To Study Unspecified Package Requests Received from Rashtriya Swasthya Bima Yojana Empaneled Hospitals

By

Shekha D Das

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2016-2018

The IIHMR University, Jaipur

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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 MAY CONCERN

This is to certify that **Shekha D Das** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **Reliance General Insurance, Hyderabad** from 5th February 2018 to 4th May 2018.

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.

Col Dr Ashok Kaushik

Dean, Academics and Student Affairs
The IIHMR University, Jaipur

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RELIANCE GENERAL INSURANCE

May 04, 2018

CERTIFICATE OF INTERNSHIP

This is to certify that Ms. Shekha D. Das of Indian Institute of Health Management Research (IIHMR), Jaipur, has successfully completed her On The Job training with Reliance General Insurance Company Limited under Health Claims department, from 5th Feb 2018 to 4th May 2018.

Project Title - "Study of unspecified package requests received from Rashtriya Swasthya Bima Yojana empaneled hospitals and Misutilization of hysterectomy packages in microinsurance."

During this period of internship, she has displayed dedication to work and excellent logical and analytical ability.

We wish her best of luck in her future endeavors.

For Reliance General Insurance Company Limited

Garima Shukla

Garima Shukla

(Human Resources)

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "A study on unspecified package requests received from RSBY empanelled hospitals and to design specific packages'' and "To study misutilization of hysterectomy packages in microinsurance". and submitted by (Name) **Shekha D Das**Enrollment No. IIHMR-U/01/2016-18/0493 under the supervision of**Col. Dr Ashok Kaushik**for award of MBA in Hospital and Health/ Pharmaceutical / Rural Management in Health and Hospitals of the University carried out during the period from 5th February 2018 to 4th May 2018 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.

Shekha D Das

Signature

ACKNOWLEDGEMENT

I extend my sincere gratitude to **Dr Mahesh Yelapure**, National Head, Health Claims, **Dr Jagadeesh Ghanta**, Team Lead (Mass) and **Mrs Ankita Mittal** who has also been my mentor, for giving me the opportunity to do the dissertation project at Reliance General Insurance Company Limited, Hyderabad. I thank them for all the trust and faith they posed in me and I only hope that I have been able to live up to their expectations. Their guidance and support has been instrumental in helping me shape this study in a desirable way.

I would also extend my gratitude towards the entire staff of the organization for their guidance and support.

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Dr Shekha D Das

ABSTRACT

By Shekha D Das

To study unspecified package requests received from Rashtriya Swasthya Bima Yojana empanelled hospitals.

INTRODUCTION- Rashtriya Swasthya Bima Yojana, a central government scheme, provides package rates for various ailments and treatment procedures. The packages which are not defined are called unspecified packages. To verify the unspecified packages the insurance company requires Unique Reference Number, available sum insured and adjudication of the request i.e., approval, rejection and query. The insurance company verifies the requested package and amount by the hospital, if required Insurance Company provides the different package amount and code is submitted to the hospital. The Insurance company rejects the request on the basis of sum Insured exhausted and Non-requirement of the treatment. The Insurance Company shall raise the query with the hospital in case of any discrepancy. For unspecified cases authorization code is generated.

Keywords: Unspecified package requests, Rashtriya Swasthya Bima Yojana, RSBY empanelled hospitals.

OBJECTIVES

The objective of the study was to design specific packages for unspecified package requests, to identify district wise trends and to include the identified package in the package list.
The study was done keeping in mind the packages which are not defined by RSBY Which are called unspecified packages.

METHODS

The study was conducted at Reliance General Insurance, Hyderabad for three months duration. The study included beneficiaries of RSBY empanelled hospitals. Sample Size of 400 beneficiaries was taken. It was a cross sectional Analytical study.

RESULTS

The result indicates that the primary reason for cases being categorized as unspecified cases is unavailability of those packages. These packages are Atrial Septal Defect Closure, Arteriovenous Fistula Creation, Renal Transplantation Trans Obturator Tape operation, Trendelenburg operation etc.

As per district wise trends District 1 and District 2 has got maximum number of unspecified claims from government organizations whereas districts like District 3 and District 4 has got maximum number of unspecified claims from private organization.

CONCLUSION

On the basis of the results obtained designing of packages for the unspecified cases, recommendations for pricing has been done as per Central Government Health Scheme standards.

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LIST OF ABBREVIATIONS

CP- Claim Processing

CRM- Customer Relationship Management

CS- Claim Supervision

DLHS- District Level Household Survey

OPD- Outpatient Department

PP- Pre-Auth Processing

PS- Pre-Auth Supervision

RGICL- Reliance General Insurance Company Limited

RSBY- Rashtriya Swasthya Bima Yojana

SCHIS- Senior Citizen Health Insurance Scheme

URN No- Unique Reference Number

INTRODUCTION- RELIANCE GENERAL INSURANCE

Reliance General Insurance Company Limited is an Indian private insurance company. It is a part of Reliance Group. It is subsidiary of Reliance Capital Limited. Reliance General Insurance was incorporated on 17 August 2000. It received the license to conduct general insurance business in India from the Insurance Regulatory Development Authority of India (IRDAI) on 23 October 2000.

Reliance General Insurance caters to health, motor, travel and home insurance. Health insurances has following dimensions: Health gain policy, Health wise policy, Wellness and Personal accident.

R Care health comprises of Health Claims and Wellness. Health claim consists of various teams. These teams are Cashless, Reimbursement, Government Body Unit, Customer Relationship Management, Process and Quality and Provider Management Team.

*For the purpose of confidentiality of the data names of the districts have been referred to as District 1, 2,3 etc. The data been used for this project is taken from various state RSBY empanelled hospitals.

HEALTH CLAIMS PROCESS

It consists of two processes-

CASHLESS

REIMBURSEMENT

CASHLESS- Cashless process involves Emergency and planned hospitalization.

In Emergency cases patient gets admitted in the hospital by flashing Health card at the cashless desk of the hospital. It gets submitted to R Care Health. It reviews the request and informs the hospital with authorization status to insured also via SMS.

In planned hospitalization cashless request is submitted to R Care two days prior to hospitalization. It reviews the request and informs the hospital with authorization status to insured also via SMS.

If the request is approved, then the patient needs to sign all the required documents before discharge. Only medical expenses will be provided by R Care health. All the non-medical expenses are to be borne by the insurer.

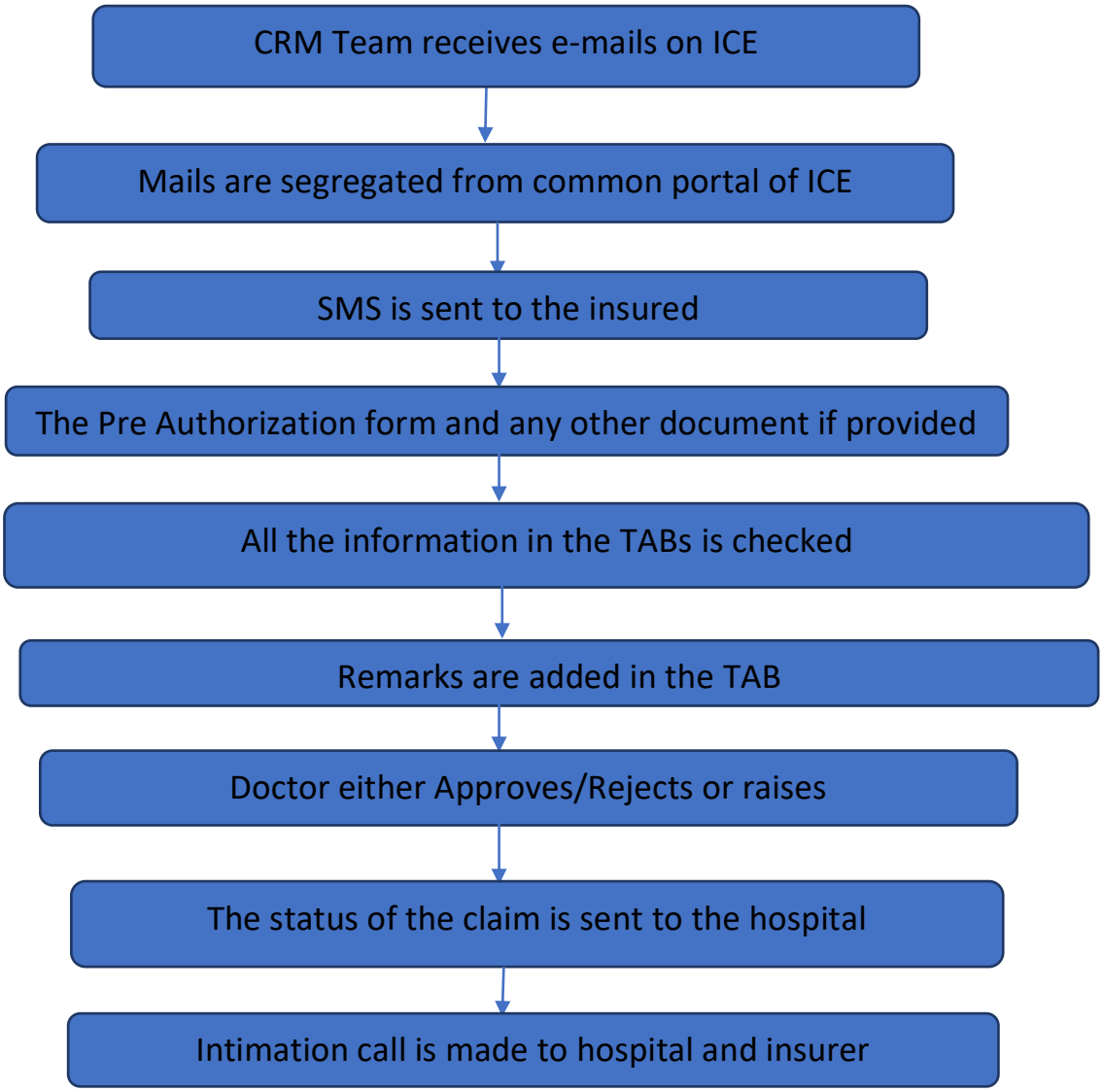
If the request is rejected customer can avail the treatment at the hospital. All the bills are to be paid by the insurer. They need to submit all the Original documents to R Care Health along with duly filled Claim form for probable reimbursement.

Patient needs to carry ID Proof, Past medical record (if required)

Cashless Team consists of

- Inward
- Executive
- Doctor's approval

PROCESS FLOW



REIMBURSEMENT

The process of Reimbursement as name suggests starts after the treatment is done and the patient is discharged. Patient gets admitted to the hospital, undergoes treatment and pays the hospital bills. Patient submits all the original documents to R Care Health along with duly filled claim form. R Care Health reviews the documents and take a decision based on the information provided.

In cases where the claim is approved payment will be made to the customer as per the policy terms & conditions

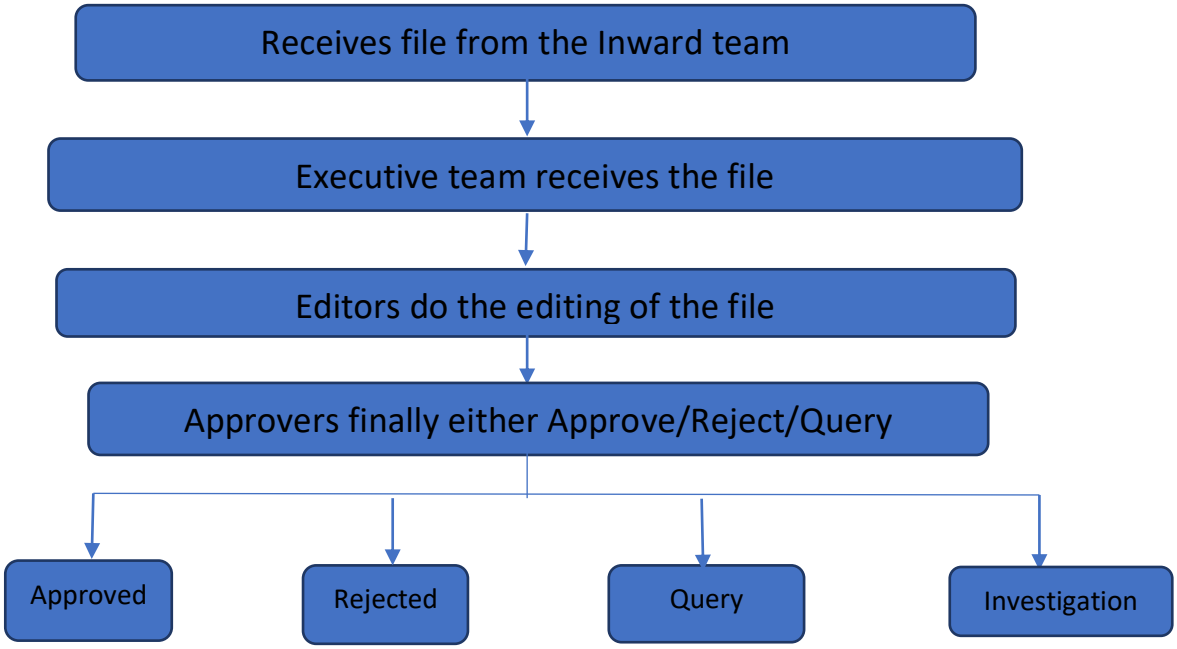
In cases where the claim is under query a Query Letter is sent for submission of required documents

In cases where claim is rejected a rejection Letter will be sent across along with reasons for rejection.

Reimbursement consists-

- Executive
- Editor
- Approver

PROCESS FLOW



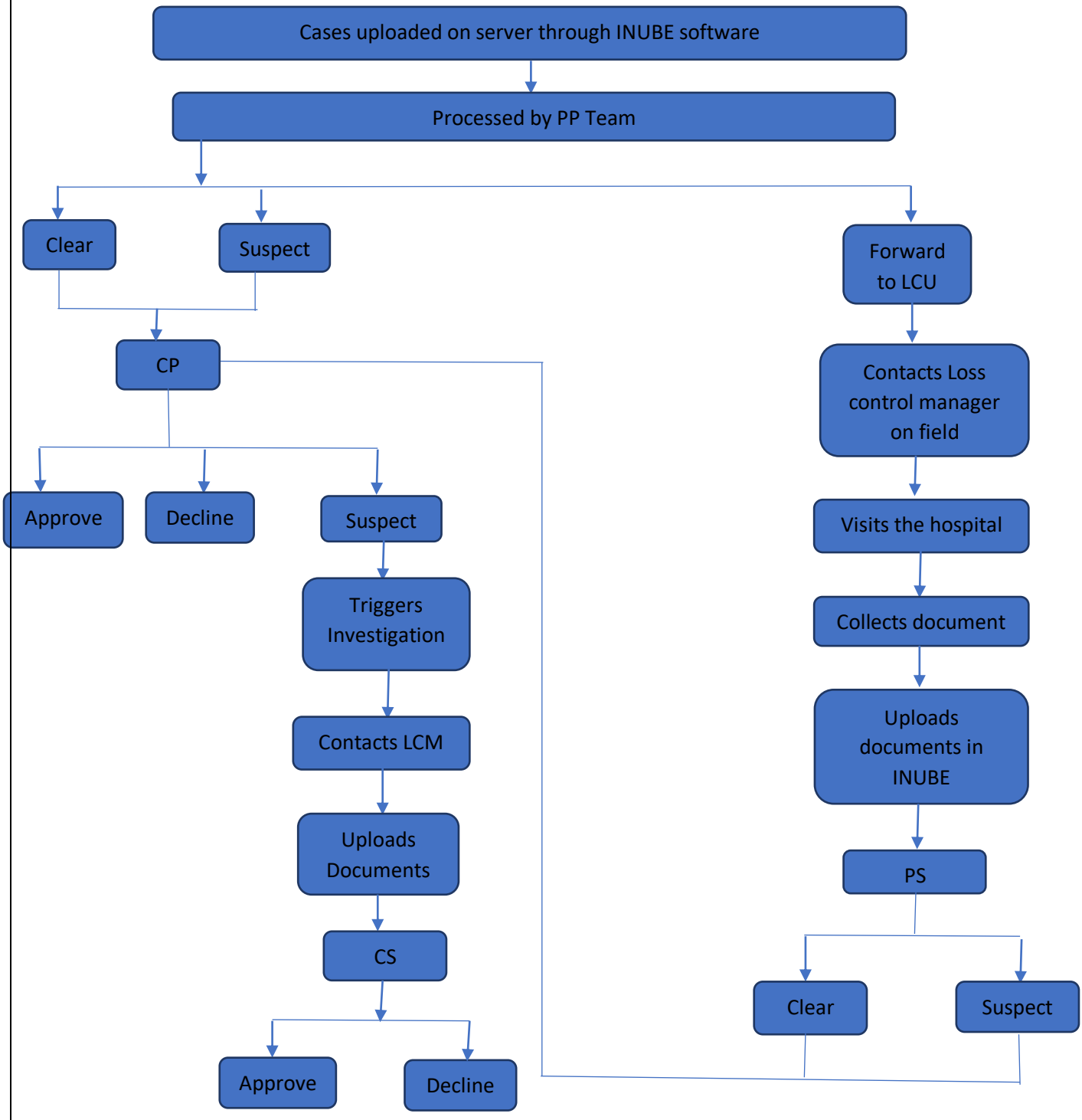
GOVERNMENT BODY UNIT-It includes Rashtriya Swasthya Bima Yojana empanelled hospitals.

PROCESSING- Processing consists of four parts

- Pre-Auth Processor- All transactions are processed at Pre-Auth. The processor downloads 301 dump at in the form of an excel sheet on daily basis to initiate claim processing. Analytical triggers run to identify common deviations, run medical quality check and take cases for claim investigation either clear or suspect the case.
  Investigate Cases- Pre-Auth team forwards the case to LCU.
  Clear Cases- to the Claim Processor Queue.
  Suspect Cases- to the Claim Processor Queue.
- Pre-Auth Supervisor- Investigates the case with investigator's report.
  Investigated cases- All claims are forwarded to LCU after the receipt of investigation report is received.
  Tag the case as Clear or Suspect case with remarks and forward it to Claim Processor queue.
- Claim Processor- All identified cases are clear or suspect from both Pre-Auth claims processor and. Supervisor.
  Analytical trigger identifies the duplication of claims, tracks claim history of each patient and family. Also identifies deviations.
  Analysis of investigator remarks and study of evidence by lines and co-relates with recommendations from Pre-Auth Supervisor.
  Claims are-
  - ❖ Approved
  - ❖ Partially Approved
  - ❖ Suspected
  - ❖ Rejected

- Claim Supervisor- Cases forwarded by Claim Processor for Supervision. Investigated cases tagged cases- All the claims under 'forward to LCU' processed by Claims Supervisor recommends further action as per evidences provided by investigator.
  Then forwards the approved cases to payment queue and in case of rejected ones auto-denial goes to the hospital.

PROCESS FLOW



RASHTRIYA SWASTHYA BIMA YOJANA is health insurance scheme for Below Poverty Line families with objectives to reduce Out of Pocket expenditure on health and increase access to healthcare. As per the Unorganized Workers Social Security Act 2008, by the Central Government to attenuate risks due to disability, maternity, old age and health shocks.

OBJECTIVES

- To provide financial protection against catastrophic health cost by reducing out.
- To improve access to quality health care for below poverty line households of pocket expenditure for hospitalization and other vulnerable groups in unorganized sector.

- The eligibility of the beneficiary is to have transportation charges of Rs 100/- per hospitalization and maximum charges of Rs 1000/- per year per family.
- For the purpose of registration, the beneficiary is required to pay Rs 30/- per year. As per the insurer selected by the State Government, both Central and State government divide their premium sharing ratio. It is based on competitive bidding. An agency called State Nodal Agency(SNA) is set up at every state in order to implement, supervise and partly finance the scheme with other stakeholders.

ROLES OF DIFFERENT ORGANIZATIONS

CENTRAL GOVERNMENT

- The payment from central government is 75%.
- The role of Central Government is planning, conceptualizing and implementing the scheme.
- Funding of premiums for the scheme.
- Setting parameters and guidelines (packages, empanelment criteria) and tracking and monitoring national level information.

STATE GOVERNMENT

- The payment from state government is 25%.
- The role of State government is implementing RSBY and setting up State Nodal Agency.
- Selection of Insurance companies through tender.
- Enrolment of beneficiaries.
- Contract management with Insurance companies.
- Tracking and monitoring State level information.

INSURANCE COMPANY

- Empanelment of healthcare providers.
- Enrolment and issue of smart cards.
- Claims processing and payment.
- Monitoring state level utilization and patient information.

CATERS TO:

RSBY caters to unorganized sectors:

- ❖ Licensed Railway Porters

- ❖ Street Vendors
- ❖ MNREGA workers (who have worked for more than 15 days during preceding financial year)
- ❖ Beedi worker
- ❖ Domestic workers
- ❖ Sanitation workers
- ❖ Mine workers
- ❖ Rickshaw pullers
- ❖ Rag pickers
- ❖ Auto/Taxi drivers

EXCLUSIONS

- OPD
- For evaluation purpose only
- Congenital diseases with defects or anomalies
- Diseases/accidents due to and or use or abuse of drugs alcohol or use of alcoholism.
- Sterility, any fertility, sub fertility or conception procedure.
- Vaccination and circumcision.
- Intentional self-injury or self-harm.

EXCLUSIONS UNDER MATERNITY BENEFIT CLAUSE

- Expense as a result of voluntary medical termination of pregnancy are not covered except in cases of accidents or other medical emergency in order to save life of the female.
- Normal hospitalization period is less than 48 hours from the time of delivery.
- Prenatal expenses treatment with respect to any complications which require hospitalization prior to delivery can be considered under procedures.

AIM- A study on unspecified package requests received from RSBY empanelled hospitals and to design specific packages.

OBJECTIVES-

- To design specific packages unspecified package requests.
- To identify district wise trends.
- To include the identified package in the package list.

UNSPECIFIED CASES-The packages which are not defined by RSBY scheme are called unspecified packages. To verify the unspecified packages the insurance company requires Unique Reference Number, available sum insured and adjudication of the request i.e., approval, rejection and query. The insurance company verifies the requested package and amount by the hospital, if required Insurance Company provides the different package amount and code is submitted to the hospital.

Processing of request at SCHIS level

Insurance company verifies the details

- URN and Member enrolment confirmation.
- Available Sum Insured.
- Insurance Company adjudicates the request- Approve/Reject/Query.

For Approved requests

The insurance company verifies the requested package and amount by the hospital, if required Insurance Company provides the different package amount and code is submitted to the hospital.

For Rejected Case

The Insurance company rejects the request on the below criteria and submit the response

- Sum Insured exhausted.
- Non-requirement of the treatment.
- Availability of the package in the RSBY package list.

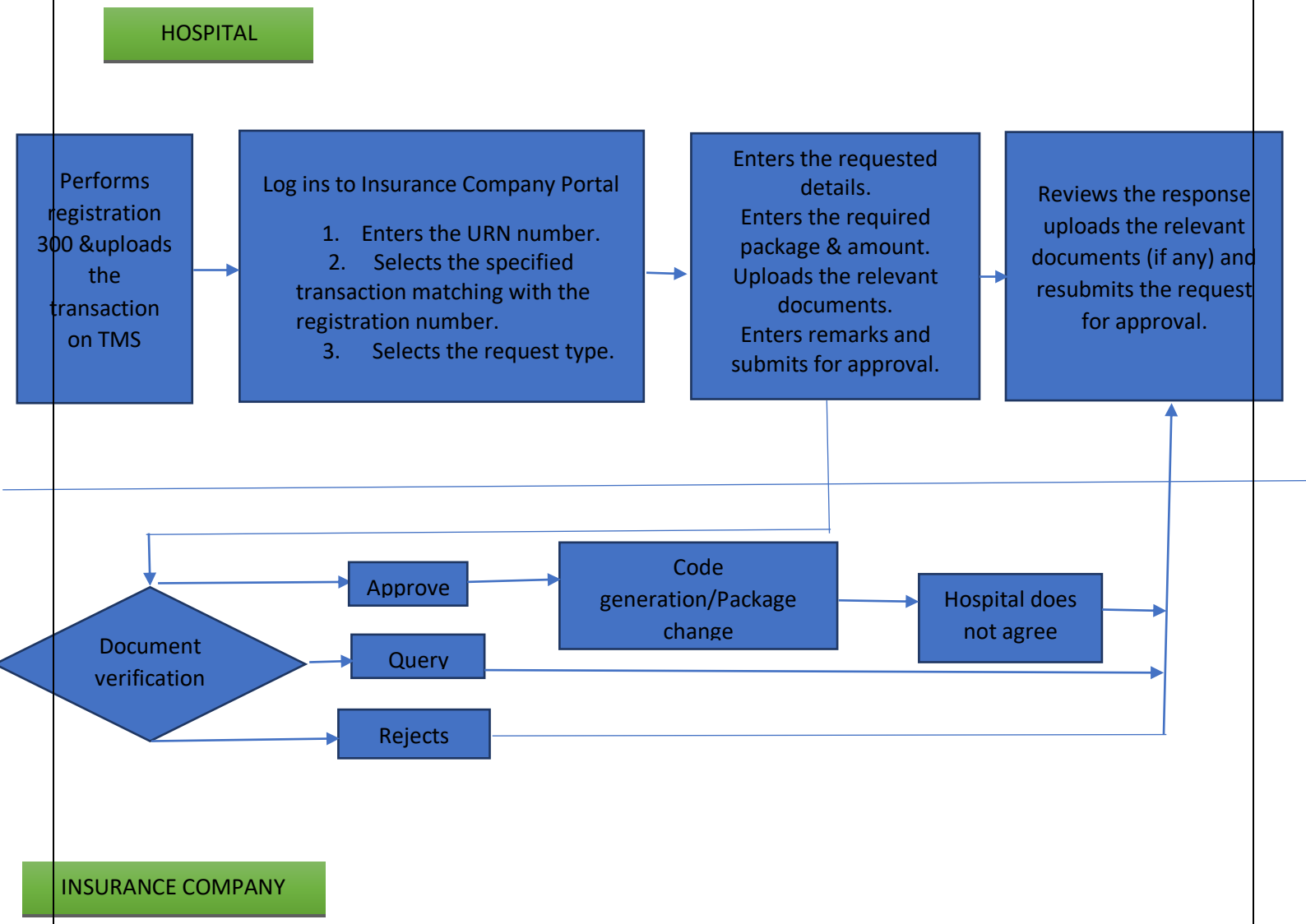
For Queried Case

The Insurance Company shall raise the query with the hospital.

Un-tag request

Hospital raises the request but tag it wrongly under different category, the insurance company shall un-tag the request. The hospital post un-tag shall raise the new request.

PROCESS FLOW



LITERATURE REVIEW

According to the current RSBY benefit package inpatient treatment facility is covered only at both primary and secondary levels. There are fifteen hundred procedures which are secondary. They are further divided into twenty-six categories. differentiated into twenty-six categories, including general surgery, ophthalmic surgery, radiology, and general medicine. Most of them are of secondary level even though primary level care is also given.

As per the package list of RSBY three levels of care has been provided which is primary, secondary and tertiary. It depends upon the treatment facility and specialist available. There are total seventy-eight services available at primary level.

The primary care level is important and will refer to advanced level of treatment if further required.

Depending upon the severity of disease level of care is provided. If more complications then proper treatment is provided. If lesser complications then secondary treatment can be carried out.

An experiment was conducted in the United States of America from 1971 to 1982 called The Health Insurance Experiment (HIE). This was basically a study on the cost sharing, service quality and service usage. Number of participants was 7700. This was the data collected from six cities in the United States of America. The primary objective of this experiment was to provide a balance between rural and urban healthcare. Many types of health insurance plan were included. This experiment mainly dealt with varying degree of cost sharing. It also focussed on the quality of dental and ambulatory services being provided.

After the experiment the result came out to be- average level of co-payment was achieved. There was twenty percent lesser hospitalization than with free care. Consumer in Health maintenance organization has percent fewer hospitalization than others. In cost sharing patients spent fewer money on healthcare.

Eichner 1998 carried a study on skewness on healthcare expenditure. In USA spending on healthcare is skewed. An average of fifty thousand dollars is spent in a year. Out of which the top ten percent of the beneficiaries account to three quarters of the total expenditure. (Berk & Monheit, 2001). Therefore, it is imperative to enforce health insurance

According to Cutler (1996) All the individuals were allowed for the adverse choice of insurance. Almost all health insurance systems where individuals are allowed choice of insurance have experienced adverse selection. According to Medicare beneficiaries chose managed care.

The federal employee health benefits program has adverse selection between more and less generous policies. The spread in premiums between more and less generous policies is sixty eight percent greater than benefits alone would dictate and almost every large firm that has employees choice has found the cost of most generous policies increases sufficiently rapidly than these policies are no longer viable.

Belli (2001) had discussions on the adverse selection of insurance. To eradicate the adverse effects suggestion was to subsidize insurance or to regulate it. Also, the regulation of private market by making changes in premium rates can cause further market instability. In a nutshell, to achieve patient satisfaction by giving them maximum options and to have better control over providers.

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In 2006 Wang et al. studied the rural areas of China which had accounted for voluntary health insurance scheme called the Rural Mutual Health Care (RMCH). They conducted study which included 3492 respondents from 1020 households. It was found that one-third of the household was partially enrolled. Even, though enrolment of seventy one percent of the rural area was achieved. But adverse selection existed in partially enrolled families only.

METHODOLOGY

STUDY DESIGN- Exploratory study

SETTING- Reliance General Insurance, Hyderabad.

DURATION OF STUDY- From 5th February 2018 to 4th May 2018.

DATA COLLECTION METHOD- Secondary data (The source of primary data is the insurers of RSBY empanelled hospitals. Data is hit on the RGICL server).

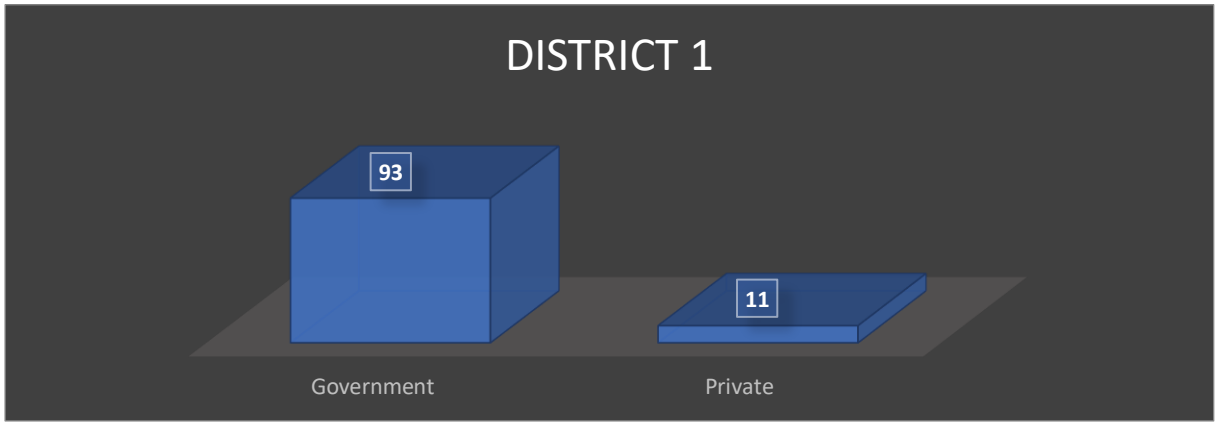
STUDY PARTICIPANTS- Beneficiaries of RSBY empanelled Hospitals.

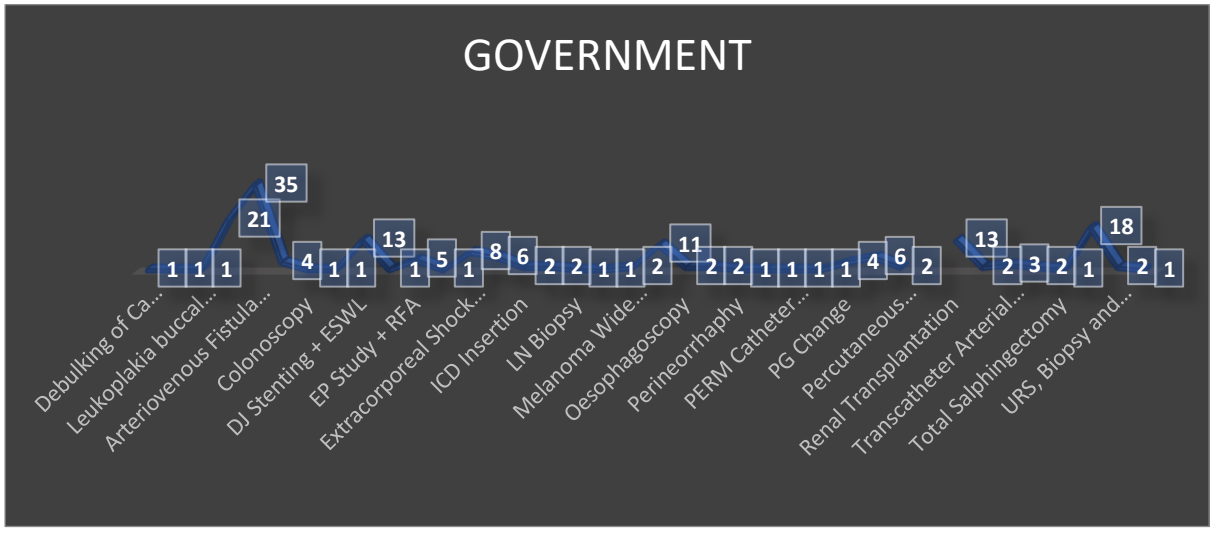
SAMPLE SIZE- 182

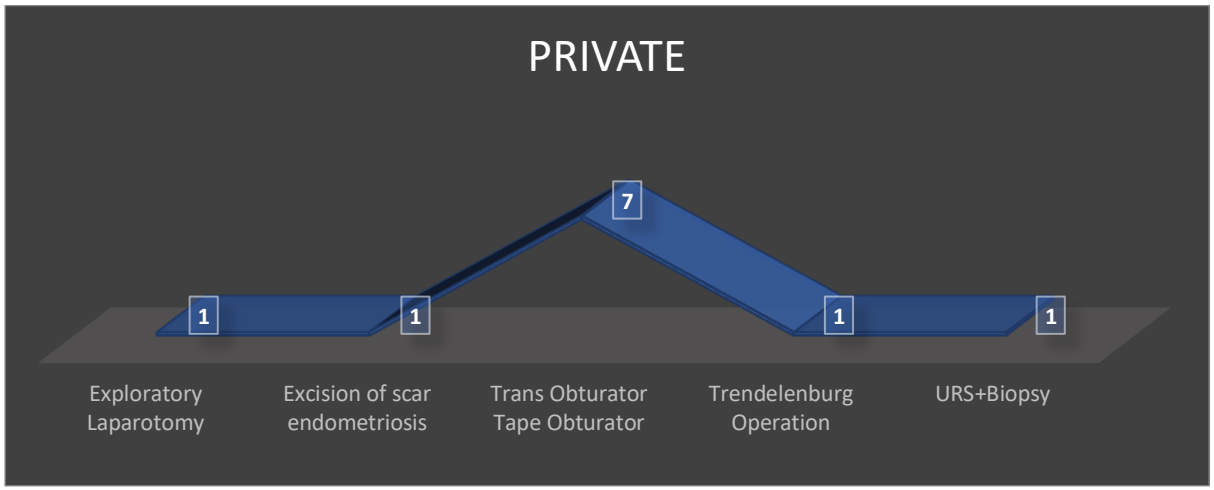
SAMPLING TECHNIQUE- Non-probability convenient sampling

*For the purpose of confidentiality of the data names of the districts have been referred to as District 1, 2,3 etc. The data been used for this project is taken from various state RSBY empanelled hospitals.

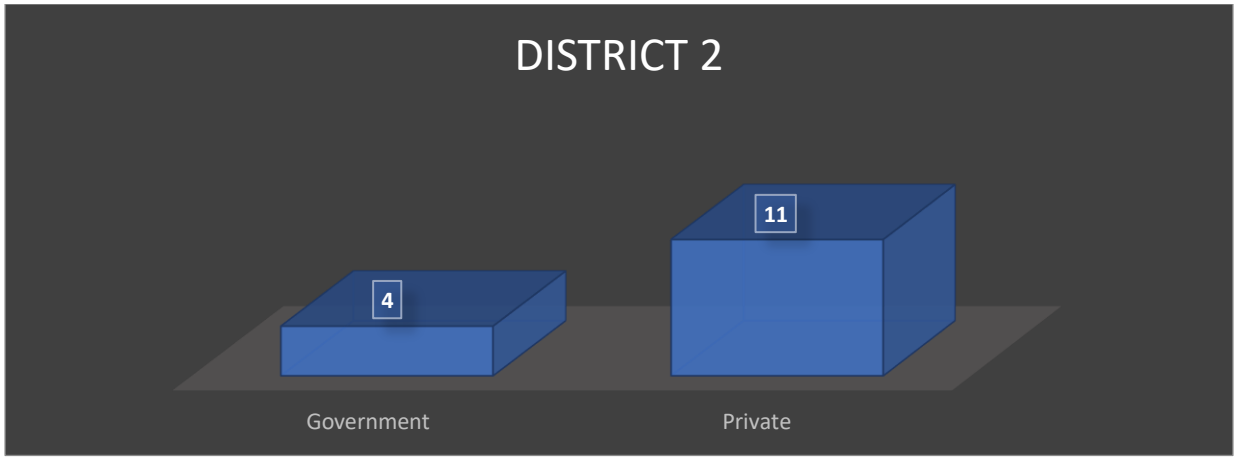
RESULTS

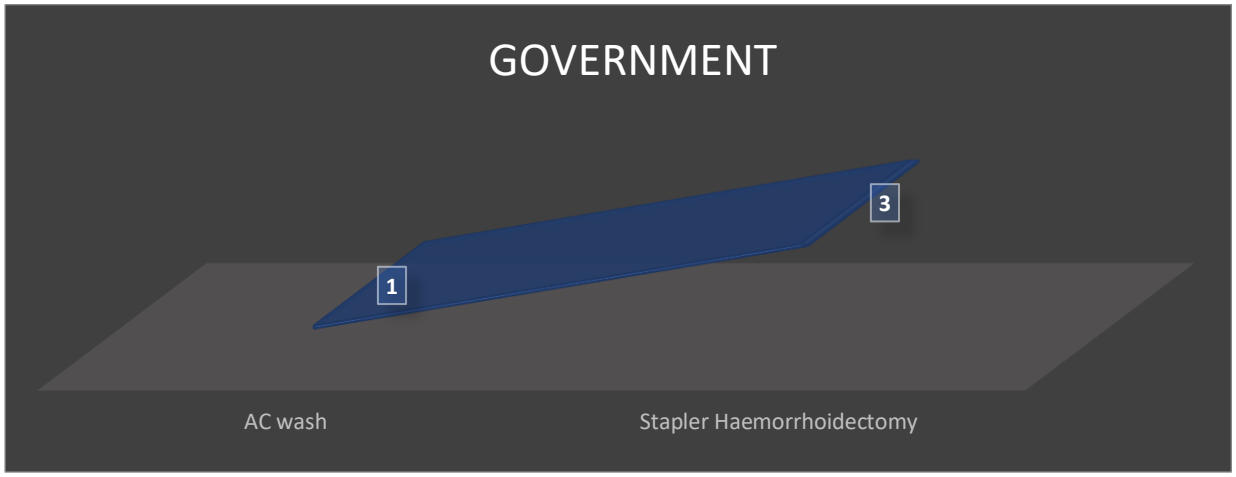


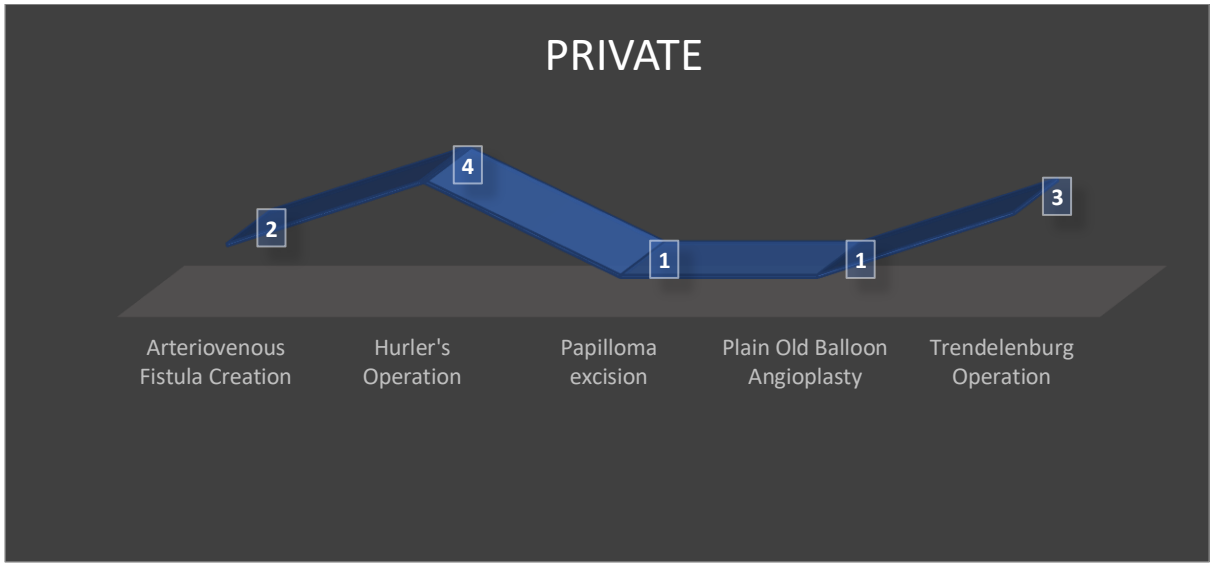




Government organizations in District 1 has highest trend for Arteriovenous Fistula Creation followed by Atrial Septal Defect Closure, Trendelenburg Operation, Renal Transplantation, DJ Stenting with Extracorporeal Shock Wave Lithotripsy and Mitral Valve Replacement whereas private organizations have shown higher number of Trans Obturator Tape Operation procedures







In District 2, private hospital has shown higher number of Hurler's Operation.

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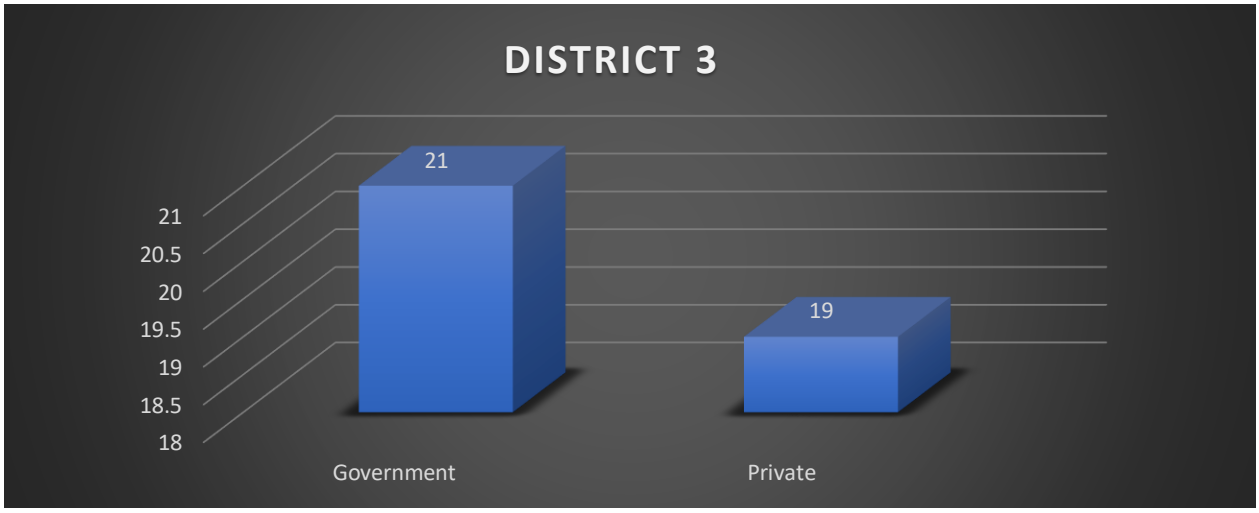
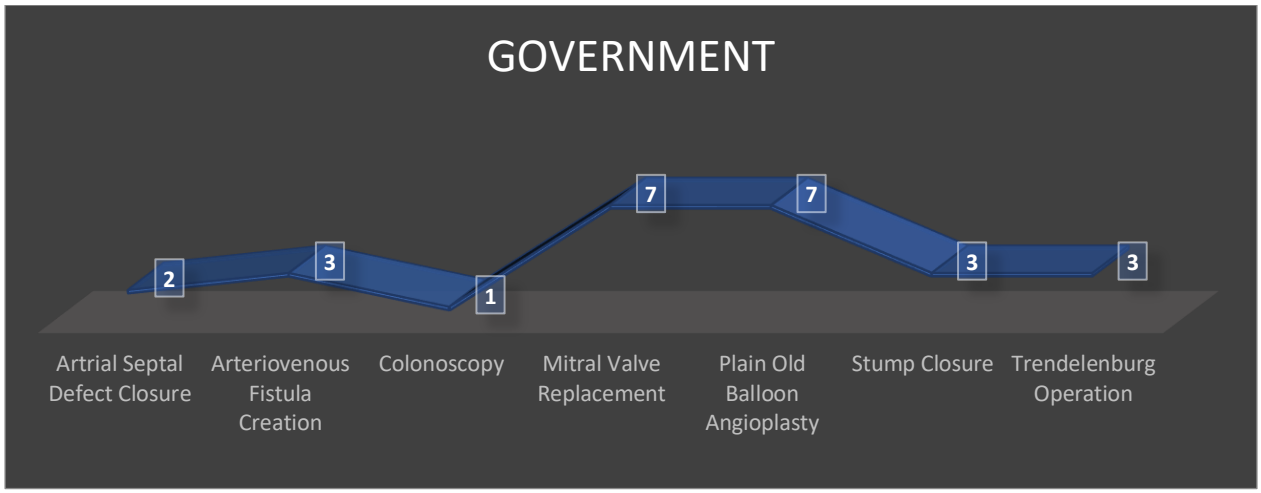
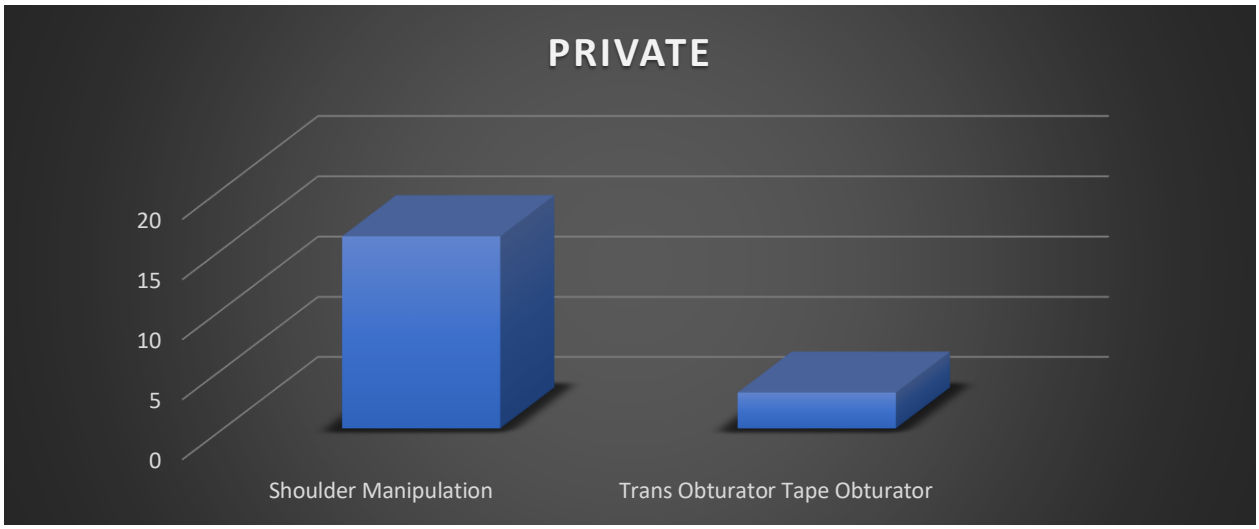
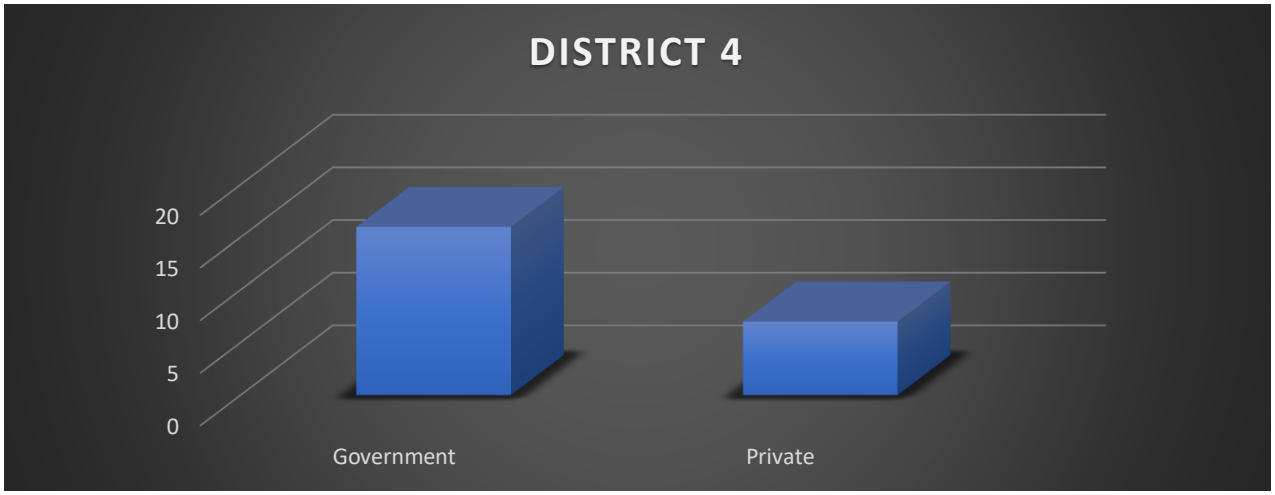
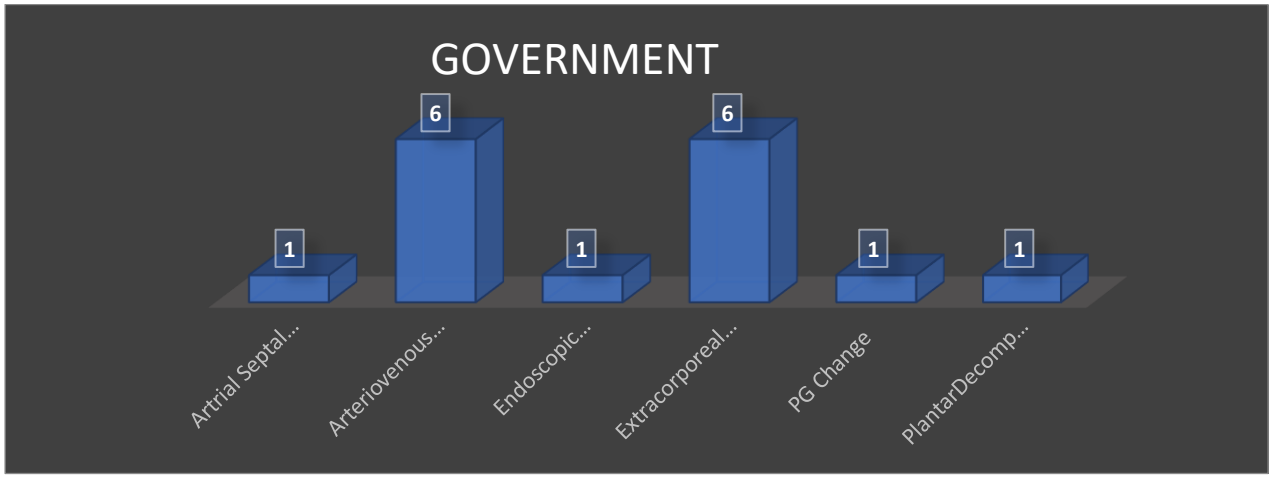


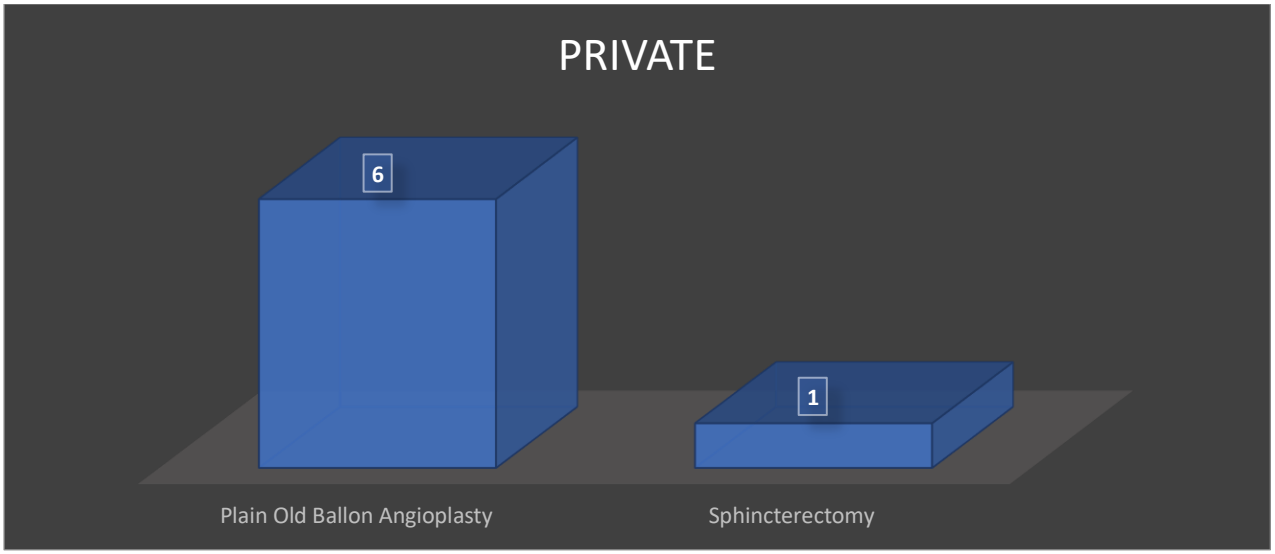




In District 3, Government organizations have shown higher number of Mitral Valve Replacement cases along with Plain Old Balloon Angioplasty whereas private hospitlas have shown higher number of shoulder manipulation cases.







In District 4, higher number of Arteriovenous Fistula Creation and Extracorporeal Shock wave Lithotripsy has been observed in government organizations whereas Plain Old Balloon Angioplasty has been observed in private organizations.

PACKAGE DESIGN FOR UNSPECIFIED CASES

Pricing and Package.xlsx

To design packages for the unspecified cases following points have been taken into consideration:

- Maximum number of unspecified cases from the sample size has been identified and specific package has been designed.
- Pricing has been done as per Central Government Health Scheme.

DISCUSSION

The factors affecting trends of diseases in particular districts and hospitals is dependent upon various determinants. These determinants are:

- Availability of resident doctors (specialists) in particular hospitals
- Availability of facilities of treatment.
- Availability of visiting doctors or consultants.

CONCLUSION

The primary reason for claims to fall under the unspecified category is unavailability of specified packages for the procedures. To address this need designing of packages have been done as per the amount allotted and according to the Central Government Health Scheme and other microinsurance companies.

The existing pattern of trends of diseases indicate that the increase in number of cases is dependent on various determinants which primarily includes availability of doctors and treatment facilities in the particular district and hospital.

INSTRUMENTATION

QUESTIONNAIRE

S.No.	QUESTION	
1.	How much time is taken for claims to reach the RGI server?	▪ Less than six hours. ▪ Six hours ▪ More than six hours
2.	What is the Turnaround Time for claim processing?	
3.	What are the reasons for processing delays?	▪ Approval from insurance companies. ▪ Base sum exhaustion
4.	What are the mandates to approve, reject or query a case?	▪ Check points
5.	What are various check points?	▪ Unique Reference Number ▪ Patient name ▪ Matching of transaction slip ▪ Case documents
	HOSPITAL REPRESENTATIVE (PRO)	
6.	What is the total strength of RSBY in hospital on data of audit	
7.	Are all the cards collected at the time of registration?	▪ Yes ▪ No
8.	What is the infrastructure of the hospital?	▪ Total No. of beds(OT/ICU/MICU/SICU/Wards)
	BENEFICIARY	
9.	What were the chief complaints at the time of admission?	
10.	When was the time of admission?	
11.	Was any surgical procedure performed?	▪ Yes ▪ No
12.	Was any money collected from the patient or bystander?	▪ Yes ▪ No

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