An Observational Study on Making Health Claims Cost-Effective for Insurance Providers

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

Ms. Shreya Sarkar

Under the Supervision and Guidance of

Dr. Daya Krishan Mangal

Professor, IIHMR University, Jaipur

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled "**An Observational Study on making Health Claims Cost-Effective for Insurance Providers**" is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Ms. Shreya Sarkar Date: 30 June 2022

CERTIFICATE BY ORGANIZATION

This is to certify that **Ms. Shreya Sarkar** in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur, has successfully completed her internship at **TATA AIG** on **March 23, 2022**, to **June 23, 2022**.

Place: Mumbai

Date: 30 June 2022

Mr. Vaibhav Jain
AVP – Health Claims
TATA AIG General Insurance Company Ltd.

CERTIFICATE BY INSTITUTION

This is to certify that dissertation titled "**An Observational Study on Making Health Claims Cost-Effective for Insurance Providers"** is a record of the research work undertaken by **Ms. Shreya Sarkar** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

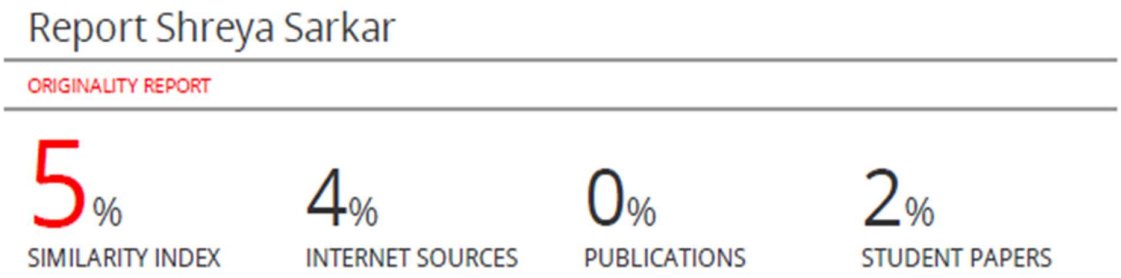
Dr. Daya Krishan Mangal
Professor & faculty guide
IIHMR University, Jaipur
Date: 02-June-2022

Dr (Col) Mahender Kumar
School Dean
IIHMR University, Jaipur
Date:

PLAGIARISM REPORT

This is to certify that the dissertation project report entitled "**An Observational Study on Making Health Claims Cost-Effective for Insurance Providers**" submitted by Ms. Shreya Sarkar for the partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur, has been evaluated for plagiarism by the university.

The thesis has **05%** plagiarism on evaluation by Turnitin software.



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"The exposure and opportunity I received at TATA AIG; Mumbai was a wonderful stroke of luck. The presence of such cooperative staff and all the faculties made my journey full of knowledge and fun. I am incredibly grateful to learn all the necessities required to be a potential research scholar and gain knowledge about the new techniques and methods needed by my curriculum, which opens a door full of opportunities in front of me.

The efforts taken in completing this project have been an admirable journey. However, it would not have been possible without the kind support and help of my external mentor Mr. Vaibhav Jain Sir (AVP-Health Claims), and his supporting staff Dr. Prudviraj Sir (Senior Manager-Health Claims), and Abhishek (MT-Health). I would like to extend my sincere thanks to all of them for guiding me throughout the project and giving me a golden chance to work as a part of his team.

I would like to thank my internal faculty guide, Dr. Daya Krishan Mangal, who has actively sent us the guidelines to prepare this report, and our institution IIHMR for giving us a chance to stand by ourselves and represent our knowledge on such platforms. I am also thankful to the dean Dr (Col) Mahender Kumar of the Institute of Health Management Research, and the complete team of placement cell for their continuous support during the tenure of my dissertation.

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I am highly indebted to all the faculties for their guidance and constant supervision, as well as for providing necessary information regarding the project and for their support in accomplishing the task.

I perceive this opportunity as a big milestone in my career development. I will strive to use gained skills and knowledge in the best possible way, and I will continue to work on the suggestions to attain desired career objectives."

Ms. Shreya Sarkar

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TABLE OF FIGURES

TABLE FOR ABBREVIATION

S.No.	Abbreviation	Meaning
01	TPA	Third-Party Administrator
02	IRDAI	Insurance Regulatory & Development Authority of India
03	RBI	Reserve Bank of India
04	CGHS	Central Government Health Scheme
05	AI	Artificial Intelligence
06	PPN	Preferred Provider Network
07	OOP	Out of Pocket
08	HIC	Health Insurance Company
09	WHO	World Health Organization
10	ID	Identity
11	RPA	Robotic Process Automation
12	TAT	Turnaround Time
13	IoT	Internet of Things
14	HAT	Health Administration Team
15	COVID-19	Corona Virus (SARS-CoV-2)
16	CKYC	Customer-Know Your Consumer
17	NEFT	Network Electronic Fund Transfer
18	Rs. 1 L	Rupees One Lakh
19	ML	Machine Learning

ABSTRACT

India is an untapped zone for insurance industries, and due to its reservation against the adoption of health coverage plans, the people suffer a lot. Over some years, a rise in medical treatment expenses has been observed, which leads to the person looking after necessities and in any event, acquiring cash to take care of the doctor's visit expense or to pay off the huge debts taken in exchange to avail substandard medical treatment. A third-party administrator acts as a middleman between the insurance providers and their policy holders. The rise in the conflict between insurance providers and TPA's have increased the turnaround time for settlement of health claims, leading the companies to reduce the number of TPA's and thereby saving their business in dire times, such as the COVID-19 pandemic. The mismatch of required supporting documents and wrongly filled forms also create an issue validating a claim for settlement and payment processes. Bajaj Allianz and other insurance giants oversaw this problem and moved their operation by establishing a separate team within their own company to process the claims faster. Insurance companies have also considered the automation processing of claims using artificial intelligence and machine learning methods. It can be speculated with the modernization that the adoption of health insurance plans among the Indian population will increase with rising awareness, the introduction of new products & policies, and automated claim settlement processes to extinguish the potential frauds. The study covers the identification of challenges faced during claim settlements in insurance companies due to third-party administrators to make the process cost-effective for insurance providers.

Keywords – Third Party Administrators, Health Insurance Claims, In-house Automation, IRDAI, Claim Settlement, Insurance Providers.

1. INTRODUCTION

1.1 History

It has been a while since the health insurance sector got introduced in India. However, the Insurance system has been deeply rooted in the pages of Indian history and has been evident in the writings of Manu Smriti, Dharma Shastra, and Ardh Shastra. Such traces of writings mentioned collecting vast amounts of resources that can be used in desperate times such as floods, epidemics, calamities, etc. The health insurance concept was first suggested in 1694 by Hughes and Elder Chamberlain from the Peter Chamberlaine family. The idea of insurance started with accident assurance which was available in the 19th century. Still, in the middle of the late 20th century, traditional disability insurance evolved into the new health insurance programs.

Throughout the previous 50 years, India has likewise accomplished a great deal regarding medical coverage. After freedom, essential medical care was given significance and has seen extensive improvement. Health care coverage history in India started with employee protection plans it was presented as an umbrella of government-backed retirement scheme for regular employees.

In 1954, a program for Central Government Health Scheme (CGHS) was proposed. It was a contributory plan to give medical services, particularly for CGHS workers and their families. The Government of India and CGHS workers likewise contributed a sum each month considering their compensation scale, which has been working out well.

In 1986, General Insurance Corporation normalized the agreements of health care coverage and sent off India's first Mediclaim policy. It was a health care coverage, covering hospitalization costs with exceptions to previous illnesses, pregnancy, childbirth, HIV/AIDS, etc. Because of the repayment statement, the uses were repaid straightforwardly through outsourced third-party components.

Moving on, in 1991, after the new economic approach and liberalization were presented by the govt of India, privatization of the insurance domain occurred. The Insurance Regulatory and Development Authority (IRDA) Bill was passed in the Indian Parliament. In the health care coverage developments, it set as an achievement with no stones unturned, and the health insurance domain began acquiring prominence & significance in India. Currently, medical coverage is one of the arising sectors in India. There are various partners in this environment, for example, private healthcare coverage organizations, TPA, and different stakeholders, pushing daily to foster the best healthcare coverage strategy for their policyholders. With moving modernization, the Indians have become the most dynamic and engaged regarding health care coverages for themselves and their families.

1.2 Health Insurance Penetration in India

Living in this high-speed world is becoming progressively unpleasant and bringing about huge ailments, particularly among Indians. A considerable number of Indians lose their lives to heart diseases and diabetes, which, per a report by WHO, is the primary source of death in India. Aside from that, respiratory illnesses, birth inconveniences, infections, and so on. A phenomenal method for getting ready for such circumstances is to benefit from health care coverage strategies.

In the fiscal year of 2020, five hundred million individuals across India were covered with health care coverage. The entrance of medical coverage in India remained at just around 35% in the year 2018. As per WHO measurements, 31% and 47%, of hospitalizations in metropolitan and country India are either supported by credits or through the sale of existing family resources. Also, according to the figure, 70% of Indians spend their full pay on medical care, and 3.2% of Indians fall under the poverty line attributable to high medical expenses. This plainly shows India is yet an undiscovered market for medical coverage strategies. Individuals in India are very little mindful of what a health care coverage plan is, and the way it works and for what reason would it be advisable for them, if they get one for themselves, because of which they lose on their lifetime reserve funds and offer their valuable resources to cover the hospital expenses, some even fall underneath the poverty line and decide to settle with substandard clinical treatment.

Health care coverage might not be required/ mandatory. In any case, the results of not accepting a health care coverage plan for one's family can devastatingly affect their funds. The COVID-19 pandemic is a fantastic illustration of how it has driven patients to the edge of debt due to the prohibitive cost of seeking good medical treatment. Thereby it can be said that medical insurance is a need, not an extravagance.

The insurance domain in India plays a unique part in the prosperity of its economy. Insurance has been recognized dawn by the financial advisories in India. The insurance business has a ton of potential to develop, infiltrate and support the country economically. The Indian insurance domain is partitioned into two classes, life insurance and non-life insurance. The non-extra insurance area has alluded to as general insurance, both life coverage and non-life coverage are administered by RBI and the Insurance Regulatory and Development Authority of India. The job of IRDAI is to completely screen the whole insurance system in India and furthermore go about as a caretaker of all the insurance customers. Therefore, all insurance providers should submit to the principles and guidelines of the IRDAI.

The insurance market in India comprises a sum of a total of fifty-eight insurance agencies, out of which 24 organizations are life insurance providers, and the leftover 34 are non-life Insurance, out of which there are seven public area organizations. The business has been prodded with product development, innovative channels, and insurance providers designed publicity and campaigns. The piece of the pie for private organizations in the general and medical coverage market expanded from 47.97% in FY 19

to 48.03% in FY 20. In India, gross premiums for non-life insurance plans reached up to 26.52 billion US dollars in FY 21 Between April 2020 and March 2021, from 26.49 billion US dollars in FY 20 Between April 2019 and March 2020. Driven by strong development from general insurance players in March 2020, health care coverage organizations in the non-life insurance sector expanded by 41%, driven by a rising interest for health care coverage items during the COVID 19 pandemic.

In any case, regardless of the consistent development throughout recent years, just around 10% of India's populace is covered under private medical coverage. The Indian health care coverage ecosystem comprises of different partners such as - insurance agencies, recipients, medical clinics and hospitals, third-party administrators or TPAs, agents, brokers, reinsurers insure-techs, new companies, diagnostics, drug stores, pharmacies, value-added service suppliers, government controllers, and the government as a buyer of social insurance plans and strategies.

The rising consideration and mindfulness are because of rising clinical expansion, progressions in clinical sciences, pandemics, and sicknesses. The accessibility of health care coverage covers senior residents, maternity and children are advocating for medical protection. Subsequently, the Indian medical coverage market has created rewarding development roads and open doors for organizations, workers, and clients.

The insurance sector in India has seen a considerable development recently alongside a huge presentation of an immense number of innovative products and policies, such that it has prompted extreme rivalry with a positive and sound result.

The TATA AIG has also observed this excursion of medical coverage development in India.

1.3 Acceptance of Health Insurance Plans by Indian Population

Despite being a major life-saving expense, individuals do not invest in medical coverage strategies because of an absence of knowledge of its advantages. Below are some of the motivations behind why individuals skip purchasing a medical insurance contract.

As medical insurance is not compulsory in India, individuals do not consider it imperative to them and their families. **They need returns for their investments**. Since medical coverage benefits are invisible, individuals consider it purposeless to put money into health care coverage. With the rising medical care expenses and how the COVID-19 pandemic has blown a catastrophe for the funds of those impacted by the treatment costs, it is judicious to invest in a health care coverage plan.

Youthful adults, particularly salaried people, often do not entertain their interest in a medical coverage plan. Medical services during crises like a pandemic or a mishap can be expected by the young and old the same. While a salaried employee might have access to medical plans, one should also know that the plan is non customizable to cater to their specific medical needs; in those cases, an **adjustable individual medical coverage plan** will unquestionably act as the financial saviour if one is laid off

from their work. When one does not have health care coverage to back them during impromptu hospitalization, whether they are young, old, or have family, it is critical to protect the monetary funds with a robust health care coverage plan as it acts as a saviour during crises.

Medical coverage requires instalments of expenses consistently. A few groups feel they cannot stand to pay charges routinely that give no profits. This can be counterproductive since health care coverage unquestionably acts as the hero during hospitalization, whether for a minor or huge treatment. Uninsured individuals endure critical monetary and well-being fallouts because of not having medical coverage.

While there is no standard that one ought to purchase health care coverage, the gamble of being uninsured is critical. Below are the dangers implied in not protecting one's family with a medical coverage strategy.

Without medical insurance, an impromptu hospitalization or a severe mishap that requires a costly treatment plan, or a serious accident that requires expensive treatment can bring about high medical services costs. A mishap, a cancer determination, or even a messed-up appendage can cost many rupees **out of pocket**. With an enormous hospital expense, one is less inclined to set aside cash and turns towards debts. **It can lead to looking after necessities and, in any event, acquiring money to take care of the doctor's visit expense or to pay off debts**.

Because of rising medication and medical services costs, a few medicines are unquestionably costly, particularly without a health care coverage strategy to cover the costs. There are chances that one might **vary the therapy or pick a cheaper clinical treatment**. The well-being of the family is fundamental, so they should protect it with the health care coverage plan not to miss excellent medical care and drugs. Medical coverage will monetarily safeguard them against high medical care expenses and medications expected for arranged and impromptu hospitalization.

While one might have command over arranged hospitalization, impromptu hospitalization because of an **unanticipated ailment or an accident can seriously influence the funds**. It is wiser to be ready than stress over impromptu hospitalization when one looks for medical consideration with no monetary assurance of the medical coverage plan by getting medical coverage. They can realize they are monetarily safeguarded against an unexpected sickness or even a pandemic like COVID-19.

The government also urges individuals to purchase medical coverage approaches and furnishes them with tax exemption on their expenses. By not buying a health care coverage plan, **one might lose their well-deserved cash as income tax**. By purchasing a health care coverage plan, one can claim tax benefits under segment - 80 D of the Income Tax Act.

1.4 Health Claims

The health care coverage strategy is highly intricate compared to other general insurance plans. This is because a medical policy includes a ton of wording. Subsequently, it is typical for some policyholders to track down troubles in grasping the specific terms of their medical coverage plans. Nevertheless, understanding a health care coverage plan does not have to be difficult. Instead of taking a gander at an outline of the whole plan, it would be much more straightforward to check out each portion at a time.

To purchase health care coverage plans, there are health care coverage organizations; however, to settle claims under those plans, there are Third Party Administrators (TPA's). A Third-Party Administrator (TPA) is a body that manages the claim processes under medical plans and policies. These heads work autonomously, however, may at times likewise go about as an element having a place with the backup plan/s. The TPAs are authorized by the Insurance Regulatory and Development Authority of India a permit to become a critical partner in the insurance ecosystem for ordinary citizens.

For years, there has been a rise in the number of insurance providers, plans/ policies sold, and products for customized health care services have enhanced and expanded, because of which the requirement for TPA's was noticed. A TPA is the foundation of any insurance agency. Without it, taking care of an enormous number of medical coverage cases, inquiries, and complaints on an ordinary premise would be a close incomprehensible errand for insurance providers.

Fig 1. Illustration of Insurance stakeholders and their processes

So how does a third-party administration work?

The TPA issues ID cards to policyholders, which should be displayed at the clinic prior to taking benefits to form cashless only hospitalization. At the hour of a case, a policyholder should intimate the TPA. He/she will be taken to an emergency clinic the TPA has a network with. They can pick another medical clinic, however, at that point, the final payment will be considered as a reimbursement claim by an insurance provider. TPA issues a pre-approval letter to the emergency clinic, after which they

track the case and release all bills to TPA's for its final payment. TPA sends all the reports supporting the validations of cases, alongside bills, to the insurance companies/providers for claims payment.

Health insurance claims concede two types of cases. These are:

1. Cashless Claims – It is a facility where you can go to an impanelled hospital and get treated for your medical emergencies without paying for them. As the hospital is on the list of insurance providers, they will send your medical bills directly to your insurance providers and make the payment against your services, given that you are a policyholder of that insurance company.

2. Reimbursement claims – It is a type of facility where you can visit any hospital, avail the medical services you need, and pay for them from your pocket. Later you can reimburse the amount spent along with the supporting documents from your insurance provider, given that the treatment taken is covered in your coverage plan.

In this study, we will be discussing the challenges faced by an insurance provider when it comes to closing off health claims and what are the potential alternatives the company can opt for to optimize their profits.

1.5 Organization Profile

Tata Group a privately owned conglomerate of 100 companies encompassing several primary business sectors: chemicals, consumer products, energy, engineering, information systems, materials, and services. Headquarters are in Mumbai.

The Tata Group was founded as a private trading firm in 1868 by entrepreneur and philanthropist Jamshedji Nusserwanji Tata. In 1902 the group incorporated the Indian Hotels Company to commission the Taj Mahal Palace & Tower, the first luxury hotel in India, which opened the following year. After Jamshedji's death in 1904, his son Sir Dorab Tata took over as chair of the Tata Group. Under Dorab's leadership, the group quickly diversified, venturing into a vast array of new industries, including steel (1907), electricity (1910), education (1911), consumer goods (1917), and aviation (1932).

Six years later, Jehangir Ratanji Dadabhoy Tata (J.R.D.) took over the position. His continued expansion of the company into new sectors—such as chemicals (1939), technology (1945), cosmetics (1952), marketing, engineering, and manufacturing (1954), tea (1962), and software services (1968)—earned Tata Group international recognition. In 1945 Tata Group established the Tata Engineering and Locomotive Company (TELCO) to manufacture engineering and locomotive products; it was renamed Tata Motors in 2003. In 1991 J.R.D.'s nephew, Indian business mogul Ratan Tata succeeded him as chairman of the Tata Group. Upon assuming leadership of the conglomerate, Ratan aggressively sought to expand it, and increasingly focused on globalizing its businesses. In 2000 the group acquired London-based Tetley Tea, and in 2004 it purchased the truck-manufacturing operations of South Korea's

Daewoo Motors. In 2001 Tata Group partnered with American International Group, Inc. (AIG) to create the insurance company Tata-AIG.

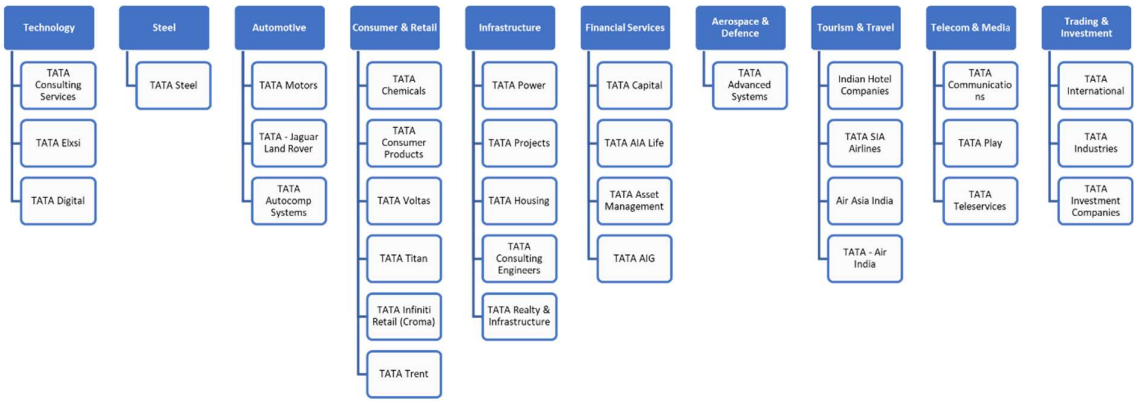

Fig 2. Company Domains

Services Provided by Organization –

TATA AIG is a general insurance company created by the TATA Group and AIG as a joint venture. TATA Group is a prominent Indian industrial conglomerate, while AIG, or American International Group, is a major financial services business in the United States. TATA AIG General Insurance has been present in the insurance industry for two decades after commencing its operations on January 22, 2001. The company has become a household name for insurance needs with the help of its wide variety of products and unparalleled services over the years.

Under its two core business verticals i.e., Consumer Lines and Commercial Lines, Tata AIG General Insurance Company Limited offers an extensive range of General Insurance covers that cater to various individual and business insurance needs. The products range from home insurance, Motor Insurance, Travel Insurance, Health Insurance, Rural-Agriculture Insurance etc. for individuals under the Consumer Line vertical, and Property & Business Interruption insurance; D&O, Professional and General Liability Insurance; and unique products like Reps & Warranties and Environmental Insurance under the Commercial Lines vertical. Each product offering is backed by professional expertise to help the customer throughout the relationship. Tata AIG General Insurance Company Limited has an empowered claims team with an in-house capability of 400 plus experts spread across 90 offices in India.

TATA AIG General Insurance offers various health insurance products ranging from health insurance plans for individuals, families, women, and senior citizens to plans designed for specific diseases and critical illnesses. The insurer maintains tie-ups with more than 3,000 hospitals in its network of cashless hospitals to ensure a quick, easy, and hassle-free claim settlement process for its customers.

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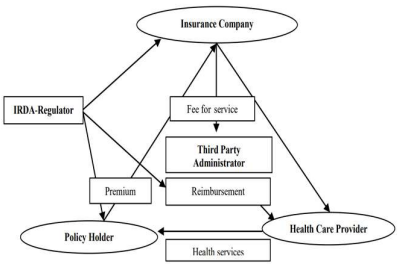
2. **REVIEW OF LITERATURE**

This portion of the study is divided into different sections to understand the relevance of the study. This section will include the following pressing points of the study-

- Working as third-party administrators in the insurance industry
- Third-Party Administrators Regulations and Guidelines
- Automation of Claim processes
- Issues and Alternatives

2.1 Working as third-party administrators in the insurance industry

S.No.	Author	Title of Study	Key Takeaways	Source
01	Janmejaya Samal, Ranjit Kumar Dehury	An Exploration and Assessment of the Current Status and Trend of Third-Party Administrators (TPA) In India	 *Fig 3. Workflow of TPA* The flow depicts the workplace of a TPA. From the figure the TPA is a go-between association that acts in the middle encompassing the approach holder, insurance agency, and the medical services supplier, whereas the IRDA controls the exercises of the strategy holder, TPA, and the insurance agency. Definitively talking, a strategy holder pays a charge to the insurance agency and gets credit only hospitalization whether arranged or crisis. The TPA deals with the other exercises through an organization of exercises in a joint effort with all the partners.	Samal, Janmejaya & Dehury, Ranjit. (2015). An Exploration and Assessment on the Current Status and Trend of Third-Party Administrators (TPA) In India. 6005

2.2 Third Party Administrators Regulations and Guidelines

S.No.	Author	Title of Study	Key Takeaways	Source
01	Gupta, I., Roy, A., and Trivedi M.	Third-Party Administrators Theory and Practice	TPAs face monstrous difficulties in the well-being area considering interest and supply-side intricacies of private medical coverage and the medical care market. IRDA plays characterized the part of TPAs as protection delegates in the administration of cases and repayment. Yet, their job is not apparent in controlling the expense of	Gupta, I., Roy, A., and Trivedi M. (2004) "Third Party Administrators Theory and Practice" Economic and Political Weekly, Vol.

			medical services and guaranteeing true nature of care.	39, No. 28, pp: 3160- 3164
02	Bhat, R., and Babu, K.S.	Health Insurance and Third-Party Administrator's Issues and Challenges	At present, the issues of normalization between the TPAs and the suppliers are passed on to the impulses of market influences, the separate gatherings utilizing their muscles to push each other, constraining the TPAs to arrange neighbourhood understanding.	Bhat, R., and Babu, K.S. (2004) "Health Insurance and Third-Party Administrators Issues and Challenges" Economic and Political Weekly, Vol.v39, No. 28, pp: 3149-3155
03	Jaswal, M.	Understanding the TPAs" Journal of Insurance Regulatory and Development Authority	TPAs are supposed to offer important types of assistance and help at the hour of affirmation and furthermore during the confirmation of patients to the emergency clinics. Yet, TPAs have neglected to offer these types of assistance fittingly.	Jaswal, M. (2010) "Understanding the TPAs" Journal of Insurance Regulatory and Development Authority, August, pp: 20-22
04	Bhat, R., Maheshwari, S. and Saha, S.	Third-Party Administrators and Health Insurance in India: Perception of Providers and Policyholders	Again, heap studies uncover that TPAs are disappointed with the 5.5 percent commission.	Bhat, R., Maheshwari, S. and Saha, S. - "Third Party Administrators and Health Insurance in India: Perception of Providers and Policyholders" Indian Institute of Management Ahmadabad, 2005, pp. 1-24
05	Ananya C V, A. Bhooma Devi, and S. Nithya Priya	Knowledge, Awareness, and Perception of Health Insurance among Insured in a Tertiary Care Hospital	A report was led to survey the information, mindfulness, and impression of a safeguarded individual about health care coverage in a tertiary clinic. A very much outlined organized survey was managed to the assessments of the 384 respondents (safeguarded and uninsured), out of which 92% are protected, and just 8% are uninsured. A couple (12%) of guaranteed do not have any idea how much strategy inclusion is for emergency clinic	Ananya C V, A. Bhooma Devi and S. Nithya Priya, Knowledge, Awareness and Perception of Health Insurance among Insured in a Tertiary Care Hospital,

			charges, and 27% of protected have picked medical coverage strategy to benefit fantastic quality therapy. The outcome obviously shows that a great many people are not that mindful of the most common way of starting credit, only hospitalization. Thus, the insurance agency, outsider overseers, and the emergency clinic should work in cooperative energy.	International Journal of Management, 11(12), 2020, pp 3647-3655

*IRDAI regulations and guidelines are summarized in the annexure.

2.3 Automation of Claim Processes

S.No.	Author	Title of Study	Key Takeaways	Source
01	J.M. Many wanda	Sustainability of Machine Learning in Health Claims Automation in the Kenyan Insurance Industry	The computerization of this information has worked on the effectiveness of the protection framework and the settlement of medical services claims. Claims handling is the main capability of any insurance agency. The speed and comfort with which the cases are settled has a direction on the overall standing of the insurance agency. Issue The protection wellbeing industry in the nation faces hardships that incorporate expanding misrepresentation, increasing expenses, and countless cases proportions. The country's thirty million cases each year should be surveyed, endorsed, and paid consistently. The significant test influencing this is the interaction is not computerized.	Manywanda, J. M. (2021). Sustainability of Machine Learning in Health Claims Automation in the Kenyan Insurance Industry (Doctoral dissertation, University of Nairobi)
02	D. Doss, R. Pawar, & R. Maddireddy	Intelligent Automation in Health Insurance	Robotization has been started in a portion of the centre elements of the medical care industry. Yet, they are not yet wholly mechanized to drive a higher degree of mental or keen computerization. In any case, with the speed increase of the new age advancements like AI and ML, Blockchain, RPA, IoT, etcetera, the whole course of medical services conveyance, right from part enrolment to medical services administrations, including paramedical and subordinate administrations of the medical care environment will turn into a completely computerized in the following 10 years.	Doss, D., Pawar, R., & Maddireddy, R. (2022). Intelligent Automation in Health Insurance. Bimaquest, 22(1).
03	Cem Dilmegani	RPA in the insurance	Mechanical Process Automation innovation offers many advantages to	Dilmegani, Cem, *, N., & says: I.

		industry: Use cases & case studies in 2022	the insurance agencies, from moving the labour force to additional significant undertakings to diminishing manual blunders in claims handling/extortion location processes. As per McKinsey, the protection business can mechanize 25% of the interaction by 2025, and a ton of its computerization expected comes from functional cycles where RPA can help. One more review from McKinsey uncovers that accident protection, property, and loss (P&C) protection, and workers' PCs are regions where backup plans can benefit most from computerization because of the great normalization of cycles. Claims handling is an escalated process where safety net providers must gather data from numerous sources. Handling the information sources physically makes the interaction dull, tedious, and inclined to blunders. As indicated by Work combination, robotized claims handling diminishes manual responsibility by 80% and the time fundamental for the interaction by half. Insurance organizations can use RPA bots to computerize the accompanying strides of cases handling: • Extraction of data • Reconciliation of guarantee-related sources • Contributing information to the frameworks • Recognizable proof and confirmation of deceitful cases	B. (2022, May 23). RPA in insurance industry: Use cases & case studies in 2022. AI Multiple
04	R. Balasubramanian, A. Libarikian, D. McElhaney	Insurance 2030--the impact of AI on the future of Insurance	Human cases the board centres around a couple of regions: complicated and uncommon cases, challenged claims where human communication and exchange are engaged by examination and information-driven experiences, claims connected to fundamental issues and dangers made by current innovation (for instance, programmers penetrate basic IoT frameworks), and irregular manual surveys of cases to guarantee	Balasubramanian, R., Libarikian, A., & McElhaney, D. (2021, July 1). Insurance 2030--the impact of AI on the future of Insurance. McKinsey & Company.

			adequate oversight of algorithmic direction. Claims associations increment their emphasis on risk observing, avoidance, and alleviation. IoT and added information sources are utilized to screen hazard and trigger intercessions when variables surpass AI-characterized limits. Client association with protection claims associations centres around keeping away from expected misfortune. People get continuous alarms that might relate to programmed intercessions for review, support, and fix. For enormous scope disaster claims, back up plans screen homes and vehicles progressively utilizing coordinated IoT, telematics, and cell phone information, expecting cell phone administration and power have not been disturbed nearby. When power goes out, guarantors can prefile claims by utilizing information aggregators, which synchronize information from satellites, arranged drones, weather conditions administrations, and policyholder information progressively. The biggest transporters pretext this framework across various fiasco types, so exact misfortune assessments are dependably recorded in a genuine crisis. Nitty gritty reports are consequently given to reinsurers to quicker reinsurance capital stream.	

COMPANY	BUSINESS FUNCTION	CASE STUDY	RESULTS
Private sector insurance company	Customer Service	Processing queries from SMEs via email, direct branch request, phone, agents and third party resellers are automated	Reduction in quote generation time
			Reduced policy booking time
			Increased conversion rate
			Reduced errors
An insurance company	Customer Service	Automatic processing of quotes and payouts	10 FTEs cost saving
			Reduced quote generation time
A life and financial services company	HR Operations	HR record processing	$200k savings p.a.
		Physician statement orders	
A health insurance company	Operations	Member enrollment process	Reduced effort
		Commercial claims testing audit	Reduced errors
A shared service provider, part of a insurance group	Operations	Streamlining processes that involves involved tracking Excel spreadsheets and consistent communication to and from all the parties involved in handling	56% reduction in incoming email resolution time
			38% reduction in incoming phone call volumes, despite an increase in transaction volumes in the same time frame
Bajaj Allianz General Insurance	Operations	Streamlining 22 processes such as procurement of proposals, approvals &	Cut down redundant tasks Improved efficiency
			Higher customer satisfaction
EXL	Operations	End-to-end claims processing	Reduced processing time
			Reduced audit
			Improved accuracy
Life insurance company	Policy Admin System	Proposal form processing	Improved customer satisfaction
			Error Reduction
			Improved SLA compliance
			Reduction in cost of service

Fig 4. Market analysis of companies that adopted automation and their results

2.4 Issues & Alternatives

S.No.	Author	Title of Study	Key Takeaways	Source
01	K. Jawahar	The problems with health insurance	The main issue is the long completion time (TAT). The TAT for the instalment of a safeguarded patient's treatment in a subsidiary medical clinic is 20 days for credit-only therapy. Most TPAs neglect to fulfil the time constraint regardless of whether the insurance agency has made the instalment to them. This is because of the planned operations associated with caring for various clinics and cases. A few medical clinics become displeased with the postponement and do not offer credit-only therapy offices. Additionally, some TPAs do not deal with Saturdays, though the most backup plans do. This defers the handling of cases. Insurance organizations like Bajaj Allianz, Cholamandalam MS, and Star Health have selected direct settlement of cases, wiping out TPAs.	Jawahar, K. (2020, March 1). The problems with health insurance. Business Today
02	Irum Khan	The conflict between insurers, TPA, and healthcare providers leaving Andheri consumers in financial turmoil	Medical services organizations, insurance agencies and outsider managers are in constant conflict regarding the new protection rules. Prior an openness draft was formed by the Insurance Regulatory and Development Authority (IRDA). "TPAs are progressively eliminating emergency clinics from their Preferred Providers Network (PPN) list for overshooting doctor's visit expenses," said Nayan Shah, Managing Director, Paramount TPA. The PPN gives a set tax bundle to the medical services suppliers. To avoid the obstruction of the TPAs and decrease clinical cases, public area insurance agency is thinking about shaping their in-house TPA. Not a long way behind is the four public area insurance agencies, which are pondering shaping their in-house TPAs. These conflicts are progressively affecting the shoppers, who run from one place to another to get their clinical cases cleared.	Khan, I. (2012, December 6). The conflict between insurers, TPA, and healthcare providers leaving Andheri consumers in financial turmoil. The Economic Times
03	N. Dubey	TPA vs in-house health insurance claim settlement process	A TPA is a middle person between the safety net provider and the inquirer, who works with the settlement/handling of health care coverage claims. The insurance agency designates a TPA. The in-house guarantee handling office,	Dubey, N. (2021, June 11). TPA vs in-house health insurance

			otherwise called Health Administration Team (HAT), is set up by safety net providers inside their organization. The two strategies help the case settlement process and have a few upsides and downsides. Preferred administrations over TPAs - To remain in the opposition, the insurance agency gives special offices to the policyholders. Building an in-house guaranteed process permits the insurance agency to provide exceptional contributions remembering ease for the cases taking care of the front, lower Turnaround Time (TAT), and so on to policyholders now and again. The cycle is smooth and quicker than TPA. Since the policyho0lder can straightforwardly manage the guarantor through the in-house claims settlement, it requires less investment to deal with the case contrasted with a TPA that goes about as the centre man between the safety net provider and the policyholder. TPAs are dependent on safety net providers - TPAs are subject to the backup plans for settling wellbeing claims, which is not true in the in-house guaranteed settlement process as, at last, the guarantors are the ones to deal with wellbeing claims straightforwardly.	claim settlement process: Differences to know. mint.
04	The Financial Express	Health insurance claims: Private insurers go for in-house settlement – Do TPAs need to Polish up their game?	With the quantity of Covid-19 health care coverage claims rising, most confidential safety net providers are selecting in-house claims settlement. In-house claims handling is quicker as the organization can make sense of costs that are not covered straightforwardly to the policyholder, and complaints can be reviewed rapidly. Interestingly, a TPA is a mediator selected by an insurance agency to work with the settlement of a case. While the outsider directors (TPAs) process the cases, the insurance agency takes a conclusion on the case's payable. The protection controller has underlined that policyholder should be given credit-only offices for Covid-19 treatment at all organization emergency clinics with whom the insurance agency or the TPA has administration-level understanding.	Health insurance claims: Private insurers go for in-house settlement – Do TPAs need to Polish up their game? (2020, August 12). Business News- The Financial Express

			The Insurance Regulatory and Development Authority of India (IRDAI) has guided insurance agencies to empanel more emergency clinics the nation over for credit-only treatment, remembering Covid-19 treatment and putting in place a complaint redressal system for grumblings connecting with the disavowal of credit-only cases.	
05	M. Saraswathy	Private general insurers set up in-house TPAs to service claims	Confidential general backup plans, including ICICI Lombard, Bajaj Allianz General Insurance, and HDFC ERGO has their in-house TPAs. Other confidential general safety net providers are setting up an incorporated inner case overhauling process either toward the finish of this spending plan year or the following. To adjust each case, safety net providers should pay a four to five percent commission to TPAs. With an in-house TPA, this cost is diminished. Regarding setting up an interior cases settlement process, Bajaj Allianz General Insurance has been one of the early movers. Suresh Sugathan, head (health care coverage), Bajaj Allianz General Insurance, said in-house claims handling was quicker and added an individualized touch. Guarantors trust in the following three to five years, all broad safety net providers would need to move to either an in-house TPA or a construction in which in-house TPAs handle 75-80 percent claims, with outside TPAs taking care of the rest. Bhandari said for TPAs to proceed, they would need to climb the worth chain by endeavouring to develop proficiency further and offering consistent support to end purchasers.	Saraswathy, M. (n.d.). Private general insurers set up in-house TPAs to service claims. Business News, Finance News, India News, BSE/NSE News, Stock Markets News, Sensex NIFTY, Budget 2022.
06	R. Saxena	TPA vs in house health insurance claim settlement process	In-house guarantee division: The insurance agency could set up a committed cases office for the handling of cases without giving them over to any TPA. This game plan is known as the in-house guaranteed division, and they straightforwardly settle the case demands got from their policyholders. The most recent age medical coverage organizations have their cases settlement division expecting to accelerate the reaction season of guaranteed settlement. The insurance agency is the principal individual in settlement of cases to the policyholder as they take a conclusion. In	Saxena, R. (2021, September 29). TPA vs in house health insurance claim settlement process. IIFL Insurance

			this manner, they are in a superior situation for individuals to accept and confide in them, yet here are a portion of the key factors that these in-house guarantee handling groups have taken over TPAs. • The time taken for guarantee handling is less contrasted with TPAs, as safety net providers accept the last bring-over endorsing or dismissing a case. TPAs depend on the insurance agency at times to get an explanation on specific case demands. • The productivity of the in-house guarantee handling division is high as they address a brand, and any mix-up will influence the brand straightforwardly. • Policyholders can contact the in-house claims division to make sense of the considerations and avoidances, obviously, which would not be imaginable with TPA on the off chance that the individual at the work area is not proficient in the arrangement.	

3. METHODOLOGY

3.1 Aim – The study aims to understand the challenges and issues faced by an insurance provider in terms with third-party administrators and recommend alternatives and suggestions for the settlement of claims.

3.2 Research Question

- What are the challenges faced by insurance providers in the settlement of health claims?

3.3 Objectives

- To understand basic terminologies of health insurance.
- To understand the process flow of health claims.
- To identify challenges in the processes of health claims.

3.4 Material & Method

- STUDY DESIGN – Observational Study carried out in the Production department of TATA AIG.
- STUDY SETTING - TATA AIG provides digital access to all the available policies and standard protocol notes.
- DURATION OF STUDY – The study covers observation of 3 months (March - June2022).
- DATA COLLECTION PROCEDURE – The collected data is qualitative. The observations are collected based on discussions with company personnel and staff to understand the challenges an insurance company faces in a fiscal year. An unstructured observation and understanding of the existing products, protocols, and management tasks are noted. The company did not provide any specific datasets, as the data used by the company is highly confidential and proprietary. Sample data is considered from open sources where ever required.
- DATA ANALYSIS PLAN – The software majorly used was Microsoft Office Suite, including the following –
    - For analysis - M.S. Excel, M.S. Word, M.S. Presentation.
        - Understanding the flow of health claims processes.
        - A discussion was planned to understand the health claim settlement process of the company with respect to third-party administrators.
        - Capturing the current challenges insurance companies face and prospects for a profitable business were discussed.
    - For communicating - M.S. Teams, M.S. Outlook
- ETHICAL CONSIDERATIONS – Access to the proprietary database was requested and provided by the company to understand the flow of the claims processes. The discussion planned were not recorded to maintain the confidentiality of the firm.

4. **RESULTS**

4.1. Process Flow of Health Insurance Claims

4.1.1. For Cashless Claims-

When an insurance agency gives a credit-only cases office, it truly intends that in the event of hospitalization, they do not have to pay anything for the covered costs; the guarantor will straightforwardly pay the emergency clinic for their sake. Notwithstanding, such an office is accessible in a specific organization of medical clinics, which concur with the insurance agency.

- Planned hospitalization

If one has marked the calendar for a specific treatment or medical procedure and knows about hospitalization ahead of time, it is an arranged hospitalization. In such a case, the accompanying advances should be stuck to:

  - Step 1: Inform the safety net provider that the credit-only case structure should be submitted to the insurance agency through email or letter no less than five days before the treatment.
  - Step 2: Wait for the letter; when the guarantor has accepted your credit-only case structure, they will inform the medical clinic and give you an affirmation letter. Credit only case affirmation letter is legitimate for seven days from the grave date.
  - Step 3: Submit the letter upon the arrival of the affirmation, one might have to present the wellbeing card and affirmation letter.
  - The protection supplier will straightforwardly cover the doctor's visit expenses to the emergency clinic.

- Emergency hospitalization

At the point when the hospitalization is abrupt and unforeseen, as in the event of a mishap, it is crisis hospitalization. In such a case, the accompanying advances should be stuck to:

  - Step 1: Inform the safety net provider - The insurance agency or their TPA ought to be hinted in something like 24 hours of hospitalization to produce a Claim Intimation/Reference Number. Important records to be delivered to profit the Cashless administrations are Listed Below -
    - Insurance Card
    - Policy Copy
    - Customer ID Proof with Photo
    - Customer Address Proof
    - Appropriately Filled CKYC Form if the Claimed sum is above Rs 1L.

- Step 2: Further archives - The clinic needs to fill the credit-only case demand structure and submit it to the insurance agency.
- Step 3: Authorisation letter - After the accommodation of the credit-only case structure, the backup plan will give an authorization letter to the emergency clinic.

For this situation, the backup plan will straightforwardly cover the doctor's visit expenses to the medical clinic. If there should be an occurrence of dismissal, one will be implied about the equivalent using a letter on the enrolled Mobile Number and E mail ID.

Cashless Approval Process Flow Chart

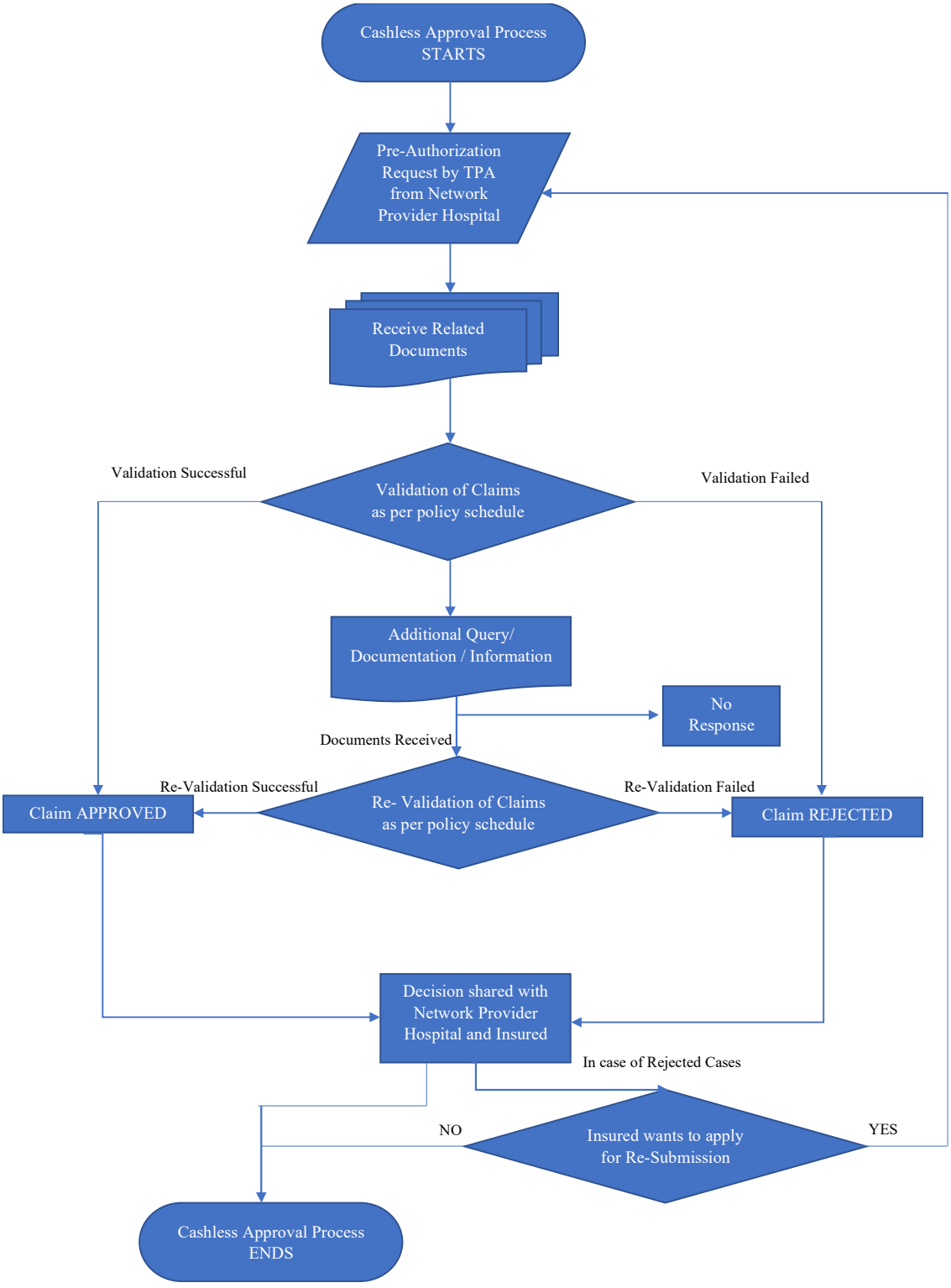


Fig 5. The flow of approval of cashless claims

4.1.2 For Reimbursement Claims

If the guarantor does not give credit to only the case office, or on the other hand, if the emergency clinic is not a piece of their organization's emergency clinics, they will need to take care of the doctor's visit expenses at the hour of hospitalization. The guarantor will later repay them for the doctor's visit expenses. In the event of the repayment guarantee process, the accompanying advances should be stuck to:

- Stage 1: Verify the subtleties - Before marking the bill, confirm whether the subtleties are precise. This is basic as any error here could affect the case cycle.
- Stage 2: Collect the records - Here is an exhaustive rundown of the reports that might be required:
    - Duly filled and marked Claim structure - Link to Download Claim Forms
    - Insurance Card or Policy Copy
    - Medical Certificate endorsed by the specialist
    - Pathological reports like X-beam reports
    - Hospital release card
    - Original Bills and receipts
    - Original Pharmacy bills
    - Investigation report if any
    - FIR/MLC Copy (if there should arise an occurrence of a coincidental case)
    - NEFT Details to credit Claim Settlement
    - Duly Filled CKYC Form if the Claimed sum is above Rs 1L.
- Stage 3: Follow up for reports - Some of the above-recorded reports may not be accessible immediately, and you could need to return following a couple of days to gather them.
- Stage 4: Submit the records - As soon as you are released, you can present this substantial number of archives to the safety net provider or the assigned TPA, contingent upon your back up plan's interaction.
- Stage 5: Wait for instalment handling - Once the reports arrive at the TPA or the safety net provider, they will be investigated. It requires around 21 days from the time the reports come at the TPA to the date of handling the instalment.

Reimbursement Approval Process Flow Chart

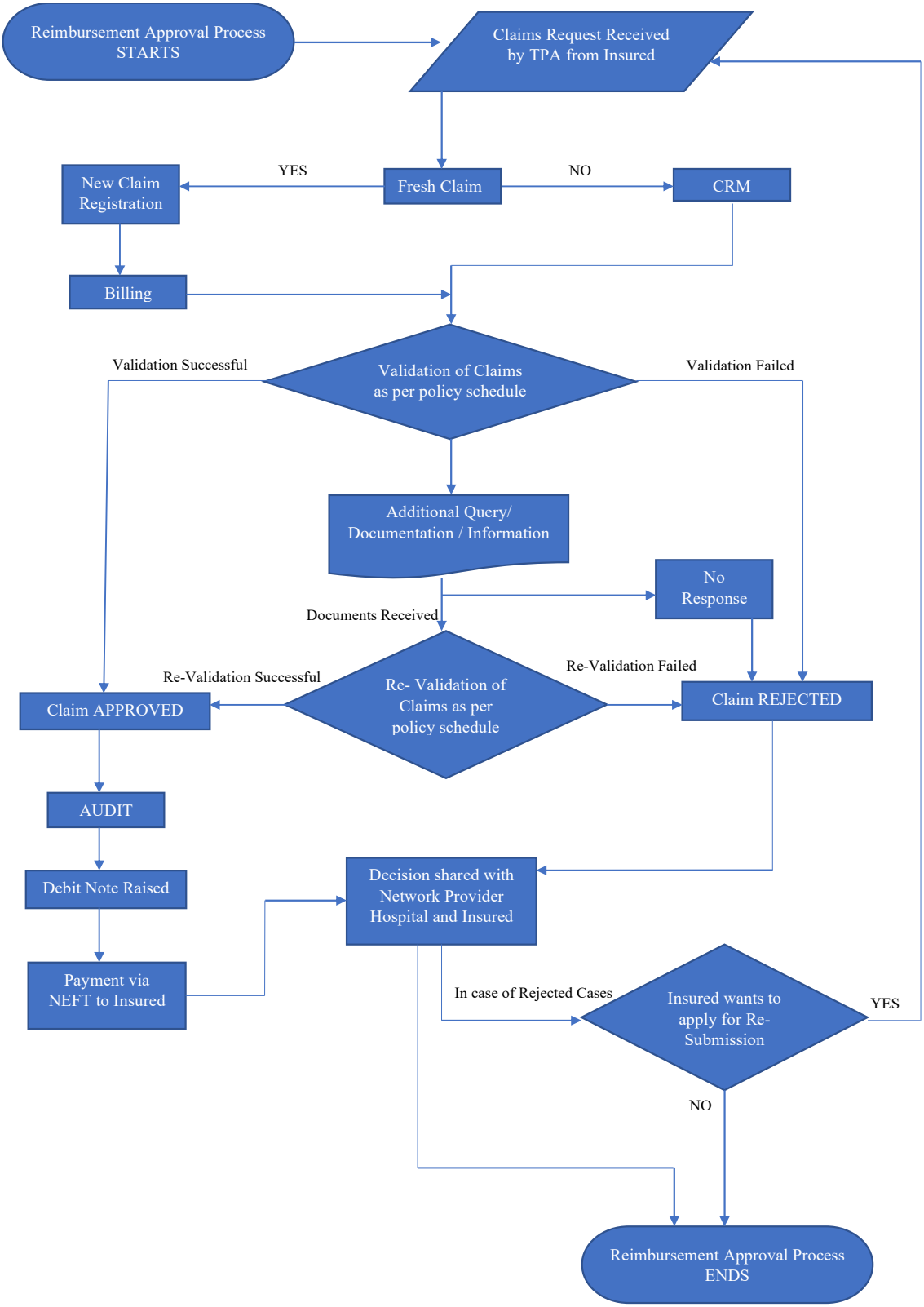


Fig 6. The flow of approval of reimbursement claims

4.2 Issues faced by insurance providers concerning Third-Party Administrators

A TPA is the backbone of any insurance company. Without it, handling many health insurances claims, queries, and grievances every day would be a near-impossible task for insurers. With the help of TPAs, every process, from basic to advanced, runs smoothly. These are the given responsibilities that explain the role of a TPA in a health insurance company:

1. **Administrative maintenance**: One of the main duties of a health insurance Third Party Administrator is taking care of and maintaining all customer information in systematic online and offline records. The responsibility of maintaining and updating these records is on the health insurance TPA also issues a unique customer identification number to their beneficiaries once a purchase of the insurance policy has been made. This identification number consists of the insurance policy number and the complete name and information of the registered Third-Party Administrator.
2. **Claim verification**: When a health insurance claim is raised, the insurer will forward the insurance claim form and details to the health insurance TPA. The TPA will check and verify the authenticity of the hospital bills, submitted documents, and claim form. To verify the genuineness of the insurance claim, they might even call the hospital querying for admission.
3. **Claim settlement**: A health insurance TPA is responsible for confirming the validity of a health insurance claim. How they do this depends on the mode of claim settlement one chooses (Cashless or Reimbursement).
4. **Hospital empanelment**: Health insurance TPAs also have the authority to curate and track the workings of registered network hospitals and add more to their network hospital list. They check the proven track record of the potential network hospital and verify its quality of services, among other factors like brand name and customer satisfaction. If the hospitals clear the verification check, they are successfully added to the hospital network list.
5. **24x7 customer helpdesk**: Health insurance TPAs are the core touchpoint for insured customers. For all the times the insurer cannot address your health insurance queries and problems, you get directed to your chosen TPA. The Third-Party Administrator is fully equipped to tackle your issues and give you actionable solutions. The helpdesk doors are open round-the-clock to deal with customers. Sometimes, the health insurance TPA also provides additional services such as emergency ambulance assistance, wellness programs, lifestyle and disease management programs, and others.

Lately, the insurance companies are facing issues in terms of TPA's associated with them, such as -

- Missing supporting documents to validate information or treatments.
- Weak networking with hospitals.
- Lack of solid standardisation procedures in terms of procurement of the final bills.
- Under-reporting across hospital chain.
- TPAs have several in-house experts such as legal experts, IT professionals, doctors, management consultants and hospital managers, and more which increases the company cost, affecting cases when influxes are low.
- Many hospitals also report additional expenditure incurred by them in terms of smooth coordination with TPAs for efficient delivery of services to the policyholders.
- Cases of fraudulent practices are also registered against TPA for scamming the insurance providers and the policyholders by cutting a deal with hospitals to lower the medical treatment and increase the claim amount.
- Commission-based pay for third-party administrators have also increased the claims influx as upon investigation and analysis, most of them turn out to be invalid claim/no claim.
- Submission of the incorrectly filled form.
- TPA's often overpromises to the policyholders that they will be paid for the treatment, without crosschecking the medical facts and underwritings mentioned in the policy documents. This often leads to a bad reputation for the insurance providers as they will only pay for what is mentioned in the policy contract.
- The processing system of TPA and insurance providers do not match, which leads to a document going back-&-forth between the two for a long time.
- The medical team of TPA may raise a higher pre-authorization amount, but the insurance company is liable to pay the excessive amounts in a claim to the policyholder.

However, new, and much smaller HIC do not require an outsider TPA to liaison them and the customer since the company is new to the health insurance industry and is growing its customer-based products more than the corporate giants. So that their claims are settled within the company itself without external help, reducing the chances of fraud and at this moment increasing turnaround time for the service being provided to the individual customer.

5. CONCLUSION

It is evident and noticeable that the insurance companies rely heavily on the analysis provided by third party administrators, thereby becoming a major stakeholder in the insurance ecosystem. The observations collected throughout the study indicate **over-dependency of insurance companies on third-party administrators**, which has now started to create some issues when it comes to the settlement of claims. Falling back on non-provider network hospitals, has begun to cause monetary loss to the insurance providers. Another issue faced by numerous policyholders in such dire circumstances is continuous follow-up with the TPA's, apart from that, TPA's end up demanding an additional instalment to settle the case totally. There are obvious examples of negligence with different amounts asked for a similar sickness at a similar medical clinic. The Insurance Regulatory and Development Authority of India (IRDAI) did not waste any time making a follow-up on this pressing matter. IRDAI has referenced in its guidelines that TPAs cannot reject any case on behalf of an insurance providers and that they can only manage cashless claims.

Insurance providers and TPA's deal with some negotiations with their preferred network hospitals beforehand for some concessions or discounts. The consumer is unaware of the negotiations and the low bill's advantages are not yet known to them. Recently the IRDAI has set up the guidelines to mention the discount details on the final bills to keep the consumer aware of the cost of medical services opted by them. This will allow the consumer to save up some money on the insured sum amounts and future claims settlements.

During the filing of claims, even though the steps are simple to follow and in case any action is skipped, it affects the complete claim process, thereby delaying the settling ratio for claims of the company. Some challenges that were identified are-

1. Submission of incomplete claim forms – it is the responsibility of TPA to collect and verify all the necessary documents before filing the claims to insurance providers. In cases when they fail to do so, the claims cannot be verified and validated. This happens too often when the family is already worried about the health status and an added stress gets piled up on their head of missing document, this often leads to claim settlement issues at the last moments. We can also consider that as a manual error in the process, however it counts as the main reason for the settlement delay. An AI driven environment can reduce this error by tagging the missing supporting documents prior to discharge, thereby eliminating one such incident.
2. The lack of regulatory guidelines – Policy holders majorly complaint about the rejection of cases by the insurance providers of cases that are genuine, knowledge of products and policy being sold, the list of network hospitals or lack of supporting documents due to communication barriers (insurance terminologies). A considerable number of these grumblings can be followed back to lacks in the current guidelines. For instance, the guidelines are not satisfactory on

revelations that insurance agencies ought to make to their buyers, how exposures ought to be made, and the technique for settlement of cases.

3. The pandemic sped up the reception of innovation for the claims processes as well, driving companies to re-evaluate how they use the staff and augment the innovation available to them. This has likewise taken care straightforwardly by moving the progressing and these strategic decisions to in-house processing than outsourcing claim processes through TPA's.
4. TPAs have also been reported to ask for commissions from hospitals on every claim filed, for the latter to be enrolled in a Preferred Provider Network (PPN) list. Since insurers rely primarily on the PPN list to allow successful cashless settlements, often many hospitals fall for this lure. They have also been asking for commissions from insurance companies on the number of claims processed by them, irrespective of the fact that later the claims turn out to be invalid.

From the above-mentioned observation this can be concluded that due to the over dependency on TPA's for processing the claims, the TPA might have found a loop in the system to take the responsibilities given to them by insurance providers for granted and hence a leak in the system got introduced. This leak/loop in the insurance ecosystem has now started to create issues for its consumers i.e., the policyholders and the insurance providers. The Indian economy relies heavily on the financial flow of these insurance companies and such a crack in the system can cause greater chaos in the insurance industries in India.

6. DISCUSSION

The movement of companies from outsourcing claim processes through TPA's to in-house processing of claims have brought a lot of change in the way the traditional insurance companies worked since the independence of the country. This change has also helped the insurance companies to identify what are they missing and what needs to be addressed to keep the business floating in the market. Moving the operations form TPA's to in house may add up a lot of tasks or burden on the company but the brand the company will not be jeopardized because of faulty delays.

There are several advantages of retaining every step of the process in-house -

- **Adherence to quality standards** - By not outsourcing any step of the health insurance process, the company is able to ensure adherence to quality in each facet of the service delivery. They will have complete control over the development, modifications, and administration of the health insurance policies. This allows them to keep the process centralised and scrutinised on a consistent basis, enabling them to deliver high-quality services to the customers.

- **Competitive pricing** - By not having to engage and pay third parties for performing parts of the process of the administration of the health insurance plans, the company is able to provide said plans to customers at competitive prices. This way, the customers get excellent health insurance benefits at feasible prices.

- **Differentiation** - Keeping the entire process of administering the health insurance plans in-house is of excellent value in creating and maintaining product differentiation and a competitive advantage in the industry. With the unique health insurance plans that can be customised according to the health and insurance requirements, the insured can be assured of quality service and benefits.

Adoption of digital techniques to lessen the burden when the claim influx is high has started to give out profitable results to some insurance giants such as Bajaj Allianz, Aditiya Birla, and a few more. This can be speculated that automation of departments with the insurance companies can help in TAT of settling claims. It also helps gather the insights as to which product or policy can be more profitable if marketed correctly to increase the revenue of the company. Using of AI and ML techniques and methods have proven to be best in the interest of both insurance providers and policy holders. It can also be debated for some cases where the AI rejects genuine cases as per the policy wordings, but some exceptions can be made to identify those case. Automation can also help in identifying cases that are fraudulent and require further manual investigation. Even if the artificial intelligence claims to be an astounding revelation in insurance industry the acceptance of it in the Indian markets can be pictured after a decade.

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8. **ANNEXURE – A**

IRDAI Guidelines for Third-Party Administrators

8.1 Health services by TPA:

1. A TPA may render the following services to an insurer under an agreement in connection with health insurance business:
    a. servicing of claims under health insurance policies by way of preauthorization of cashless treatment or settlement of claims other than cashless claims or both, as per the underlying terms and conditions of the respective policy and within the framework of the guidelines issued by the insurers for settlement of claims.
    b. servicing of claims for Hospitalization cover, if any, under Personal Accident Policy and domestic travel policy.
    c. facilitating carrying out of pre-insurance medical examinations in connection with underwriting of health insurance policies provided that a TPA can extend this service for life insurance policies also
    d. health services matter of foreign travel policies and health policies issued by Indian insurers covering medical treatment or hospitalization outside India
    e. servicing of health services matters of [travel or health or medical Insurance] policies issued by foreign insurers for policyholders who are travelling to India: provided that such services shall be restricted to the health services required to be attended to during the visit or the stay of the policyholders in India.
    f. servicing of non-insurance healthcare schemes as mentioned in Regulation 22 (3) of these Regulations
    g. any other services as may be mentioned by the authority
2. While performing the services as indicated at Regulation 8.1 (1.a) of these regulations, a TPA shall not
    a. Directly make payment in respect of claims
    b. Reject or repudiate any of the claims directly
    c. Handle or service claims other than hospitalization cover under a personal accident policy
    d. Procure or solicit insurance business directly or indirectly
    e. Offer any service directly to the policyholder or insured or to any other person unless such service is in accordance with the terms and conditions of the policy contract and the agreement entered in terms of these regulations.
3. A TPA can provide health services to more than one insurer. Similarly, an insurer may engage more than one TPA for providing health services to its policyholders or claimants.
4. The policyholder can choose a TPA of their choice from amongst the TPAs engaged by the insurer, where services of TPAs are engaged by the insurer for a given insurance product.
    a. Where the services of the TPA are terminated during health services rendered by the said TPA, every insurer shall allow the policyholder to choose an alternate TPA from amongst the TPAs engaged by it.
    b. The insurer shall explicitly provide the names of the TPAs amongst whom the policyholder may choose the TPA of their choice at the point of sale. The policyholder may be allowed to change the TPA of their choice only at the point of renewal.

Provided that the policyholder shall have no right to seek dispensing the services of the TPA and request the insurer to undertake rendering the health service directly.

Provided further that the insurer shall have the prerogative of whether to engage any TPA or to terminate the services of the TPA or not to engage the services of the TPA for a particular health insurance product or discontinue the services of the TPA to service a particular health insurance product.

Provided further that the insurer shall have the prerogative of changing the TPA in accordance with the provisions of sub-regulation (8) of regulation twenty of these regulations.

c. Where the policyholder did not choose any of the TPAs, the insurer may allot the policy servicing to a TPA of its choice.
d. Where the insurer engages the services of only one TPA, no option need be provided to the policyholder.

5. The authority may specify guidelines for disclosure of qualitative and quantitative parameters by all insurers and TPAs with respect to the health services rendered.

8.2 Settlement/Rejection of claim by insurer:

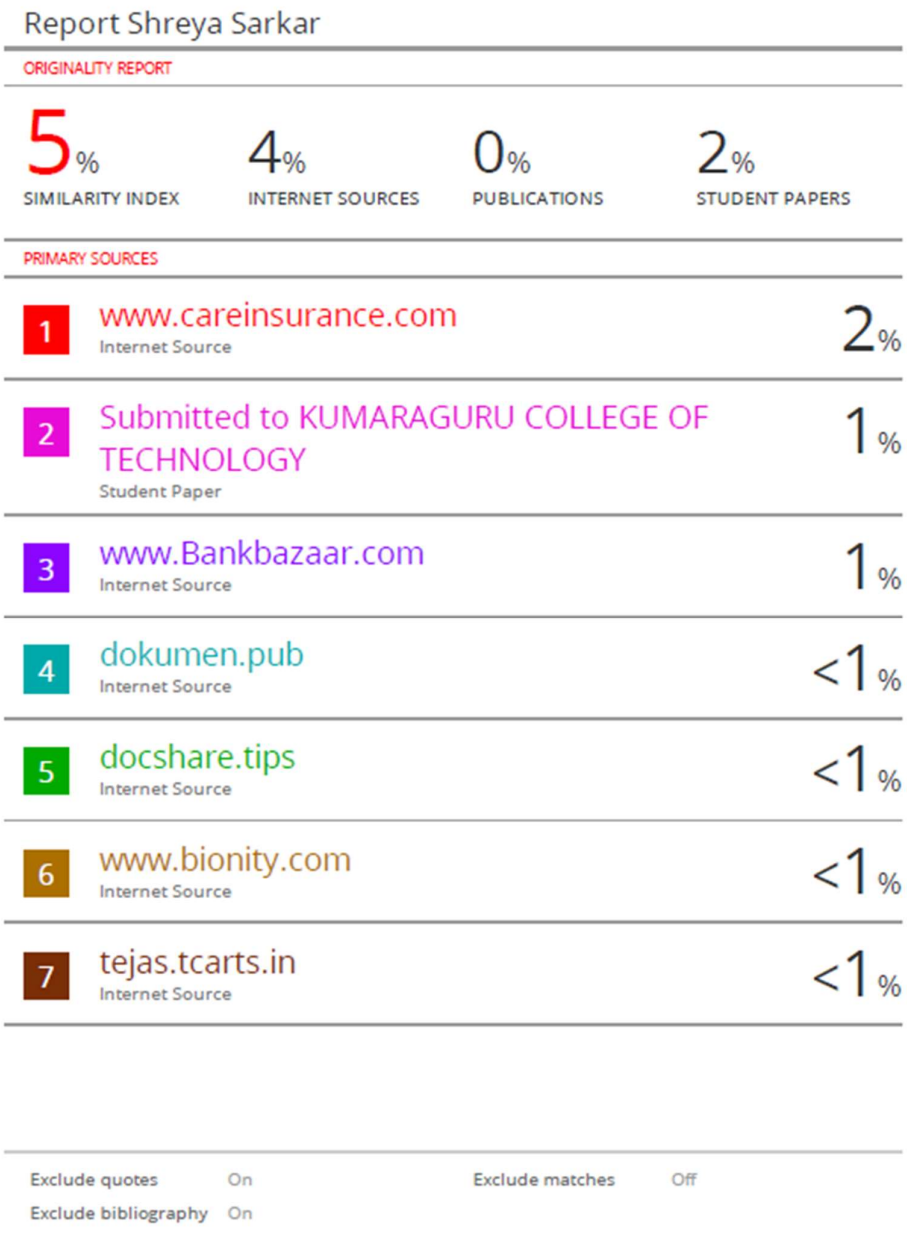
1. An insurer shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.
2. Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The insurer shall ensure that all the documents required for claims processing are called for at one time and that the documents are not called for in a piece-meal manner.
3. The information that the insurer has captured in the proposal form at the time of accepting the proposal, the terms & conditions offered under the policy, the medical history as revealed by earlier claims, if any, and the prior claims experience shall all be maintained by the insurer as an electronic record and shall not be called for again from the policyholder/insured at the time of subsequent claim settlements.
4. Insurer may stipulate a period within which all necessary claim documents should be furnished by the policyholder/insured to make a claim. However, claims filed even beyond such period should be considered if there are valid reasons for any delay.
5. Every Insurance Claim shall be disposed of in accordance with the Terms and Conditions of the policy contract and the extant Regulations governing the settlement of Claims. No Claim shall be closed in the books of the Insurers

8.3 Payments to Network Providers and Settlement of Claims of Policyholders:

a. To claim settlement, insurer shall make direct payments to the Network provider and to the policyholders by integrating their banking system platform with the Network Provider or the insured. Provided that, if a claimant opts for payment through a cheque or Demand Draft, the insurer shall not deny such request.

9. **ANNEXURE - B**

Plagiarism Report



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