bring in better deals with the hospitals in terms of the Costs of Services, hospitals are providing.

2. Literature Review

The bigger the health insurer, the lower the prices it can negotiate from physician groups. Large insurers with market shares of 15% paid prices for independent physician office visits that were 21% lower on average than prices negotiated by small insurers with shares of less than 5% of a given market, according to the study published in Health Affairs.
The bottom line: "Bigger insurers have this bargaining power they are using to negotiate lower prices". The researchers used a multi-payer claims database, to analyze how much commercial health plans paid. They analyzed three different types of standard doctor's visits, many of which were billed by primary-care doctors. The 10 commercial insurers included in the study were a mix of small local players as well as national insurers. Using this method, researchers were able to study the variation in the price an insurer pays different physician practices in the same area for the same service. For one type of basic visit with an established patient, insurers with less than 5% market share paid $86 to physician practices. But insurers with market share between 5% and 15% paid just $70 to the same providers for the same service. The study further concluded that only large insurers are able to negotiate relatively lower prices from large provider groups. Small and midsize insurers pay higher prices to large provider groups for the same services.[1]

Hospitals must negotiate with their payors periodically. Now, with both reimbursement cuts as well as health coverage expansion, payors might be asking a lot from hospitals. Typically, large health systems do not have problems with the pre-negotiation steps; it's usually community and regional hospitals that have a more difficult time because the people that negotiate payor contracts usually wear several different hats at the hospital and may not have all the software tools that can help model contracts. Hospitals must benchmark contracts against each other, see how all of their managed care contracts and figure out the financial impacts of each contract. For example, comparing rates among Aetna, CIGNA and Blue Cross Blue Shield plans can give a hospital an idea of where rates are at in the market and how a hospital's current contract can be improved. Hospitals should do the research to know what percentage of the insurer's business comes from the hospital. If a hospital shows a payor that it is

40 percent of the payor's business in cardiology, it builds a picture and gives the hospital leverage to show just how many patients they are serving on the payor's plan. Conducting research on current contracts goes hand-in-hand with keeping an inventory of all contracts and setting up a system that indicates which payors are coming up for a renewal.[2]

Healthcare costs are a constant focus of attention. Most typically, the provider and payor begin negotiating contract renewals nine months before the contract is up. Most contracts are one to three years in duration, so these negotiations happen quite frequently. Often, the provider chooses a number (a percentage increase in reimbursement rates) and announces it to the payer: "We want a 7 percent increase for the next three years!" The payer, in turn, brings a briefcase of data to the table, trying to prove to the provider that this is an outrageous request and that "the market suggests that even a 1 percent increase might be too much." In turn, the provider attacks the data, points to their rising costs and decreased levels of reimbursement from Medicare and Medicaid, and indicates, "We could come down a bit, but a 6 and three-quarters percent increase is our best offer." Of course, the payer comes back with "the most significant concession"—and an appeal for both sides to "be reasonable"—of moving up to a 2 and half percent increase. The parties then explore possible ways to work together on each of the issues. For example, they could look to see if there are types of data the payer could share with the provider that might help improve treatment decisions, or process improvements the provider could take to help improve claims coding and processing for the provider, or ways to jointly be involved in a capital investment the provider is looking to make, or new forms of technology in which to jointly invest, or ways of sharing greater risk in more costly service areas for the provider, just to name a few. As opposed to approaching this as a game of chess or a battle, the payers and providers invent these ideas together. Based on this, either party then develops a set of packages which include different combinations of the ideas invented together. Each package is then associated with a different proposed rate increase, depending on the amount of value created by the content of the given package. If the packages are well developed, there is already a far greater chance that rate increases will be lower, improved quality measures and administrative simplicity will be achieved, and both providers and payers will be putting their dollars to work in the areas most needed.[3]

References:

January 9, 2017; Shelby Livingston; "Modern Healthcare Journal; Larger Insurers Negotiate Lower Prices from Physicians"[1]

September 21, 2011; "The Ins and Outs of Successful Hospital Insurance Negotiations and Service Pricing"[2]

April 6, 2012; Jeff A. Weiss; "A better way to negotiate healthcare Costs"[3]

3. RESEARCH QUESTION

What strategies can be developed for negotiating tariffs from empanelled hospitals with Aditya Birla Health Insurance Co. LTD. (ABHICL)?

4. OBJECTIVES

1. To build Cost Saving Strategies for ABHI from networked hospitals.
2. To prepare hospital specific recommendations to negotiate with the hospitals through central operations team.

5. METHODOLOGY

Source of Data: Primary and Secondary Source Data Collection

Research Design: Descriptive Cross Sectional Study Design
The study was conducted as a cross- sectional sampling survey method to collect primary and secondary data from different hospitals and ABHI networking department data.

Sample Design: Simple Random Sampling

Sample Size: 50 hospitals already networked with ABHICL across country were selected at random.

- Tariff revision analysis for all 50 hospitals was done
- Out of 50 hospitals, 26 hospitals ended up following the negotiation strategies and were closed making final deals with ABHICL
- Out of these 26 hospitals, 19 were Tertiary Care hospitals and rest 8 were Secondary Care hospitals

Duration of Study: It will be a study for three months from February 2019 to April 2019.

6. RESULTS AND FINDINGS

Comparative study was done between proposed tariff lay down by the networked hospitals with that of list of old tariffs already present with central operations team, ABHICL.
After the comparative study of tariffs for each hospital individually, the impact was calculated viz a viz;

- Medical Management Impact: by what rate this section may affect the total claim paid by ABHICL
- Surgical management Impact: by what rate this section may affect the total claim paid by ABHICL
- Overall Impact: summation of both the impacts giving an overall picture that may be paid by ABHICL for the proposed tariff by the hospital.

Average for all the impacts was calculated and was compared based on the type of hospital; tertiary care or secondary care and locations of the hospitals.

To get a much clearer idea about what can be the variation among hospitals with similar setting and delivering same kind of services to the patients but with different rates, service specific average was also compared with the types of hospitals.
Based on the impacts studied individually or in groups, several Cost Saving/ Negotiating Strategies were formulated which were hospital specific.
These strategies were implemented each time, negotiation with the hospital is done by the regional team. On the basis of the deals agreed, Cost Saving Scenario in the favour of ABHICL was calculated obtaining the final impact.
This final impact will be helpful for ABHICL to estimate the projected business with those hospitals in the coming financial years and many more.

PROCESS FLOW

- Request raised by hospital to regional team
- Request accepted by Regional Team
- Tariff received by Regional Team
- Forwarded to Central Operation Team
- Tariff is read with agreement provided & conditions
- Old and New Tariffs are analysed by Central Operation Team
- Impact observed & negotiation strategies given by Central Team to Regional Team
- Regional Team negotiates with the hospital for better deals & packages
- Hospital agrees to provide discounts/ packages with approval
- This Discounts/packages are analysed with the overall impact & final impact calculated
- Difference between overall impact and the final impact determines the actual savings from hospital for ABHI

7. DATA ANALYSIS

Sample Distribution

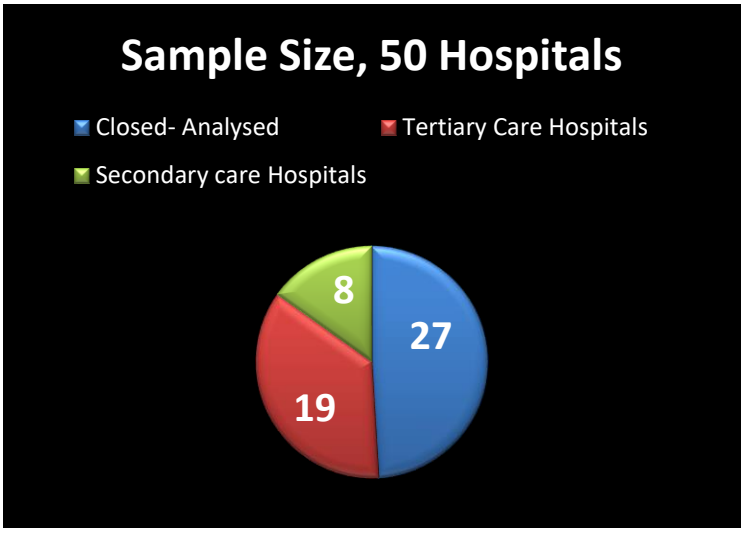


Fig.1: Distribution of Sample

1. **Impact Analysis as is Tariff Plans by Tertiary Care Hospital (Table 2)**

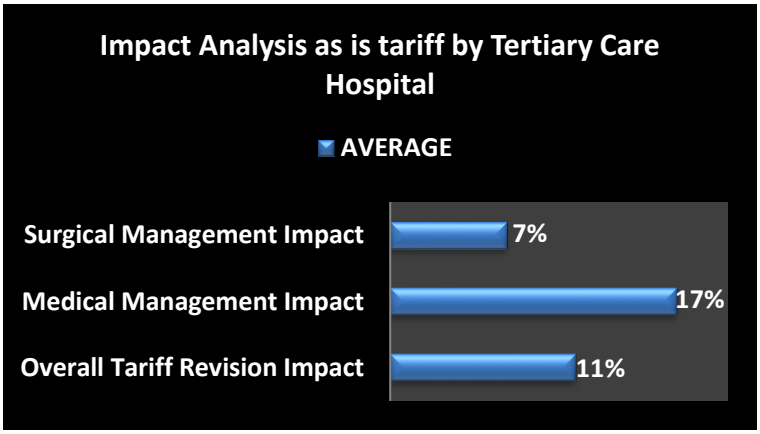


Fig.2: Impact by Tertiary Care Hospitals

When SOCs were compared, in tertiary care hospitals, 11% of overall impact falls on the ABHICL claim ratio.
Major impact is through surgical management, ie; 17%, it shares the maximum share of the total claim amount.
Comparatively lesser impact is by medical management, ie; 7%

2. **Impact Analysis as is Tariff Plans by Secondary Care Hospital (Table3)**

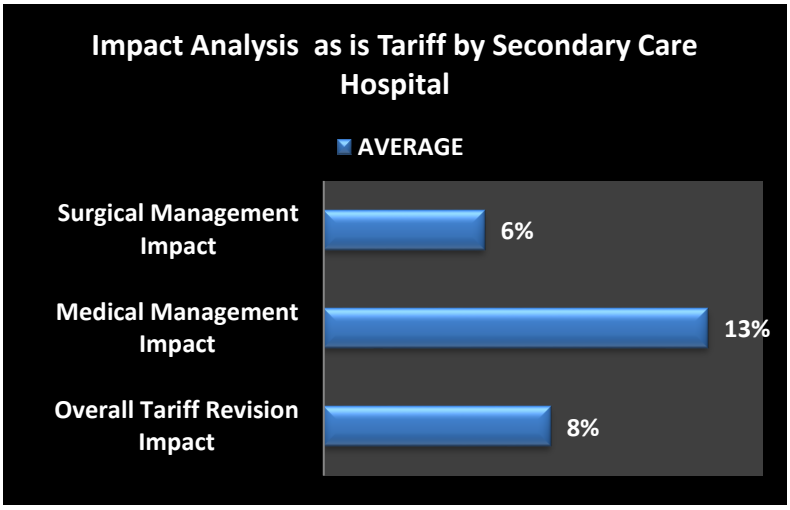


Fig.3: Impact by Secondary Care Hospital

When SOCs were compared, in secondary care hospitals, 8% of overall impact falls on the ABHICL claim ratio.
Major impact is through medical management, ie; 6%, it shares the maximum share of the total claim amount.
Comparatively lesser impact is by surgical management, ie; 13%

3. **Old Discount versus Agreed Discount in Tertiary Care Hospitals (Table4)**

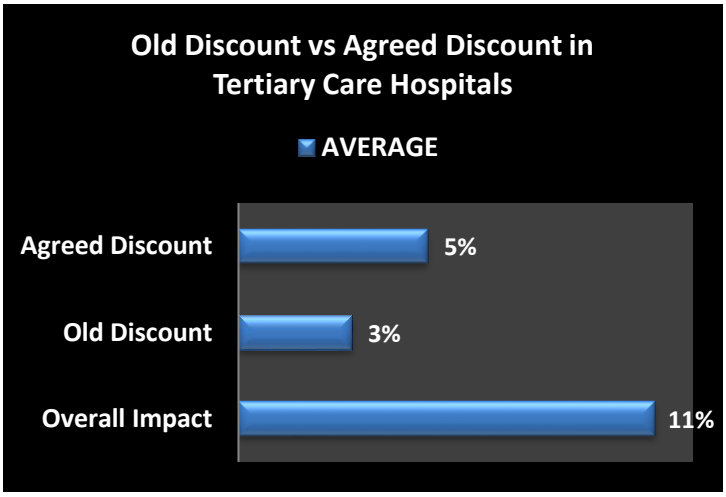


Fig.4: Old v/s Agreed Discount

When compared against overall impact, in tertiary care hospitals, generally the average discount is 3% that was promised by the hospital at the time of empanelment.
It is very important to consider old discounts, this helps in negotiating for new revisions in the discounts with better deals.

After implementing cost saving strategies, average discount agreed by tertiary care hospitals was 5% excluding the basic expenses such as drugs, consumables, investigations and implants.

4. **Old Discount versus Agreed Discount in Secondary Care Hospitals (Table 5)**

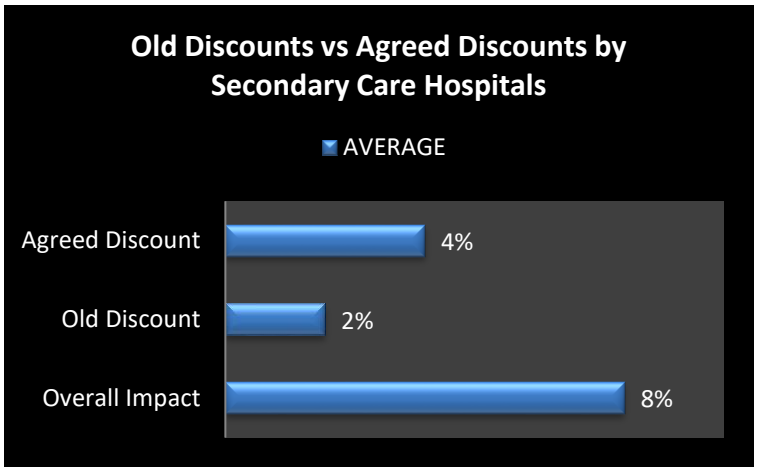


Fig.3: Old v/s Agreed Discount

When compared against overall impact, in secondary care hospitals, generally the average discount is 2% that was promised by the hospital at the time of empanelment. It is very important to consider old discounts, this helps in negotiating for new revisions in the discounts with better deals.
After implementing cost saving strategies, average discount agreed by secondary care hospitals was 4% excluding the basic expenses such as drugs, consumables, investigations and implants.

5. Surgery wise comparison in Tertiary Care Hospital (Table 6)

Surgeries	NARAYANA HRUDALYA	Fortis Escorts, Jaipur
ASD Closure	**48%**	**76%**
VSD Closure	**10%**	**32%**
Total Hip Replacement	**34%**	**88%**
Total Knee Replacement	**10%**	**73%**

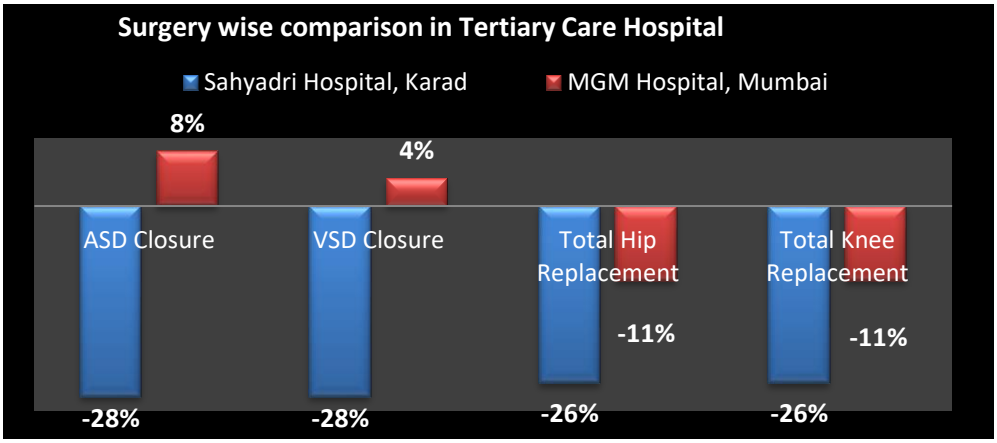


Fig.6: Surgery Wise comparison in t care hospital

When the surgeries were compared between two tertiary care hospitals but in different kinds of cities,
Surgeries are cheaper comparatively in Narayana Hrudalya, Bangalore which is a Tier I city and in Fortis Escorts, Jaipur, which is Tier II city shows much higher surgery rates.
Hospitals generally increase their rates for cashless patients to make more money through TPAs or health insurance companies.
Through cost saving strategies, ABHICL tries to balance their loss ratio in these terms.

6. Surgery wise comparison in Secondary Care Hospital (Table 7)

Surgeries	Sahyadri Hospital, Karad	MGM Hospital, Mumbai
ASD Closure	-28%	8%
VSD Closure	-28%	4%
Total Hip Replacement	-26%	-11%
Total Knee Replacement	-26%	-11%

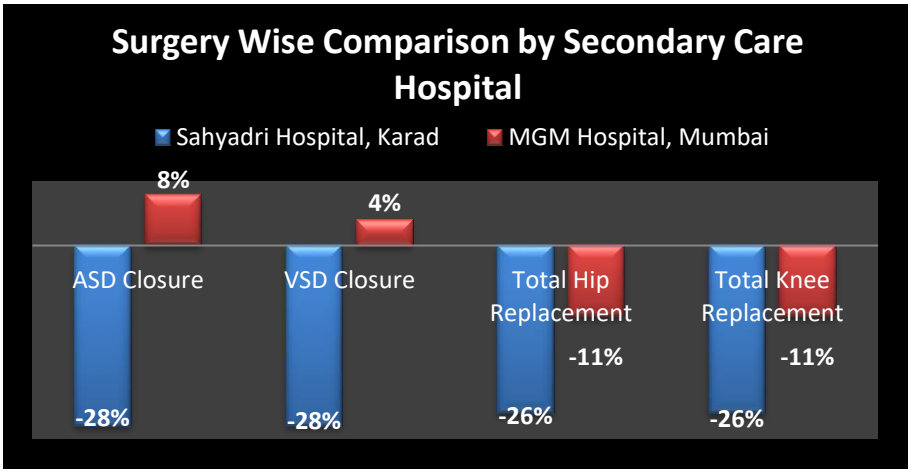


Fig.7: Surgery wise comparison by secondary care

When the surgeries were compared between two secondary care hospitals but in different kinds of cities,
There is a negative variation in the rates of Sahyadri Hospital, Karad; Pune, Tier I city, as they have decreased their rates in surgeries, but must have increased their rates in other categories to bring higher variation.
MGM Hospital have increased the rates in cardiac surgeries, to convert them into packages.
Hospitals generally increase their rates for cashless patients to make more money through TPAs or health insurance companies.
Through cost saving strategies, ABHICL tries to balance their loss ratio in these terms.

7. Graph showing Single Room Rent in Tertiary Care Hospital (Table 8)

	Kailash Healthcare, Delhi	Medanta Hospital
Single/ PVT Room	2%	3%

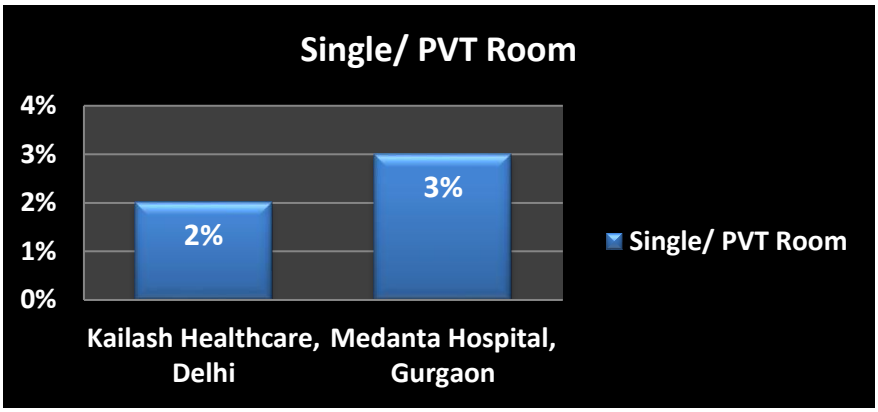


Fig.8: Single Room Rent in Tertiary Care Hospital

Hospitals charged more for special room because of facilities they provide with it.
When the impact of private or single rooms was compared between hospitals of same category in metro cities, it was found that both the hospitals are increasing their room rents only by a considerable rate.
But this small variation may bring a great impact on the final billing in the type of surgeries where room rents are not included in the packages.
To save cost, it is very important to focus on these small variations which may bring a great influence on the final claim amount.

8. REASONS FOR INCREASING COST OF HEALTH CARE FACILTIES

1. There is no control on the professional surgeon charges in most of the hospitals which is effecting the claim ratio of insurance companies.
2. No regulatory body is present to check constantly increasing rates of health care facilities.
3. Most of the health providers are private hospitals which are profit oriented.
4. No access to hospital information regarding patient's billing.
5. Increasing cost of commodities in market.
6. Considerable part of total procedural amount of surgery is consist of surgeons fees, surgeons charge their fees according to their will and this is mostly depend on his speciality, popularity and experience instead of quality of service provided by him.
7. No market bench marking activity done by healthcare providers.
8. Use of new and costly technologies.
9. Tariffs are more in the certified hospitals, NABH etc.
10. Cost of health care is changed from region to region, no standardisation.
11. Infrastructure and Expansion in Hospitals, fees of which is generated from the patients and insurance companies.

Above mentioned reasons are only few but there are many more, to reduce discrepancies in the costing of healthcare service we have to come together and work in united way by taking it as a mission.

9. RECOMMENDED STRATEGIES FOR NEGOTIATIONS

1. Regional team with field investigators must visit to the hospitals to observe why the hospital is increasing rates and where they can negotiate.
2. Regional team with field negotiators must come with agreed discounts with least terms and conditions attached to it.
3. We must also ask for Early Payment Discounts (EPDs): which will help in bringing in good relation with the hospitals if ABHICL promise to settle claims as early with the least TAT possible.

These EPDs will be in addition to the overall discounts on the final bill that is decided eventually with the hospitals.

4. Discounts on final bill excluding DCI/ Implants: considering what impact does DCI/ implants have in that hospital.
5. Hospital must work on packages covering maximum discount including professional charges, OT charges, DCI etc.

6. Lock in period of 3 years etc.: so that even if there is any inflation in the coming years, hospitals have to deliver on same rates decided for 3 years with ABHICL during negotiation.
7. ABHICL must observe the utilization rates of different surgeries and investigations to understand better the hospital wise scenario to pitch in for better discounts.
8. ABHICL must focus on group hospitals to build better relations in future and increase network.
9. By these conditions, Cost Saving can be determined, which will give a clearer picture of approximately how much ABHICL may save with these hospitals on the panel.
10. ABHICL business in the coming 3 years with these hospitals may also be estimated by such cost saving strategies.

10.COST SAVING SCENARIO (Table 9)

Cost Saving	ALL Hospitals	Tertiary	Secondary
Average Overall Impact	10%	11%	8%
Effective Saving	3%	3%	3%
Average Final Impact on ABHI	7%	8%	5%

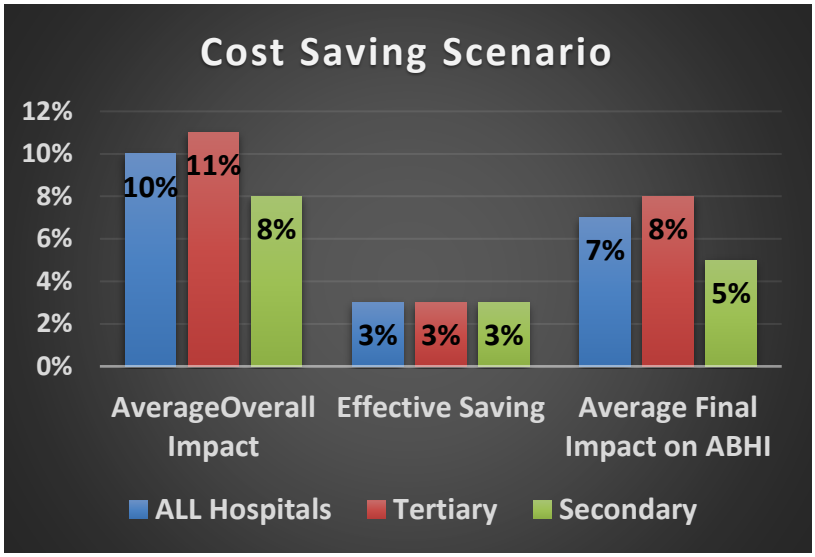


Fig.9: Cost Saving Scenario

When those cost saving strategies were applied to hospitals in the last two months, above results were obtained.
These strategies helped in saving considerable cost while negotiating with hospitals.
Average of 3% cost was saved on the total bill amount payable in coming years.
Final Impact on claim ratio of ABHICL was the difference of overall impact and cost saved by negotiations.
7% was the final impact by all the hospitals analyzed, whereas 8% and 5% was the final impact by tertiary care and secondary care hospitals respectively.

11.CONCLUSION

- It is observed that hospital rates generally depend on specialities and infra-structure, bed strength, location, doctors' panel and expansions if any.
- In order to understand the rates and impact, intelligence must be taken through market benchmarking activity.
- Based on this data, strategies should be designed to control this impact of different hospitals.
- It was observed that accurate analysis will help design these strategies along with benchmarking comparison and identify the areas to ask for discounts, packages, EPD or any other strategies.
- From the above graphs, we can say that there are marked variations in the tariff charged by the networked hospitals.
- It shows that there are no fix criteria used in budgeting and costing of these services in hospitals.
- ABHICL needs to benchmark market rates to balance it's Loss Ratio.
- Average Claim Size also plays a major role in projecting business for new financial year, which will directly depend upon the total claim amount that was passed the previous year through this negotiations and discounts.
- It is observed that out of 50 hospitals analysed thoroughly by SOC/ tariffs comparison, we could save 3% of amount of ABHICL which otherwise would have been a hit to the company.

CASE STUDY: MEDANTA MULTISPECIALITY HOSPITAL, GURGAON, HARYANA

When the analysis for Medanta Hospital was done, following outcomes were observed:

1. **Medical Management Impact**

Medical Management	Variation
Room Rent (incl. Nursing Charges)	6%
Visit Charges	10%
Investigation Charges*	4%
Total	20%

2. **Surgical Management Impact**

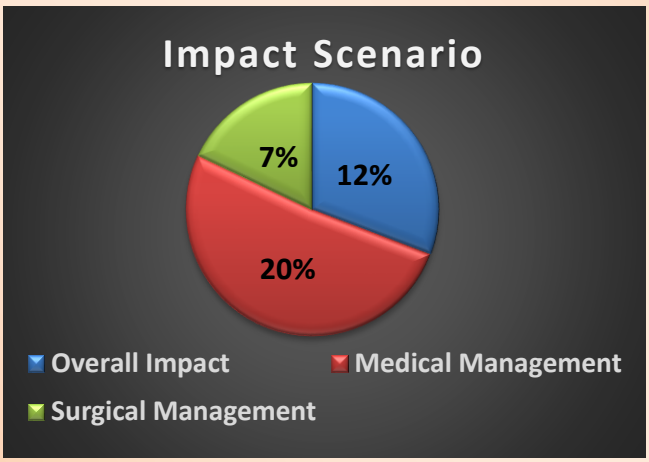
Surgical Management	General Ward	Twin AC	Single AC
Variation In %	9%	9%	9%
Traffic	30%	30%	40%
Traffic Effective Change	3%	3%	4%
Net Impact	9%		
IL PPR WT	80%		
Total Net Impact	7%		

3. **Overall Impact (Surgical + Medical)**

Particulars	Change	Pay Wts	Net Impact
Medical Management	20%	40%	7.92%
Surgical Management	7%	60%	4%
Net Impact		100%	12%

4. Overall Impact Scenario in Medanta Hospital

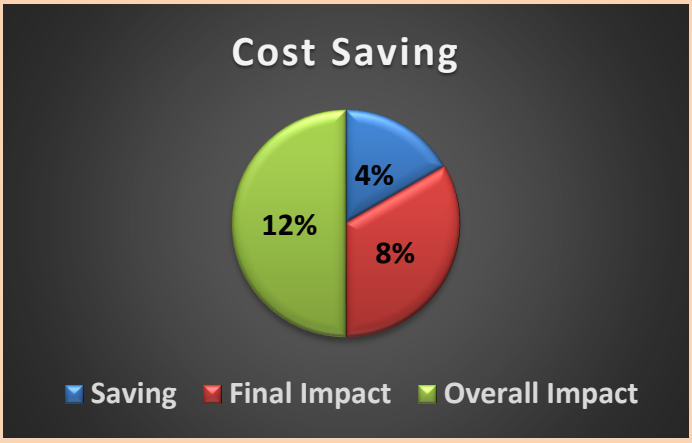
Impact Scenario	Variation
Overall Impact	**12%**
Medical Management	**20%**
Surgical Management	**7%**



This pie-chart shows that, according to the analysis, out of the overall impact by Medanta Hospital, maximum share is taken by medical management ie; 20%.
Which means that, they have increased variably in the rates of medical investigations or room rent and doctor visits, which are excluded from the final bill and will directly impact on the total amount.
Surgical Management on other side, also shows lesser impact here ie; 7% this is because they have kept surgeries as open rates and no other charges are clubbed with these rates.
This will directly influence on total bills as every expense will be charged separately that will be payable by ABHICL.

5. Cost Saving Scenario after implementing Negotiation Strategies

Old Discount	Current Discount	Actual Discount	Saving	Final Impact	Overall Impact
0%	Accepted with 8% discount on services excluding DCI and Implants	8% on 50% of bill	4%	8%	12%



In this case, the old discount was 0% or NIL, as in no discount was offered by this hospital to ABHICL.
After tariff analysis and some negotiation strategies, discount of 8% on services excluding drugs, consumables, investigations and implants.
That is 8% discount is not on the final bill.
According to the industry scenario, generally, DCI captures around 30% of bills and implants captures around 15% of bills. Therefore, round about 45% of bill is excluded from the total discount offered by the hospital.
Remaining 55% of bill plays with the 8% of discount which determines the saving component.
Similarly, in this case, Saving was done of 4% on that 55% of bill.
Thus final impact is calculated deducting saving from overall impact, which comes out to be 8%.

This 8% of impact finally influence the claim ratio of ABHICL and determines the projected business in the next coming years holding with that hospital.

This is how Cost Negotiation Strategies are formulated and implemented to decrease claim ratio as well as loss ratio in every hospital's case.

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