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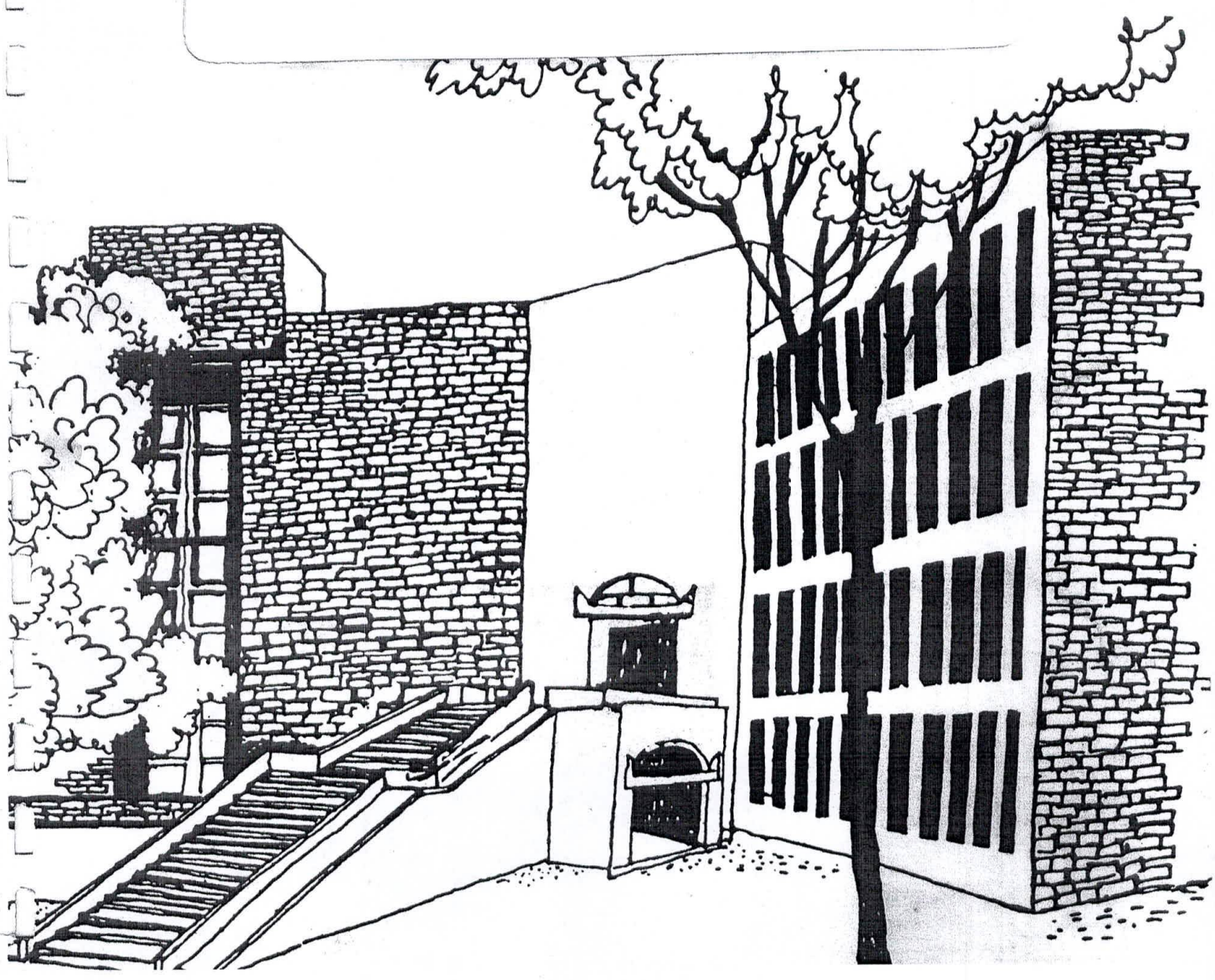

Health Insurance and Third Party Administrators: Issues and Challenges

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Health insurance and third party administrators: Issues and challenges*

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Health insurance and third party administrators: Issues and challenges

Abstract

With the growth of private voluntary insurance in the unregulated healthcare market, costs of healthcare are likely to go up. Managed care organisations in many developed countries play important role in containing costs. The Insurance Regulatory and Development Authority (IRDA) has paved the way for insurance intermediaries such as third part administrators (TPAs) which are going to play pivotal role in setting up managed care systems. TPAs have been set -up with the objective of ensuring better services to policyholders and mitigate some of the negative consequences of private health insurance. However, given the demand and supply side complexities of private health insurance and health care markets, insurance intermediaries face challenging tasks to achieve these objectives. Right in the early stages of its development IRDA has defined the role of TPAs to manage claims and reimbursements. Their role in controlling costs of health care and ensuring appropriate quality of care remains less defined.

1 Introduction and objectives

The ability of health care systems in meeting health care needs of people is determined by the way financing of health care is organised and structured. The financing mechanisms influence the efficiency and effectiveness of health care delivery. The health financing system in India has been dependent on government budgetary allocations. However, public financing through the tax system has not kept pace with the increasing demands. The public health infrastructure characterised by a wide network of health facilities at village and district levels is experiencing financial pressures in meeting the growing needs.

The role of private financing has increased significantly in recent years. It is estimated that people spend about 4.5 per cent of GDP on meeting their healthcare needs and this is about three-fourths of the health care expenditure (World Bank, 1998). Most of this expenditure is out-of-pocket. Private expenditure has grown at the rate of 12.5 per cent and for each one per cent increase in per capita income private expenditure on health has increased by about 1.44 per cent (Bhat 1999). It is argued that significant dependence on private financing has many negative consequences. In the absence of effective regulation of private provision of health services, high dependence on private sectors leads to increasing health care costs and people belonging to lower income classes suffer most. In recent times healthcare has become unaffordable and has given rise to serious equity issues. Thus, it has become imperative to find alternative health financing mechanisms. Health insurance is one such alternative.

Health insurance is a financial mechanism with which people are protected against catastrophic financial burden arising from unexpected illness or injury. Having a well functioning insurance system ensures pooling of resources to cover risks. The health insurance sector in India is in a nascent stage and contributes only a small proportion of health expenditure. The government through its state-run schemes such as the Employee State Insurance Scheme (ESIS), Central Government Health Scheme (CGHS), and the Mediclaim scheme offered by government-run insurance companies has played a significant role in developing the health insurance sector in India. NGOs

and community based organisations such as SEWA also offer a number of schemes to protect the poor and vulnerable groups of population from the high cost of health care. Recently the government has allowed private insurance companies to offer health insurance products.

The existing private medical insurance scheme is indemnity based. Under this system policyholders at the time of needing health care services first pay for expenses and later they are reimbursed these amounts depending on the sum insured and coverage. Indemnity based schemes have a number of limitations and are considered to be inefficient, besides having cost escalating characteristics. There are various reasons for these inefficiencies. Insurance companies have to deal with unregulated healthcare providers who work in an environment having no standards, quality benchmarks, treatment protocols, highly variable billing systems, significant price variation across providers etc. This is reflected by the adverse claim ratios. It has also been observed that hospitals tend to charge more from patients having insurance cover. In the absence of monitoring and control mechanisms it becomes difficult to handle fraudulent claims. To address these issues the role of insurance intermediaries such as third party administrators (TPAs) is considered important. TPAs are a separate entity that coordinates with insurance companies, customers and healthcare providers. TPAs arrange cashless hospitalisation and closely monitor the use of resources and services. Health insurance companies generally tie up with TPAs for the back office function of managing claims and reimbursements. These intermediaries will become part of the institutional set up of managed healthcare system and have implications for its future growth and development. IRDA has also come up with regulatory guidelines for TPAs. These guidelines envisage TPAs to fulfil certain requirements and observe a code of conduct.

The objective of this paper is to discuss the role and importance of TPAs in the emerging health insurance market in India. Specifically the paper aims at:

- Understanding the functioning of TPAs in the health insurance
- Analysing the existing TPA system
- Examining issues and challenges TPAs face in unregulated health sector
- Analysing IRDA regulations on TPA and their implications

The paper is divided into six sections. The second section gives the salient features of healthcare system and health financing in India. The third section explains the health insurance system and the current scenario of health insurance in India. The next section discusses the concept of managed care. The fifth section describes TPA and its functioning. The last section discusses IRDA regulations and impacts, regulatory issues, and the prospect of intermediaries in the insurance sector in India.

2 Indian health care system

India has made considerable progress in improving the health status of its population. The crude death rate has reduced from about 40 per 1000 at the time of independence to 9 per 1000 in 1998. A significant proportion of this decline is attributed to reduction in mortality of the under 5 age group. The infant mortality rate is estimated to have declined from around 161 to 71 per 1000 live births over the same period. Consequently, life expectancy has increased from about 31 years to 63 years. Despite

this impressive progress, many challenges remain. Life expectancy is still 4 years below the world average. So is under 5 mortality (12 per 1000 per year) higher than the world average. India is one of the major countries, along with Nigeria, where polio has not yet been eradicated. HIV incidence has been increasing. Tuberculosis and malaria also take a high toll.

While communicable diseases are still not under control, the extent of chronic non-communicable diseases such as heart disease, diabetes, and cancer has been rising. Thus the health sector faces dual challenges: starting to address non-communicable diseases while attempting to control communicable diseases (e.g. incidence of diabetes and heart disease in India is double that of China). The primary health care system is not yet geared to diagnose and treat chronic degenerative diseases. India faces the daunting challenge of meeting healthcare needs of its population and ensuring accessibility, efficiency, equity, and quality of health care.

The government through its budgetary allocations has set up remarkably impressive health infrastructure. The system envisages availability and accessibility of publicly funded healthcare to all, regardless of their ability to pay. However, it is facing serious challenges in meeting its objectives.

The present healthcare system is characterised by mixed ownership pattern and different types of providers who practice different systems of medicine. The interdependent and overlapping nature of these components makes it difficult to define the exact role of each component. In India, both public and private facilities provide health services. The bulk of the curative services is skewed towards the urban areas and dominated by the private sector.

Public health sector: The Bhore committee set up in 1946 set the foundation for current public health care system. The committee recommended a free health care funded by the state, with general and local taxation generating funds to provide for it. The government provides medical care through government run hospitals, dispensaries, primary health centres, sub centres, and other health facilities. Primary care consists of health centres and dispensaries where basic medical treatment for common ailments is provided. Immunisation and health promotional activities are also carried out by primary care centres. Secondary medical care is provided by specialists at district, sub-divisional, and community health centre level. Tertiary medical care is provided by super specialists at multi-speciality and super-speciality hospitals and medical colleges. Research, training, and education are also carried out at tertiary levels. State governments own the bulk of the health delivery system and have to bear the costs of operation. Government hospitals accounts for 30 per cent of hospitals and 60 per cent of beds whereas local bodies own 2 per cent of hospitals and 3 per cent of beds. State owned enterprises like Coal India, railways, police have developed their own health care facilities.

Private health sector: The private sector plays a very important role in India's health delivery system. There is a wide network of facilities that cater to health requirements of both urban and rural population. The presence of the private health sector has profound implications for the existing character of the Indian health care system since it affects both cost and quality of services available (Bhat, 1996).

The private sector consists of organised private and voluntary institutions, accounting for 68 per cent of hospitals and owning 37 per cent of hospital beds. Variations in hospitals and beds are quite significant across states. The organised private sector is primarily profit oriented. This includes all levels of private hospitals, dispensaries, nursing homes, general practitioners, pharmacies, etc. The voluntary sector not-for-profit institutions are run by charitable trusts. About 10 per cent of hospitals and 13 per cent of hospital beds are in the voluntary sector. The informal private sector consists of practitioners with no formal qualifications and various types of less-qualified providers.

Utilisation surveys show that majority of the people seek care from private providers. Concern about the quality of public services is the main reason for this.

2.1 Health care financing

Current health expenditure in India is estimated to be around Rs. 1030 billion. India spends 6 per cent of GDP on health. The share of government is less than 2 per cent (Tulasidhar 1992). The World Health Organisation has recommended that governments must spend at least 5 per cent of GDP on the health sector. Bulk of health care spending is direct out-of-pocket household expenditure (see Table 1).

Table 1 National health spending: sources and uses (per cent)

	Central government	State and local government	Corporate third party	Households out-of-pocket	Total
Primary care	4.3	5.6	0.8	48	58.7
Secondary and tertiary inpatient care	0.9	8.4	2.5	27	38.8
Non-service provision	0.9	1.6	na	na	2.5
Total	6.1	15.6	3.3	75	100

Source: World Bank (1995b)

Though the demand for health care is increasing owing to population pressure, the government is finding it very difficult to maintain its health facilities. Government allocations are also showing declining trend over the years (see Table 2).

Table 2: Health Expenditure as Percentage of GSDP of the States

	1	2	3	4	5	6	7	Avg	(7) – (1)
States	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97		
Andhra Pradesh	0.94	0.90	0.95	0.96	0.90	0.84	0.95	0.92	0.01
Assam	1.04	1.20	1.05	1.17	1.16	1.23	1.20	1.15	0.16
Bihar	1.03	0.99	1.12	0.99	1.00	1.21	1.04	1.05	0.01
Gujarat	0.90	0.93	0.78	0.80	0.71	0.77	0.72	0.80	-0.18
Haryana	0.60	0.58	0.62	0.60	0.58	0.58	0.55	0.59	-0.05
Karnataka	1.04	0.98	1.09	1.03	1.03	0.98	0.93	1.01	-0.12
Kerala	1.51	1.27	1.15	1.26	1.27	1.32	1.30	1.30	-0.21
Madhya Pradesh	0.90	0.94	0.92	0.91	0.91	0.84	0.87	0.90	-0.04
Maharashtra	0.74	0.72	0.68	0.65	0.61	0.60	0.59	0.66	-0.15
Orissa	1.24	1.12	1.13	1.08	1.06	1.06	1.07	1.11	-0.17
Punjab	0.88	0.79	0.75	0.72	0.64	0.64	0.68	0.73	-0.20
Rajasthan	1.21	1.21	1.23	1.35	1.32	1.33	1.24	1.27	0.03
Tamil Nadu	1.21	1.15	1.14	1.06	1.00	1.03	0.99	1.08	-0.22
Uttar Pradesh	1.12	0.97	1.04	1.16	1.00	1.00	0.99	1.04	-0.13
West Bengal	1.24	0.96	0.99	1.02	0.88	0.90	0.90	0.98	-0.34

Source: Selvaraju (2000)

Government allocations in the health sector have declined from 1.3 per cent of GDP in 1990 to 0.9 per cent in 1999 (National Health Policy, 2001).

The central government plays an important role in supporting national health programmes such as malaria, TB, HIV/AIDS, etc. Funds for these programmes are channelled through state governments. These schemes give priority to primary health care whereas state governments bear the major responsibility of recurrent costs, especially the cost of operating the hospitals.

The significance of alternative sources of financing has increased significantly. There are four major alternatives for mobilising resources other than government funds.

Community financing: Individuals, families, or community groups make voluntary contributions towards meeting healthcare costs. The cost is shared among members regardless of individual use. This works out well for small groups.

User fees: This is fee for services or out-of-pocket expenses from users. This helps in improving revenue and rationalises the utilisation in government systems. However, fee-for service in the unregulated health sector has many perverse incentives.

Employer based: The corporate sector or employers provide healthcare facilities to employees or reimburse healthcare expenses.

Health Insurance: Health insurance is a mechanism of pooling resources and sharing risks or uncertain events between many people. It ensures some form of equity. The focus is on contributory arrangements.

The private out of pocket expenses by the households make up most of the health expenditure, which is more than 75 per cent of total expenditure on health. Only 3 to 4 per cent of health care provision is presently funded through prepayment schemes and third parties such as corporations.

Most of the budgetary allocation of the government is for preventive, promotive and primary care and curative services whereas private expenditure is largely on curative services. Over the period private health care expenditure has grown at a rate of 12.84 per cent annually and for each one per cent increase in per capita income private health care expenditure has increased by 1.47 per cent (Bhat 1996).

3 Health Insurance

Health insurance in a broad sense is an arrangement through which consumers can avoid, reduce or delay full payment on health expenditure at the time of use of services. Individuals or groups buy health insurance in advance by paying a premium. Insurance is a contract in which the insured person pays a premium for the right to receive a compensation in the case of contingency. The level of premium is generally based on actively determined likelihood of illness of the insured. Insurance provides protection against risks or uncertain events and is based on the principle that what is highly unpredictable to an individual is predictable to a group of individuals. Health insurance protects against the cost of illness, mobilises funds for health services, increases the efficiency of mobilisation of funds and provision of health services, and achieves certain equity objectives (Mills 2000).

Various forms of health insurance can be broadly categorised (based on ownership of scheme) as follows: state-based systems, market-based systems, member organisation (NGO or cooperative)-based systems, and private household-based systems (Jutting 1999).

Social health insurance: Health insurance organised by the state or a public body is usually termed as social insurance. Funding consists of payroll taxes levied on workers and employers, often supplemented by user fees, and government contributions from tax revenues. A wide range of benefits is offered but access is based on healthcare need. Social insurance schemes are managed by autonomous bodies under government regulations and the providers of care have to meet certain standards in terms capacity, staff, equipment, etc.

Private actuarial insurance: This is voluntary. Both individuals and groups can avail the coverage. This could be not-for-profit or for-profit. Contributions are based on risk and coverage. Benefits are specifically defined in this type of insurance.

Community based insurance: Expenditure on healthcare of members is shared among the community. Usually community organisations or NGOs handle the business. Contributions can be mandatory or voluntary, usually a flat rate per individual or household.

Health insurance is complex compared to other segments of insurance. There are serious market failure problems. In any market driven system, market mechanisms are expected to allocate the resources optimally and provide the best to consumers. In others words what should be produced, how should it be produced and for whom it should be produced are determined by market forces. Competitive environment in market takes care that resources are used efficiently (at lowest cost) and effectively (with optimum outcomes). However, because of various demand and supply side imperfections, there are inherent problems in health insurance markets. Important constraints on insurance contracts are (Burgess and Stern, 1991):

- moral hazard
- adverse selection
- covariate risks and
- information problems

Moral hazard: In insurance markets moral hazard is serious problem. This arises because policyholders would like to take decisions and actions which maximise their own benefit. In many situations, and particularly in insurance setting, this behaviour is detriment since the beneficiary does not bear the full cost of his/her actions and decisions. The seminal works of Arrow (1963) and Pauly (1968, 1974) who proposed the moral hazard problem in medical care suggest that the policyholder will not consider the insurer's costs. Unregulated healthcare markets and private insurance provide adequate ground for this behaviour to perpetuate. This happens because insurance lowers or avoids the cost of treatment at the point of treatment, so consumers tend to demand more (consumer moral hazard). The providers have an incentive to provide more or unnecessary care than might be medically appropriate (provider induced moral hazard). Most insurance companies would be confronted with this problem and use mechanisms and conditionality which create a burden on

policyholders with the part of cost (Sonderstrom, 1997). Increasing the burden on policyholders would encourage them to avoid these costs where possible. Some of the mechanisms insurance companies have adopted are co-payments or co-insurance, deductibles, or a reduced premium bonus for the future. Another possibility of coping with moral hazard is to arrange special contracts (Jutting 1999).

Adverse selection: The works of Akerlof (1970), Spence (1973), Stiglitz (1975), and Rothschild and Stiglitz (1976) have pioneered the concept of adverse selection problem. Adverse selection arises when persons belonging to high risk groups seek coverage and the insurer can not identify the risk. All policyholders are required to pay the same premium whereas those belonging to higher-risk groups are likely to consume higher than average quantity of services. High risk individuals will find the insurance policy more attractive and those with good health will find insurance premium too high. Less and less good cases will enrol in insurance scheme and, as a result, the insurer finds having a pool of more risk cases. As Newberry and Stiglitz (1981) and Newberry (1989) have shown, insurance pools work best with easily identifiable risks.

Covariate risks: The basic objective of any insurance mechanism is to protect individuals from risk. In most situations, the insurer helps in protecting policyholders from unique health risks and it is expected that these risks are not related to others in the insurance pool. However, this may not be the case. Covariate or collective risk means that a possible risk would cause damage to many or even to all members of the pool at the same time (Jutting, 1999). In relation to such risks, there is nothing to be gained by cooperation (Sonderstrom, 1997). The stronger the degree of positive covariance, the higher will be the cost, whereas negatively correlated risks will have the effect of reducing the total cost of risk-bearing (Platteau, 1991). High incidence and prevalence of communicable diseases in a community can give rise to high covariate risks. In a study of claims and reimbursements, about 22 per cent cases arose from communicable diseases (Bhat and Reuben 2002). In India 50 per cent deaths takes place because of communicable diseases. If all policyholders face similar risks, risks cannot be reduced much through having insurance (Jutting, 1999).

Information problem: Availability of information would have significant bearing on the development of insurance contracts. In insurance setting, the severity of moral hazard problem and adverse selection problems will depend on differences in availability of information between insurer and policyholders. In order to address this problem insurance companies need significant investments in infrastructure and development of systems.

How do these different forms of insurance address these risks? Each insurance setting has strengths and weaknesses (Jutting, 1999) as summarised below.

Risks and concerns	Insurance settings		
	Govt	Market	Member
Moral hazard	--	+	++
Adverse selection	+++	--	-
Covariate risks	+++	++	+/-
Cost efficiency	--	++	+/-
Quality	-	+++	+/-
Equity of access	++	---	++

+++ strong comparative advantage / (---) strong disadvantage
Govt: universal insurance run by government
Market: private voluntary insurance
Member: insurance systems run by member-based organisations
Source: Jutting, 1999

3.1 Features of health insurance

Reimbursement system: This system refers to the manner in which providers are paid. The characteristics of health insurance programme can be described as follows (Kutzin and Barnum, 1992):

- in the traditional indemnity system, customers first incur expenditure on services and later submit claim to insurance company for reimbursement (e.g. Mediclaim insurance scheme).
- managed indemnity in which a third party administrator (TPA) takes care of the claim settlement of enrolees and directly reimburses service provider.
- insurer pays service provider a fixed amount out of which provider will serve health needs of enrolees for a specific period.
- reimbursement can be fee-for-service, which would involve charging for each individual service, such as in-patient bed-days, drugs, investigations etc.
- case specific reimbursement based on category of patient admitted. Under this system admissions are grouped into categories, called diagnostic related groups (DRGs), based on their clinical characteristics.

Services covered by insurance: Coverage of services varies with each insurance programme. Some cover only curative services whereas others cover primary OPD care too. Coverage varies according to the extent of hospitalisation also.

Role of the insurer: An important feature of insurance is whether the insuring institution plays an active or a passive role in provision of healthcare services. Sometimes insurer is merely a funding entity and does not get directly involved in provision of healthcare services. In these situations controlling costs becomes difficult. Insurers develop mechanisms of cost sharing to mitigate the negative impacts of insurance. Health insurance beneficiaries are asked to pay an amount each time they use services such as deductibles and co-payment. Under deductibles, the insured pays a specific amount before receiving insurance benefits whereas under co-payment a fixed percentage of cost of service is paid by the beneficiary to the insurance company. On the other hand, the insurance company can directly get

involved in organising and providing healthcare services and are called managed care organisations. These insurers can enforce cost discipline more rigorously.

3.2 Health insurance in India

The first major step in introducing health insurance in India came with the promulgation of the Employee State Insurance (ESI) Act in 1948. This legislation paved the way for introducing the mandatory social insurance scheme with managed care concepts for employees in the formal sector. The Employee State Insurance Scheme (ESIS), introduced in 1952, is managed by the Employees State Insurance Corporation (ESIC), a wholly government opened enterprise. It provides cash benefits, medical benefits, preventive and promotive care, and health education. This is conceived as a compulsory social security benefit for workers having income less than Rs. 6500 a month in the formal sector covering employees and their dependents and is mainly financed by contributions from employers, employees and government. Employers and employees contribute 4.75 per cent and 1.75 per cent of wages respectively. The state governments' share is 12.5 per cent of total expenditure. In 2000 about 33.4 million beneficiaries were covered by the scheme. ESIC has set up 136 hospitals with 43 annexes having 23720 beds. There are 1443 ESI dispensaries, 6542 medical officers, and 2988 medical practitioners.

The second initiative was the Central Government Health Scheme (CGHS) in 1954 for employees of central government, members of parliament, judges, freedom fighters, and their families. This is a contributory health scheme and provides comprehensive medical care. Contribution varies from Rs.15 to Rs. 150 per person based on salary of employee. The scheme is mainly financed by the central government. There were about 4.4 million beneficiaries in 1996. Separate dispensaries are maintained for this scheme. In-patient facilities are available in government hospitals and approved private hospitals on referral.

For persons not covered by the above schemes, government-run insurance companies have introduced market-based schemes. The most popular among these is Mediclaim scheme of General Insurance Corporation, introduced in 1986. It has undergone several changes after that. In 1991 internal limits for doctor's fee, medicines, diagnostics, and room charges were removed making it a single benefit policy. This is an indemnity based health cover. It covers only in-patient treatment. The premium is based on age and sum insured. Clients can avail medical services from any public or registered private hospital. The policy, however, has failed to attract a large number of people because of various restrictions. Insurance companies also encounter problems such as lack of cooperation from hospitals.

There are health benefit packages which are directly managed by employers: employer setting-up healthcare facilities and providing healthcare to its employees and reimbursement of medical expenses or Mediclaim insurance premium amount. Many public and private sector employers cover their employees with one of these two schemes. Large public sector and private sector companies have their own health infrastructure. Other employers cover their employees through reimbursement. Many organisations cover their employees through a group Mediclaim scheme.

There are a large number of charitable and voluntary organisations that have designed social security schemes for specific groups of population. Efforts have been made by various NGO's to provide some kind of social security to poor and people working in unorganised sector. The most prominent among them is the Self Employed Women's Association (SEWA). Other important organisations which have taken initiatives in this area are Child in Need Institute, Streehitkarini, Tribhuvandas Foundation, and Accord. NGOs provide valuable health services in many parts of the country, especially rural areas.

The government has now allowed private companies to enter into health insurance and has established the Insurance Regulatory and Development Authority (IRDA) to regulate this sector. It is estimated that the present health insurance market is in the region of Rs. 2500 to Rs. 3000 million and it has a potential to grow to Rs. 50 billion in next five to seven years time. The potential insurable lives in the country are estimated around 300 million. It is estimated that only 10 percent of health insurance market has been tapped till today and there is a scope to increase this in near future.

4 Managed care

During the 1960s and 1970s researchers in the United States identified that health insurance motivates people to seek unnecessary health benefits (customer moral hazard) and that providers have financial incentive to recommend costliest of treatments (provider induced moral hazard or demand inducement), that have little or no impact on health outcomes (Dranove, 2000). These behaviours ultimately drive up costs without commensurate increase in the quality of care. Managed care organisations came into existence in US to contain the cost of healthcare under the insurance system and address the issue of dysfunctional fragmented services (Fairfield, 1997).

Under managed care, health insurance companies establish linkages with healthcare providers. Service providers assume responsibility and accountability for the resources they use in providing healthcare services. For this purpose mechanisms are developed which ensure that services providers share part of financial risk inherent in assuming the responsibility. The goal of managed care is also to provide quality of care to policyholders. Managed care places special emphasis on coordinated and comprehensive services, appropriate use of both ambulatory and inpatient settings, evidence-based decision making, cost-effective diagnosis and treatment, population-based planning, and health promotion and disease prevention. Utilisation review, case management, coordinated care, home healthcare, pharmacy benefit management, information technology systems, physician contracting, and network development are some of the features of managed care (Fairfield, 1997).

Cost control is achieved by fixing fees for services, monitoring the need for procedures such as tests and operations, and stressing preventive care. There are three dimensions of managed care: rules and policies, systems management which includes how policies and rules are administered, and disease management focusing on how diseases presenting to the system are dealt with (Fairfield, 1997).

Managed care concept began in US in the early part of twentieth century. However, it did not gain much success during its early phases. The trigger for its growth came as

insurance gained popularity. The launch of the Kaiser Health Plan during World War II resulted in the first clinic-based system of managed care. After World War II, American employers began offering workers health plans with a variety benefits and having 100 per cent coverage of healthcare costs. During the 1960s healthcare became more technology intensive and highly specialised. With the introduction Medicare and Medicaid in US, costs of medical services skyrocketed. The Health Maintenance Organisation (HMO) Act of 1973 paved the way for managed care organisations to become publicly funded companies, providing capital and accelerating their growth. The decade from 1985 to 1995 saw the proliferation of HMOs and PPOs in an effort to contain escalating costs. Today more than 90 per cent of the health care industry and three out of four American workers go through managed care organisations (MCOs).

Managed care organisations use utilisation management strategies to control the use of services. The basic idea is to review and supervise expensive decisions, ensuring that they are in accord with prescribed guidelines and treatment protocols. Utilisation management is done through ensuring pre-certification of inpatient admissions for use of expensive technologies, concurrent review of length of inpatient stay or other expensive courses of treatment, management of high cost cases, and having a system of second opinion. Before admitting non-emergency patients to hospital or undertaking other specified expensive treatments, doctors in managed care organisations are required to call the insurer's utilisation management company and have the decision approved. After admission, utilisation managers monitor inpatient stay to ensure earliest possible discharge. In complex or difficult cases a case manager may work with the doctor to develop a treatment plan that substitutes less expensive care whenever possible. Utilisation management seeks to reduce healthcare costs primarily by avoiding unnecessary hospital admissions and reducing length of stay.

Managed care companies are able to reduce costs by negotiating aggressively with hospitals and provider groups on rates and use of inexpensive resources in inpatient care.

4.1 Forms of managed care

There are different types of managed care structures. Most managed care is carried out in one of two basic types of organisational settings: health maintenance organisation (HMO) or preferred provider organisation (PPO).

Health maintenance organisation (HMO): HMOs insure and provide comprehensive medical services to voluntarily enrolled members on a prepaid basis. They own health facilities and employ health professionals to run these facilities. Members are required to choose a primary care physician (PCP) whom they must consult for all their health care needs. PCP typically authorises most referrals to specialists and other services. Customers pay a fixed fee for services, instead of separate charge for each visit or service. The monthly fee remains same regardless of services availed. HMOs are typically the cheapest option

HMOs can be grouped under four categories based on how physicians are organised: staff model, group model, independent practice association (IPA), and net work model. Staff model HMO employs its own physicians. Group model HMOs are

insurance companies that contract with large physicians groups to organise services. Physicians in staff and group models often work exclusively for a HMO. IPAs and network model HMOs develop linkages with existing providers and agree to use their infrastructure. There are models that combine the features of IPAs and networks.

Preferred provider organisation (PPO): Under PPO, health insurance companies contract with independent service providers, hospitals, and other healthcare professionals who become the preferred or participating providers. Providers typically accept reduced, discounted fee-for-service rates of reimbursement from the health plan in exchange for access to PPO's enrolees. PPOs have fewer restrictions than HMOs. For example, patients are not required to select a primary care physician or seek prior authorisation for services. Patients may choose to receive care from providers who do not participate in PPO, with higher co-payments and deductibles attached to services provided by non-participating providers.

There are various variations of these arrangements. For example, point-of-service health plan (POS) combines the features of an HMO with indemnity insurance option. The member uses the plan like an HMO and receives HMO coverage; but the member may exercise freedom of choice and seek care outside the HMO system with additional charges (higher co-payments and deductibles, and submission of claims forms). Members choose how and from whom to receive services at the time they need them. Another variation is independent practice association (IPA) in which health care professionals maintain their own separate practices, while forming an MCO to contract with purchasers to provide care at established rates. A third is physician hospital organisation (PHO) which is a legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests.

4.2 International experiences

Managed care has had its origin in US and majority of its people are enrolled in some kind of managed care plan. Managed care organisations such as HMOs and PPOs constitute 87 per cent of the American health insurance sector. It is estimated that managed care is saving patients over $300 billion annually and the quality is comparable to traditional indemnity insurance. More than 70 per cent of the physicians in US are working for MCOs. Managed care has been successful in containing costs. Clinicians are subject to prospective utilisation reviews and pre-authorisation requirements, concurrent reviews as treatment proceeds, retrospective reviews once treatment has been completed, and sometimes even mandatory second opinions. They have to follow clinical guidelines and their performance is continuously monitored and compared with that of their peers. At the same time there is a widespread dissent among patients towards managed care. Patients do not trust managed care because they think that aggressive intervention by MCOs might limit the ability of their doctors to control and coordinate the resources necessary to deliver quality care. Health care professionals also hold negative views towards managed care (Simon, 2001). Physicians feel that managed care restricts their freedom of patient management.

Managed care is new in Europe. European organisations prefer to use integrated care or coordinated care instead of managed care because of its negative connotation in

US. However, they see managed care as an absolute necessity for delivering quality. Britain's largest private health insurer, BUPA, is adopting principles of American-style managed care, but this has brought widespread resistance from the physicians. They fear that managed care will limit their freedom and management. In France, the first PPO was formed in 1995; in Poland, the first managed-care organisation was launched in 1997; and in Germany, health reforms in 1997 permitted pilot projects to use some aspects of managed care such as physician contracting. Germany's healthcare system provides health care through statutory medical insurance to 90 per cent of the population. Since costs are rising Germany has called for new alternative forms of controlled and organised healthcare based on the philosophy of managed care. Switzerland was the first European country to adopt managed care style on a broad scale and has achieved considerable cost advantages from reduction in hospital stay.

European consumers have a different outlook on managed care plans from Americans. While in US consumer argue that managed care limits choice, in Europe consumers experience that private insurance increase their choices and decrease the waiting time typical of government-sponsored care. Providers in managed-care projects coordinate care so patients can obtain care at any hour of the day by a network physician (Katzman, 1998).

In Asia, China opened up its insurance sector to foreign players in 1992. China concentrates on home care, which is different from managed care. The reason for home care is the rising cost of hospital care. Thailand introduced the concept of managed care in 1996. Philippines allowed entry of foreign insurance companies in 1991 and presently HMO is a well accepted mechanism in the healthcare system. The concept of managed care is picking up in Singapore, Indonesia and Malaysia too. It is too early to asses the impact of managed care in these countries.

5 Third party administrators (TPAs)

Third party administrators (TPAs) are not technically managed care organisation but play an important role in health insurance markets. TPAs are neither insurance companies nor care providers. They are independent organisations that provide specialised services to support the administration and management of health insurance products offered by insurance company. These services include: cashless service at hospitals, call centre support to policyholders, medical cost management, and management of claims and reimbursements. They also provide services to the corporate sector in designing and managing health benefit packages for their employees. Given the demand and supply side complexities in health insurance and healthcare markets, TPAs provide an important link between insurance companies, healthcare providers, and policyholders (see Figure 1).

Intermediation by TPAs ensures that policyholders get hassle free services, insurance companies pay for efficient and cost effective services, and healthcare providers/policyholders get their reimbursements on time. TPAs are intermediaries in a chain of integrated health delivery system that brings all components of healthcare such as physicians, hospitals, clinics, long-term facilities, and pharmacies together.

The core product or service of a TPA is ensuring cashless hospitalisation to policyholders. Policyholders do not have to worry about arranging money for hospital deposits or medical bills for treatment which are covered by the policy. Besides this, TPA may provide a range of services depending on the requirements of insurance companies or corporate sector. TPAs require skills to integrate, manage finance, and delivery of appropriate healthcare services to its clients.

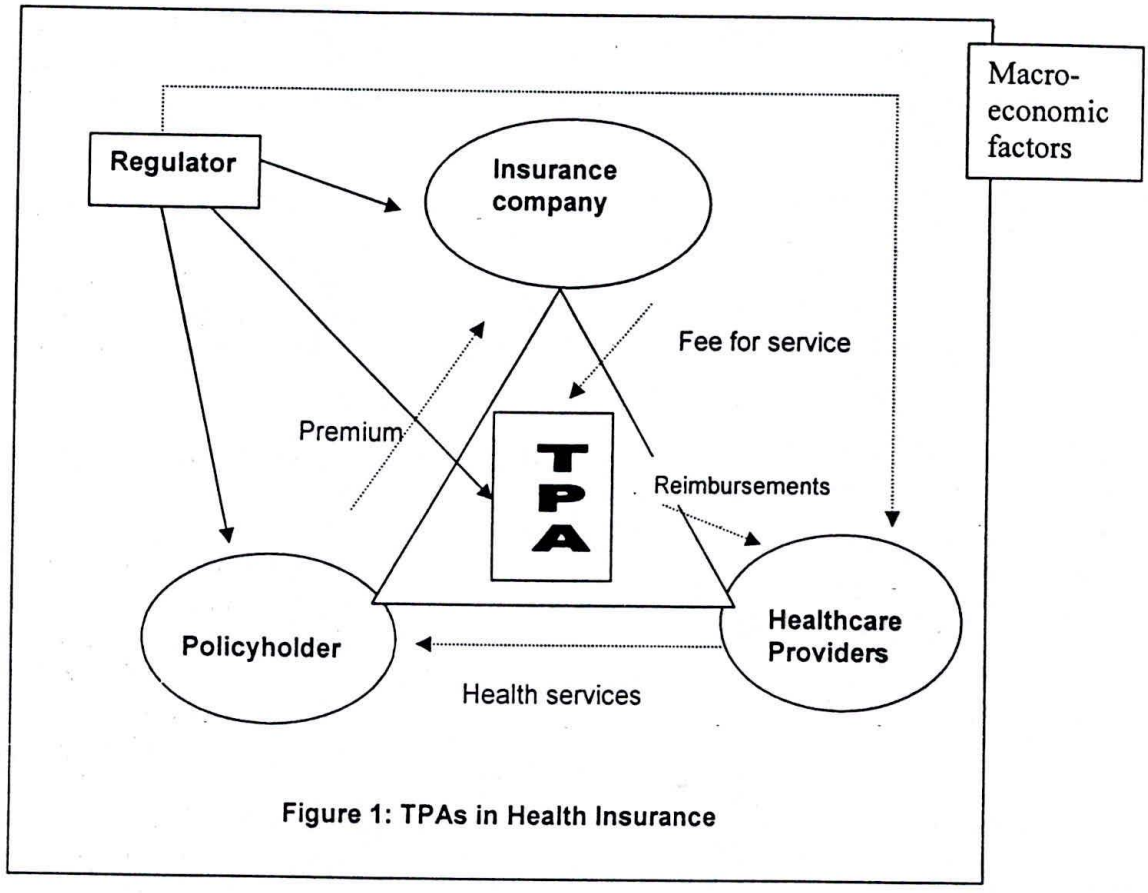

Figure 1: TPAs in Health Insurance

5.1 Functioning of TPA

Insurance companies face difficulties in developing cash-less hospitalisation services for policyholders in a setting where healthcare providers are geographically dispersed, small in size, and unregulated. TPAs organise healthcare providers by establishing networks and through this networks offer services. TPAs have to ensure that providers are part of the network. TPA's main function is to develop this network of hospitals, general practitioners, diagnostic centres, pharmacies, dental clinics, physiotherapy clinics, etc. TPAs sign a memorandum of understanding with insurance companies according to which they inform policyholders about the network of healthcare delivery facilities and various systems and processes for settling claims. With the introduction of TPAs, policyholders are enrolled and registered with TPAs to avail these services. In the case of hospitalisation, health facilities are expected to inform TPA. The medical referee of TPA examines the admissibility of the case and informs the healthcare facility.

The agreement between TPAs and healthcare facilities provides for monitoring and collection of documents and bills pertaining to the treatment. Documents are audited and after processing are sent to the insurance company for reimbursement. TPAs have the responsibility of managing claims and getting reimbursements from insurance company and paying the healthcare provider. Sometimes TPAs pay the healthcare provider without getting reimbursement from the insurance company. For this purpose, the insurance company keeps a corpus amount with TPAs.

With the introduction of the TPAs the reimbursement system has undergone a change. Earlier clients were handling all claims and reimbursements themselves. In the process they were assuming the risk of delay in reimbursements, non-payment of some expenses incurred, and delay in reimbursements. Under the new system all claims and reimbursements would be routed through TPAs. TPAs become a nodal agency to handle all claims and reimbursements. With the introduction of TPAs risks in claim settlement have shifted from clients to providers. Providers now face the risk of not getting reimbursements from TPA, delay in reimbursements, and admissibility of various expenses. In addition to these, providers also face other risks which were not there in the previous system. Once the patient is admitted and if treatment costs exceed the sum insured, the provider faces the risk of non-reimbursement of the difference in treatment cost and sum-insured.

As part of the agreement between healthcare providers and TPAs, some providers insist on getting a part of the expected costs as advance.

TPAs generally have in-house expertise of medical doctors, hospital managers, insurance consultants, legal experts, information technology professionals, and management consultants. The backbone of a TPA is the information management system. Proper networking and timely documentation is the core of their operations. Information technology has an important role. Special software are used for documentation and managing the network of providers. Web enabled management information system helps in prompt networking. Analysis of data regarding hospital admissions across the network, analysis of treatment, tracking documents pertained to each case, and tracking shortfalls in claims are essentials of claim management. Analysis of data also helps in identifying and tracking health needs of population and effective treatment protocols. The information and learning generated would contribute significantly towards managing claim settlement process effectively. Various functions of TPAs are summarised in Figure 2.

Clientele

The client groups of TPAs can be divided into two broad groups: corporates and individuals. TPAs provide a wide range of services to various organisations. In many situations the entire administration of medical facility and benefits for employees of corporates are handled and managed by TPAs. TPAs work with companies to design and customise a policy to suit the needs according to the nature of health risks employees' face. Organisations that have many complex claims would benefit from outsourcing as would organisations which have geographically dispersed operations.

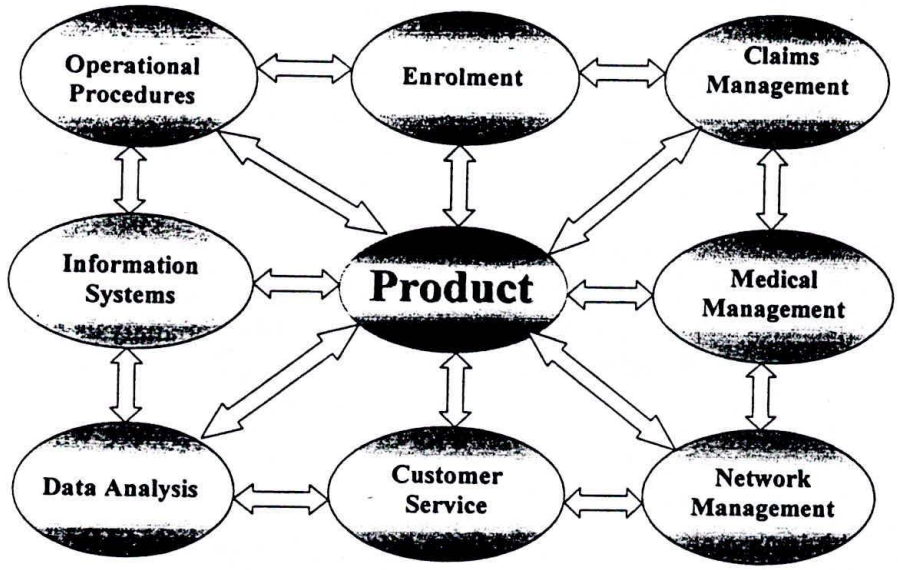

Figure 2: Range of services offered by managed care organisations. Source: Shah (2000)

Most of the TPAs operating in India have been focussing on corporate clients. Organisations which spend significant amounts on meeting health costs of employees would find the services of TPA cost effective. TPAs having expertise in organising healthcare services would be in a better position to design tailor-made packages of healthcare services to corporate clients and helping them minimise the costs. TPAs interface between client and hospital, offering medical consultation and advice to employees during office hours would help in avoiding delays in medical consultation. TPAs also manage group policies or customise suitable packages of managed care for organisations.

Revenue generation

The major source of revenue for TPAs is fees charged for providing various services. In case TPAs handle insurance policies (group or individual) of organisations, they get fees directly from insurance companies according to the volume and scope of services provided by them. This is usually a fixed percentage of the premium collected from the enrolees. However, TPAs may provide many other services to organisations for which the fee is paid by the organisation directly. These services may include the following:

1. Benefit management: TPAs help in designing appropriate health plans for the corporate sector and insurance companies.

2. Medical management: This is basically disease management and involves the medical follow-up of the case. TPAs track the line of treatment and ensure genuine treatment.

3. Provider network management: This is the key task. TPAs need to negotiate with service providers regarding quality of care, credit facility, discounts, package pricing, priority appointments and admissions, etc. Periodic review and evaluation of the performance of service providers are also vital.

4. Claims administration: This involves the claim adjudication process. The tasks include documentation, checking eligibility and coverage, claim submission and arranging payment for the service provider.

5. Information and data management: TPAs can generate a lot of reports and database. This can be used as management tools for analysis and controlling cost and besides helping design new products.

Apart from these, TPAs can offer a lot of value added services whose importance is likely to grow in future.

Health insurance markets suffer from several shortcomings. TPAs provide support function in assuring that the client has received most appropriate and cost-effective medical treatment while in hospital. They ensure that clients do not experience delay in getting treatment to keep check on costs. However, delay in seeking treatment from client side is not ruled out. Owing to this, costs may go up. The justification for introducing TPAs' services is that they help in minimising moral hazard. For this purpose, TPAs follow each case in an individualised way. TPAs do comprehensive review of records and keep constant communication with healthcare providers and families. They also evaluate the outcome of treatment and have adequate data to compare it across different service providers. The knowledge base helps them to be more effective in handling future cases.

Value added services provided by TPAs are arrangement of ambulance services, medicines, and supplies. For this purpose TPAs may have tie-ups with selected pharmacies and suppliers. TPA may provide this service to healthcare providers or their clients for a fee. TPAs guide members for specialised consultation, provide information about health facilities, hospitals, bed availability, etc. They may organise life-style management and well-being programmes for their members, and provide a 24 hours helpline.

TPAs and health insurance

TPAs are in nascent stages in India. However, they are well known in countries such as US. Managed care assumes critical significance in India as the private practice and hospitals are not regulated and face a number of challenges. Considering the current trends most of the government-owned insurance companies offering Mediclaim insurance have started hiring TPAs. New entrants in health insurance will also find the services of TPA inevitable.

The role of TPAs will not remain limited to managing indemnity insurance policies. For example, the Mediclaim insurance scheme is currently the sole health insurance product and TPAs will have a role in managing it. There are several employer managed medical schemes – in-house or sourced-out schemes – where TPAs will play an increasingly important role. Employers will source-out the management of most of these schemes.

Companies which have plans to offer health insurance products have tied up with various TPAs for their service. With more private insurance companies starting operations in India, the role of the TPAs as insurance intermediaries will increase significantly.

IRDA has made it mandatory for TPAs to acquire licence to operate in India. So far IRDA has granted licence to 23 TPAs (see Annexure 1, 2 and 3 for a list of companies and major players). TPAs have formed an association called Indian Association of TPAs to organise themselves and protect their interests.

The corporate sector is likely to remain the main clientele of most TPAs. Public sector insurers (subsidiaries of GIC) are developing partnerships with TPAs for managing their health insurance products, particularly claim management and providing cash-less facility. The insurance company is able to attract TPAs in a geographical location only if they have sizable presence and the insurance company has large health policy coverage. Once associated with the insurance company TPAs are given details of all policy holders and TPA issues photo identity cards to Mediclaim policy holders, monitors, and process claims, and conducts investigations if required into claims.

6 Regulatory issues, potential impacts, and challenges

The effectiveness of TPAs in managing claims and reimbursements depends on their bargaining power vis-à-vis healthcare service providers. Their position would also determine the amount of savings and cost containment TPAs will succeed in producing. It is envisaged that TPAs can get better negotiated agreements with hospitals and medical practitioners and will introduce better monitoring system leading to lower claim ratios. However, in practice there are many challenges which TPAs face in achieving these goals. The management of claims and reimbursements in a highly fragmented, and unregulated markets, and dealing with large number of small-sized services providers is expensive. Revenue generation of TPAs would be under serious pressure. For doing their job effectively, TPAs will be required to employ medical management experts and managers who can negotiate deals with a large number of service providers. Given that healthcare providers are not regulated and there is no information on various operational aspects of healthcare facilities such as occupancy rates, length of stay etc., negotiating rates and levels of quality of care will be a tough task. The role of TPAs will remain in managing indemnity. Many concepts and mechanisms of managed care which help in containing costs are difficult to implement in current circumstances. For example, there no system of capitation payment and therefore there is less scope to negotiate deals and get discounts in hospital charges.

TPAs face several challenges. These are emanating from regulatory structure, lack of training facilities for TPAs, consumer concerns, demand and supply side imperfections in the health sector having implications for organisation of service provision, and inherent risks in health insurance. We discuss these in following sections.

6.1 Regulation of TPAs

The Insurance Regulatory and Development Authority (IRDA) has approved services of TPAs as insurance intermediaries and would be regulating their practices. IRDA has formulated regulations in 2001 for companies staring TPA ventures with the objective of developing health insurance. IRDA defines TPA as "an insurance intermediary licensed by the Authority who, either directly or indirectly, solicits or effects coverage of, underwrite, collect, charge premium from an insured, or adjust or settle claims in connection with health insurance, except as an agent or broker or an insurer." The final draft of these regulations has strictly barred TPAs from marketing health insurance products and charging the insured.

IRDA in consultation with the Insurance Advisory Committee has formulated the Insurance Regulatory and Development Authority (Third Party Administrators - Health Services) Regulations, 2001 to regulate TPA services. The salient features are as follows.

- Only an organisation registered under the Companies Act 1956 with a share capital of at least Rs 10 million in equity shares can set up TPA in health services.
- TPA will be required to start with a minimum working capital of Rs. 10 million at any point of functioning.
- The primary object of the company should be to carry on business in India as a TPA in health services. It should not engage itself in any other business.
- At least one of the directors shall be a qualified medical doctor registered with the Medical Council of India. The CEO or CAO of TPA should have successfully undergone a course in hospital management from an institution recognised by IRDA and have passed the licentiate examination conducted by the Insurance Institute of India, Mumbai. Apart this he should have undergone practical training of at least three months in the field of health management. TPAs should have access to competent medical professionals to advise insurance companies and clients on various matters.
- Foreign equity in TPAs is limited to 26 per cent. In case of any share transfer exceeding 5 per cent of paid up capital, IRDA has to be informed within 15 days of such transfer.
- TPAs should obtain licence from IRDA to function. The application fee is Rs. 20,000 and, once the application is approved, another Rs. 30,000 has to be paid as licensing fee. The licence will be renewed every third year by IRDA. If the application is rejected, TPA is not entitled to apply within two years. TPA should furnish all documents including the agreement with the insurance company while applying for licence. This agreement should contain the details of the remuneration that may be payable to TPA by the insurance company.
- TPA will be allowed to enter into agreement with more than one insurer and similarly insurance companies can engage more than one TPA.
- TPA has to spell out the scope of services that it will deliver, while entering in an agreement with a insurance company
- TPAs shall not charge any kind of fee from the clients.

- IRDA guidelines do not permit marketing of health insurance policies by the TPA.
- TPAs would also have to maintain and report to IRDA on transaction carried out on behalf of the insurer. The authority envisages TPAs to maintain all records properly and maintain professional confidentiality between the parties. The authority holds the power to monitor and check the performance of TPAs from time to time. TPAs are expected to furnish to the insurance company and the authority an annual report and any other return as may be required by the Authority.
- IRDA has drawn up a code of conduct for the TPAs refraining them from trading in information, submitting wrong information to insurers, and making advertisements without prior approval of the insurer among other things. Licence will be revoked in such instances.

IRDA regulations put stringent conditions for licensing TPAs. The current regulation requires TPAs to meet a minimum equity capital of Rs. 10 million. The capital requirements for entering in this sector are not stringent. As a result of this sector may see proliferation of players many of them not having serious interest. By having a large number of players, there will be pressure on margins. Besides this TPAs need to set up infrastructure which would involve large investments, the payback period of which is likely to be long. TPAs face high operating risk of obtaining economies of scale necessary to break-even. Volumes are critical because the revenue generation of TPAs is linked to the number of policies they undertake to administer. According to current regulations, TPAs will get 6 per cent of premium collected as their share of revenue.

It is expected that with the introduction of TPA services, claim settlement process would be simplified. IRDA has suggested that all claims should get settled in seven days. In a case study done in Ahmedabad, it was observed that the insurance company takes on an average 121 days to settle a claim (Bhat and Reuben, 2002). Outsourcing claim processing services may help in reducing the claim period. But settling claims in seven days is still a very ambitious target in current scenario. TPAs will face major challenge in bringing down the settlement period to 7 days. It has been observed that lack of proper documents related to treatment often results in deferred or non-payment of claims. Of course, examination of exclusion clauses in the policy is imperative before authorising admissibility and further treatment. TPAs will have to sort these issues right at a time policyholder is seeking healthcare services. Winning the confidence of policyholders and maintaining the client base will be challenging. Competitive marketing strategies and use of innovative mechanisms will be important. All attempts by insurance companies to tie up with private hospitals through the system of TPAs in the past have yielded little success, as there is generally a mutual feeling of distrust. This will pose a major challenge.

6.2 Consumer concerns

Increased costs for consumer: Introduction of TPA services result in higher costs. Who bears this cost? So far, government-run insurance companies were following the policy of referring claims cases to a panel of doctors. In 46 per cent cases medical referral was sought (Bhat and Reuben, 2002). Insurance companies spent less than Rs. 150 per case. Introduction of TPAs will have significant implications for costs.

The policyholder has to bear the cost of payment to TPA and as a result this increase cost of TPA payment will result in increase in premium rate. Premium of Mediclaim insurance policies have already gone up by 6 per cent.

Choice of service provider: The advantage of having a TPA is assuring cashless hospitalisation facility which did not exist in previous system. This will certainly increase accessibility to health care. Currently all indoor admissions in hospitals require some cash deposit or guarantees. This often makes it difficult for people to seek healthcare even if the patient has insurance. In most situations TPA provide a list of healthcare facilities policyholders can use. This arrangement may have implications for restricting the choice of facilities. Though patients are free to choose any hospital, for cash-less facility they may be required to go to a facility chosen by TPA.

TPA would face serious pressure from insurance companies to keep the claim ratio down. TPAs would have less influencing role in containing costs. They may get in serious conflict with healthcare service providers. The delicate balance between insurance company, providers and customers is difficult to maintain. For example, introduction of similar services in Hong Kong resulted in all local physicians deciding not to participate in the network mechanism and this seriously affected the availability of healthcare services to policyholders who were in need of getting treatment (Parekh, 2003).

According to IRDA guidelines TPAs are not allowed to market health insurance policies. Selling insurance products directly by TPAs is seen creating conflict of interest between insurance company and TPA on one hand and between TPA and policyholder on the other. In case TPAs are allowed to market insurance products, there would be tendency to be biased towards policyholders keeping the customers interest in mind. There might be a conflict of interest if the same entity is allowed to collect premium and also settle claims. The system may create perverse incentives which give opportunities to healthcare providers, policyholders, and TPAs to collude and TPAs may favour healthcare providers and policyholders in settling claims in order to attract more business. However, TPAs feel that by not allowing them to market insurance products, the health insurance sector will experience less participation of TPAs in areas such as consumer education and making them aware of differences in various policy options. This will also discourage competition in the insurance sector and as a result the objectives of insurance reform will not be achieved. As an intermediary, TPAs are in position to help customers get best deal. TPAs argue that if they are allowed to market and sell health policies, they can develop appropriate infrastructure and systems to reduce many unintended consequences of health insurance.

6.3 Training of TPAs

TPA is a complex organisation and, therefore, must have adequately trained managerial staff to address various complexities. TPAs have to ensure that they have range of management competencies and capabilities which can handle sensitive customer service requirements to hardcore financial management and specialty technical/medical knowledge to robust information technology. TPAs must be

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organised with an emphasis on the selection of the adequately qualified personnel and an intensive comprehensive training regime (Parekh, 2003).

There is no knowledge base which guides the policy makers to develop appropriate training interventions. There are no recognised training facilities and availability of trainers in this field is almost non-existent. The limited training imparted to personnel of most insurance companies is also inadequate. The lack of training has several unintended consequences to the growth and development of health insurance market in India. The current regulations do not address these concerns.

6.4 Characteristics of healthcare provision

Quality of healthcare is a critical issue in an unregulated private medical sector (Bhat 1999). TPAs are expected to develop a network of healthcare providers. It is expected that TPAs will follow some process in selecting providers to form the network. The quality of care can be ensured by insisting on following certain criteria such as minimum qualification of service provider, evidence that service providers follow basic minimum standards of care. However, TPAs will face a number of challenges here. The minimum standards of care are not defined. Healthcare service providers have a much higher bargaining power in the system and TPAs will not be able to persuade the providers to follow standards and quality guidelines. Also, TPAs would have less influence on controlling the cost of care. In the case of indemnity insurance arrangement, moral hazard problems because of provider side demand inducements are quite high. There are no mechanisms or incentives in place which TPAs can use to address these issues. Patients would have no interest in resisting this. These combinations of factors would continue to reinforce the increased demand for healthcare services and diagnostics which are expensive and resource intensive. In many situations increased use of resources generally has no significant impact either on overall quality of care and/or health outcomes. Without proper regulation of private practice on what is being provided and at what cost, indemnity system will continue to lead to more expensive healthcare. TPAs and IRDA will have a less influencing role in regulating healthcare service providers.

Lack of standardisation or accreditation system for hospitals also makes the concern of pricing and billing serious. Billing systems differ from facility to facility. Most of the payments are cash based and less transparent. TPAs would face difficulties in scrutinising and processing claims and reimbursements using common standards across facilities.

There is no standardisation of charges across hospitals in the country. In many situations, billing systems are not in at par with standards of care. One observes significant variations in charges across hospitals. The following table presents information from 670 claims and reimbursement data for various healthcare services.

Health	Treatment cost range (Rs.)	Age group
Entric fever	1800 -18000	5 yrs - 35 yrs
Cataract	5500 - 20000	44 yrs - 66 yrs
Gastroenteritis	1500 - 11000	35 yrs - 50 yrs
Accidents	2000 - 1.71 lakhs	all age groups
Heart disease/chest pain	5000 - 1.70 lakh	35 yrs - 68 yrs
Appendicitis	12000 - 20000	below 50

One of the ways a managed care organisation bargains for better prices and discounts is by providing volume business. In indemnity insurance arrangement, TPAs cannot assure a certain volume of business to a particular healthcare service provider upfront. Since the insurance company and TPAs function as separate entities and TPAs have to deal with a large number of service providers, offering bulk deal to one single provider is not possible. This would have implications for costs of medical services.

TPAs make arrangements with care providers and guarantee reimbursements of fee for services. The risk of collection has shifted from the policyholder to the healthcare service provider. In many situations healthcare providers would insist on advance payment even in the new system. In these cases TPAs will be required to make advance payment for a part of expected charges as soon as admission is notified to TPA.

IRDA recognises that future health insurance products should be customised focusing on meeting clients' demands. There is no actuarial involvement in designing health insurance products. Past experiences are important in calculating premiums. A centralised database containing information on costs of insurers and healthcare providers is, therefore, desirable. However, there is lack of information on healthcare services and utilisation. Recognising this as problem, IRDA has constituted a committee with representation from insurers, third party administrators (TPAs), the Tariff Advisory Committee (TAC) and IRDA to suggest framework for collection of health related data and advise on use of this information in (a) building health insurance products by insurance companies, (b) establishing benchmarks for the services to be provided by TPAs, and (c) standardising the services to be provided by hospitals to policyholders (IRDA Journal, 2003).

There is very little information and documentation on approaches which can be used to influence consumer behaviour, provider practices and restructuring the market – both health and insurance. The approaches such as standardisation of treatment protocols as proposed by IRDA can be problematic. These efforts may imply proposing treatment practices that may be contrary to existing practices and the regulators may face serious opposition from powerful professional groups. The monitoring function is vital but difficult to sustain in the long term. Such efforts are highly resource intensive, especially when they involve working with large number of geographically dispersed and small sized service providers having backing of highly politicised professional bodies. The regulator has to make careful judgments in developing appropriate strategies to deal with the private healthcare service providers. It is also not clear that how without involving the service providers the standards of care can be set. Also, given the diversity of providers and absence of uniform standards, getting information on disease management and costs/pricing are going to be challenging tasks.

6.5 Other inherent risks and issues

Do TPAs have incentive in controlling costs? The remuneration of TPA has been decided as a fixed percentage of the policy premium. In case reimbursements are controllable (which in practice are), the payments to TPA for their services are not linked to the effort of controlling reimbursements. Hence, how TPAs are paid for their services should take into account TPA's efforts and successes in controlling the costs and reimbursements. In any insurance system, focus on prevention and promotive services can cut down many costs. TPAs can play an important role in these areas. However, the mechanisms for these are not in place and their role is not clearly defined. TPAs are in position to offer and organise these services but this will come at a cost.

In many situations policyholders are not aware of various conditions and exclusion clauses in insurance policies. As a result, disputes between policyholders and insurance companies have increased. In many situations both parties have resorted to litigation. In many situations these problems arise because of lack of information and lack of awareness. There is also inadequate understanding of various nuances of insurance. It is expected that TPAs can play an important role in educating consumers and bringing awareness. TPAs are the interface between the insurer and the insured and they are in a position to educate the insurer on health insurance.

TPAs are not allowed to charge any kind of fees or demand a share of proceeds or indemnity from the claimant. Most other important services will remain neglected. TPAs point out that if they can collect money from the customer, it will mean more competition and thus better service.

On demand side, one positive impact of TPAs' existence would be on service utilisation. In most situations utilisation of high cost speciality care will need approval and concurrence from TPA. Utilisation of such services would be rationed by restricting direct access to specialists. TPAs face serious challenge in mitigating negative consequences of health insurance and control malpractices. While dealing with a large number of policyholders TPAs would be in position to generate lot of comparable data on utilisation of services and their cost structures. This information can be used to set benchmarks for costs and quality of care. However, this is going to take time. Developing these benchmarks and putting them in place will need research on understanding of cost drivers.

In order to mitigate the risks of working capital, insurance companies may be required to keep cash balances with TPAs to meet the reimbursement pressure. There is no regulation on cash management practices of TPAs. Insurance companies and IRDA need address this area as there are perverse motives to use these funds for other than meeting working capital requirements.

IRDA can revoke the licence of TPA if the financial condition of TPA deteriorates at any point of time. TPAs stand as guarantor between insurer and provider of service. The risks are high. What happens if a TPA fails? Who stands as the guarantor for TPA to meet its liabilities in case of failure? Many healthcare providers are reluctant to offer cash-less service without receiving advance from TPA. Healthcare facilities consider the risks are too high in dealing with TPAs.

IRDA has made it mandatory for health insurance companies to have significant presence in rural areas. As part of fulfilling this obligation IRDA requires a detailed plan on how the insurance company will cover rural areas. For this insurance companies would require TPAs to set up infrastructure in rural areas. Addressing the rural segment will be a challenge for TPAs.

There are several other areas which have not been addressed clearly in the present regulations. For example, in case there is dispute between TPA and insurance company what will be the process of resolving the conflict? Who will audit TPAs? It has become mandatory for the insurance company to appoint TPA. What will be the process of selection of TPA? How are TPAs going to market their services? Who would set prices for TPA services? As TPA is a new concept, there is little awareness about these services provided by TPAs among the people.

Appendix 1

List of TPAs who have been granted licence by IRDA

	Company	Location
1.	Dawn Services	Secunderabad
2.	Parekh Health Management	Mumbai
3.	Medi Assist India	Bangalore
4.	Guardian Health Management	Bangalore
5.	MD India Healthcare Services	Pune
6.	Paramount Health Services	Mumbai
7.	E Meditek Solutions	New Delhi
8.	Heritage Health Services	Kolkata
9.	Universal Medi-Aid Services	New Delhi
10.	Medicare Foundation	Goa.
11.	Tower Insurance Services	Mumbai
12.	Medicare TPA Services (I)	Kolkata
13.	Family Health Plan	Hyderabad
14.	ICAN Health Services	Pune
15.	Raksha TPA	New Delhi
16.	TTK Healthcare Services	Bangalore
17.	Anyuta Medinet Healthcare	Bangalore
18.	East West Assist	New Delhi
19.	Med Save Health Care	New Delhi
20.	Genins India	NOIDA
21.	Alankit Healthcare	New Delhi
22.	Bhaichand Amoluk Insurance Services	Mumbai
23.	Good Healthplan	Hyderabad

Appendix 2

TPAs in India

Sedgwick Parekh Health Care Management Limited is one of the first TPAs in managing health care products in India. The company was set up in 1996 in Mumbai as a joint venture between the Sedgwick Group through its subsidiary Sedgwick Noble Lowndess, and Dr Ramnik Parekh family in Mumbai. Sedgwick Parekh specifically provides services to the corporate sector. The services are customised health benefits strategies for employers, supported by state-of-art software and health management processes. Sedgwick Parekh provides a host of health services that complement a company's health benefit plan and covers a wide spectrum of healthcare needs of employees. It currently provides service to about 108 companies with coverage of 85,000 employees and dependants. Sedgwick Parekh has a network of 255 hospitals nation-wide covering 77 cities - from small community based hospitals to large hospitals. The company recently added 123 diagnostic centres and 184 general physicians spread across more than 10 cities. Germany based re-insurance major General Cologne Re has formed a strategic alliance with Sedgwick Parekh to enter the Indian insurance market as TPA. Recently, the US based health services company United Health Care International finalised a deal to control 80 per cent stake in Sedgwick Parekh.

Paramount Healthcare Management is another leading TPA operating from Mumbai. Munich Reinsurance Company of Germany has picked up one-third stake in Paramount and plans to make it into a world class TPA in India. Munich Re has also the option to increase its stake to 51 per cent in this venture. Paramount has a network of 386 hospitals nation-wide.

Family Health Plan Limited is a subsidiary of the Apollo Group and is based in Hyderabad. The company has its offices in Delhi, Chennai, Calcutta, Mumbai, Bangalore, and Pune. The company was established in 1995. Major clients of FHP are public sector companies. It caters to the corporate sector and individual policyholders as well. FHP networks with around 600 hospitals, 250 diagnostic centres, and 1000 general practitioners across the country.

Dawn Services Private Limited operates from Secunderabad since 1997. The network consists of 45 hospitals, 33 diagnostic centres, 6 dental clinics, 4 hearing aid centres, 3 physiotherapy centres, 24 pharmacies, and 142 general practitioners. Individual Mediclaim policy holders are the major clients of this company. The company also provides services to other companies and institutions.

Appendix 3

United Healthcare, USA: United Healthcare (UHC) is an HMO and is part of the United Health Group, one of the largest and prominent health care companies in the United States. The company offers a wide variety of health services internationally.

United Healthcare offers consumer-oriented health benefit plans for individuals, small businesses, and mid-sized businesses. Healthcare plans and services reach over 16 million people, from groups ranging in size from 2 to over 5000 with one and multiple locations. UHC also serves Medicare and Medicaid population. Customers can access 400,000 physicians and 3,300 hospitals. Over 50 per cent of US hospitals are part of the network. Customers have the choice of various health plans. It is also involved in designing healthcare benefit plans and services that provide access to quality physicians and other healthcare professionals, offering greater consumer choice and control over healthcare services, and supporting informed decision-making by delivering relevant information to consumers and physicians. The services can be categorised into: (a) medical, (b) life, (c) dental and (d) vision. In America, the traditional health insurance plans require a primary physician's referral to get access to a specialist. In 1984 UHC pioneered the introduction of what it calls "open access" or "no gatekeeper" model for health care. Patients could have direct access to specialists.

United Healthcare International (UHI) was set up as an international health service provider. The company is interested in investing or building health service organisations that provide expert management and administration of health insurance portfolios for partners and clients throughout the world. In effect, UHC facilitates the provision of local health insurance products for insurers and/or self-funded employers, but does not provide actual insurance.

The company has long experience in health administration for clients and subsidiaries in countries throughout Europe, Asia, Africa, and South America. UHI's health insurance administration system is designed specifically for use in the international market.

The core strengths of UHC are:

- The largest US portfolio of comprehensive insured health products
- The largest US administrator of self-insured health products
- Specialised companies that manage supplemental health products (mental health, dental, vision, and alternative care)
- A flexible, comprehensive proprietary IT platform to manage health products internationally
- Innovative data mining tools to manage health risk
- Effective care coordination programs
- Significant expertise in establishing and managing provider networks
- Significant expertise in developing/managing international private health insurance products

For its international companies, UHI typically has a strong local partner. These partners provide the local market expertise to complement the technical expertise and know-how contributed by UHI. The make-up of the partners may differ from country to country and can include the following:

- Insurers (multi-line and health specific)
- Supplemental health benefit insurers
- Third party administrators (TPAs)
- Assistance companies
- Preferred provider organizations
- Medical management companies

Till now UHC has ownership interests in health service operations in Hong Kong, India, Malaysia, the Philippines, Portugal, and a health care administrative system in South Africa. This company offers comprehensive health care administration services, outsourcing the "back-office" services typically provided in-house by insurers and large employers. The services depend upon the operational strategy and tie-up with local partner.

United Healthcare India: United Healthcare estimates a big health insurance market in India. United Healthcare International in February of 2002 purchased equity stake in Sedgwick Parekh Health Management (Private) Limited, a Mumbai based third party administrator and health management company. Sedgwick Parekh since its establishment in 1996 has pioneered the concept of managed healthcare services in India. United Healthcare India has positioned itself as a leading company for consultation, evaluation, and development of corporate health plans and employee health benefits. United Healthcare India today has offices located in Mumbai, New Delhi, Bangalore, Chennai, Hyderabad, Ahmedabad, and Pune serving a client base of 135 corporations with over 100,000 members. The provider network which is called Health Connect spans over 510 hospitals and nursing homes in 171 cities, over 200 diagnostic centres, specialist consultants, and primary care physicians giving a network spread of over 900 providers in 179 cities.

UH India offers a complete range of managed health care services such as:

- Claims and benefit management for both network and indemnity products, for both inpatient and outpatient services
- Billing and enrolment services
- Provider network services, through our contracted network,
- Care coordination and health services programs
- Customer service/call centre facilities for all constituencies, including members, providers, and employer groups
- Nurse line/Help line for health care questions and information
- Health care communications
- Employee health plan design; claims management and administration, call centre services
- Preferred provider organization marketed as Health Connect
- Health risk management
- Occupational health
- Case management and disease management services
- Pre-enrolment screening and medical examination services and logistics for life insurers

In addition, the following value added products and services are also offered depending upon the operational strategy in each country.

- Healthcare management consulting services
- Product development and underwriting support
- Benefit design
- Member communications materials
- Member education and training programs
- Customised medical and dental products, for example, well woman, and flu management programmes

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