TATA AIG INSURANCE
WITH YOU ALWAYS

IIHMR UNIVERSITY

An observational study on making health claims cost-effective for insurance providers

DISSERTATION PRESENTATION

Presented By

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Introduction

- 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 expense has been observed, which leads to the person looking after necessities and for any event, acquiring cash by to take care of for the doctor's visit expense or to pay off the huge debts taken in exchange to avail substandard medical treatment.
- Third-party administrator acts as a middleman between the insurance providers and its policy holders. The rise in the conflict between insurance providers and TPA's have increased the turnaround time for settlement of a health claims, leading the companies to reduce the number of TPA's and thereby saving their business in the dire times, one such as 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 its operation by establishing a separate team within their own company to process the claims at a faster pace. 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, introduction of new products & policies and automated claim settlement processes to extinguish the potential frauds.
- The study covers identification of challenges faced during claim settlements in insurance companies due to third party administrators to make the process cost effective for insurance providers.

Rationale

- The insurance company might set up a dedicated claims department for processing of claims without handing them over to any TPA. This arrangement is called the in-house claim department, and they directly settle the claim requests received from their policyholders. The latest generation health insurance companies have their claims settlement division hoping to speed up the response time of claim settlement.
- Inclusion of automation has been initiated in some of the core functions of the health care industry, but they are not yet fully automated to drive the next level of automation. But, with the acceleration of the new age technologies like AI & ML, Blockchain, RPA, IoT, etcetera, the entire process of health care delivery, right from member enrolment to health care services, including paramedical and ancillary services of the health care ecosystem will become a fully automated.

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

Author	Title of Study	Key Takeaways	Source
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
Irum Khan	The conflict between insurers, TPA, and healthcare providers leaving Andheri consumers in financial turmoil	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
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.	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
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 insurance providers are setting up an incorporated inhouse 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.	Saraswathy, M. (n.d.). Private general insurers set up in-house TPAs to service claims. Business News,
J.M. Manywanda	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)
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 descriptive study design was conducted to assess the knowledge, awareness, and perception of an insured person about health insurance in a tertiary care hospital. A well-framed structured questionnaire was administered to the opinions of the 384 respondents (insured and uninsured), out of which 92% are insured and only 8% are uninsured. Only a few (12%) of insured do not know how much policy coverage is there for hospital charges and 27% of insured have chosen health insurance policy to avail excellent quality treatment. The result clearly shows that most people are not that aware of the process of initiating cashless hospitalization. Hence the insurance companies, third-party administrators, and the hospital must work in synergy.	Ananya C V, A. Bhooma Devi and S. Nithya Priya, Knowledge, Awareness and Perception of Health Insurance among Insured in a Tertiary Care Hospital, International Journal of Management, 11(12), 2020, pp 3647-3655

Methodology

Aim of Internship

- The study is to understand the challenges and issue faced by an insurance provider in terms with third party administrators and recommend alternatives and suggestions for settlement of claims.

Research Question

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

Study Setting

- TATA AIG is providing access to all the available policies and standard protocol notes digitally

Objectives of Internship

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

Study Design

- Observational study

Duration of Study

- The study covers observation of 3 months (March – June 2022)

Methodology

Data Collection Procedure

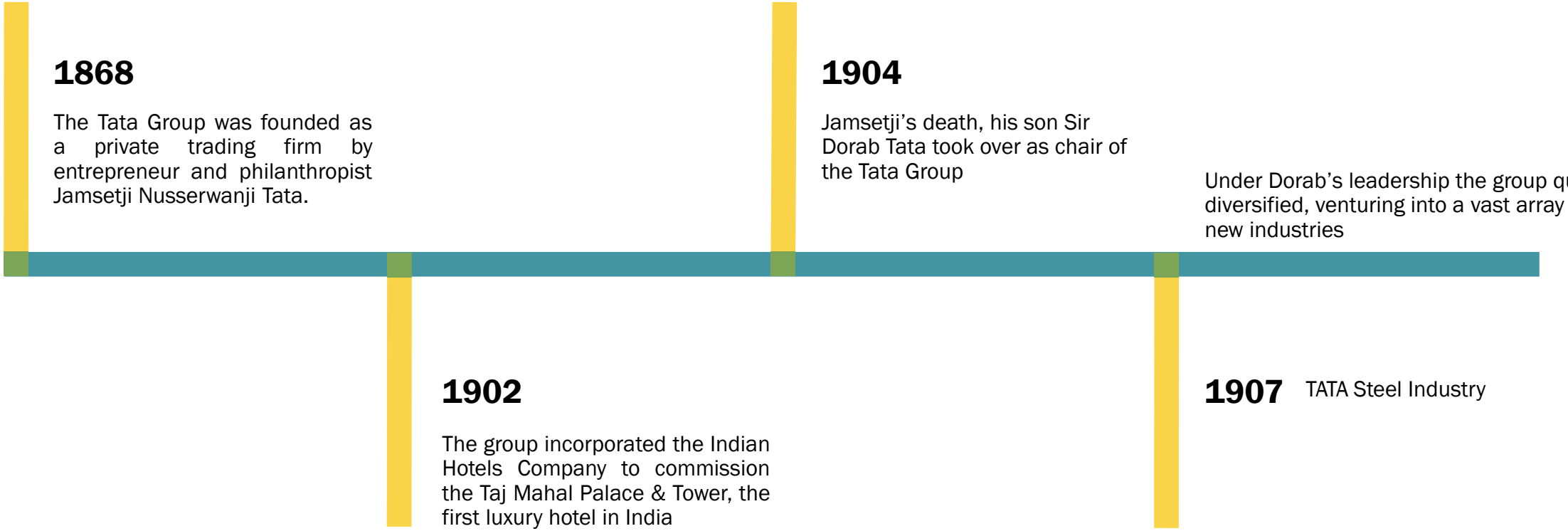
- The collected data is qualitative.
- The observations are collected based on discussions with company personnel and staff to understand the challenges an insurance company faces in a fiscal year.
- An unstructured observation and understanding of the existing products, protocols and management tasks are noted.
- The company did not he provide any specific datasets, as the data used by the company is highly confidential and proprietary in nature.
- Sample data is considered from open sources wherever required

Data Analysis Plan

- Software majorly used were 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 faced by insurance companies and prospects for a profitable business were discussed.
- For communicating - M.S. Teams, M.S. Outlook

Organization Profile

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



Organization Profile

1910 Electricity Industry

1911 Education Industry

1917 Consumer Goods Industry

1932 Aviation Industry

1938

Jehangir Ratanji Dadabhoy Tata (J.R.D.) took over the position. His continued expansion of the company into new sectors

1939 Chemical Industry

1945 Technology Industry

1952 Cosmetics Industry

1954 Marketing, Engineering & Manufacturing Industry

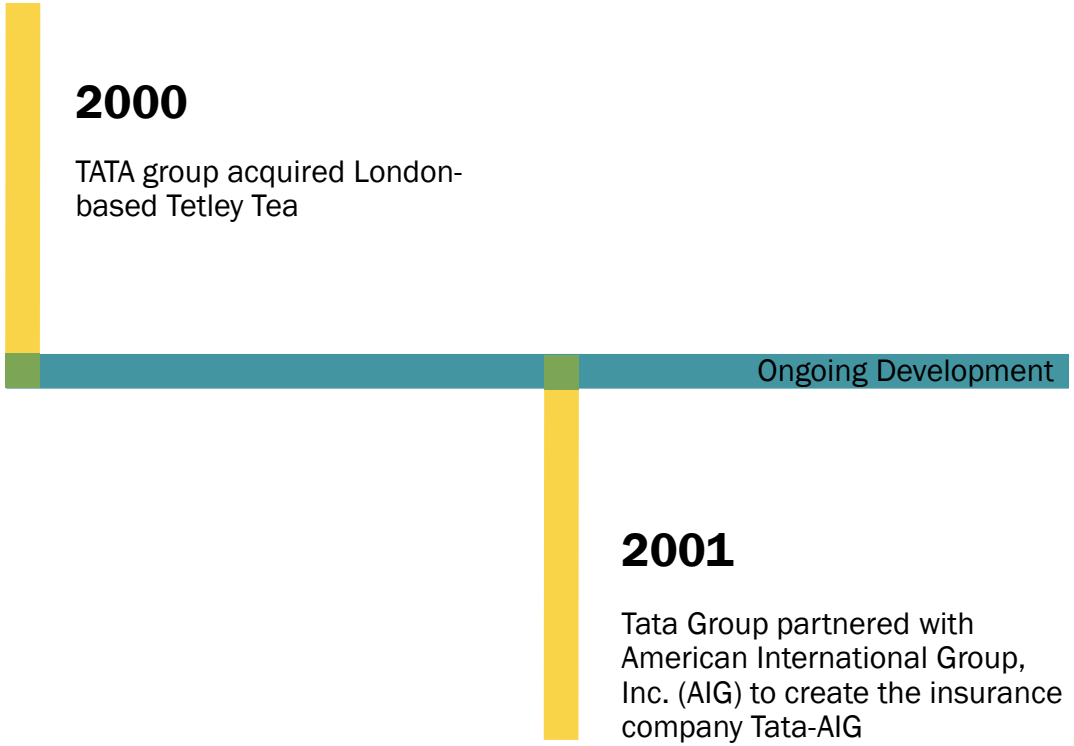
1962 Tea Industry

1968 Software Industry

1991

J.R.D.'s nephew, Indian business mogul Ratan Tata, succeeded him as chairman of the Tata Group

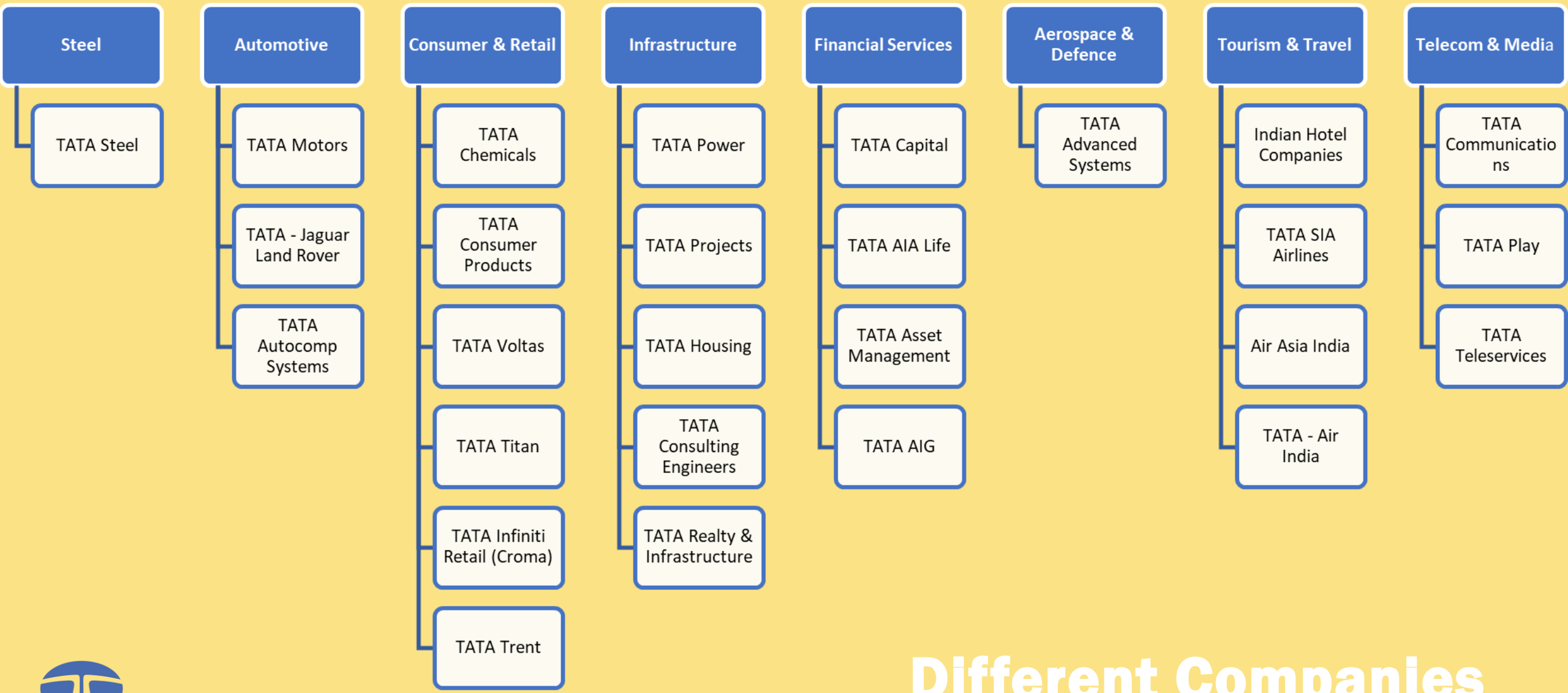
Organization Profile



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. 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.

Tata AIG General Insurance Company Limited has an empowered claims team, with a in-house capability of 400 plus experts spread across 90 office in India.

TATA AIG General Insurance offers a host of health insurance products ranging from health insurance plans for individuals, families, women, 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.



TATA

Different Companies Under TATA Group

Results

A TPA is the backbone of any insurance company. Without it, handling many health insurances claims, queries, and grievances on an everyday basis 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

- Administrative Maintenance
- Claim Verification
- Claim Settlement
- Hospital Empanelment
- 24*7 Customer Helpdesk

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

- Missing supporting documents to validate information or treatments.
- Weak networking with hospitals.
- Lack of strong standardization 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 cost to company, affecting in 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 policy holders 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 increase the claims influx as upon through investigation and analysis most of them turn out to be invalid claim/no claim.
- Submission of incorrectly filled form.
- TPA's often overpromises to the policyholders that they'll be paid for the treatment, without crosschecking the medical facts and underwritings mentioned in the policy documents. This often leads to a bad reputation of the insurance providers as they will only pay for what is mentions 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, than required but the insurance company is liable to pay the high amounts in claim to the policy holder.

Conclusion

It is evident and noticeable that the insurance companies rely a lot on the analysis provided by third party administrators, thereby becoming a major stakeholder in the insurance ecosystem. The observations collected over the course of study indicate over dependency of insurance companies on third party administrators, that has now started to create some issues when it comes to settlement of claims.

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

1. Submission of incomplete claim forms| missing documentation
2. The lack of regulatory guidelines for maintaining standardization
3. 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 later.
4. Moving the progressing and these strategic decisions to in-house processing than out-sourcing claim processes through TPA's.

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 stared to create issues for its consumers i.e., the policy holders and the insurance providers. The Indian economy relies heavily on the financial flow by these insurance companies and such a crack in the system can cause greater chaos in the insurance industries in India.

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 won't be jeopardized because of faulty delays.

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

- Adherence to quality
- Competitive pricing
- Differentiation

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, Aditya Birla, and 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 seems to be 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

Understandings

Key Activities

- Presented a presentation on claims process.
- Presented a presentation on IRDAI guidelines w.r.t. TPA's and claims management.
- Tracking of defects in the new database.
- Presented a presentation on TPA functions in company
- Prepared a functional document on the TPA developments required by team
- Standardization of form formats for data enhancement project.

Key Activities other than Dissertation

- Understanding of the services provided by the organization
- Understanding of the management in the team and department
- Understanding of the basic processes of company
- Understanding of the development done and what needs to be done in future
- Understanding of the projects I'll be handling as I join the firm

Key Learnings

- Understanding of the products provided by the company.
- Understanding of claim processes.
- Understanding of IRDAI guidelines.
- Understanding of current developments in the ongoing project
- Understanding of the requirements of users (Doctors).
- Understanding of different upcoming projects and tracking the progress of the same to catch up, when I join them.

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Thank you

for your kind attention.

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