STUDY INTO THE WORKING OF AAFIYA TPA SERVICES, DUBAI

Dissertation
At
Aafiya TPA Services, Dubai

By
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Under the guidance of
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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 Dr Astha Soni student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at Aafiya TPA services, Dubai from 15th March to 14th May 2015.

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 fulfillment of the course requirements.
I wish her all success in all his future endeavors.

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This is to certify that **Dr. Astha Soni** holder of Indian Passport Number K4932977 was working in our institution as Management Trainee from 15th March 2015 till 15th May 2015, as a part of dissertation of her MBA in Hospital & Healthcare Management program. She has completed the assigned project.

We wish her all the best.

For Aafiya Medical Billing Services LLC

AKBAR MOIDEEN THUMBAY

Director
Healthcare & Retail Division

Aafiya

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

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **'A study into the working of Aafiya TPA services'** and submitted by **Dr Astha Soni,** Enrolment No. **1428** under the supervision of **Mr. Alok Mathur** for award of MBA Hospital and Health Management of the university carried out during the period from 15th March to 14th May 2015 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.

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Abstract

Title: A study into the working of Aafiya TPA services

Author: Dr. Astha Soni

Key words: Basic health plan, Participatory insurers, Dubai health authority, Agreed tariff

Introduction: The study focussed on the basic health system of UAE with main focus on Dubai. Under the new Health Insurance Law, health insurance was compulsory for all residents of, and visitors to, the Emirate of Dubai including all the free zones within the Emirate. It was permissible for insurers to provide enhanced cover over and above the DHA Health Plan. Only Participating Insurers were permitted to provide the Basic Health Plan which was mandatory by governing body of Dubai. Regulatory bodies were for controlling premiums and TPA was for controlling the cost of the treatments. TPA and insurance companies together work for better utilisation of premiums collected. Claims processing is an important step which affects the performance of a TPA and insurance company indirectly.

Objectives: To assess the functioning of various departments with respect to the standard working processes and to understand the status of claims in TPA.

Methodology: Source of data: Primary source was interviews and discussions with staff to understand the process flow and the complaints they receive from the providers and patients. Secondary source was from MIS/Toshfa utilization. Reports of 15th October to 31st March was downloaded to find out the number of claims under each category. 500 claim forms were selected on convenient basis during processing to find the disease burden. Study design was descriptive to understand the process flow and analytical to study reasons for rejection, types of cases, claims from each network and different types of diagnosis. Type of data was quantitative. Data tool for understanding the process, reasons for rejection and complaints was observing the steps and discussions with staff. For status of claims, data from MIS and selected files was taken. Data collected was number of OP and IP cases, number of claims from each network, reasons for rejection of claims, types of cases under OP, number of claims from each category of diagnosis.

Results: It was found that number of OPD claims were higher than IPD claims. Majority of cases were basic types. Under disease burden, respiratory cases and digestive system disorders were high. GMC group of hospitals cover majority of patients. Major reason for rejection of claims was providers not following agreed tariff.

Conclusion and suggestions: E-referral, E-prescription, E-claims, E-approvals (PBM) was to fasten the process and keep control on providers and TPA. Overutilization of services was checked as co-payment was per encounter of services basis. Premium was fixed for basic plans which controls the high premium taken from insurance company. Base agreed tariff prevented cost escalation from provider's side. Different networks for different income strata of people depending on premium, co-payments and annual limits so that cost was justified accordingly.

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(Dr. Astha Soni)

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List of Abbreviations

1. PEC-Pre-existing conditions
2. CH-Chronic
3. GP-General physician
4. SP-Specialist
5. PH-Pharmacy
6. DHA-Dubai health authority
7. TPA-Third party assistance
8. PBM-Pharmacy benefit management
9. IP- Inpatient
10. OP- Outpatient
11. HAAD- Health authority of Abu Dhabi
12. CPT-Current Procedural Terminology
13. ICD-International Classification of Diseases
14. NLGI-National life and General Insurance Company
15. UCAF-Universal card holder authentication field
16. GMC-Gulf medical centre
17. CEED-Coding edit engine of Dubai
18. ABP-Alternate base period
19. HR-Human resource manager
20. RM-Relationship manager
21. LLC-Limited liable company
22. GCC-Gulf Cooperation Council

INTRODUCTION

HEALTH INSURANCE

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement.

Risk is what insurance companies measure when determining whether to offer you an insurance and how much it will cost. More is the risk, more is the premium.

Risk Factors considered in Health Insurance:

- Eligibility status of the member
- Medical history
- Insurance Plan
- Network Coverage

Stakeholders involved

1. Employers/company-Pays for the cost of the insurance plan for its staff and eligible dependents.
2. Patients-Insured Members / Beneficiaries who are the end users of the health insurance plan.
3. Providers- Licensed professionals who provide medical services to insured members.
4. Payer-Insurance Company / Reinsurer who takes the risk of a potential loss.
5. Brokers-Retail side of the insurance who acts as the intermediary between the policyholder and the Insurance Company.
6. TPA-Organization that handles the administration process of a health insurance plan.
7. Government-Regulatory body that oversee the implementation of the country's health system.

Health insurance plan consist of

1) Benefits schedule-Provides an outline of the main provisions of the health insurance plan; includes aggregate limit, Geographical Scope, network providers, covered benefits, deductible, co-insurance, etc.
2) Covered services/ EOB (explanation of benefits)-Listing of major services covered under the plan; may also provide specific limits and requirements for some types of coverage.
3) Exclusions-List of items that are specifically excluded from coverage.
4) Terms and conditions-General and special arrangements, provisions, requirements, rules, specifications, and standards that form an integral part of the insurance policy; includes definition of terms, eligibility of insured members, reimbursement procedures, etc.

THIRD PARTY ADMINISTRATOR

A third-party administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.TPA handles the claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA.

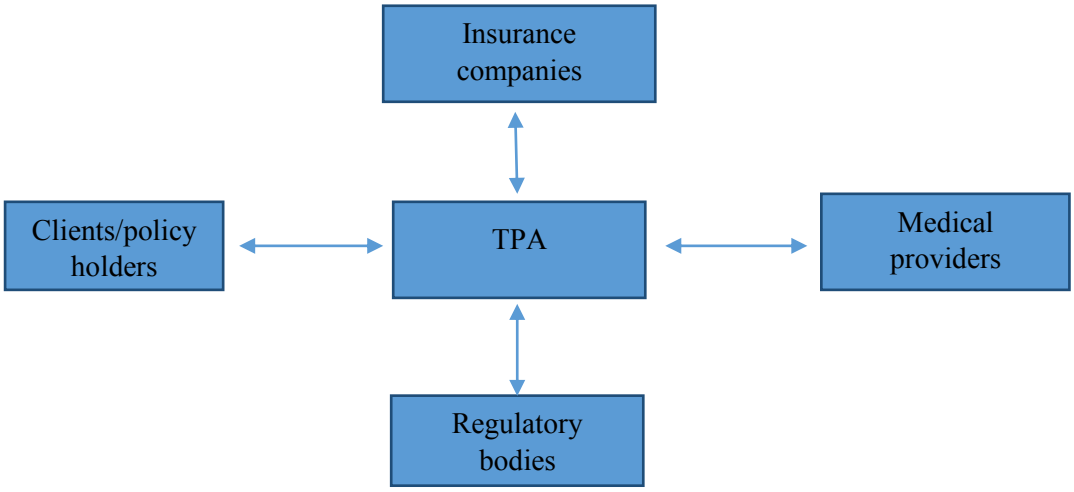
HR of company which has bought insurance policy for its employee deals with RM of TPA, who is connected with insurance company though broker

The concept of TPA

It was a costly affair for an insurance company to do the claims processing and also it needed expertise for this work. Hence a requirement for setting up a third party to do the needful. Insurance companies find the processing of claims to be a repetitive and standardized activity and use TPAs to outsource some of their administrative burden for a cost.

Stakeholders of health insurance

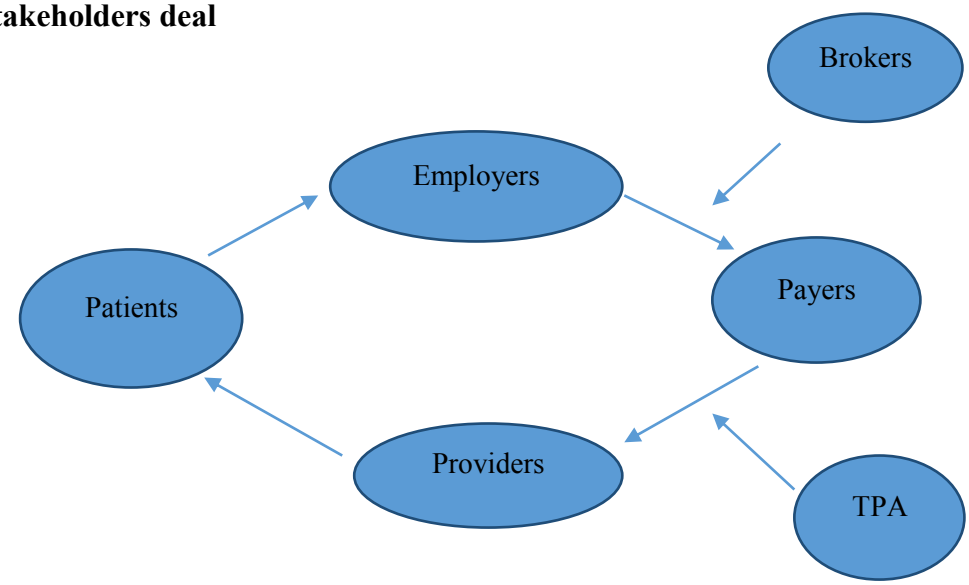
Fig1.1



TPA deals with brokers, who then sends information of plans and networks to the clients and to the insurance companies. Regulatory body prepares guidelines which are to be followed by providers, clients, TPAs and insurance companies.

Cycle in which stakeholders deal

Fig 1.2



HEALTH SYSTEM OF UAE

The UAE has 40 public hospitals.Dubai has 33 hospitals. Government hospitals in Dubai are Latifa hospital, Rashid hospital, Hatta hospital, Al Amal Hospital , Al Baraha/Dubai hospital, Al Maktoumhospital, and Al Wasl Hospital. Besides there are primary health care centres and speciality centres. There are 20 health centers & peripheral clinics in Dubai, offering a ratio of one health center or clinic for every 30,000 individuals. The Department of Health and Medical Services (DOHMS) of Dubai runs the Emirate's public health care.

The health sector is comprised of government and private facilities, and a free zone: DHCC (Dubai Healthcare City) which is a hospital free zone that offers international standard advanced private health care and provide an academic medical training center. Its governing body is Dubai Healthcare City Authority. It has a medical center, teaching hospital, the Harvard Medical School Dubai Center and the Boston University Institute of Dental Research and Education. DHCC is home to two hospitals, over 120 outpatient medical centers and diagnostic laboratories with over 4000 licensed professionals. Mohammed Bin Rashid Academic Medical Center (MBR-AMC) is the education and research arm of Dubai Healthcare City and aims to establish an integrated academic and clinical environment for excellent healthcare, education and research.

Effective January 2006, all residents of Abu Dhabi are covered by a new comprehensive health insurance program. Here costs will be shared between employers and employees. It’s a medical insurance cover for corporate groups (comprising employees and/or their dependents. Prior to 2007, government owned health care facilities were managed by the General Authority for Health Services, GAHS. In 2007, this authority was restructured into HAAD (Health Authority Abu Dhabi) which is responsible for regulating the healthcare industry and developing Abu Dhabi’s health policy. Abu Dhabi health Services Company, SEHA is responsible for managing government owned healthcare facilities in Abu Dhabi. SEHA manages 57 Primary Health Care Centers, 13 Hospitals, 3 Maternal and Child Health Centers, 3 Specialized Dental Centers, one center for Autism, and 5 Specialized Facilities like rehab, blood bank and herbal center.

MOH is a regulating body for public and private healthcare facilities in the Emirates of Sharjah, Ajman and the rest of the north emirates, also few public facilities in Dubai like Al Baraha Hospital and Al Amal Psychiatric Hospital.

HEALTH INSURANCE IN UAE

Mandatory Health Insurance(2013)states that all residents and visitors to Dubai must have a minimum of basic healthcare coverage by 2016.Dubai's Universal Health Coverage (UHC) is based on mandatory enrollment through employment, which will remove the burden of financial considerations for the patient. A hospital can be in link with more than one TPA. Some of the TPAs in UAE are Musalla net, penta care, med net, next care, fortune care, neuron, wap med, nasetc

Three regulating bodies governing health insurance system are

1. MOH/Ministry of health-for Sharjah,Ajman,Ras al khaimah,Fujairah,Um Al Quwain
2. HAAD/Health Authority of Abu Dhabi-for Abu Dhabi and Al Ain
3. DHA/Dubai Health Authority-for Dubai

HAAD claims & adjudication rules

Mandatory tariff pricelist is applicable to all health insurance products regulated by the health insurance scheme. Mandatory prices correspond to the gross amount due to the healthcare providers for services performed for insured patients. Patients will need to pay a patient share while the payer is to pay the remaining net amount. Medication/Drugs, blood and blood products are not subject to 1 to 3 times the mandatory tariff range, and therefore must be charged at the set rate. For all other services and codes, providers and payers are permitted to negotiate multipliers per service category (Laboratory, Radiology etc), or CPT codes range but not allowed to negotiate individual price per service code. Multiplier must fall within the range of 1 to 3 times the Mandatory Tariff.

According to DHA

- By 2014, all companies with more than 1000 employees be covered under health insurance.
- By 2015, companies with more than 100 and less than 1000 employees be covered.
- By 2016, companies with less than 100 employees and their dependents be covered

Insurance System for Advancing Healthcare in Dubai (ISAHD) is a comprehensive initiative of the Dubai Health Authority (DHA) intended to provide sustainable high quality healthcare. Insurance companies and TPAs have already started registering with the DHA to obtain their DHA Health Insurance Permit (HIP). This process will facilitate the provision of a variety of quality health insurance packages for employers and sponsors that meet their needs and are compatible with the mandate. All providers of Dubai must be registered on E-Claim Link and submit their healthcare related transactions through the Dubai Health Post Office (DHPO).

Online services by DHA

1. Online transactional service provide following services: issue new health card, health card renewal, setting upcoming appointment reminder, health card expiry reminder and online change of address, check-up, appointments, request a medical report and other services.
2. Online Licensing Services- For obtaining license to practice in Dubai by medical professionals using the DHA's online licensing system.
3. Birth and Death Notification System
4. Infectious Disease Notification System

ENAYA scheme

The Government of Dubai Employee Healthcare Benefits Scheme for employees' of Dubai as well as their families' health

Benefits:

1. Maternity-Under ENAYA, expectant mothers and their babies are cared for from the start of the pregnancy to birth and afterwards.
2. Pre-existing and Chronic Diseases.
3. Disease Prevention-Routine periodic check-ups and vaccinations are fully covered and can be availed at DHA facilities.

For Dubai basic plan

Per person minimum premium was fixed at 600 by DHA. Seven Permitted insurance companies were selected to sell this plan. Minimum premium decides by Takaful was 625 depending on its administration and other cost. Unconditional TPAs can join with these seven insurance companies. People with salary less than 4000 can avail services from any of these seven insurance companies.

There are coinsurance and co-pay for patients in basic plan. With the enhanced plans the premium increases and co-payment decreases along with this there is cap for co-pay. Example, for cost of drugs the annual limit is more for enhanced plans. Per visit limit for drugs also increases. In enhanced plans chronic conditions are covered from the start of policy whereas in basic plan it's covered after six months that is there is a waiting period.Maternity is covered in basic but there is no coinsurance for it in enhanced plans. More number of hospitals are available in enhanced plans. People of high net worth usually go for enhanced plans and higher networks.

For northern emirates

MHO plans through NLGI.

Plans of DHA and MHO differ in terms of maximum aggregate limit patient can avail of, coverage of different services(example maternity), co-payments, SP consultations, chronic limits etc.

E-claim portal by DHA

E-claims is an electronic platform launched in January 2013, which connects the providers and the insurance companies via a DHA hub. It includes-

1. E-claims-Monthly e-claims will be submitted by the providers. By DHA it was first started in 2012 for neuron TPA for Enaya policy. With this e claim, there is no need of submitting the claim forms (hard copy) to TPA on monthly basis. It is less time consuming than paper claims. Only clinics need to send the monthly claims.
2. ERX-From the e-claim portal, drugs and diagnosis is selected by the provider. He prepares prescription and gives numeric code to the patient. This is a unique code.
3. PBM- It's a software called pharmacy benefit management. With the unique code, the patient goes to pharmacy. Pharmacist opens PBM and submits this code. He goes through the details of the patient like the network, policy and approval limit of the patient. He will submit the approval request to TPA through a code which is unique to a TPA for payment of claims.
4. E referral- At first patient has to go to GP and only then he will be referred to SP through e referral.
5. E authorisation-For any lab tests, x ray and for all the services approval is given online.

Dubai medical coding system by DHA

1. Dubai service list(DSL) –It's for consultations, room and board, ICU
2. CPT code/Current Procedural Terminology–For medical procedure, investigation, lab, radiology. This number is of 5 digits. It is send by provider.
3. CDT/Code on Dental Procedure-Code is for dental and this code is universal (given by ADA). It has alphabet D followed by 4 digits.
4. HCPCS/Healthcare Common Procedure Coding System-Its alphanumeric (letter and then a number) code– it's for consumables and supplieslike cannula, syringes etc.
5. ICD/International Classification of Diseases-It's for diagnosis
6. Dubai drug code-For drugs

Healthcare financing schemes

1**.** Government schemes and compulsory contributory health care financing schemes
   a) Central government schemes
   b) Local/state government schemes.

2. Voluntary health care payment schemes- Employers funded the health care system,via the health insurance companies. Both insurance and corporations other than insurance that is private companies pool fund.
   a) Voluntary health insurance schemes
   b) Enterprise financing schemes

3. Household out-of-pocket payment

Health insurance companies

Some of the PSU/Semi private(subsidised by government) insurance companies are

1. Oman insurance company-life, medical, general insurance (motor, property, energy etc.). OIC has operations across most Emirates in the United Arab Emirates, as well as in Oman, Qatar and a subsidiary in Turkey). Its head quarter is in Dubai.
2. The National Health Insurance Company Daman-A non-life insurance company that is 80% owned by the Abu Dhabi government with the remaining 20% owned by Munich Re. As health insurance is mandatory for all residents in the Emirate of Abu Dhabi, HAAD offers a basic coverage plan also known as Abu Dhabi Basic Plan which is managed by Daman.

Other than participatory insurance companies, other insurance companies are Al Buhaira national insurance, Dubai Islamic,Abu Dhabi national insurance company(ADNAIC), Dubai Insurance Company, Qatar Insurance Company, Al Fujairah National Insurance Companyetc.

Risk factors to be considered for health insurance are age, gender, marital status, medical history of patient. Not more than 70 years of patient be covered but according to government of Dubai there is no age limit to cover a member under basic DHA plan.

MARKET OF HEALTH INSURANCE

The growth of health insurance premiums in the Gulf region, which involves massive government expenditure each year, is the highest in the world. Every year average insurance premiums rise anywhere between 10 and 16 per cent in the UAE. Regulation of premiums is essential for stability and sustainability of the health insurance market. Medical inflation was also an issue. DHA will approve price increase of medical services based on 136 indicators, including performance such as readmission rates, patient satisfaction, clinical outcomes and external economic factors such as cost of staffing, rent and the availability of new medicines. Categorising people on their salary so that not everybody is charged the same price.

The DHA expects insurers to set an index rate in respect of premiums charged for the Basic Health Plan. It is between AED 500 to AED 700 per month / per year. Premiums are only allowed to vary by +/ – AED 25 from the index rate. The index rate needs to be approved by the DHA prior to a health plan being launched and sold in the market. Compliance with the compulsory health insurance requirements is linked to the Emirate's immigration and trade licensing processes, which requires employers and employees to provide suitable evidence that they have local health insurance in place in order to obtain trade licenses and residency visas. Financial penalties are imposed on employers who do not comply with their obligations under the law to provide insurance to its employees.

While Abu Dhabi has state-backed Daman insurance as the primary provider for low-income individuals in the emirate, the Dubai government has chosen seven preferred insurance providers to cover people earning AED 4,000 per month or less. Dubai follows an open market route and allows private insurers to provide both the essential and enhanced plans. DHA has imposed requirements that all payers (insurers, TPAs or brokers) should have registered with or obtained a DHA permit in order to continue to deal with DHA registered healthcare providers. In order to apply for the permit, it is necessary to ensure that insurers, TPAs and brokers comply with DHA and UAE insurance authority requirements. Insurers needs to apply to become "Participating Insurer". Applicants need to demonstrate their ability to meet certain general and technical requirements including in relation to their capacity; complaints handling procedures; data security; financial reporting; policy wordings / benefits schedules; staffing; training and competence; reinsurance and minimum retention (30 per cent) requirements; complaints ratios; underwriting performance etc. Although all insurers are permitted to provide health insurance in Dubai, only participating insurers are permitted to provide the Basic Health Plans.

The UAE has been the fastest-growing insurance market among the GCC states, with a compounded annual growth rate (CAGR) of 17 per cent over the past six years. There will be an increase in outpatient, inpatient markets and number of beds in hospital. This will be a boost for investors. Also medical tourism industry has grown.Premium flow will increase due to mandatory policy, giving more business to TPA. The more is the negotiating power of a TPA for base rates with providers, more business it brings to the TPA and the health facilities. TPA gets some percentage of premiums which will increase with increase in lives. Inefficient members (TPAs) who are not able to negotiate or coordinate with brokers or not fulfil the criteria of DHA, exit from the market. Those who fulfil the criteria of DHA and could collaborate with licensed insurance companies can sell the DHA plan and have good market in health insurance.

PROBLEM STATEMENT

Health insurance is a service which is provided in collaboration with doctors and his technical staff, administration of hospital, third party insurer and an insurance company. In order to solve the issues concerned with the claims processing, it's important to understand the basic functioning of a TPA and how a health system in a country work. There is a system consisting of different departments and their work. Issue at any department involved in the process flow can become a reason responsible for delay in processing. An understanding of the process responsible for settlement of claims helps in reducing the errors in future.

RESEARCH QUESTION

1. What are the departments of Aafiya, TPA working in Dubai under Thumbay group and their functions in order to understand the process flow?
2. What are the reasons responsible for rejection of claims?
3. What is the pattern of utilization of services by member?

OBJECTIVES

1. To assess the functioning of various departments with respect to the standard working processes.
2. To understand the status of claims in TPA

LITERATURE REVIEW

In the U.A.E., there are five government healthcare regulators: the Ministry of Health, Ministry of Finance, Federal Health Insurance Authority, Dubai Health Authority, and the Health Authority Abu Dhabi. U.S. partnership with U.A.E. healthcare entities include Children's National Medical Centre, Cleveland Clinic Abu Dhabi, GE Healthcare, and Johns Hopkins.

Due to high health expenditure, U.A.E. government agencies went with public-private partnerships and foreign direct investment. In 2010, a requirement in Abu Dhabi was enacted for all hospitals and insurers to bill on a diagnosis rate group (DRG) system. This requirement, plus other measures such as standardized contracts, is expected to slow the rising cost of medical services.

Under mandatory health insurance schemes, companies get health insurance permit license from DHA. Daman is the first and largest specialized federal health insurance company to be formed in the UAE. In 2011, a study by insurance companies estimated that misuse accounts for 30 percent of the nation's healthcare costs. People are kept longer than necessary in a hospital or an ICU. These things are daily issues that insurers face and they need to be protected. It is estimated to add 10 per cent to medical premiums across the globe.
The private sector provides 54% of out-patient services in the emirate. Growing cost of medical care, no uniformity in cost of treatment, and burden of NCDs called for strong insurance system so that healthcare becomes affordable. Other than CVD, injuries, cancer

and respiratory disorders are main public health issues. Currently, only a third of Dubai'spopulation of three million is insured.According to International Diabetes Federation estimates,9 >US$5.5

billion is spent annually on diabetes mellitus in the Middle East and Africa region, amounting to almost 14% of the health budget.

GDP per capita in the GCC has grown at a CAGR of 6 percent between 2000 and 2009. Over the ten-year period, health expenditure per capita has grown at an annualized rate of 7.9 percent for the GCC nations as a whole. Kuwait's health expenditure per capita grew at 10.8 percent per annum. In absolute terms, Qatar's health expenditure per capita was the highest, despite the fact that the amount as a proportion of GDP was the lowest in the GCC. The Saudi Arabian Ministry of Health has made it mandatory for Haj pilgrims to be vaccinated against communicable diseases including yellow fever, cerebrospinal meningitis fever and polio.

A number of public health issues, particularly non-communicable diseases, significantly contribute to morbidity, mortality, and economic losses in the UAE like CVD,cancer,injury,respiratory diseases. UAE population has increased substantially over the past four decades, and this is primarily due to the high net inward migration of expatriate workers. Key health indicators of the UAE, Fertility& life expectancy in the UAE, communicable diseases in the UAE

MSH International (Dubai) is the first UAE based third party administrator (TPA) entirely dedicated to managing personal insurance for people living and working in the GCC and MENA regions. Mandatory health insurance system called ISAHD (Insurance System for Advancing Healthcare in Dubai) is available with seven insurance companies - Oman, MetalifeAlico, Daman, AXA, Orient, Takaful andRas Al Khaimah national insurance companyThese participatory insurance companies can sell basic plan for low salary bracket (LSB) employees (gross salary of less than 4000).An electronic website for health insurance claims ensured minimum fraud and abuse by providers.

All organizations that offer coverage to employees also offer coverage to family members, although such coverage is less likely than individual coverage to be fully financed by the employer. some employers are deliberately encouraging their employees to switch their coverage to a spouse's plan. Federal law imposes a payroll tax on employers (and employees) to help finance Medicare benefits and Social Security Disability Insurance. Workers' compensation benefits are required under a combination of federal and state laws. All but three states require employers to provide workers' compensation benefits, which are cash payments for workers killed, injured, or made ill in the course of work.

METHODOLOGY

Primary source of data

Interviews and discussions with the staff of TPA to understand the process flow and the complaints they receive from the providers and patients

Secondary source

From MIS/Toshfa utilization reports of 15th October to 31st March was downloaded to find out the number of claims under each category.

Some of the claim forms(500) were selected on convenient basis during processing to find the disease burden.

Study design

Descriptive to understand the process flow and analytical to study reasons for rejection, types of cases, claims from each network and different types of diagnosis.

Type of data

Quantitative

Data collection tool

For understanding the process, reasons for rejection and complaints; observing the steps and discussions with staff was done along with the data from MIS and files selected.

Data collected

- Number of OP and IP cases
- Number of claims from each network
- Reasons for rejection of claims
- Types of cases under OP
- Number of claims from each category of diagnosis

Ethical consideration

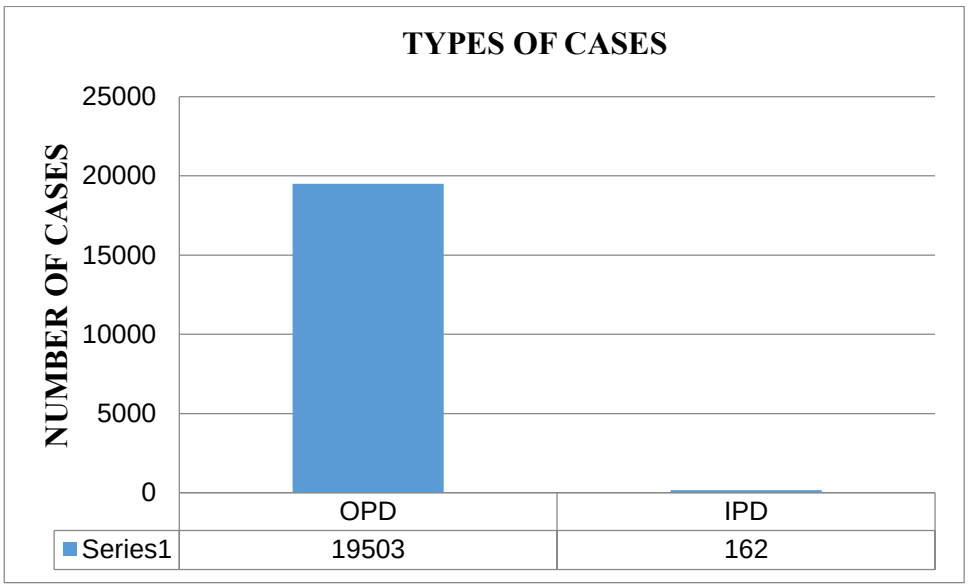
Purpose of study was explained to staff and confidentiality of data collected was taken care of.

RESULTS AND DISCUSSIONS

Findings of the study

1) **Type of cases-**Both OP and IP medical claims are processed by the TPA. By the time the TPA started functioning in October 2013 till March 2015, total number of claims received were analysed. Data from 15th October to march 31st was taken. To find out which type of cases are received more in number this data was taken.

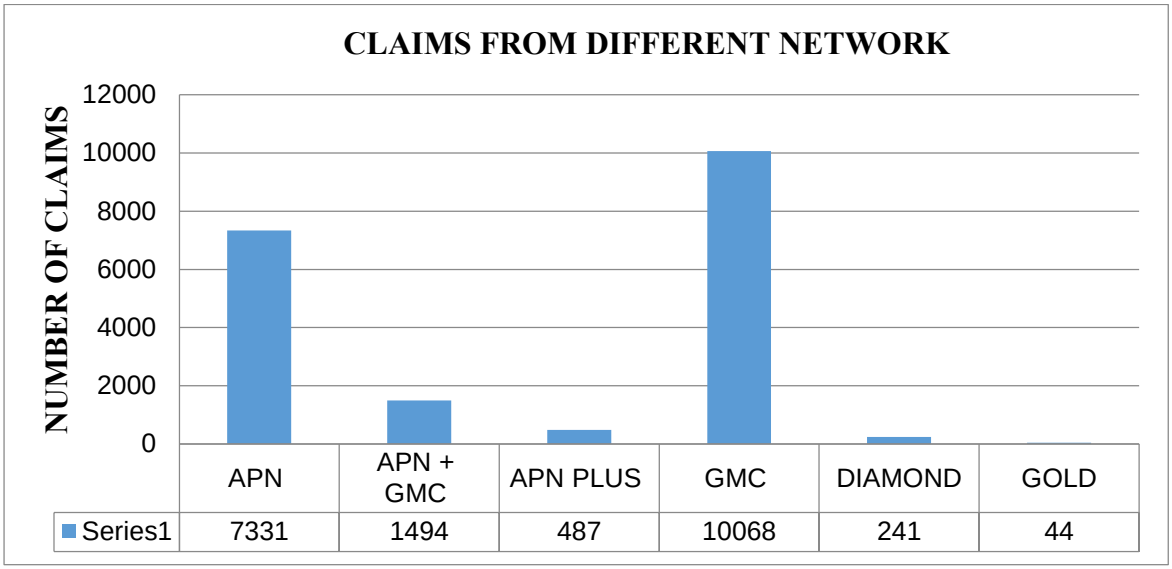
Figure 1.3



Interpretation: It could be seen from the graph that majority of cases were of out-patient departments.

2) **Network category**-To find out majority of claims received are from which network, data was analysed.

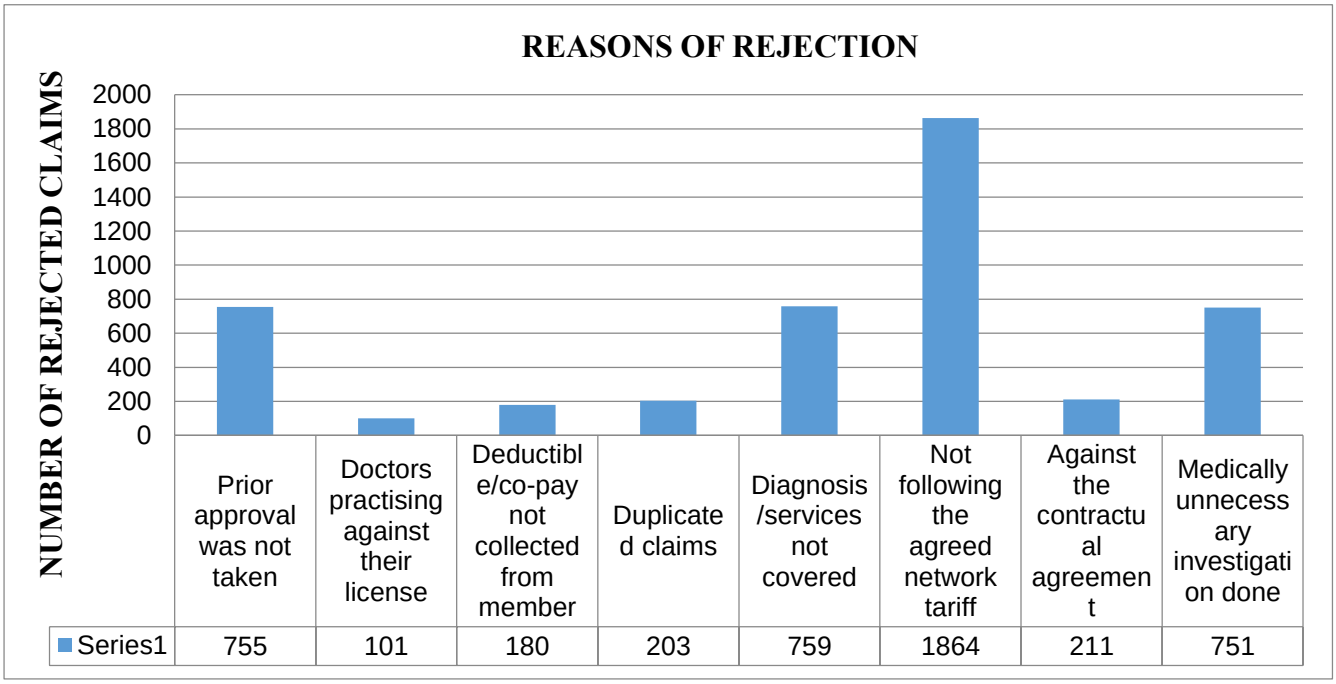
Figure 1.4



Interpretation : Majority of claims were from GMC network and then from APN network. APN plus, diamond and gold were few comparatively. Network covering only GMC group of hospitals is highest, showing preference of people and the level of services provided in GMC group. More affordable network for labour class is APN. They were utilising the services more when compared to others.

3) **Reasons of rejection-**To find out various reasons responsible for rejections and to get an idea which reason is responsible for majority of claims rejection, the reasons were analysed.

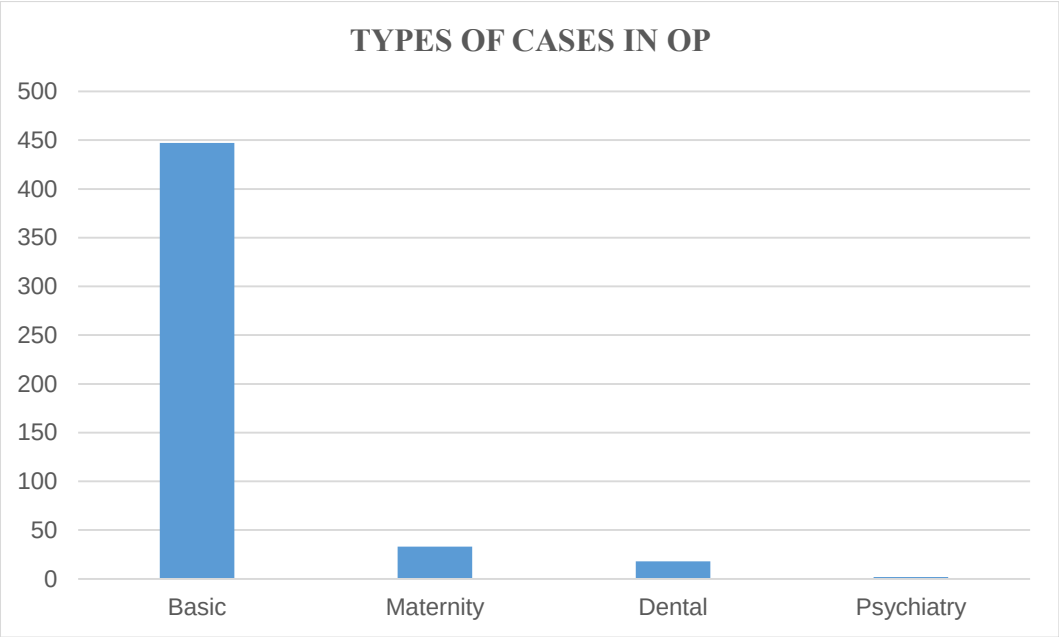
Figure 1.5



Interpretation: Majority of rejections were because of doctors not following the agreed base rates. When doctors charge more and claim for higher amount (requested claimed amount/RCA is high) than that was agreed with TPA, claims get rejected. At time of reviewing the claims, calculation discrepancy comes.Next was the reason of services or diagnosis not covered according to the policy. Against the contractual agreement refers to going against what was decided between TPA and providers like submitting claims beyond 60 days of duration or not resubmitting in 28 days, or service taken by non-network provider etc. Doctors practising against their license comes least where in SP act as GP or vice versa, hence claims got rejected.

4) **Types of cases in OP**-Out of 500 claims randomly selected during claims processing, diagnosis types were analysed.

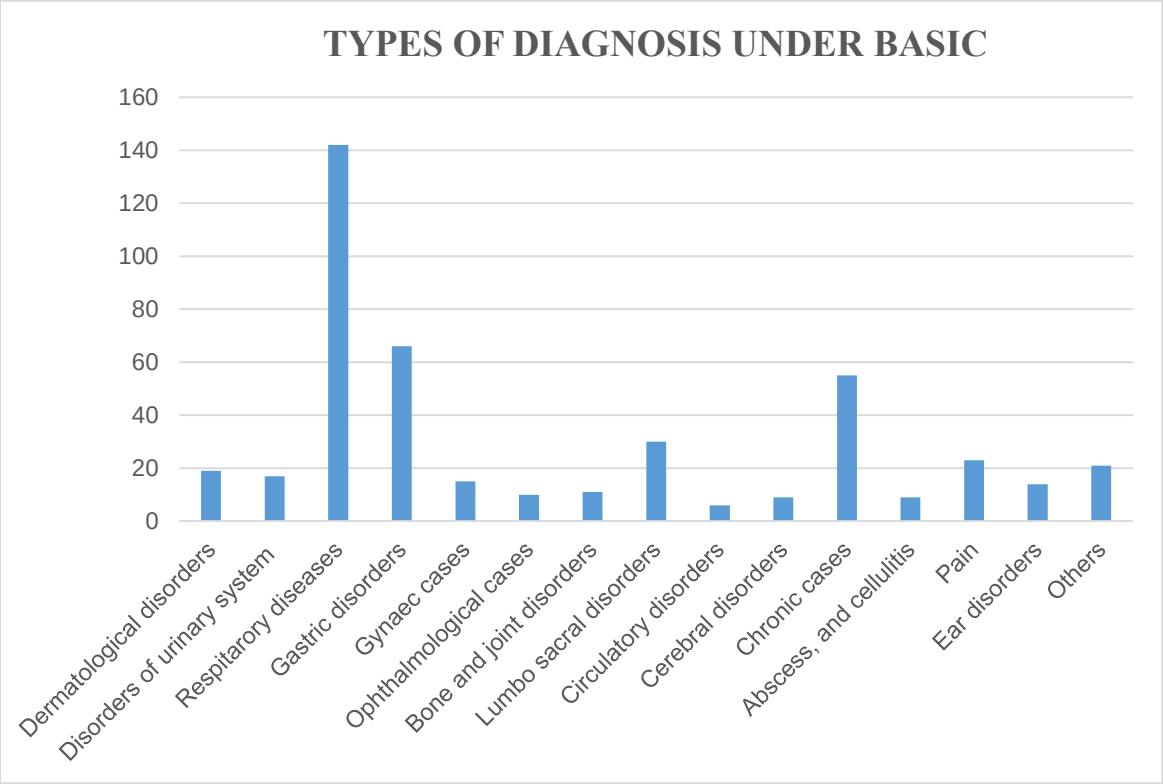
Figure 1.6



Interpretation: Majority of diagnosis belonged to category of basic. Next were maternity and least was the frequency of psychiatry cases.

5) **Types of diagnosis under basic type -** In order to understand majority of claims belongs to which type of clinical case, this analysis was done.

Figure 1.7



Interpretation: The graph shows the disease burden among the population. Majority of cases were related to respiratory disorders like pharyngitis, tonsillitis, rhinitis, respiratory tract infections, asthma, epistaxis etc. Next were digestive disorders like gastritis, abdominal pain, colitis, enteritis, haemorrhoids, hernia, dyspepsia, constipation, diarrhoea, cholecystitis,gastro oesophageal reflux disease, peptic ulcers, acidity, irritable bowel syndrome, etc.

Pain can be in any part of body like knee pain, shoulder pain, musculoskeletal pain, myalgia, general body pain. Gyaenac cases included irregular menstruation, vaginitis, galactorrhoea, PCOD. Eye disorders includes chalazion, conjunctivitis, hordeolumetc

Dermatological cases lie allergic rashes, dermatitis, purpura, erythema, tineacorporis, impetigo, urticaria, chloasma, pyoderma etc. Disorders of urinary system included hyperuricaemia, urinary tract infections, ureteric colic, renal colic etc

Lumbo sacral disorders included lumbago with sciatica, spondylosis, vertebral disc displacements, low back pain etc. Joint disorders included gout, arthritis, osteomalacia,tempero-mandibular joints. Abscess and celluitis included cutaneous abscess and wound abscess. Circulatory disorders included chest pain, chest injury, arrythmia, deep vein thrombosis etc. Cerebral disorders included headache, migraine, vertigo etc. Ear problems included otalgia, otitis media, otitisexterna. Category of other cases included infections like influenza, herpes; vitamin deficiency, anaemia, injuries, sprain, spasm, fractures etc. Understanding disease burden helps in targeting the common causes.

As a sales strategy

1. Providing OP coverage in basic plan in all GMC group of hospitals (four hospitals), Belhoul hospital, and in cedar hospital, Jabel Ali. No other TPA covers OPD in hospitals with such low premium of network. This increases people enrolment in the plan.
2. Also maternity was covered in basic plan. Coverage depends on table of benefits and network. Outside Dubai these benefits are not covered. This gives additional privilege.
3. Keeping base prices minimum so as to make health care affordable which increases lives in a network.
4. Coordinating with brokers and insurance companies and explaining them the advantage a patient can get when compared to other TPAs. Brokers then coordinate with clients.
5. Coordinating with providers in order to agree with a tariff for services which will be a win-win situation for providers too.
6. Keeping different cost for different income level of people. Low premium for blue collar, higher for middle level manager and higher for senior managers.

   KPI-For performance of organisation there were key performance indicators which were calculated for each department. This includes approval request, approvals approved, approvals under process, and claims settled or rejected etc. Turn -around time (TAT) for endorsements, new policy and card printing is also calculated. This kept a check on the performance of the TPA.

Frauds and abuse

1. Doctors prescribe unnecessary tests, screening, in cases like fever which is not justified. They take approvals from TPA but those who are within the approval limit go unnoticed and only visible at the time of claim processing.
2. Even when the patient doesn't need medicines and can recover on own, then also doctors prescribe drugs.
3. Conducting vitamin D test for joint pain rather than first putting patient on medicines or going for X -ray or blood tests.
4. Approvals are taken once the treatment is done.
5. Skipping GPs and directly sending patients to SP
6. Cost of administering the drug is always higher than the drug itself.
7. Extending patient's stay in hospital.
8. Providers mention those procedures and tests which were never conducted at all. Example, case of a child for whom vitamin tests were not conducted but were mentioned in the claim form. If TPA suspects such activities then can go for audit in clinics. People from network department are the ones checking such activities and dealing with providers.

TPA's step to cut cost

Training of general practitioners -in this GPs are asked to

- Just treat patient according to their chief complaints. Only symptomatic treatment be done. If patient comes back with same complaints then only should process further that is unless lab tests are required, they should not be conducted and that too only some and not all the tests which are in the package.
- They were asked to prescribe generic drugs which are cost effective brands.
- For emergency, within 24 hours approvals can be taken so patients be not kept waiting and doctors can start the treatment immediately.
- They were told about the diseases and procedures which are not insured like congenital, HIV, accidental, optical surgeries, work related injuries, mental disorders, sports injury, obesity, alcoholism, cosmetic surgery, epidemics etc.
- To fill the claim form completely. Certain things be noted like

1. Handwriting must be clear and readable to prevent any delays.
2. Aafiya card number should be mentioned clearly on the claim form to prevent any delay in the payment process.
3. Doctor's stamp with license number and signature is mandatory.
4. Patient signature is mandatory.
5. The copy of claim form should be handed to the beneficiary along with the prescription to take to the pharmacy.
6. The name of the referred facility should be mentioned on the claim form.

CONCLUSION

The study helped in understanding the health system of UAE and the functioning of a TPA.
Dubai health system be adopted in other emirates too along with making the health insurance mandatory. E-claims was mandatory only for Dubai providers also PBM was mandatory only for Dubai pharmacy whereby they send approval requests online. This could also be adopted in other emirates. E-referral, E-prescription, E-claims, E-approvals(PBM) is to fasten the process and keep control. GP consultation before SP is to reduce overcrowding and bypassing of health facilities. Governing bodies kept a check on overutilization by charging co-payments from patients per encounter of services basis. Premium was fixed for basic plans which prevents insurance companies to raise the premiums beyond a limit. Base agreed tariff prevented cost escalation from provider's side. Different networks for different income strata of people depending on premium, co-payments and annual limits so that cost was justified accordingly.

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1Hauwa Hussain Usman, Ryan Sisson, GolalehTavakoli, Rami El Khatib Health Insurance Utilization among Undergraduate Students of Canadian University of Dubai

Majorie van Leijen:Health insurance made compulsory for all in Dubai

APPENDICES

1) Dubai plans for Takaful insurance company

Plans	cover age	Emergency coverage	Network	IP co-pay	OP Consultation	Medicine Copay	Medicine Annual Limit	Maternity Copay
Dubai basic plan 1	UAE	UAE	APN with GMC	20%	20% coinsurance	30%	AED1500	10%
Dubai basic plan 2	UAE	UAE and ISC	APN with GMC	20%	20% coinsurance	30%	AED1500	10%
Dubai basic plan 3	UAE	UAE	APN with GMC	20%	20% coinsurance	30%	AED1500	10%
Dubai enhanced plan1	UAE	UAE	APN with GMC	20%	20% coinsurance, max AED25	Nil	AED1500	10%
Dubai enhanced plan 2	UAE	UAE	APN with GMC	20%	20% coinsurance, max AED25	10%	AED1500	10%
Dubai enhanced plan 3	UAE	UAE	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED1500	Nil
Dubai enhanced plan 4	UAE, ISC	UAE	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED1500	Nil
Dubai enhanced plan 5	UAE	UAE	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced plan 6	UAE	UAE, ISC and home countries	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil

Dubai enhanced plan 7	UAE	UAE and ISC	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced plan 8	UAE	UAE and ISC	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED5000	Nil
Dubai enhanced plan 9	UAE	UAE, ISC and home countries	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED5000	Nil
Dubai enhanced plan 10	UAE	UAE and ISC	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED5000	Nil
Dubai enhanced plan 11	UAE	UAE	APN Plus	Nil	20% coinsurance, max AED25	Nil	AED5000	Nil
Dubai enhanced plan 12	UAE	UAE and ISC	APN Plus	Nil	20% coinsurance, max AED25	Nil	AED5000	Nil
Dubai enhanced plan 13	Within Dubai	UAE	APN	13%	20% coinsurance, min AED10 max AED25	10%	AED1500	10%
Dubai enhanced plan 14	UAE	UAE	APN Plus	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced 15	UAE	UAE and ISC	APN with GMC	20%	20% coinsurance, max AED25	10%	AED3000	10%
Dubai	UAE	UAE	APN with	Nil	20%	Nil	AED5000	Nil

enhanced plan 16			GMC		coinsurance, max AED25			
Dubai enhanced plan 17	UAE	UAE and ISC	APN Plus	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced plan 18	UAE and ISC	UAE	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED5000	Nil
Dubai enhanced plan 19	UAE	UAE and ISC	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED1500	Nil
Dubai enhanced plan 20	UAE, ISC, Philippines	UAE	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced plan 21	UAE	UAE	APN Plus	Nil	20% coinsurance, max AED25	Nil	AED2000	Nil
Dubai enhanced plan 22	UAE	UAE	APN Plus	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced plan 23	UAE and ISC	UAE	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED3000	Nil
Dubai enhanced plan 24	UAE, home country (excluding Europe, US and Canada)	UAE and ISC	APN with GMC	Nil	20% coinsurance, max AED25	Nil	AED1500	Nil

2)
TableofBenefitsfortheEssentialBenefitsPackage(alsotheminimumstandardforANYpolicy ofhealthinsuranceissuedintheEmirateofDubai)

	Benefit	**Conditions**	**Coinsurance andlimits**
Annual upper aggregate claimslimit (including any coinsuranceand/ or deductibles)	150,000AED		
Geographic scope ofcoverage	Basic healthcareservices	Within the Emirate of Dubai (andother emirates or countries at the discretionof theinsurer)	
	Emergency medicaltreatment	Within all emirates of theUAE	
Providernetwork	Limited network isacceptable	The network must providereasonable geographic access for the insuredin relation to place of work andresidence	
Pre-existingconditions	Cover cannot be denied due topre-existingconditions	Treatment for chronic andpre-existing conditions excluded for first 6 monthsof first scheme membership.Included thereafter	

Basic healthcare services:in-patient treatment at authorizedhospitals Referralprocedure: In respect of Essential BenefitPlan members, no costs incurred foradvice, consultations or treatments providedby specialists or consultants withoutthe insured first consulting aGeneral Practitioner (or equivalent asdesignated by DHA) who is licensed by DHAor another competent UAE authority willbe payable by the insurer. The GPmust make his referral together withreasons via the DHA e-Referrals system forthe claim to be considered by theInsurer.	Tests, diagnosis, treatments andsurgeries in hospitals for non-urgent medicalcases	Prior approval required fromthe insuranceco mpany	20% coinsurance payable by theinsured with a cap of 500 AED payableper encounter and an annual aggregate capof 1000AED. Above these caps the insurer willcover 100% oftreatment.
	Emergencytreatment	Approval required from theinsurance company within 24 hours of admissionto the authorisedhospital	
	In-patient services will be receivedin rooms of two or morebeds	Prior approval required fromthe insuranceco mpany	
	Healthcare services for emergencycases (Where a pre-existing or chronicconditio n develops into an emergency within the6 month exclusion period this mustbe covered up to the annual aggregatelimit)		

	Ground transportation services in theUAE provided by an authorized partyfor medicalemergencies		
	Companionaccommodation	The cost of accommodating aperson accompanying an insured child up tothe age of 16years	Maximum 100 AED pernight
		The cost of accommodation of aperson accompanying an in-patient in thesame room in cases of medical necessity atthe recommendation of the treatingdoctor and after the prior approval ofthe insurance company providingcoverage	Maximum 100 AED pernight

Maternityservices Note: Where any conditiondevelops which becomes an emergency,the medically necessary expenses willbe covered up to the annual aggregatelimit.	Out-patient ante-natalservices	Requires prior approval fromthe insurancecompany	10% coinsurance payable by theinsured 8 visits toPHC; All care provided by PHC obstetricianfor low risk or specialist obstetrician forhigh riskreferrals Initial investigations toinclude: • FBC andPlatelets • Blood group, Rhesus statusand antibodies • VDRL • MSU &urinalysis • Rubellaserology • HIV • Hep C offered to high riskpatients • GTT if highrisk • FBS , random s or
	In-patient maternityservices	Requires prior approval fromthe insurance company or within 24 hoursof emergencytreatment	10% coinsurance payable by theinsured Maximum benefit 7,000 AED pernormal delivery, 10,000 AED formedically necessary C-section, complications andfor medically necessary termination (Alllimits includecoinsurance)
	New borncover		Cover for 30 days frombirth. BCG, Hepatitis B and neo-natalscreening tests (Phenylketonuria (PKU),Congenital Hypothyroidism, sickle cellscreening, congenital adrenalhyperplasia)

Basichealthcareservices: out-patient in authorizedout-patient clinicsofhospitals, clinicsand healthcentres Referral procedure: Inrespect of Essential Benefit Plan members, no costsincurredforadvice, consultationsor treatments provided by specialistsor consultantswithoutthe insuredfirst consultinga General Practitioner(or equivalent asdesignated by DHA) whoislicensedby DHAor another competent UAEauthoritywill be payableby theinsurer. TheGPmust make hisreferraltogether withreasons via theDHAe-Referralssystem for the claim to beconsidered by theInsurer.	Examination, diagnosticandtreatment servicesby authorized general practitioners, specialistsandconsultants		20% coinsurance payable by theinsured per visit No coinsuranceif a follow-upvisit made withinsevendays
	Laboratory test services carriedout inthe authorizedfacility assignedtotreat the insuredperson		20% coinsurance payable by theinsured
	Radiology diagnosticservicescarriedout intheauthorizedfacility assignedtotreat theinsuredperson.	Incasesof non-medicalemergencies, the insurancecompany's prior approval is requiredfor MRI,CTscansand endoscopies	20% coinsurance payable by theinsured
	Physiotherapy treatment services	Prior approval of theinsurancecompany isrequired	Maximum 6 sessions per year. 20% coinsurancepayableper session.
	Drugsandother medicines	Cost of drugsandmedicinesup toan annual limitof 1,500 AED (including coinsurance). Restrictedtoformulary productswhereavailable.	30%payable by theinsuredinrespect of eachand every prescription No cover for drugsandmedicinesin excessof theannual limit

Preventiveservices, vaccinesand immunizations	Essential vaccinationsandinoculationsfor newbornsandchildrenasstipulatedintheDHA'spoliciesanditsupdates (currentlythesame as Federal MOH)		
	Preventiveservicesas stipulatedbyDHAtoinclude initially diabetesscreening	TheDHA hastonotify authorized insurancecompaniesofany preventive servicesthat will beaddedtothebasic packageat least threemonthsinadvance of theimplementationdateandthe newly covered preventive serviceswill be coveredfrom that date	Frequency restrictedto:Diabetes: Every 3 yearsfrom age30 Highriskindividuals annually from age18
Excluded healthcareservicesexcept in casesof medical emergencies	Diagnosticand treatment servicesfor dentalandgum treatments		Subject to 20% coinsurance
	Hearing andvision aids, andvision correction by surgeriesandlaser		Subject to 20% coinsurance

Excluded(non-basic) healthcare	1. HealthcareServiceswhichare not medically necessary 2. All expensesrelatingto dentaltreatment, dentalprostheses, 3. Home nursing; privatenursingcare; carefor the sakeof 4. Custodial careincludıng (1) Non-medical treatmentservices; (2) Health-relatedserviceswhich donot seek to improve or patient. 5. Serviceswhich donot requirecontinuousadministration by 6. Personal comfortandconvenienceitems(televısion, barber supplıes). 7. All cosmetichealthcareservicesand whicharerelatedtoanInjury, sicknessor congenitalanomaly of theinvolved partof the body and breast 8. Surgical and non-surgical treatment for obesity supplies. 9. Medical servicesutilizedfor thesakeof research, medically weight reductionregimens. 10. HealthcareServicesthat are notperformed 11. Healthcare servicesandassociated expensesfor thetreatment 12. Health servicesand suppliesfor 13. Any investigations, testsor procedurescarriedout 14. Treatment and servicesfor contraception 15. Treatment and services for sextransformatıon, dysfunction.Sterilizationisallowedonly if medically 16. Externalprostheticdevicesandmedical equipment. 17. Treatmentsand servicesarısıngas a result of of power-vehiclerace, water sports, horseridingactivities, wrestling, bungeejumpingandany professional 18. Growth hormonetherapy. 19. Costsassociatedwithhearingtests, visioncorrections, 20. MentalHealth diseases, bothout-patient andin-patient 21. Patient treatmentsupplies(includingfor example: products;non-prescriptiondrugsandtreatments,) duringa Medıcal Emergency. 22. Allergy testinganddesensitization(excepttestingfor allergy physical, psychiatric or psychological examinationsor 23. Servicesrendered by any medicalprovider whoisa relative degreerelatives. 24. Enteralfeedings(via a tube) and other nutritional and treatment. 25. Healthcare servicesfor adjustment of spinalsubluxation. 26. Healthcare servicesandtreatments by acupuncture;

	homeopathictreatments,andallformsof treatment by alternativemedicine. 27. All healthcareservices& treatmentsfor in-vitrofertilization(IVF), embryotransfer;ovum andspermstransfer. 28. Elective diagnosticservicesandmedical treatment for correctionof vision 29. Nasal septumdeviationand nasalconcha resection. 30. All chronic conditionsrequiringhemodialysisor peritoneal dialysis, andrelatedinvestigations, treatmentsor procedures. 31. Healthcare services, investigationsandtreatmentsrelatedtoviralhepatitisandas sociatedcomplications, except for the treatment andservicesrelatedto HepatitisA. 32. Birth defects, congenital diseasesand deformities. 33. Healthcare servicesfor seniledementia and Alzheimer'sdisease. 34. Air or terrestrial medical evacuationand unauthorizedtransportation services. 35. Inpatient treatment receivedwithout prior approval from theinsurancecompany includingcasesofmedical emergency which were not notifiedwithin24hoursfrom the dateof admission. 36. Any inpatient treatment, investigationsor other procedures, whichcan becarriedout onoutpatient basiswithout jeopardizing theInsuredPerson'shealth. 37. Any investigationsor healthservicesconductedfor non-medical purposes suchasinvestigationsrelatedtoemployment, travel, licensingor insurance purposes. 38. All supplieswhichare not consideredas medical treatmentsincludingbutnot limitedto: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skincare products, shampoosandmultivitamins(unless prescribedas replacement therapy for knownvitamin deficiency conditions); andall equipmentnot primarilyintendedtoimprove a medical conditionor injury, includingbutnot limitedto: air conditionersor air purifying systems, archsupports, exerciseequipment and sanitary supplies. 39. Morethanoneconsultationor followupwitha medicalspecialist ina single dayunlessreferred by thetreatingphysician. 40. Health servicesandassociatedexpensesfor organandtissuetransplants, irrespective of whether theInsuredPersonisa donor or a recipient. Thisexclusionalsoappliestofollow-uptreatmentsandcomplications. 41. Any expensesrelatedtoimmunomodulatorsandimmunotherapy. 42. Any expensesrelatedtothetreatment of sleeprelateddisorders. 43. Servicesandeducationalprogramsfor handicaps.

Healthcare servicesoutsidethescopeof healthinsurance	1. Injuriesor illnessessuffered by theInsuredPersonas a result of military operationsof whatever type. 2. Injuriesor illnessessuffered by theInsuredPersonas a result of warsor actsof terror of whatever type. 3. Healthcare servicesfor injuriesandaccidentsarisingfrom nuclearor chemical contamination. 4. Injuriesresultingfrom natural disasters, includingbut not limitedto: earthquakes, tornadosandany other typeof natural disaster. 5. Injuriesresultingfrom criminal actsor resistingauthorityby theInsuredPerson. 6. Injuriesresultingfrom a roadtraffic accident. 7. Healthcare servicesfor workrelatedillnessesandinjuriesasperFederalLawNo. 8 of 1980 concerningtheRegulationofWork Relations, itsamendments, andapplicablelawsinthisrespect. 8. All casesresultingfrom theuseof alcoholicdrinks, controlledsubstancesand drugsand hallucinating substances. 9. Any investigationor treatment not prescribed by adoctor. 10. Injuriesresultingfrom attemptedsuicideor self-inflictedinjuries. 11. Diagnosisandtreatment servicesfor complicationsof exemptedillnesses. 12. All healthcareservicesfor internationally and/or locally recognizedepidemics. 13. Healthcare services for patients sufferingfrom (and relatedtothediagnosisandtreatment of) HIV–AIDSanditscomplications and all types of hepatitis except virus A hepatitis