A Study On Process of Health Insurance Claims

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Background

- **TPA:** TPA is to maintain databases of policy holders and issue them identity cards with unique identification numbers and handle all the post policy issues including claim settlements. In terms of infrastructure, the TPAs run a 24-hour toll-free number, which can be accessed from anywhere in the country. And they will have full-time medical practitioners under their employment who will immediately take a decision on whether the ailment is covered under the policy or not.

Review of literature

- **Bhat and Babu (2004)** provided that introduction of IRDA has paved the way for (TPAs) third party administrators who are playing the role of insurance intermediaries in setting up of managed health care systems. The objective to ensure the better health services to the policy holders and mitigate the negative consequences.
- **Indrani gupta et al (2004)** carried a study to understand the role of TPA's and examines the issues that need to be taken into account while evaluating the usefulness and the functioning.
- **Ramesh bhat et al (2004)** studied that the TPA role in controlling costs of health care and ensuring appropriate quality of care is less well defined.
- **Maheshwari and Saha (2005)** ascertained the experiences and challenges faced by hospitals and policyholders in availing the services of TPA in Ahmedabad, Gujarat. The results of the study shown that only a small percentages of respondents have knowledge about existence of TPA, there is substantial delay in settlement of claims between TPAs and health care providers, administrators of hospital perceive burden in terms of efforts and expenditure after the introduction of TPA.

Rationale of the study

- To know the role of TPA in health insurance companies so that the actual process of claim settlement can be assess.
- The awareness about the policy is not up to the mark among the insured clients is leading difficulty in availing the services.
- Many clients apply with false claim cases, due to this the trust of insured clients come apart from the company as well as the reputation of health insurance companies going towards negative side.

Research Questions

- What are the basis of deduction and rejection of claims?
- Whether the genuine cases also get rejected?, if yes, what are the reasons?

Objectives

- To understand the claim process in terms of acceptance, rejection and deduction of claimed cases.
- To identify the reasons behind rejection & deduction of claims.
- To know the level of knowledge and awareness of claimant about the claimed health insurance scheme/ policy.
- To suggest the ways to reduce the rejection and deduction of genuine cases, if identified.

Methodology

Study area: E- Meditek Services Limited (EMSL) Gurgaon

Study duration: February 2014 to April 2014 (3 months)

Study Respondents :

a) Provider - EMSL staff (Assistant Vice President, Managers, Medical officers)

b) Beneficiary – Claimant.

Sample size – Processed cases 1200 (Feb to April)

Claimants 28

Sampling- Purposive sampling (for 28 claim cases)

Methodology
Details of data collection

PARTICULARS	RESPONDENTS	NUMBERS	TECHNIQUES	TOOLS
Quantitative	Processed claim cases February to April 2014	1200	–	–
Quantitative	Claimant	28	Face to Face in-depth interview	Semi structured interview schedule
Qualitative	EMSL staff and medical officers	6	Face to Face in-depth interview	Semi structured Interview schedule

Analysis & Results

Analysis approach - Univariate analysis

(Claim Process- Cashless & Reimbursement cases)

Cashless claims process → **After preauthorization approval**

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Treatment & Procedure done by hospital

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After Treatment Patient Discharged from Hospital

↓

After discharge claim is submitted

↓

Claim information viewed by TPA executive

Claim process continue…

Documents viewed by Claim Doctors/ TPA Doctors

Claim Doctor Approved

GM accounts verifies the account

Claim sent for payment in Hospital Account

Claim paid

Claim Doctor Pending

Documents incomplete/Not Submitted

Query raise to hospital for proper documentation

Hospital provides the documents

Proper Reply of raised query received.

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If reply received is not justified or incomplete

Claim amount Reduction done

Reimbursement claim process

Patient sent documentation after treatment from hospital as a fresh claim or file for deducted amount during cashless

Claim information viewed by TPA executive & bill entry done by them

Claim processed by TPA doctors

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Claim approved for payment

Query raise to patient for proper documentation

Two reminders for query reply

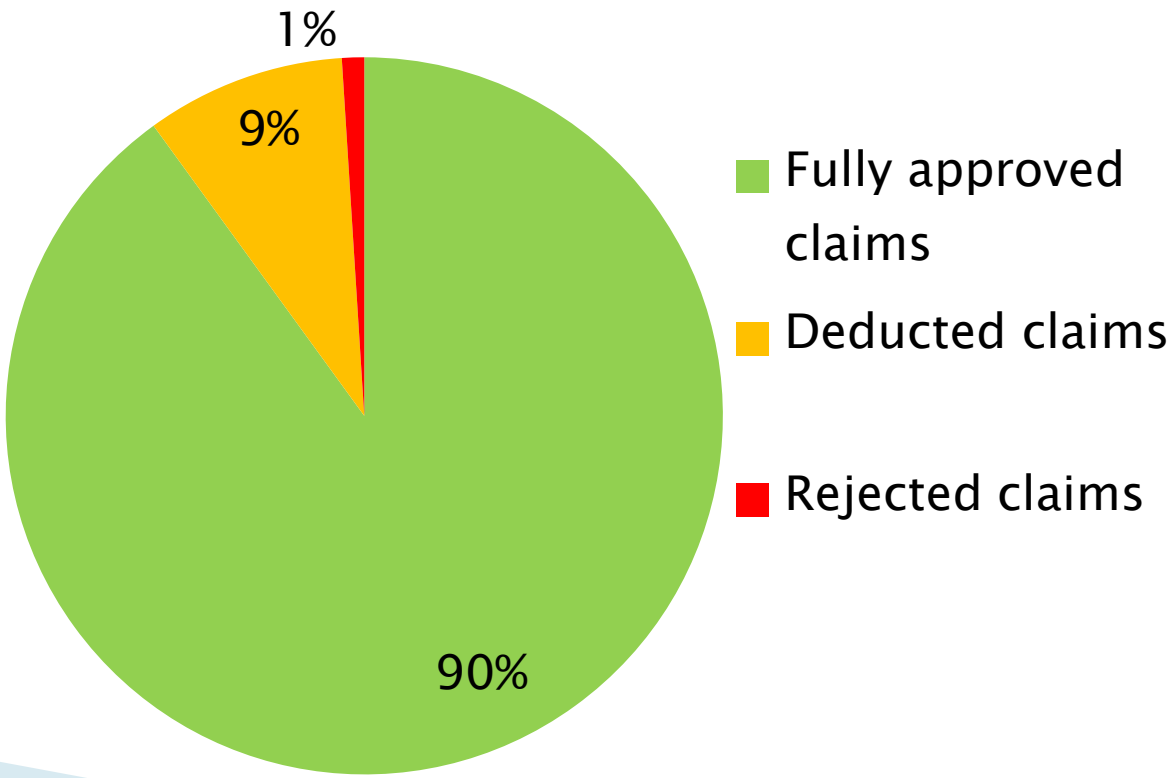
If query reply not received then claim processed for payment

If query reply received then No\Claim/Rejected

(Intradepartmental and interdepartmental process, duration 30days maximum)

Status of processed claims

- Total number of claims processed =1200
- Approved cases = 1188 (1081 fully approved + 107 partially approved cases)



Reasons for Deductions (N=107)

Reasons of Deductions	Number of case	Percentage distribution
S.I exhausted, previous year policy copies not provided	10	9%
Stent not visible, x-ray not clear, sticker not provided, irrelevant medicine is prescribed from the diseased diagnosed	25	23%
Copy of MLC/FIR not provided	15	14%
lack of document confirming diagnosis, two procedure done simultaneously, deviation from preauth approved procedure	12	11%
Non payable deducted as per policy T& C	5	5%
Non payable deducted as per policy T& C, History of Disease with original first consultation paper.	7	7%
S.I exhausted	9	8%
Report not signed by MD pathologist, lack of document confirming diagnosis	10	9%
Above reasonably & customary expenses	14	13%

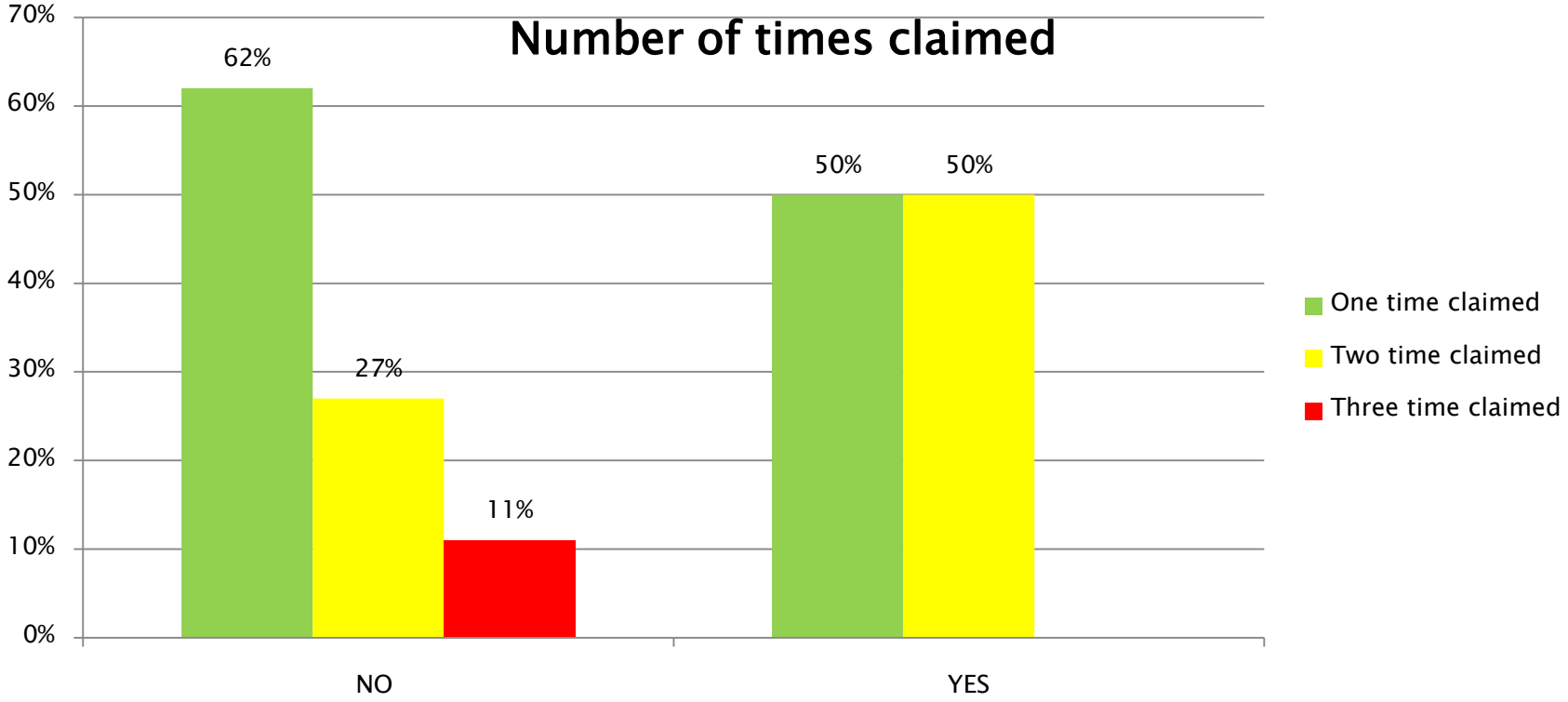
Reasons of Rejections(N=12)

Lack of mandatory documents for claim approval (original documents including discharge summary & final bills.)	2
Report not Genuine/ Patient unavailable on bed during DMO visit	1
Deviation from actual procedure which was approved by Preauth. Department	1
Report not signed by MD pathologist/radiologist, Document Discrepancy (Document doesn't contain name of patient/date etc)	1
BSI exhausted (Already consumed the sectioned amount of 150000)	1
Claim falling under pre existing diseases exclusion clause	1
Claim related to Maternity/Pregnancy	2
Claim falling under the first 2 years waiting period exclusion clause	3

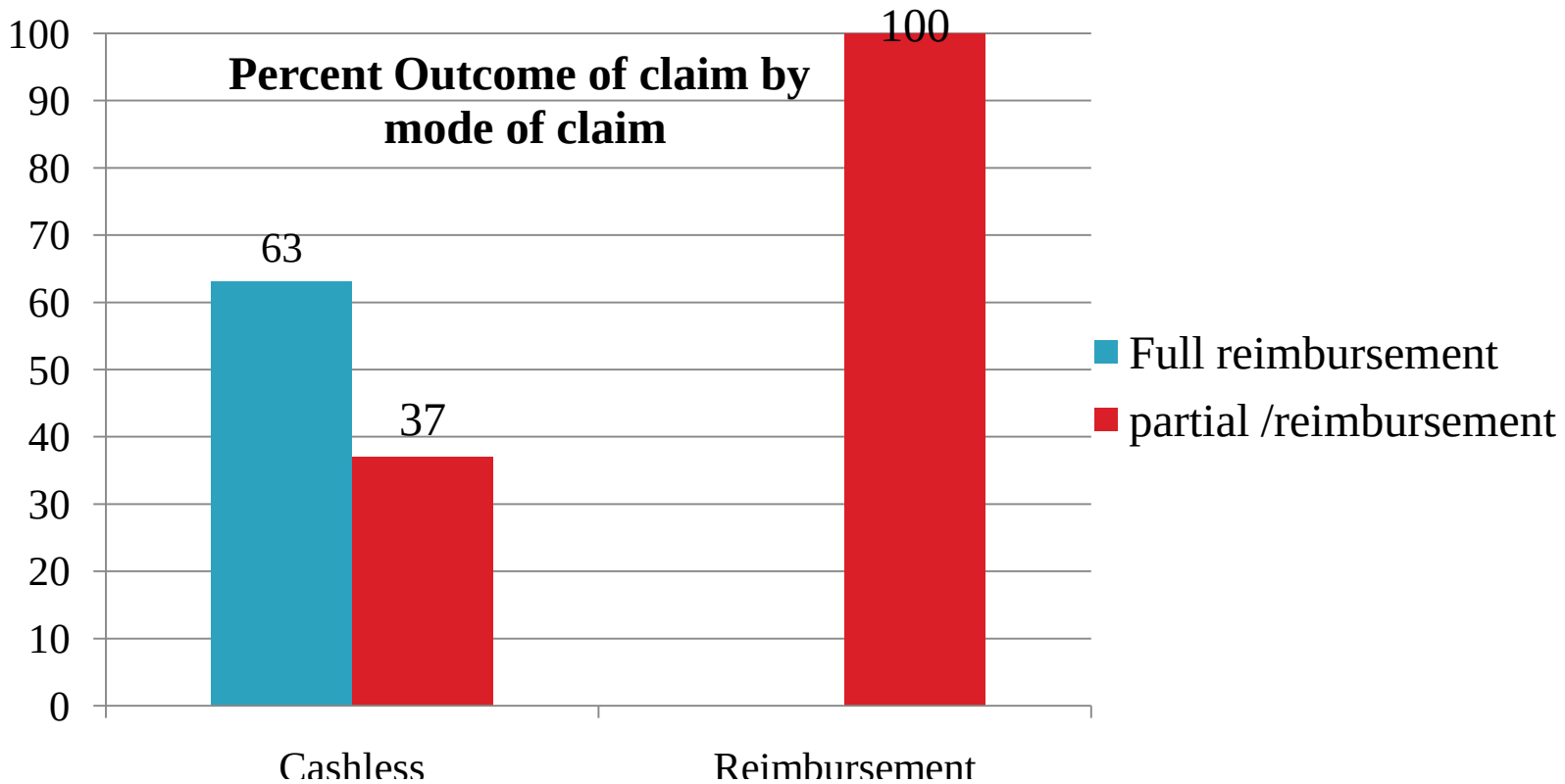
Knowledge about policy terms and conditions

- 93 percent people were not aware about the policy Terms & Conditions, only 7 percent were aware.

Number of times claims made by knowledge (N=28)



Reimbursement status by mode of claim



410 Reimbursement & 790 Cashless cases

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	Claim outcome			
Mode of claim	Full reimbursement	Partial reimbursement/ deducted	Total	P value
Cashless	63%	37%	8	0.001
Reimbursement	0	100%	20	
Total	5	23	28	

Statistic used: Chi Square
Statistically significant: P-value is 0.001

Rejection of genuine cases

- Yes genuine cases do get rejected
- As per one of the official " *The knowledge about policy T&C is less among claimant due to that their claims get rejected".*
- The other official said that " *policy ke terms and conditions toh har saal badalte hai claimant ko kya pta...."*.

Reasons of Rejection of genuine cases

- Lack of knowledge about policy terms and conditions
- Time of intimation of hospitalization
- No update of changes in terms and conditions of policy among the policy holders.
- Multiple meaning of policy terms and conditions
- Policy terms and conditions changes every year
- Indian legal system is very complex

Suggestions

At Individual level

- People should get proper knowledge about all policy T & C before taking any policy.
- Ask the agent if any confusion arises if agent is not providing proper information ask him/her to give the written consent whatever he /she assuring, as well as read the basic guidelines of policy before claim.

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At Hospital level

- Hospital should inform the claimant about payables and non payables items and also if the disease fall under any exclusion criteria.
- If claimant is going through cashless facility then tell him/her the approved amount.
- In case of reimbursement hospital should provide all the original document.

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At TPA & Health Insurance Company Level

1. Intradepartmental and interdepartmental coordination should be channelized in TPA.
2. All policy terms and conditions should be clear with proper font size of words so the claimant can read without hurdle
3. Insurance company should directly send the insurance card
4. Misleading Agent involvement should be minimized.
5. In case of change in policy T& C inform the insurer


Thank You