A Study on Issues and Concerns of Health Insurance: Third Party Administrator and Consumer Perspective

Internship Training
at
E-Meditek TPA Services Private Limited, Mumbai

By
Rekharani J Sharma

Under the guidance of
Dr S.D.Gupta

Post Graduate Diploma in Hospital & Health Management
2012–14

Institute of Health Management Research
Jaipur
2014

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TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Rekharani J Sharma student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone dissertation at E-meditek TPA Sevices Limited, Mumbai from February 03, 2014 to April 30, 2014.

The candidate has successfully carried out the study designated to her during dissertation and her approach to the study has been sincere, scientific and analytical.

The internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavours.

Dr. Ashok Kaushik
Dean, Academics and Student Affairs
IHMR, Jaipur

Dr. S D Gupta
Director
IIHMR, Jaipur

E-MEDITEK
EMSL — (TPA) SERVICES LIMITED

Ref No.: EMSL/13277/Internship/2014

Date:-14/05/2014

This is to certify that Dr Rekharani J Sharma has sucessfully completed her Internship and dissertation at E-Meditek (Tpa) Services Ltd. Mumbai from 3rd February 2014 to 30th April 2014. During her tenure she was working on "Issues & concerns of Health Insurance market in India : TPA & Consumers perspective" project and was associated with Claims Processing department.

Her behaviour was found satisfactory during her internship and dissertation period with the Organization.

We wish her success in her future career.

Mr Yashovardhan Rana
Branch Manager

E-Meditek (Tpa) Services Ltd.
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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled 'A study on issues and concerns of Health Insurance: Third Party Administrator and Consumer perspective' submitted by Dr. Rekharani J Sharma, Enrollment No. 1364 under the supervision of Dr. S D Gupta for award of Post Graduate Diploma in Hospital and Health Management of the Institute carried out during the period from 03rd February 2014 to 30th April 2014 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.

Sharma
Signature

Contents

Preface

IIHMR is a pioneering institute of Health and Hospital Management. It empowers students to become efficient and effective managers in their respective fields. The course structure is designed in a manner to give an entire overview of the health sector and its basic fundamentals during the first year. During internship we are expected to get a better practical knowledge and functioning of health sector, operations and issues. The three months internship at the end of final year is an integral part of the PGDHM curriculum. As an internee we are expected to study on the topic assigned to us by the organization and submit a report on it.

As a part of this I got the privilege of working for my dissertation at E-meditek, Mumbai. It basically aims to provide quality healthcare services to the insured.

There are several challenges for health financing in India. The country still struggles with low population coverage and financial protection with poor outcomes for the vulnerable and underprivileged. Addressing the coverage gap is a huge challenge in the light of low levels of public health spending. This suggests that much more needs to be done to ensure more equal access to health care and suitable financial protection. The health insurance industry is in infantile stage, rather an experimental phase, wherein it is trying to do demand analysis and consumer need assessment to be able to provide consumers with the right products and options that would suit their needs. Thus it becomes imperative to gain a critical understanding of the consumer perspective to steer the industry in the right direction to become more consumer sensitive as well as consumer friendly.

The Third party Administrators (TPA) form a critical linkage between the health insurance provider, the consumer and the hospital network. They have to deal with a range of issues while dealing with the other afore mentioned stake holders in the process of business. Thus understanding their perspectives and stand point is equally important.

Acknowledgement

Any research project requires lots of hard work and efforts. A research project is never a work of an individual. Similarly my study is the outcome of efforts of many people whom I would like to thank from the core of my heart for their constant guidance and support.

First and foremost, I want to thank my research guide and the Director of the Institute Dr S D Gupta, who has been a source of constant energy and inspiration for the students. I sincerely thank him for timely guidance and support. I would also like to thank my mentor Shri J P Singh for guiding me throughout the whole tenure of my research endeavor. At every step he was there with a warm smile and a kind heart to show me the way. I also extend my thanks to Col Dr A Kaushik, Dean of the institute for arranging an internship at Emeditek and all faculty members for proper guidance and assistance extended by them.

It has been an enriching experience for me to undergo my internship & dissertation at Emeditek TPA services, Mumbai which would not have been possible without the support and goodwill of the people around. I want to express my gratitude towards Shri Gopal Verma, Managing Director, Emeditek for giving me an opportunity to work in the organization and complete my project. I also extend my warm thanks to Manohar Sir, Senior Vice president, and Shri Yashvardhan Rana, Branch Head, Emeditek TPA services, Mumbai for extending guidance to me from time to time. I would also like to extend my sincere thanks to Dr Sachidanand Kadam, Senior Manager without his help it was difficult for me to complete my project. I am also thankful to other staff for their support and help. Their inputs have enriched the quality and overall content of the analysis.

I am also thankful to my parents, family and friends for their moral support. Finally I extend my heartfelt gratitude to all those people whose insights and experiences have shaped the content of the study directly or indirectly.

However I accept the sole responsibility for any possible error of omission and would be extremely grateful to the readers of this project report if they bring any mistakes to my notice.

Dissertation

A study on Issues and concerns of Health Insurance: Third Party Administrator (TPA) and Consumer Perspective

I. Introduction:

Since Independence, India has struggled to provide its people with universal health coverage. Whether defined in terms of financial protection or access to and effective use of health care, the majority of Indians remain irregularly and incompletely covered. As specified in the National Health Policy, the government is committed to rising public health spending to between 2 and 3 percent of GDP. Vigorous economic growth and a reformed regulatory environment have propelled the voluntary private health insurance industry into a period of accelerated expansion, with annual growth rates of more than 30 percent since 2001–02. At the same time, the insurance industry has crafted innovative products to improve the breadth of benefit coverage and is increasingly contributing to the expansion of the private supply of health services. Most recently government-sponsored health insurance schemes (GSHISs) has emerged to provide the poor with financial coverage. Briefly, the main objective of these new GSHISs was to offer financial protection against catastrophic health shocks, defined in terms of an inpatient stay. Between 2007 and 2010, six major schemes have emerged, including one sponsored by the government of India and five state-sponsored schemes. The designs and rate structures of these new schemes were drawn from the experience of existing social insurance schemes and private insurance products in India. This new wave of schemes provides fully subsidized coverage for a limited package of secondary or tertiary inpatient care, targeting below poverty populations. Similar to the private voluntary insurance products in the country, ambulatory services including drugs are not covered except as part of an episode of illness requiring an inpatient stay. The schemes have organized hospital networks consisting of public and private facilities, and most care funded by these schemes is provided in private hospitals.

In the current scenario, health insurance is perceived to be an effective health financing tool in India. The need of health insurance can be analyzed both at the macro level in a broader framework of understanding as well as at the micro level taking into account a household or even an individual as a unit. Fundamentally; the insurance mechanism helps the communities pool their risks and transfer such risks from their own shoulders to insurance providers. The risks of tomorrow"s unexpected healthcare costs and consequent catastrophic financial burden are thus minimized by virtue of a pre-determined fixed premium today (Griffin 1992). Unfortunately, the health insurance penetration has been very low in India and in early 2000 less than 10 per cent of the population had any kind of coverage. Despite recent gains, the country still struggles with low levels of population coverage and financial protection, poor outcomes, but rapidly rising costs. Since Independence, the health financing scenario in the public sphere has not changed much. It consists of mostly central government public health programs, state-financed service delivery systems, and insurance schemes for formal sector workers and civil servants. Reflecting low levels of public spending, out-of-pocket spending at the point of service surpasses all other sources of financing, suggesting that much more needs to be done to ensure more equal access to health care and suitable financial protection.

II. Rationale:

Market based health insurance products have been available in India for almost three decades since the introduction of the public sector mediclaim policy. However, the emerging health insurance market now with many private players is a reflection of broader policy changes being felt in Indian economy. Though the expected growth of the health insurance sector *per se* has not been realized but it has been the fastest growing sector in the non-life insurance industry (IRDA, 2007). At this juncture, it is worthwhile to study various aspects of the health insurance market from the perspective of the several stakeholders involved in the market.

The Study tries to identify the issues and concerns the Health Insurance market has which are hampering the industry from reaching its optimal potential. The study on the one hand, has tried to capture the perspectives of the TPAs as they form a vital linkage in the business and are the repository of the information. Concerns and issues have been captured from the consumer perspective as their aspirations remain vital for a well-functioning health insurance system.

III. Research Questions:

1. What are the issues TPA have to face in their functioning and what are their perspectives about public and private health providers?
2. What are the issues and concerns among the consumers about Health Insurance in India?

IV. Objectives of the study:

- To understand the issues TPAs have to face within their functioning and their perspective on the comparison between the public and private market based health insurance providers
- To understand the consumer‟s demands, their expectations and issues in health insurance industry

V. Literature Review:

Indian insurance industry and its regulators are currently undertaking a number of actions to further India‟s goal of developing a strong health insurance market, which would improve the general status of Indians, ease the government burden of public health delivery system, help families avoid catastrophic financial losses, and improve the overall quality of healthcare in India.(Gilson 1998: Sauerborn, Nougtara et. al. 1994). Since liberalization of insurance industry in 2000, the private players also entered the market and posed competition to the monopolistic public sector market-based insurance providers (Rao S, Health Insurance: Concepts, issues and challenges, August 2004). The

trajectory for the health insurance sector in India has not been so smooth, but given the infantile state at which the health insurance sector is, the growth has been significant. In 2006-07, the year-on-end growth in health insurance premium was 35% and over the span of last 5 years, the premiums have almost doubled. But the health insurance penetration in India continues to be low and there are various challenges posing as deterrents to the growth of the sector (Bhat Ramesh & Mavlankar Dileep, 2000). IRDA established TPAs through a regulation in FY 2001-02. The underlying idea was to establish a linkage between the consumers, the insurers, the health care providers and act as a facilitator in the process, especially in the claim settlement. (IRDA journals) The issues and delays in claim reimbursement process have sharpened a negative perception by insurance companies and customers about TPAs. There are several issues and challenges for the Third Party Administrators. Revenue for TPAs is the fee for services rendered, usually a *fixed* percentage of fees collected from enrollees and thus there is no incentive for the TPAs to actively control the costs. The market is highly fragmented and unregulated. TPAs have to deal with a large number of small –sized service providers. Thus, the market management of claims and their reimbursement is a challenge in itself as per IRDA regulations. (Mahal A, Assessing private health insurance in India: Potential impacts and regulatory issues, 2002). TPA‟s have to face high operating risk, since the setting up of infrastructure calls for huge capital investment, and the gestation period of such large-scale investments is also considerably long.

VI. Study design and methods:

a. Type of study:
Exploratory qualitative study with certain elements of quantitative data

b. Location of study:
Mumbai
The respondents were interviewed in five regions of Mumbai, namely, Mahalakshmi, Borivali, Lower Parel, Chembur, and Govandi.

c. Study subjects:
i) The list of TPA‟s was taken by the website of IRDA and those functioning in Mumbai. They were contacted via emails and telephones for interview. The TPA‟s who agreed to be a part of the research was interviewed. (Namely, E-meditek, Paramount, Medi-assist and MD India)

ii) Beneficiaries who availed Health Insurance in last One year. The respondents were interviewed in five regions of Mumbai, namely, Mahalakshmi, Borivali, Lower Parel, Chembur, and Govandi.

d. Sample size:

i) Beneficiaries: 50 respondents

Nearly, 135 people were approached, out of them 50 people were interviewed who fitted the criteria. People having some kind of Health Insurance and having made any claim whatsoever in the past One year for themselves or for some family member insured under the insurance coverage were interviewed

ii) TPA : who agreed to be a part of the research (Four TPA‟s were interviewed)

e. Sampling method:

Selection of beneficiaries: Non probability convenient sampling. (The residential and office complexes within the vicinity and easy reach was selected for convenience)

Reference Period: Beneficiaries who have availed the service within last one year were interviewed.

f. Data collection method:

i) TPA: Face to face interview

ii) Beneficiaries: Survey method

g. Data collection tools:

Separate interview schedules in the form of semi structured questionnaire were designed for both the organization as well as the beneficiary

i. Interview Schedule for the Consumers

Some broad themes were identified for framing the interview schedule and analyzing the findings as an outcome of the survey. The Sub sections were built based on the broad themes namely, the Choice of Insurance provider and products, Awareness on the health Insurance and claim settlement, Consumer satisfaction and expectations from the Policy and the Claim settlement

In the first section, questions were incorporated on the respondent‟s reasons or rationale for purchasing health insurance, preference for Life Insurance over the health insurance and the underlying reasons for the same.

In the second section, respondents were asked to about the salient features of the policy they hold and knowledge about the claim-making and claim settlement process. Finally, questions were framed to gauge the consumer satisfaction with the policy and the respondent was also asked to comment on the coverage, sum assured, premium, benefits and exclusion criteria etc. The purpose of incorporating question on exclusionary criteria is to understand the neutrality of the policy and the consumer‟s views on the same.

The questions were included to tap customer satisfaction with the customer support and with the services rendered by the health care provider and their experience of any issue of healthcare

provider side moral hazard, which is one of the biggest threats to the sustainability of an insurance scheme. The questions on the policy clauses and if the policy holder was clarified on these things were included to assess the transparency maintained in the process of buying the policy. Claim settlement experiences of respondents were studied and their views on importance of TPA in the claim settlement process were assessed.

ii. Interview Schedule for the TPA's

The interview schedule for TPA tries to understand some of these issues and understand their views on the problems they have to face in day to day functioning from the external factors. The TPAs were asked to reflect on their comparative Analysis of the Public versus Private health insurance providers and understanding of the market trends and probable reasons for the same. The probing technique was employed to capture the impact of recent developments taking place in the health insurance market.

The main service areas of the TPAs encompass enrolment of clients to the policy, issuing identification Cards, claim investigation, smooth processing of claims etc. To gain a cutting edge in the competitive market, most of the TPAs offer value-added services like e-Cards, 24×7 call centers, fast cashless hospitalization, online renewal of policies, conducting health talks and health check-ups in the corporate clients‟ placœ, etc.

VII. Ethical Consideration:

The respondents consent was taken before filling of the questionnaire and interview. The nature and purpose of the study was communicated to them. It was mentioned to the respondent he/she can withdraw anytime during the filling of questionnaire or interview according to his/her wish. It was also mentioned that the confidentiality and privacy of the information will be maintained and this data will be solely used for dissertation purpose.

VIII. Data Analysis and discussion

As stated earlier, information was collected from two important stakeholders in the health insurance market: The TPAs and the consumers.

1. Consumer Perspective:

A survey was conducted to capture the consumer perspective. The residential and office complexes within the vicinity and easy reach were selected for convenience. The residents of such buildings belonged to middle, high-middle and higher class socio-economically and hence served the purpose of this study, because the people belonging to these socioeconomic categories are expected to have some level of awareness and knowledge about health and health insurance. They usually are the target consumers for insurance companies.

Nearly, 135 people were approached, out of them 50 people were interviewed who fitted the criteria. People having some kind of Health Insurance and having made any claim whatsoever in the past 1 year for themselves or for some family member insured under the insurance coverage were interviewed. An attempt was made to gain a rich mix of the public versus private market-based health insurance policies. Each beneficiary interview took nearly half-an-hour.

1.1 The socioeconomic profile of the consumers:

The selection of the consumers was done based on non probability convenient sampling so that purpose of the survey is served and to get data that can throw light on problems of current health insurance market. Hence, socioeconomically stronger sections were interviewed.

The educational level and occupation were the two criteria to assess the socioeconomic status of respondents.

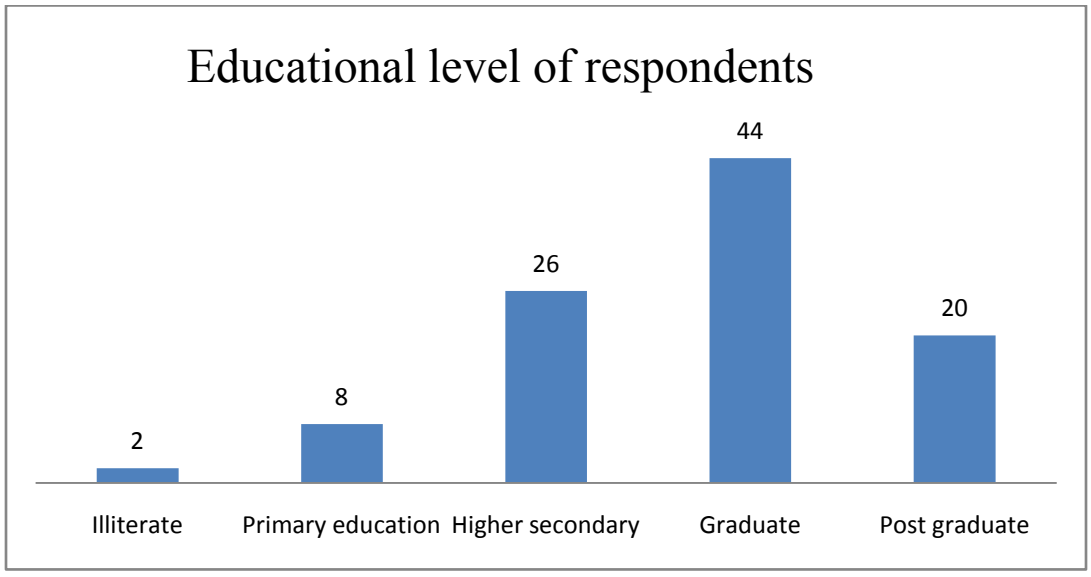

Fig.1. Distribution of Educational level by percentage to assess the socio-economic status of the respondents

1.2 The occupation status of respondents as percentage was as follows:

Government employed	20
Private employed	36
Self employed	40
unemployed	4

Table1. Occupational status to assess the socio-economic status of the respondents

1.3 Source of knowledge about health insurance:

The Indian consumers are too ignorant about the market research concept and still depend on the people they are surrounded with for buying health insurance. When asked 46% of respondents stated that they bought health insurance because their friends have it too, 34% were corporate insured because their company provided with health insurance, 6% of respondents had bought health insurance because someone fell ill at their family and they were saved from the high health expenditure only because they had health insurance, hence the other family member too bought it, 10% of respondents directly went into the IC to buy health insurance while 4% came to know about health insurance from the internet.

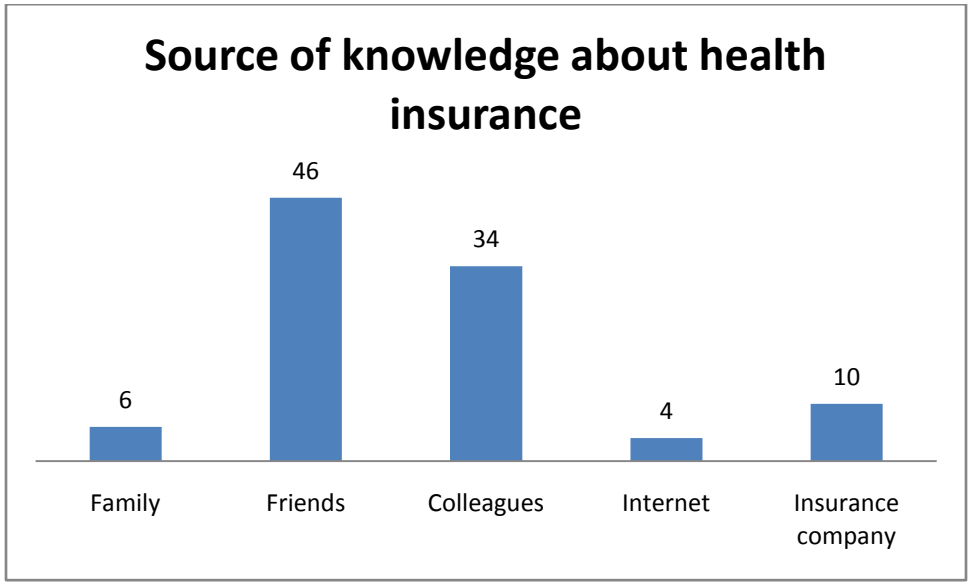

Fig2. Distribution of Source of knowledge about health insurance as percentage (Multiple responses were accepted)

1.4 Awareness of the consumer:

There is a good level of general awareness about health insurance. Almost all the respondents understood what health insurance is and many cited the benefits of having a health insurance as a protection cover against rising health costs in case of any medical emergencies.

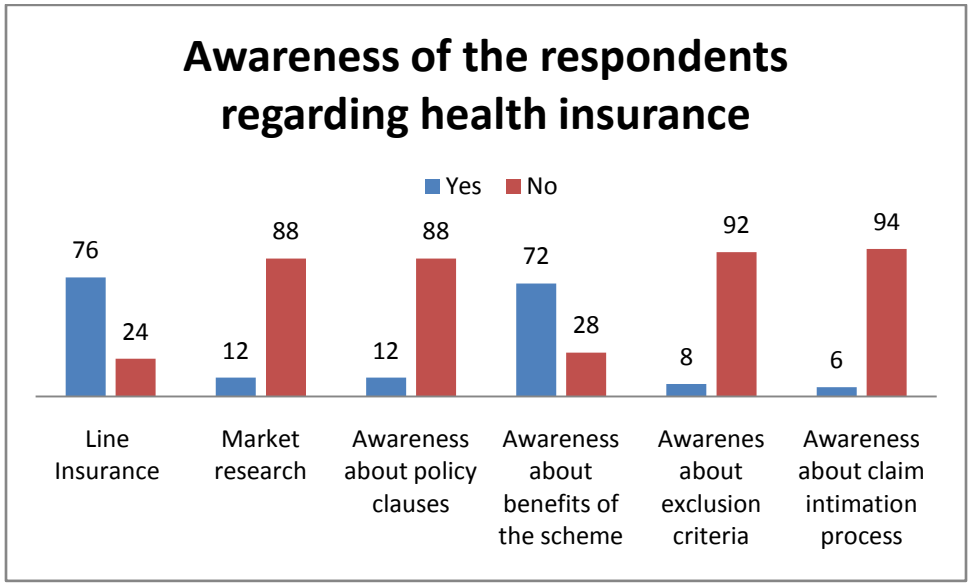

Fig3. Distribution of Awareness of the respondents regarding health insurance as percentage

In the following bar graph it is evident that 76% of respondents had life insurance along with having health insurance. The market is highly disorganized and Indian consumes do not conduct any type of research while buying any product. This is evident from the fact that only 12% of respondents did some sort of market research while opting for specific health insurance.

The Indian consumers are more aware about the benefits of the scheme (72%) than the policy clauses (12%), exclusion criteria (8%) and claim intimation process (6%) which limits the uses of the policy.

1.5 Perception of the respondents:

As discussed earlier about 72 % of respondents were aware about the benefits of the scheme. Out of these, only 25% respondents had the perception that „X" amount will be covered in case of any health risk, 20% perceived that OPD benefits is being covered and 45% perceived that only IPD expenses will be covered while 10% had the perception that it covers all the three benefits.

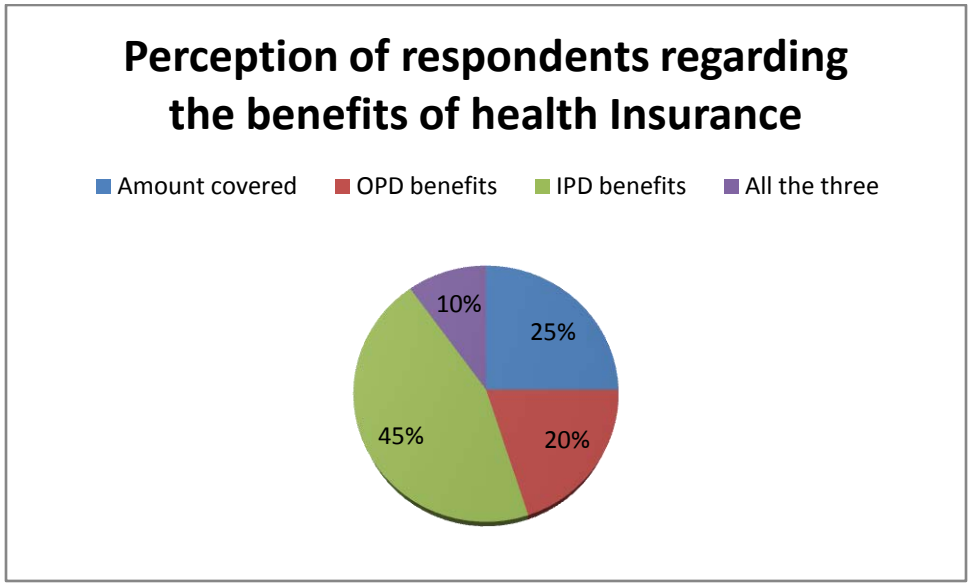

Fig4. Perception of respondents regarding the benefits of health insurance

1.6 Premium against risk covered:

Majority of respondents (70%) felt that the premium they pay against the risk of disease is fair enough while 20% of them felt that it is quite less, only 4% perceived that premium is too much while 6% were unable to comment on it.

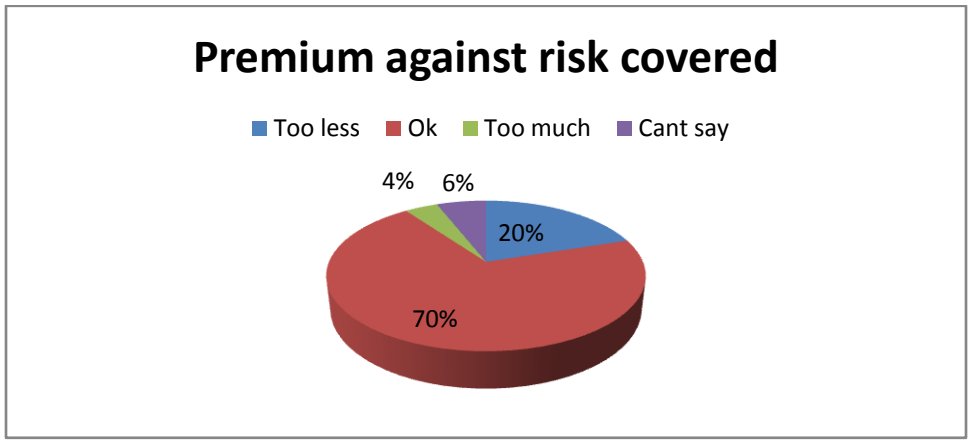

Fig5. Perception of respondents about Premium against risk covered

1.7 Experience of respondents who availed health insurance:

1.7.1 Experience of respondents with network service provider:

The network hospitals are the service providers where the consumers can avail health care services. Among the respondents who availed health insurance 44% had bad experience like negligence, delay in health care services with the NSP‟s, only 18% of them cited that they were treated well at the NSP‟s while 38 % of the respondents had average experience at the NSP‟s.

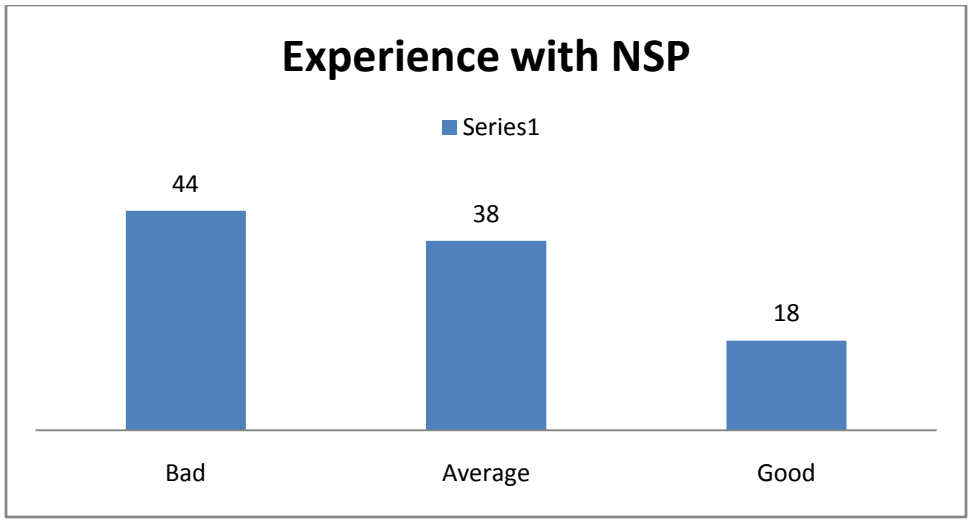

Fig6. Experience of respondents with NSP while availing healthcare services

1.7.2 Claim settlement period:

Majority of the respondents (72%) said that it took more than one month for their claim settlement, 18% of respondents cited that it took somewhere between 15 days to one month for their claim settlement, while only 10% of the respondent‟s claim were settled in less than 15 days.

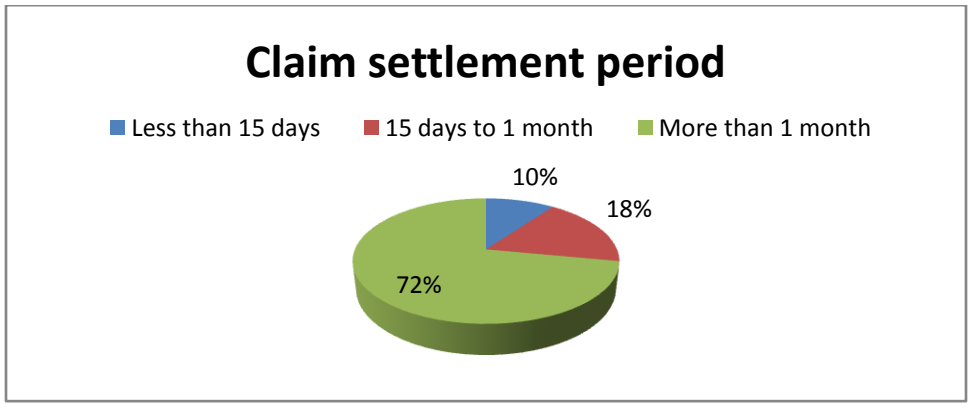

Fig7. Average time required for claim settlement period of the respondents

1.7.3 Experience with the Insurance company/TPA‟s while claim settlement procedure:

The claim settlement procedure is tiresome for the consumers. Majority of the consumers had to go to the IC/TPA‟s repeatedly to settle their claim at the earliest. The most common reason was insufficient documents to process the claim, policy copies of health insurance or internal errors by the TPA‟s /IC‟s. About 34% respondents had bad experience with the IC‟s/TPA‟s while the claim settlement procedure was going on, 54% of them had an average experience while only 12 % came out smiling from the processing companies.

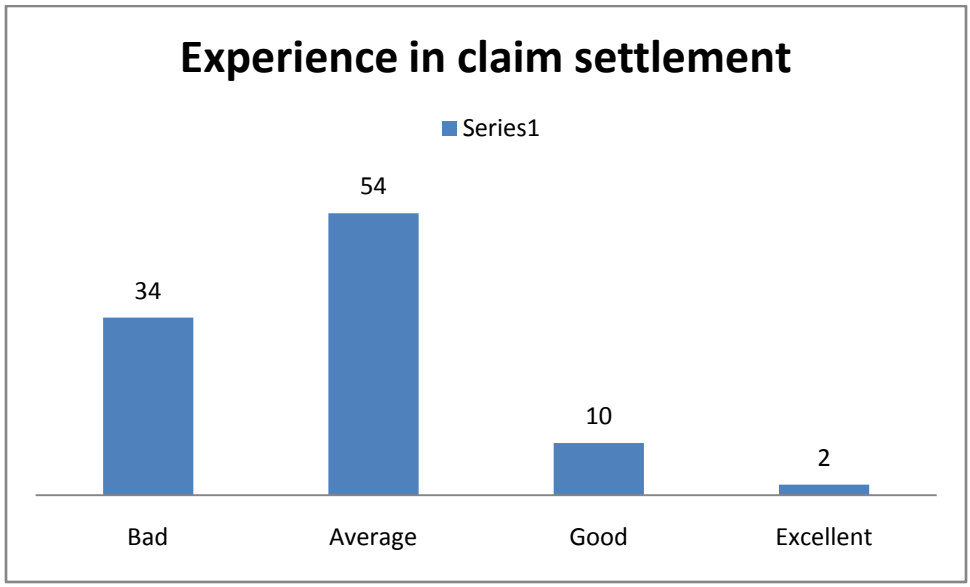

Fig8. Experience of respondents with TPA‟s/ Insurance company during claim settlement as percentage

2. TPA perspective:

For the TPA perspective, the List of Third party Administrators operating in Mumbai was taken from the website of IRDA, following they were contacted for appointments through emails and over telephone. The TPAs who agreed to be part of the research were administered an in-depth face to face interview.
Four TPA‟s were approached who agreed to be part of research of which three officials were interviewed from each TPA. The interview on an average lasted for 45 min.
The findings are as follows:

2.1 Experience in health insurance:

Out of the twelve officials interviewed, 40% respondents had experience of about 6 to 10 years of working in health insurance, 30% of respondents had experience of 11-15 years and 2-5 years each. This helps us to understand that the officials who were interviewed had in-depth knowledge of current issues in health insurance.

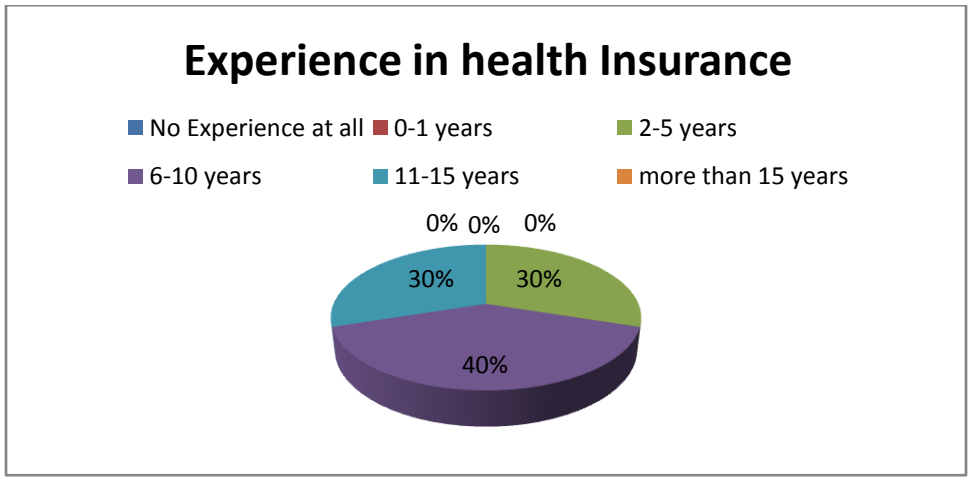

Fig9. Years of work Experience of TPA officials in health insurance

2.2 Training in Health Insurance (in percentage):

No formal training	0
Attended training workshops	80
Conferences	0
Attended both training and conferences	20

Table2. Training received by TPA officials in health insurance as percentage

As observed from the following table majority (80%) of officials had attended training workshops organized by insurance company or the TPA itself. But very few officials (20%) had attended conferences. This helps us to understand that the TPA‟s did not give due importance to arranging or attending conferences.

As per the opinion of TPA spokespersons, public sector is perceived to be more dominant in the market, because of following reasons:

1. More consumer friendly
2. Wider options
3. Lesser restrictions

Whereas, the private insurance has more restrictions, are more aggressive and has limited options. Hence consumers tend to prefer Government based policy more over private health insurance.

2.3 Major problems faced by consumers according to TPA:

1. Lack of clarity on insurance policies
2. Service providers spread
3. Problems in documentation

- Though this picture is gradually changing and public sector companies are losing out their lion‟s share to the private competition steadily.
- According to the TPA spokespersons, private sector does not find health insurance to be a lucrative business portfolio, but it still offers health insurance to corporate sector.
- Profits earned from such non-health insurance businesses by the insurance company are used to cross-subsidize the losses borne out of health insurance portfolio.
- Corporate plans are very lucrative in their designing, with vast coverage and very little exclusion.
- It is also observed that Health insurance is primarily confined to urban areas.

IX. Conclusion and discussion:

1. Discussion on consumer problems and concerns:

1.1 Lack of awareness of the details:
Most respondents did not remember the name of the policy; many of them could not recollect the name of the company, more so in case of public sector insurance companies. Even, many times, respondents were confused with the names of insurance provider and the TPA. Premium amount was something which was distinctly remembered by most respondents.

1.2 Lack of awareness regarding policy clauses:
Consumers find the policy document complicated and difficult to understand the various jargons and paperwork involved in the health insurance policy , hence they tend to have a casual attitude towards health insurance in cases where the policy is employer provided and more so if it does not require any contribution from them.

1.3 Lack of awareness regarding the processing organizations:
A significant proportion of respondents were not actually having a precise idea about TPAs and their role in insurance. They could not differentiate between their insurance provider and the Third Party Administrators in many cases. Most of them did not remember the name of the TPA, and had to check it from the health card issued to them by the TPA. People on one hand expressed their desire to have expedited claim settlement through cashless facility, but at the same time, did not understand the need of having the TPA as a mediator for the process

1.4 Lack of awareness regarding the claim settlement procedure:
Most people had some basic idea about the claim making and settlement procedure. But, many of them were not aware of the process in its entirety. TPA involvement in the claim process was grossly unclear; they only knew that they had to call up their toll-free number before hospitalization. Few respondents also admitted their ignorance about claim procedure as the claim is settled by the hospitals or doctors themselves according to their perspective.

2. Consumer Preference and Awareness

2.1 There is a casual attitude of the consumers towards health insurance as far as reading into the fine prints of the policy document or doing any market research for buying

the health insurance. The people though understand the rationale of the health insurance, there is a lack of enthusiasm towards buying health insurance, unlike life insurance as it is not looked at as an investment. The today"s consumer is not a very well-informed consumer regarding health insurance.

2.2 The consumers prefer cashless and faster disbursement of claims but most of them do not understand the rationale of having TPAs as an intermediary in the system. There is a general dissatisfaction on the clause of hospitalization for being able to file a claim.

2.3 The position of customers is not that strong as there is a high opportunity cost involved in selecting an insurance provider – the likelihood of claim reimbursement is higher in public sector whereas the customer service is better and prompt in the private companies. So, it is a trade-off for the consumer to go for either of these, not having the best of both worlds.

2.4 In terms of choice for the customer, the policies and the products offered by either of the public or the private sector insurers are not much different from each other. There is lack of variety for different needs of different consumers. There is lack of portability and comparability across the products and the fine differences in various attributes of the product remain obscure to the consumers. A lot of consumers have expressed their willingness to pay higher premium, if the policy provides them the desired additional benefits.

2.5 The health care provider market is extremely fragmented and pluralistic making it further difficult. It lacks any semblance of ethics in medical practice and there are no uniform Standards and definitions of Quality of care.

2.6 Provider malpractices and System Leakages lead to supplier side moral Hazard and have thus escalated the cost of care. The health insurance has been declared as a portfolio of insurance business with the maximum litigation. The customer is not aware of or is not informed about the procedure or whom to approach in case of need. It has been seen that the claim settlement is easier in case of a group health insurance schemes than in case of individual health insurance policy holders. Also, the claim settlement becomes difficult if the patient has been treated in a non network hospital.

3. Discussion on Third Party Administrators problems and concerns:

3.1 The TPAs are at a vulnerable position in the market in the sense that not only is the initial investment very high, but even the operating risks are high for the business. The environment is extremely challenging for the TPAs as the face issues from all the ends, the insurance companies, the customers and the health care providers end. .***"Life insurance is a sucker punch to attract customers, basically they get their own money back and they feel very happy; whereas, health insurance is about common good and people feel cheated unless they put claims."***

3.2 Most of the TPAs and insurance companies target the corporate clients. This is on account of the large risk pool available with corporate houses, timely and prompt premium payments and long-lasting business relations expected out of them.

3.3 Lack of marketing by public insurance companies adds to the woe of the sector, as the TPAs do not get enough business volume being attached to such insurance providers because of lack of visibility to potential customers TPAs feel that customers make undue demand to include every possible health related events to be reimbursable, which is not possible. Such events also at times lead to litigations to the TPAs as they are responsible for scrutinizing these issues. The end result is high litigation rates in health insurance business

3.4 TPA agencies are not too happy with their role in the insurance business. They find it unattractive to operate as TPAs on account of meager commission amounts paid to them in comparison to premiums earned by insurance companies.

3.5 They also find some practical barriers in efficiently settling claims in the presence of some representative of the insurance company to be present at their office to oversee the claim procedure.

3.6 The IRDA was formed with the purpose of not only regulating but also steering the market. It was IRDA who had introduced TPAs into the system, but it is not coming to the rescue of TPAs when the insurance companies are now going back to having the TPA activities in-house. IRDA is thus showing apathetic attitude towards the future of the TPAs in the industry. The insurance companies enjoy the maximum chunk of profit with TPAs getting only a meager share.

X. Concluding remark

The health insurance market is majorly group- and employer-based, leaving the retail segment with a small share of the business volume. This implies that the coverage would remain limited to the formal sector and would hardly be able to extend its reach beyond it. This raises doubts on the very fundamental premise with which health insurance was introduced into the system with a hope that health insurance could be used as a health-financing mechanism. Another issue that need s to be addressed is how this segment is going to cater to the below poverty line population. Though the segment is far from realizing its target, its potential, nonetheless, cannot be undermined. In the coming years, how various stake holders respond to issues and concerns within the segment would finally shape the health insurance market.

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XII. Appendix

A) Questionnaire for consumer

1. Name of the consumer: _____
2. Education: _____
3. Occupation: _____
4. Are you covered by any health insurance policy? If yes, please mention the name of the insurance company?

   _____
5. Which Health insurance scheme you have?

   _____
6. Salient Features of the policy
   Family based_____ Individual based _____
   Self insured _____ Employer based _____
   Cashless _____ Indemnity _____
7. Are you aware of the Benefits of the policy? If yes please mention details:

   _____
   _____
   _____
8. Are you aware of the claim intimation and claim settlement process?

   _____
9. Do you have life insurance besides health insurance _____

If the policy holder has a public based scheme

10. Why did you choose to go for a government/ Public health insurance policy over a private health insurance policy?

_____
_____
_____
_____

If the policy holder has a private based scheme

11. Why did you choose to go for a private health insurance policy over a market based public health insurance policy?

_____
_____

POLICY SATISFACTION

1. Are you satisfied with the health insurance policy you have? _____

2. Scale of Satisfaction (tick the appropriate answer)
   i. Not happy at all
   ii. Somewhat happy
   iii. Moderately happy
   iv. Quite happy
   v. Very happy

Reason:

_____
_____
_____

3. Premium compared to risk covered:
   i. Too less
   ii. Ok
   iii. Too much
4. Are you aware of exclusion criteria of the policy? _____

5. If yes, mention few exclusion criteria you are aware of

_____
_____
_____
_____

Customer services

1. Were all the clauses of the policy clarified to you at the time of issuance of the policy?

_____

2. Were there any hidden clauses? _____

3. If yes, then what were those?

_____
_____
_____
_____

4. How was your experience in terms of handling of your enquiries /queries as a customer?
   i. Very bad
   ii. Bad
   iii. Average
   iv. Good
   v. Excellent

Network Service provider

1. How was your experience with service provided by the NSP hospital or doctor?
   i. Very bad
   ii. Bad
   iii. Average
   iv. Good
   v. Excellent

2. Do you feel that doctors or hospitals over prescribe or overbill your case because you are insured?

   _____

Third Party Administrator

1. Do you feel the need for a TPA for processing health insurance? Why?

   _____
   _____
   _____
   _____
   _____

CLAIM SETTLEMENT

1. Have you ever filed a claim with your insurance company in the past?

   _____

2. If yes, then what was the amount claimed and what was the amount paid?

   _____

3. What was the claim settlement period?

   _____

4. Did you know the claim intimation and claim settlement process before you filed a claim?

   _____

5. Kindly scale your experience on claim settlement?
   i. Very bad
   ii. Bad
   iii. Average
   iv. Good
   v. Excellent

CONCLUDING QUESTIONS

1. What health insurance products existing in the market are you aware of?

   _____
   _____
   _____

2. How did you get to know about this health insurance policy? (multiple answers accepted)
   i. Family
   ii. Friends
   iii. Colleagues
   iv. Internet
   v. Insurance company
   vi. Others

3. Did you do any market research before buying the health insurance policy you have?

   _____

4. Do you agree that health insurance covers the risk of disease?
   i. Partially disagree
   ii. Totally disagree
   iii. Partially agree
   iv. Totally agree

5. Any suggestion you would like to give to improve the policy?

_____
_____
_____
_____

B)Questionnaire for Third Party Administrator

Dear Sir/Madam,
Greetings. This is **Dr Rekha J Sharma** from **Institute of Health Management Research, Jaipur**. I am pursuing Postgraduate diploma in Health Administration. As a part of curriculum we need to submit **Thesis** for the completion of course. Accordingly I am conducting **study** on **"Issues and concerns of Health Insurance market in India: Third Party Administrator and Consumer Perspective"**. The purpose of this assessment tool is to assess the problems faced by Third Party Administrator in day to day functioning as well as their perspective on the comparison between the public and private market based health insurance providers. This survey elicits information on the core competency of the organization, the role of external factors, the public and private sector insurance schemes and the services offered by them. It is not intended to go into details of qualitative issues. You can withdraw anytime during the filling of questionnaire or interview according to your wish. The confidentiality and privacy of the information will be maintained and this data will be solely used for study purpose.

1. Name of the TPA interviewed_____

2. Name of the person interviewed_____

3. Designation in the organization_____

4. Date of inception of the organization_____

5. Training in health insurance (if any) _____

6. Number of years of practice _____

7. Who all are your clients (companies)? _____
(Please provide the list if possible)

8. Which health insurance policies you are dealing with? _____
(Please provide the list if possible)

9. What services are provided by you? _____
(Please provide the list if possible)

10. Which insurance schemes are more preferred by the consumers, the government based or private based and why?

_____
_____
_____

_____
_____

11. Which schemes / policies are usually opted by consumers? (Tick the appropriate answer)
a. Family _____ Individual based_____
b. Individual insurance_____ Group /Employer_____
c. Cashless_____ Indemnity_____

12. Is your TPA working to prevent demand side moral hazard? If yes how?
_____
_____
_____
_____

13. What do you think are the problems that consumers have in health insurance industry today?
_____
_____
_____
_____
_____

14. What problems are faced by the public policy holders and private health insurance policy holders?
_____
_____
_____
_____

_____

15. What are the problems your organization has to face while day to day functioning from external factors?
IRDA_____
Insurance Company_____
Clients_____
Consumers_____
Others (if any) _____