COMPREHENSIVE STUDY ON MEDICAL INSURANCE: PERCEPTIONS OF PROVIDERS AND POLICYHOLDERS REGARDING SERVICE QUALITY OF CASHLESS PROCESS

Internship Training
at
Shri B.D. Mehta Mahavir Heart Institute, Surat

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2015

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. Manisha Maheshwari student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at Shri B. D. Mehta Heart Institute from 12 Feb 2015 to 11 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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Shri Bachubhai Dahyabhai Mehta Mahavir Heart Institute
"Gujarat's 1st 'NABH Accreditation' in a Single Super Speciality Cardiac Charitable Trust Hospital

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr.Manisha Maheswari MBA (Healthcare) Student of IIHR, Jaipur , has successfully completed her internship at our hospital. The internship had started on 12.02.2015 to 11.03.2015 and 23.03.15 to 23.04.2015.

During this period, her work and conduct were found good.

We wish her all success.

Dr.M.C.Dasilva
CEO & Medical Director

Shree Mahavir Health & Medical Relief Society
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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled A Comprehensive Study On Medical Insurance : Perceptions of Providers & Policyholders regarding service quality of Cash-less Process submitted by Dr. Manisha Maheshwari Enrollment No. IIHMR-U/01 /2013-15/0059 under the supervision of Dr. Alok Mathur for award of MBA Hospital and Health Management of the university carried out during the period from February 2015 to 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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TITLE: A COMPREHENSIVE STUDY ON MEDICAL INSURANCE: PERCEPTIONS OF PROVIDERS & POLICYHOLDERS REGARDING SERVICE QUALITY OF CASHLESS PROCESS

AUTHOR: Dr. Manisha Maheshwari, MBA-HM-18, ROLL NO. 1463

BACKGROUND: The advent of cashless by a hospital is expected to play an important role in health insurance market in ensuring better services to policyholders. However, the hospitals and insurance sector still faces challenge of effectively institutionalizing the services of the cashless. A lot need to be done in this direction. Towards this the study describes the findings, which was carried out with the objective to ascertain the experiences and challenges perceived by hospital administrators and its policyholders in availing services of cashless.

OBJECTIVE: The main objective of study is to:

To understand the perception of healthcare providers about the performance of cash-less services in hospital.
To ascertain the experiences and challenges perceived by provider and policyholders in availing services of cashless reimbursement.

KEY WORDS: TPA, Cash-less, policyholders

METHODS: Type of study: Prospective & Observational study

Data and fact collection: Questionnaire and In-depth interview

Study duration: 2 Months

RESULT AND CONCLUSION: The proliferation of various healthcare technologies and increase in cost of care has necessitated the exploration of health financing options to manage problem arising out of increasing healthcare costs. To enable the poor to access the in-patient healthcare they demand, there is a need for effective, affordable insurance. Post-liberalization of the Indian healthcare insurance sector, some companies have been licensed as third party administrators (TPAs) of health services with the aims of bringing more professionalism into claims management, and facilitating cashless payment. Managing large numbers of clients and a large claims volume necessitates a highly efficient administration system capable of speedy and accurate response to clients' hospitalization needs.

This study attempts to develop an understanding of what healthcare providers and policyholders think about the cashless hospitalization services. The major findings from the study are: (1) low awareness among policyholders about their policy. (2) Policyholders mostly rely on their insurance agents. (3) Healthcare providers do experience substantial delays in settling of their claims by the insurance provider. (4) Hospital administrators perceive significant burden in terms of effort also. However, there is an indication that hospital administrators foresee business potential in their association with TPA in the long run. There is a clear indication from the study that the regulatory body needs to focus on developing mechanisms, which would help TPAs to strengthen and ensure smooth delivery of cashless services in emerging health insurance market.

SUGGESTIONS:

TPAs should devote more attention on care management issues related with policyholders rather than focusing on financial issues.

TPAs must settle the claim to the hospital on time so as to build a strong relationship with hospitals

Policyholders should be made more aware about the TPA and the services it provide. Also policyholders should contact directly with insurance company rather than depending on insurance agent.

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The Project training at Shri B. D. Mehta Mahavir Heart Institute, Surat, helped to provide me a both learning experience as well as a glimpse into the daily managerial level issues of this renowned hospital. I was fortunate enough to interact with the esteemed authorities and staff of the hospital, who have encouraged and guided me with their support and patience.

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Finally I acknowledge my indebtedness to the staff of the Hospital and our respected teachers of IIHMR for providing their constant support by guiding me throughout my internship tenure.

Dr. MANISHA MAHESHWARI

May 2015

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ABBREVIATIONS:

TPAs: Third Party Administratiors
IRDA: Insurance Regulatory Development & Authority
SMS: Short Message Service
ID: Identity
NABH: National Accreditation Board of Hospitals & Healthcare Providers
ALOS: Average Length Of Stay
CGHS: Central Government Health Scheme
ESIS: Employee State Insurance scheme
ESI: Employee State Insurance

HEALTH INSURANCE TERMS:

Claim: A notification to your insurance company that payment is due under the policy provision.

Coverage: The portion of charges you pay to your provider for covered health care services in addition to any deductible.

Certificate of coverage: A document issued to a member of a group health insurance plan showing evidence of participation in the insurance.

Deductible: A fixed amount which is deducted from eligible expenses before benefits from the insurance company are payable.

Policy: The written contract between an individual or group policyholder and an insurance company. The policy outlines the duties, obligations, and responsibilities of both the policyholder and the insurance company. A policy may include any application, endorsement, certificate, or any other document that can describe, limit, or exclude coverage benefits under the policy.

Exclusion and/or limitations- Conditions and circumstances spelled out in an insurance policy which limit or exclude coverage benefits. It is important to read all exclusion, limitation and reduction clauses in your health insurance policy or certificate of coverage to determine which expenses are not covered.

Independent Medical Review: a process where expert medical professionals who have no relationship to your health insurance company or health plan review specific medical decisions made by the insurance company.

INTRODUCTION: The health infrastructure in India is facing daunting challenge of meeting the health goals and complexities emerging from the changing disease pattern. The proliferation of various healthcare technologies and increase in cost of care has necessitated the exploration of health financing options to manage problem arising out of increasing healthcare costs. Health insurance is emerging fast as an important mechanism to finance the healthcare needs of people. Further, the uncertainty of disease or illness is accentuating the need for insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needed hospitalization by charging premium from a wider population base of the same community. However, the complexity of health insurance industry has been much talked about but less understood, especially in Indian scenario.

To enable the poor to access the in-patient healthcare they demand, there is a need for effective, affordable insurance. Post-liberalization of the Indian healthcare insurance sector, some companies have been licensed as third party administrators (TPAs) of health services with the aims of bringing more professionalism into claims management, and facilitating cashless payment. This has made it easier for health insurance to be offered on a cashless payment basis for in-patient treatment.

With the advent of Third Party Administrators (TPAs) this sector has assumed new dimension. TPAs are presumed to infuse new management system and enrich knowledge base of managing healthcare services and costs. TPAs potentially have a wider role to play in standardization of charges and managing cash-less services in health insurance.

Claims management is perhaps the most important aspect of providing effective in-patient healthcare because it is the intersect of misuse control and client service. Thus hospital needs to design the mechanism to claim cash-less reimbursement process as simple as possible. Managing large numbers of clients and a large claims volume necessitates a highly efficient administration system capable of speedy and accurate response to clients' hospitalization needs.

Whilst a number of cashless insurance schemes have since been introduced, many lack a suitable network of hospitals near enough to the users or lack an efficient cashless mechanism which means that the users are forced to pay cash and seek reimbursement, effectively putting them out of reach of the poor who simply don't have the resources to pay cash at the time of treatment.

This paper attempts to present and discuss the findings of this study. The study focuses on developing an understanding what healthcare providers and policyholders think about the cashless hospitalization services.

REVIEW OF LITERATURE:

"A number of cashless insurance schemes have since been introduced, many lack a suitable network of hospitals near enough to the users or lack an efficient cashless mechanism which means that the users are forced to pay cash and seek reimbursement, effectively putting them out of reach of the poor who simply don't have the resources to pay cash at the time of treatment. "(Arvind Panagariya, 2008)

"Cash-less policies, where the insurer directly pays the hospital bills to the healthcare provider, have not yet fully materialized (Kalyani 2004). "

"TPA health services in India have been licensed with the aims of bringing more professionalism into claims management and facilitating cashless payment. They in their current form in India are suffering from weak hospital networking, delay in issuing of identity cards to policyholders. (Vishwanathan and Narayanan 2003)

RATIONALE: Cash-less claim management is perhaps the most important aspect of providing effective in-patient healthcare. Thus hospital should design the mechanism to claim cash-less reimbursement process as simple as possible. Managing large numbers of clients and a large claims volume necessitates a highly efficient administration system capable of speedy and accurate response to clients' hospitalization needs.

RESEARCH QUESTION: What are the perceptions of provider and policyholders in availing services of cashless reimbursement in Shri B.D. Mehta Mahavir Heart Institute, Surat. Also to find out the issues which may be hampering the service quality of the same?

OBJECTIVES:

- To understand the perception of healthcare providers about the performance of cash-less services in hospital.
- To ascertain the experiences and challenges perceived by provider and policyholders in availing services of cashless reimbursement.

INDIAN HEALTH CARE SYSTEM- THE PRESENT SCENARIO

The present health care system in India is characterized by mixed ownership patterns and divers kinds of providers who practice different systems of medicine. They can be broadly divided into two types- the public and the private health sector. Under the public health sector the government provides medical care through government run hospitals, dispensaries, primary health centres, sub-centres and other health facilities. Under the private health sector, all levels of private hospitals, dispensaries, nursing homes, pharmacies are included. Voluntary, non-profit institutions managed by charitable trusts also come under this category. Most of the health expenditure comes from private expenses by households.

HEALTH INSURANCE:

Health insurance safeguards against the cost of illness, mobilizes funds for health services and increases the efficiency of such services. The different types of health insurance can be broadly categorized based on ownership of scheme as: state based systems, market- based systems, and member organization based systems and private household-based systems.

SALIENT FEATURES OF HEALTH INSURANCE IN INDIA:

Under health insurance the customers first incur expenditure on services provided and later submit their claims to the insurance company for reimbursement. The insurance company pays the service provider a fixed amount, out of which the provider will serve the health needs of the insured. There is usually the presence of a third party administration (TPA) to handle the claim and directly reimburse the service provider.

Some of the health schemes can be traced back to as early as 1940s. The employee state insurance (ESI) act of 1948 heralded health insurance in India. Then there was the Employee State Insurance Scheme (ESIS) of 1952, the Central Government Health Scheme (CGHS) of 1954 and the Mediclaim Scheme of General Insurance Corporation of 1986. Several charitable institutions and NGOs have also come out with social security schemes foe specific group of population. The government has also set up the Insurance Regulatory and Development Authority (IRDA) to regulate this sector.

THE HEALTH INSURANCE WORKFLOW:

When a patient requires medical treatment, he or she attends an empanelled hospital, and presents the ID card. Enrolment is the first step in which policyholder is asked to complete a one page application form in local language as part of the claim approval process; the insurance coordinator has been provided training on how to assist the policyholder to complete the form correctly.

There is an examination of the patient there by a doctor or consultant who writes a consultation report of his diagnosis, this diagnosis is then submitted to the TPA via email. As soon as it arrives at the TPA it is scanned immediately and reviewed by doctors employed by the TPA to perform a peer review. This peer review is normally conducted within an hour. This peer review is normally conducted within an hour. The peer reviewer has the option to send the report back to the hospital electronically if there are any questions on the report, which ensures transparency throughout the consultancy process.

When the peer reviewer is satisfied with the consultation report, an agreement is automatically generated detailing the agreed treatment and costs per item. This agreement also contains the patient's photograph and identification details. The agreement is faxed back to the hospital as authorization for the treatment. Simultaneously, the agreement is also sent to a client executive who is employed by the TPA and who will visit the patient whilst they are in hospital on a random basis to ensure that the person being treated is in fact the insured and also that the level of service being provided by the hospital is adequate.

The hospital issues a bill to TPA. At this point the hospitals bill is run through six claims filters to ensure the hospital bill is valid, these include; legitimacy of the coverage, the treatment protocol, and correct drug patterns. Once the bill has been approved, a cheque is issued to the hospital – the target payment period is six days so that the hospital cannot complain that they are suffering from cash flow issues and hence deny treating future cashless clients. TPA can also contact the client directly by SMS to discuss any issues regarding treatment, drug usage etc. providing another level of transparency.

TPA will pay the hospital or nursing home by cheque upon receipt of correct claim documentation, for such expenses as are admissible under the policy but not exceeding the sum insured. This is a cashless facility.

The whole process is designed to provide security against fraud by both patient and service provider. The system is web-based with access to management reports and the details of individual client cases to any authorized person.

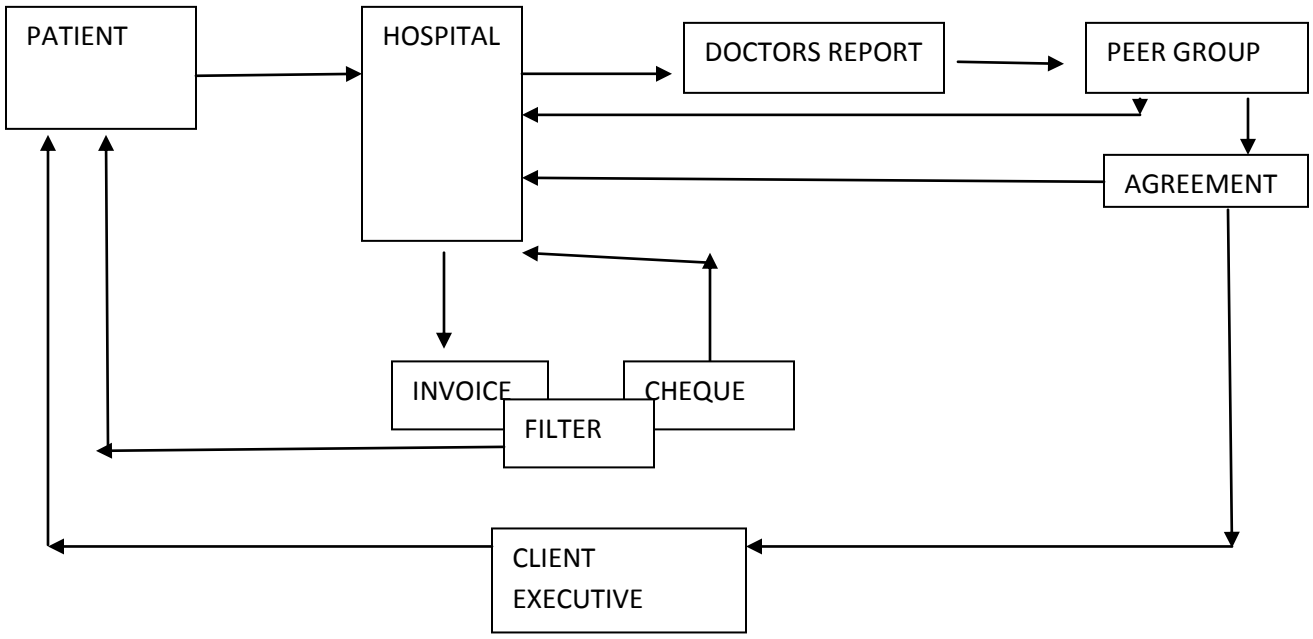

FIGURE 1: Schematic showing how the Third Party Administrators works

THIRD PARTY ADMINISTRATORS AND THEIR ROLE:

The evolution of a new body for cash-less claim processing in the form of Third Party Administrators (TPAs) marks a new chapter towards addressing some of the problems of health insurance industry.

Third Party Administrator (TPA) was introduced through the notification on TPA-Health Service Regulations, 2001 by the IRDA. Their basic role is to function as an intermediary between the insurer and the insured and to facilitate the cash-less service of insurance. The core product or service of a TPA is ensuring cashless hospitalization to policyholders. Intermediation by TPAs ensure that policyholders get hassle-free services, insurance companies pay for efficient and cost-efficient services, and healthcare providers get their reimbursement on time. However, the system is currently going through teething troubles. Cash–less policies, where the insurer directly pays the hospital bills to the healthcare provider, have not yet fully materialized.

Patients need to attend a network hospital with their identity card in order to avail themselves of the cashless facility. The third party administrator handles all the administration of claims providing online real time information to all concerned parties including the policyholder, provider and insurance company. Managing large number of clients and a large claims volume necessitates a highly efficient administration system capable of speedy and accurate response to client's hospitalization.

METHODOLOGY:

Study Area and Design: The prospective and observational study was conducted in the health insurance field of Shri B. D. Mehta Mahavir Heart Institute from February 12, 2015 to April 25, 2015. Patient care was not affected by the study, and individual patient information was not used during the analysis of data.

Shri B. D. Mehta Mahavir Heart Institute is a 110-bed NABH accreditated, a leading super-specialty hospital having in total 27 critical care beds. This observational study was conducted on all the policyholders who had availed for cash-less hospitalization.

Sampling Unit: The policyholders who are admitted in the hospital and had availed for cash-less reimbursement

Sampling Size: In all 100 policyholders were selected at random for the purpose of survey, but 85 policyholders were usable for purpose of analysis.

Sample characteristics: Out of 85 policyholders interviewed, 18.9 % percent were covered under individual policy cover, while 81.1 % percent were covered under family policy. The mean age of respondents is 48 years. Majority of the policyholders were insured within 1year of survey, with the mode value of duration since insured being 1 year. About 64.7 percent of the respondent never placed any claim since insured. Policyholders submitting any insurance claim were mainly insured for more than 2 1years.

Table-1: Sample characteristics consumer study

Sample characteristics	Mean
Age of respondent	48.59
Family size of person with family cover	4.32

Table-2: Claim incurred vs. period since insured

			Claim incurred			
Period since insured	Never	Once	Twice	Thrice	>Thrice	Total
1 Year	29					29
2 Year	4					4
3 Year	11	6	3			20
4 Year	6	1	1			8
5 Year	3	2	2	1	1	9
6 Year		1				1
7 Year	1	1	1			3
9 Year		1				1
10 Year	1		1			2
12 Year			1		2	3
13 Year		1		1		2
15 Year		2			1	3
Total	55	15	9	2	4	85

Inclusion Criteria: Policyholders were included if they avail for cashless hospitalization.

Exclusion Criteria: Policyholders were excluded if they avail for mediclaim.

Design Technique: The technique used to collect data was participant observation.

Design Tool: Based on literature review and discussion with key stakeholders in the industry, In-depth interview along with questionnaires was prepared for hospital administrators empanelled with TPA and questionnaire was also prepared for policyholders of health insurance. The questionnaires were responded by policyholders as well as by healthcare provider during In-depth interview. The objectives of these questionnaires were to understand the perception of hospital administrators regarding the service quality of TPAs and awareness and experiences of policyholders with the TPA.

The key variables included in the questionnaires and rationales for choosing the variable are discussed below in brief.

The perception of the hospital administrators regarding TPA were assessed with respect to the following variables:

TPA services when policyholders need them: TPAs can follow each case in an individualized way, arrange for specialized consultation for the patient, ascertain false claim and thereby reduce the moral hazard and provider induced demand. TPAs could also do comprehensive review of records and maintain constant communication with healthcare providers and families and evaluate the outcome of treatment and have adequate data to compare it across different service providers. TPAS can also play important role in tracking the case of the insured at the hospital and streamline the claim process. They collect all the bills, reimburse them and send all necessary documents for the consideration of claims to the insurer. This gives them an opportunity to design and develop information systems which would allow them to analyze data regarding hospital admissions, ascertain the health needs of patients and check for effective treatment protocols, tracking documents pertaining to each case and tracking shortfall in claims. This study examined these different roles played by TPA from providers and policyholder perspectives.

Time taken to settle claims of providers of healthcare services: TPAs were introduced as intermediaries to facilitate claim settlement between the insurer and the insured. They have the responsibility of managing claims, getting reimbursements from the insurance company and paying to the healthcare provider/hospital. It is expected that with the introduction of TPA services, the claim settlement process would be simplified. IRDA has suggested that all claims should be settled in 7 days, but settling claims in seven days looks very ambitious target in current scenario.

Many private insurers have a reputation of slow claim servicing due to a high level of procedures and bureaucracy; many private insurers have a policy of cancelling or restricting cover/approval, this has had a significant negative effect on the hospital reputation with policyholders blaming the hospital when cover is cancelled. The policyholders need to understand that hospital is just a service provider between the insurer and insured.

Impact of TPAs on hospital administration and cost: The introduction of TPAs as claim settlement intermediaries in health insurance gives rise to certain concerns. For example, many hospital administrators feel that TPAs put additional burden on their administration. TPAs also influence their payment rates.

Policyholders questionnaire were designed to assess the following issues:

Awareness about TPA services: With the introduction of TPA, insurers outsource their administrative activities to TPAs. Their activities include issuing identity cards to the policyholders, 24-hour help-line for customer services, informing the hospital regarding empanelled hospitals, arranging for specialist consultation and claim processing during admission of the policyholders. Hence, it is expected from them to have strong communication skills in dealing with the policyholders. In a traditional insurance market, heavily dominated by insurance agent, knowledge and impact of TPA is a matter of determination. This survey of policyholders attempts to understand the level of awareness and knowledge among the policyholders about TPA services.

Knowledge about coverage and exclusion in policies: Examination of exclusion clauses in the policy is imperative before authorizing admissibility and further treatment. There is a real lack of knowledge about health insurance and the role it can play in mitigating risks and preventing economic hardships.

Services and customer education by the TPAs: TPAs are expected to provide value added services to the consumers which include arrangement of ambulance services, medicines and supplies, guide members for specialized consultation, provide information about health facilities, hospitals, bed availability, organization of life style management and 24-hour help-line services. Policyholders will be directed to an empanelled hospital with which TPA has tie-up management. However, policyholder has a choice to go to any hospital. But cashless facility will be available at only empanelled hospitals. To put in short, the jobs of TPAs is to maintain database of policyholders and issue them identity cards with unique identification numbers and handle all the insurance policy related issues including claim settlement.

Experiences of policyholders with healthcare providers: Hospitals empanelled with TPA appointed by insurance company agree on providing cashless facility to policyholders of the insurance. TPAs directly pay the healthcare providers. For this TPAs get reimbursements from the respective insurance company. However, after the introduction, many hospitals complain delay in getting their reimbursement of bill.

Data collection: After designing the tool for data collection, the data was collected and recorded by asking policyholders to fill the questionnaire. Also by daily communicating and taking In-depth Interview of Insurance coordinators and manager administrator handling the insurance work.

DATA ANALYSIS & FINDINGS:

PROVIDER PERSPECTIVE:

1. TPA SERVICES AT THE TIME OF ADMISSION OF PATIENTS:

Table 3: TPA activities during patient admission

Activities that TPA carried out when patient is admitted		Percentage
Arranged for specialized consultation		0
Asking about treatment protocols	Yes No Don't know	12.5 62.5 25
Audit and scrutinize the bills	Yes No Don't know	75 12.5 31.25
Enquire about test room rates	Yes No Don't know	43.75 18.75 37.5
Enquire about the length of stay	Yes No Don't know	68.75 6.25 25
TPA always visits to hospital	Yes No Don't know	87.5 12.5 0

Interpretation of TPA services at the time of admission of patients: According to the hospital administrators, TPAs most of the times visit their clients during admission in the hospital. The key activities of the TPA are to enquire about duration of stay in hospital, enquiring about tests/room rates, scrutinizing the bills and enquiring about treatment protocols. The findings suggest that TPAs do not arranged for any specialized consultation on the patient condition. TPAs devote more attention on financial issues than on care management issues.

2. CLAIM SETTLEMENT WITH HOSPITAL:

Table 4: Claim settlement with hospital

Item		Percentage
TPAs delay in claim settlement	Yes No Don't know	93.75 6.25 0
TPAs reimburse 100 percent of bills	Yes No Don't know	56.25 31.25 12.5
Pay interest on due amount	Yes No Don't know	0 100 0

Interpretation of Claim settlement: Hospital report that TPAs always delay in settling claims. While the agreed time of claim settlement with the TPA is less than 1 month, actual time for claim settlement varies from 2 to 3 months

3. INFLUENCE AND IMPACT OF TPA ON HOSPITAL:

Table 5: Influence of TPAs on Hospital

Influence of TPA	Mean (SCALE:5.0)	Standard Deviation
Insist on following standard protocol	2.44	1.44
Try to influence diagnostic process	1.75	1.07
Try to interfere in treatment decision	1.54	0.85
Influence to prescribe new drugs	1.44	0.73
Influence to acquire new technology	1.68	0.98

Table 6: Impact of TPA on hospital performance

Impact of TPA on hospital performance	Mean (SCALE:5.0)	Standard Deviation
No. of admission in hospital has gone up	2.49	1.27
ALOS has gone up	1.87	1.00
Rate of occupancy has gone up	2.10	1.15
Cost per bed day has increased	1.93	1.06
Maintaining relationship with TPA is difficult	3.65	1.20
Time spend with insurance company is substantial	2.97	1.47
Staff expenditure has gone up	2.97	1.29
Overall Hospital expenditure has gone up	3.13	1.11

Interpretation of Influence and impact of TPAs: In order to understand the influence and impact of TPAs on hospital management practices and activities, questions focusing on different parameters using a scale of 5 (from strongly agree to strongly disagree) were included. Hospital administrators perceive no significant influence of TPAs in their routine hospital administrations. Simultaneously, TPAs have minimal control on treatment procedures and protocols of the hospital. Hospital administrators do not perceive having experienced any marked increase in patient turnover after formalizing association with the TPA. However, this new partnership imposes significant burden on hospital expenditures as efforts in liaisoning with the insurance companies and TPA.

AWARENESS AND PERCEPTIONS OF POLICYHOLDERS:

Table 7: Policyholder's knowledge about the policy

Knowledge about insurance policy	Mean (Scale:5.0)	Standard deviation
Knowledge of disease covered	3.71	1.41
Informed about disease not covered	3.52	1.32
Informed about cash-less services	3.52	1.60
Empanelled hospital list provided	2.90	1.74
Knowledge about TPA	1.73	1.15
Knowledge about documents required	3.34	1.52

INTERPRETATION:

Knowledge about policy and TPAs: It was quiet evident that policyholders have very little information about their insurance policy. Generally policyholders avoid dealing directly with their insurance companies due to various procedural hassles. Insurance agents seem to have major influence on policyholders' decisions and policyholders have more trust and faith in them. Policyholders due to the influence of insurance agents and their trust in them blindly accept the policy terms without knowing themselves the complete clause and conditions. Sometimes this lack of knowledge creates problem later on when patient avail for cash-less services. Also if the insurance agent leaves that insurance company then policyholders think that it's the hospital responsibility to complete all the formalities needed for cash-less approval. The insurance companies and intermediaries have to work hard to ensure that policyholders are aware of the policy content, benefits and provisions for TPA's.

Knowledge about coverage and exclusions in policies: Policyholders have inadequate knowledge on illnesses covered in their policies, exclusion of illnesses in the policy, cashless reimbursement and the list of empanelled hospitals.

Knowledge about documents, reports, forms and records needed for reimbursement: Policyholders have inadequate knowledge about the documents, reports, forms and records needed by the hospital for cashless and reimbursement health insurance policies.

CONCLUSION:

The aims and objectives for which the study was undertaken, has been moderately achieved. It was the first attempt to study cash-less related process and procedures of the hospital. A lot of effort was put in for search, extraction and composition of data. Many facts and remarks were appeared during study period .

This study discusses the perception of hospital administrators and health insurance policyholders about the TPA services. Only small percentages of the policyholders in the sample have knowledge about existence of TPAs. General awareness about the TPAs existence and services they provide is low. Policyholders rely more on their insurance agents than on the insurance companies or third party administrators. TPAs are the interface between the insurer and the insured and they are in a position to educate the policyholders about health insurance. However, there role in consumer education does not infuse much confidence on their intention or ability to do so. Hospital administrators do not perceive introduction of TPAs has increased their patient turnover and at the same time they perceive that this has increased the burden on their expenditure as effort level to manage the relationship has gone up. However, there is an indication that hospital administrators foresee clear business potential in their association with the TPA system. The TPA services on the other hand need to focus on developing their competencies and capacities and take care of various operational issues in provision of services. This will need significant amount of investment on developing their human potential. The advent of cashless by a hospital is expected to play an important role in health insurance market in ensuring better services to policyholders. However, the hospitals and insurance sector still faces challenge of effectively institutionalizing the services of the cashless. A lot need to be done in this direction.

Currently, there are no mechanisms in place to appraise the performance of the TPAs. The IRDAs present role of TPA appraisal is more based on their financial performance rather than on customer satisfaction. There is a need to link incentive on TPAs with their performance rather than fixed percentage of policy premium presently accreditation and grading system are based on quality of care of the hospitals alone. Eventually, the industry need to gear up to link accreditation for TPAs based on tie-up with insurance companies and quality of TPA services.

Claims management is perhaps the most important aspect of providing effective in-patient healthcare because it is the intersect of misuse control and client service. Thus hospital needs to design the mechanism to claim cash-less reimbursement process as simple as possible.

This study attempts to develop an understanding of what healthcare providers and policyholders think about the cashless hospitalization services. The major findings from the study are: (1) low awareness among policyholders about their policy. (2) Policyholders mostly rely on their insurance agents. (3) Healthcare providers do experience substantial delays in settling of their claims by the insurance provider. (4) Hospital administrators perceive significant burden in terms of effort also. However, there is an indication that hospital administrators foresee business potential in their association with TPA in the long run. There is a clear indication from the study that the regulatory body needs to focus on developing mechanisms, which would help TPAs to strengthen and ensure smooth delivery of cashless services in emerging health insurance market.

RECOMMENDATIONS:

- TPAs should devote more attention on care management issues related with policyholders rather than focusing on financial issues.
- TPAs must settle the claim to the hospital on time so as to build a strong relationship with hospitals
- Policyholders should be made more aware about the TPA and the policies.
- Policyholders should contact directly with insurance company rather than depending on insurance agent.
- Need to focus on developing mechanisms, which would help TPAs to strengthen and ensure smooth delivery of cashless services in emerging health insurance market
- The hospital needs to send the bills on time. delay in the bill dispatch process will create delay in receiving the amount from the concerned authority.
- Constant follow -up need to be done with the corporate/TPA after bill has been dispatched
- The insurance companies and intermediaries have to work hard to ensure that policyholders are aware of the policy content, benefits and provisions for TPA's.

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ANNEXURE:

A.QUESTIONNAIRE FOR POLICYHOLDERS

A COMPREHENSIVE STUDY ON MEDICAL INSURANCE

1. Full Name: ……
2. Date of Birth:……..
3. Phone:…….
4. Email address:……..
5. Occupation:……..
6. Age group you belong to:
   - Less than 20
   - 20-40
   - 41-60
   - More than 60
7. Do you have medical insurance?
   - Yes
   - No
8. The medical insurance you have belong to which category?
   - Mediclaim
   - Cash-less
9. What kind of medical insurance cover you have?
   - Personal Insurance
   - Family Insurance
10. If you are covered under family insurance, then how many members are included in it?
    - 2
    - 3
    - 4
    - 5
    - More than 5
11. Since how long you have been under medical health insurance coverage
    ……
12. How many times you have incurred your claim?
    - Never
    - Once
    - Twice
    - Thrice
    - More than thrice

Tick the appropriate option suitable to you in the table given below:

	Strongly Agree (1)	Agree (2)	Don’t know (3)	Disagree (4)	Strongly disagree (5)
13. I am well informed about all diseases covered under policy					
14. I am informed about diseases not covered under policy					
15. I am informed about cash-less services					
16. I am provided with empanelled list of hospitals under cash-less					
17. I m aware about TPA					
18. I m aware about document needed at the time to claim cash-less					