Economics of Health and Healthcare

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Lecture - 32
Third Party Administrator

When we talk about you know we are facing troubles in case of a developing country like India, facing trouble in terms of this health insurance operations by the health insurance firms, by the government, by the people.

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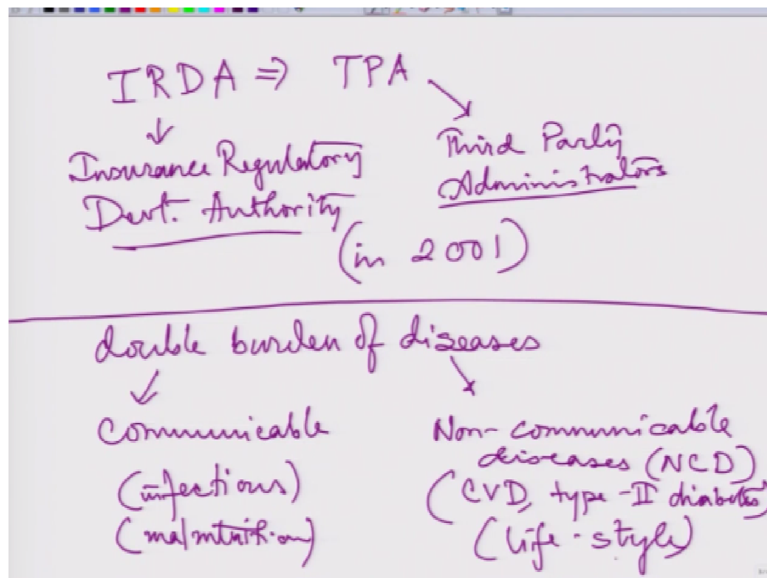

Then, IRDA Insurance Regulatory Development Authority, IRDA has decided that they will launch a forum or a group of organizations who are known as third party administrators. So this IRDA are Insurance Regulatory Development Authority whereas TPA is third party administrators yes. So this IRDA has launched this TPA in 2001 yes and IRDA actually is the regulatory body for the entire insurance operations across the country.

And these third party administrators are under this IRDA. So what generally these third party administrators do? So in India the healthcare system is really, really changing fast. So we are in a transition during this last say a couple of decades, a lot many things have been privatized, service sector, manufacturing sector and the affordability among people have really increased.

With this you know privatization, westernization, urbanization, the lifestyle has changed. The food pattern, the exercise pattern and finally the disease pattern has changed. People are more often falling prey to these non-communicable diseases which are known as cardiovascular diseases, type 2 diabetes you know like all these lifestyle related diseases, cancers. So the disease pattern is really changing and this is changing very fast.

So at the same time India is not actually have got rid of those infectious or communicable diseases. So there is a double burden of diseases you know, so double burden of diseases which talk about both communicable as well as non-communicable diseases which is also known as NCDs. These communicable diseases are infectious diseases primarily or diseases with you know malnutrition, chronic energy deficiency.

Whereas over here these are cardiovascular diseases, type 2 diabetes you know, cancer, primarily the lifestyle related diseases but what happens with this double burden of diseases? The total number of people with diseases have increased with this changing disease pattern and what these non-communicable diseases do, they generally do not you know push people towards mortality.

People do not really die with a very short span of time, what used to happen when people have cholera, people have measles back on old days while with (()) (04:19) and all but what happens now with non-communicable diseases people live longer because life expectancy has increased, people are living longer around 70 years and on an average and at the same time they are living longer days with morbidity, with diseases that increases their healthcare expenditure.

When there is more you know the expenditure towards healthcare, there is a necessity of insurance. At the same time, why this necessity is suddenly being felt not only because of increasing healthcare expenditure but also because of the awareness and affordability. With the education, people's awareness have increased. They have information; they can synthesize the information whereas with the affordability they can afford the insurances.

They are not really nonsense payment for them. What government is doing to encourage them is they are trying to give some tax exemption if a person has insurance and all these things but they are secondary. After you know people are buying a lot of many insurances, people

are falling sick with non-communicable diseases and very frequently, so there is a large number of claims.

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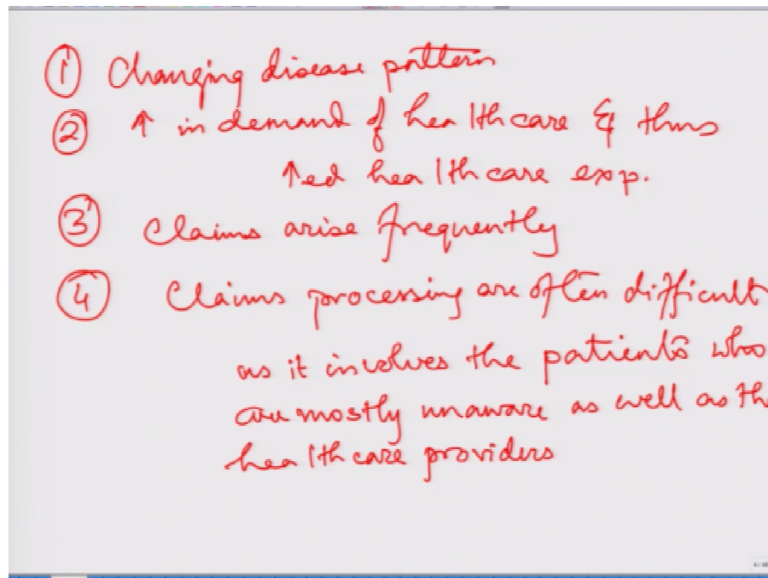

So if I can note them down, one is changing disease pattern, number two is increase in demand of healthcare and thus increased healthcare expenditure. Three, because of more health insurance and more morbid people, diseased people, claims arise frequently, claims from the insurance companies that they need their money back and you know unlike life insurances because in life insurances claims arise only one.

Nobody die more than once right, so in life insurances claims arise more than just once whereas in health insurances a person can go for a hospitalization, can get admitted several times in his lifespan and asking for claims. So the claims arise very frequently with these transitions and number four that some companies deals with the claims themselves but some companies find it really, really difficult.

And with this claims processing are often difficult as it involves the patients who are mostly unaware about their you know health insurance profile as well as the healthcare providers who are very difficult to deal with because you know they have their own payment mechanism, they really do not want to alter with that, they have their own logics and all and then the patients are not entertained with the healthcare providers when that treatment is done.

So and then it is once they have an insurance company, the health care providers will say just deal with the insurance company you know. Therefore, these are the basic reasons that why we have our requirement of a third party administrator. So in case of a third party administrator what we look for? We look for a greater efficiency.

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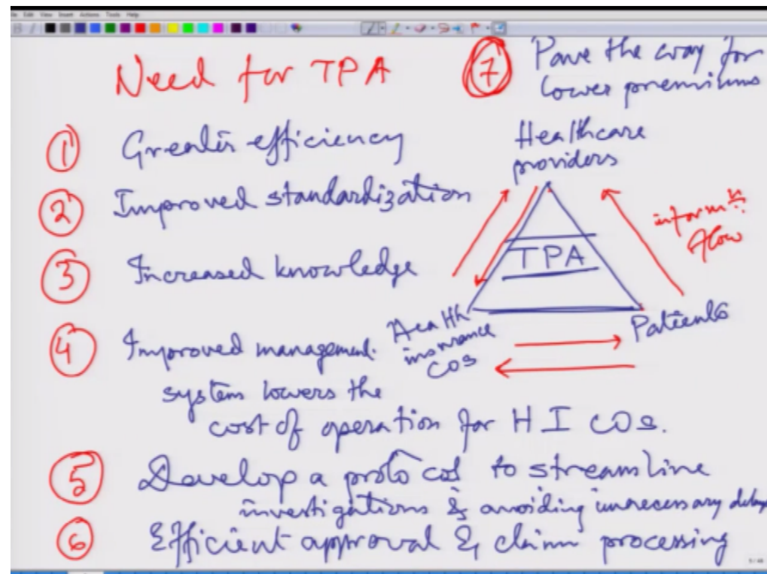

So we have a need for TPA to have greater efficiency in processing the cases, in dealing in case of cashless services, they will return the cash or they do not have to pay you know, they will give the cash directly to the hospital because the patient is not paying anything. In case of reimbursement, within 90 days they have to get the money from the insurance company and give it to the patients.

So while I say this the TPA basically connects 3 stakeholders. One is healthcare providers, health insurance organizations companies and patient’s right or the customer’s right. The patient goes to the healthcare providers. Healthcare providers send the document to health insurance companies and health insurance companies paying the money to the patient but often in case of a reimbursement the patient pays to the healthcare provider.

The healthcare provider gets its money. Now the patient has to ask the money back from the health insurance companies. Now within 90 days again the health insurance company is looking at all these documents, you know they have their set of doctors who look at the documents that whether this particular surgery or this particular treatment process fall under the qualified you know disease or treatments.

In that particular case, your insurance case, so the health insurance companies will pay back the money. This is the reimbursement while in case of cashless; the patient would not pay anything to the insurance to the hospitals. The healthcare providers will get the money from the insurance companies yes. So the healthcare insurance companies do not have to pay make any payment to us the patients as well.

So the money directly goes from the health insurance companies to the hospitals but at the same time you know the patients are actually getting a cashless service. They are not paying anything yeah. The previous one was reimbursement. Anyways, so this is how the third party administrator works now. What they do? They connect the TPA to the healthcare provider.

I mean patient to the healthcare provider when the patient needs to make the payment and then looks at the bills, verify that you know the healthcare bill and everything verifies the documents. They send it to the third-party administrator. They send it to the third party. The third party administrator sends it to the health insurance companies and then they get the money from the health insurance companies.

If it is a cashless, they will only manage the flow of the money from health insurance companies to health providers. If it is a reimbursement case, the money has to be paid to the patient's' health insurance companies. Then, they will collect the money from the health insurance companies and pay to the patients. They will sell the policy to the patients on behalf of the health insurance company.

Will keep some agents who will sell on behalf of them the policies to the patients. They will collect the premiums and submit it to the health insurance companies. They can also suggest the patients that in which healthcare providers they can go and you know and connects the information flow between the patient and then the hospital providers that if the patients have a query that why the hospitals are charging me for this particular treatment.

Then, they know the policy better so the third party administrators will answer the patients. If the health insurance companies will ask that why it has been you know a particular treatment process has been charged very highly, so the third-party administrators ask the question from the hospitals and get the answers to the health insurance companies. So this is how the third party administrator works.

They are a kind of networking agent. They do network across the hospitals. They do network between the patient and the hospitals, hospitals and the health insurance companies, health insurance companies and the patients. So the first thing is we expect from them is the greater efficiency, the second one is improved standardization that improved standardization is you know these hospitals especially the corporate or private hospitals charge differently from different patients you know whether they have insurance or they do not have insurance.

Even if they have similar insurance, hospital A charges differently from hospital B, hospital B charges differently from hospital C and mostly few of which you know hospitals charge because of they have a fantastic facility, beautiful looking building, nice styles, wonderful TVs and all these you know. So and it is very difficult to justify because it finally creates a cost for the health insurance companies which can be a particular surgery if that can be done.

Say a pregnancy in a particular government hospital or charitable hospital if that can be done without any benefit, without any scheme at 30,000 rupees. In a small time, private hospital, it charges 80,000 rupees. In you know cesarean section in a particular corporate tertiary hospital with insurance which covers pregnancy; it can charge 1.5 lakhs to 2 lakh rupees is not less than that. I am talking about Bangalore yeah.

So and this 70,000, 80,000 from this government hospital to the I can understand the government hospital and then that you know premier tertiary care hospital but the private hospital which charges 80,000 and the premier hospital. This difference is enormous and then the health insurance is paying for that. So they ask the questions and then this TPA is who actually forced these hospitals for standardization in terms of pricing mechanism which is highly varying.

The third is increased knowledge of healthcare services. You know the hospitals have knowledge about other hospitals. The patients have knowledge about the hospitals, their health, the diseases which are covered so and the information is really ready. So they do not have to knock all the possible doors and then you know. So they have clear idea about that you know which is this particular insurance is covering, which are the diseases, where to go, which are the hospitals which charge high which charge low.

Basically, all these informations are supposed to be there yes it is still not that clear but still it is getting better, the improved management system with the greater efficiency of course. So this improved management system says that cost is coming down with system lowers the cost of operation for health insurance companies yes. So when they have a management is efficient and this is solely by this TPAs when the management is efficient.

You know there is lesser jostling confusion which information asymmetry and all these information asymmetry, confusion, going back and forth you know misunderstanding actually adds up to the cost of that entire operation, health insurance operations and this third party administrators are actually working nicely to bring down this cost of operations. The next one is develop a protocol to streamline investigations and to avoid unnecessary delays.

Investigations and avoiding unnecessary delays. What happens that these health insurance companies have bulk you know claims avoiding unnecessary delays? So they find it difficult to manage, so there is a delay. This third party administrators you know being there they make things easier and then that is how and you know they are doing a lot of things on behalf of these health insurance companies.

So on behalf of the hospital on behalf of the patients, so the average time, turnaround time that is the time taken for a particular process. So at the average time at a turnaround time is coming down and that also saves the time value of money. So that you know that the cost associated with the time transaction time is actually coming down. So this is also a highly positive this thing.

And the claims process you know the approval process are also efficient approval and claim processing that when I go for a hospitalization you know most often I have to submit the document, the doctor's prescription and all other documents, my insurance documents for the approval that whether this particular case can be covered under my insurance or not. They will send all these documents to their doctors.

And then they will approve that this particular health insurance scheme, this particular treatment process can be taken, can be covered by this particular health insurance schemes or this cannot be. So this process is also faster because and also the claims because after I get

the treatment my bill is generated I ask for and the claim can start even before the bill is generated but the process can start but the final bill is always required.

So when we get the bills and then the TPAs only take the bills to the insurance companies and they send it to the designated doctors who think that who decide that whether what has been you know decided or what was supposed to do the treatment process whether the bill has followed that particular treatment process or not or whether there is any anomaly and depending upon that they will decide that how much we can be covered.

You know because often what has been approved like when the approval came that time the health status or you know the treatment status are very different from when the final bill is being generated so and that is why both these cases are you know are need to be followed carefully and the time and the efficiency time is reduced and the efficiency is increased by the third-party administrators.

And when you go to a hospital, any corporate hospital generally have even the government insurance schemes they have their own TPAs. Generally, with the government you know a branch under the same insurance scheme or sometimes out sourced but at the same time as a PPP model but at the same time you know when you go to a private tertiary care hospital you will find a third party administrator who is sitting in that hospital premise.

And you will be suggested whenever there is a hospitalization required, the hospital administrators will ask you to go and consult with that TPA desk. So there will be the people who will be guiding you in terms of this approval, in terms of this claims processing and what kind of bid can you avail given this you know the cost given your premium that because the hospital will estimate a rough cost of the entire treatment.

So given that cost and then they will match that with your premium I mean with your insurance policy and then they will say that what kind of bid you can avail for how many days and otherwise how much you need to pay you know if you want to get a better bid or better rooms.

So all these are generally done by this third party administrator and then the other thing is that what they also do with this reduction in cost, the loads that is the operating cost of a

particular health insurance company comes down and with that operating cost coming down they can actually you know charge lower premium. So they pave the way for lower premium, lower premium rates which makes health insurances more affordable.

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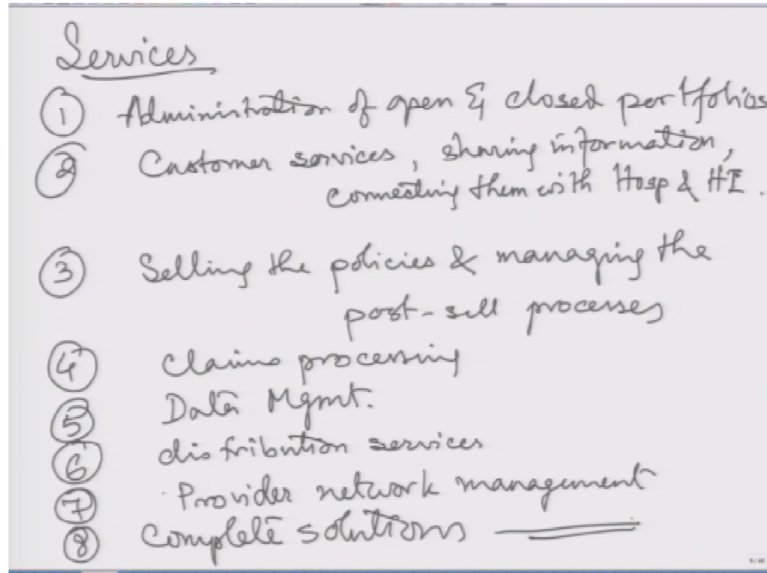

So the services they generally render are one is the services they generally render. Number 1 is administration of open and closed portfolios that different cases. Number 2, customer services. Customer services is also in terms of sharing information, connecting them with hospitals and health insurance companies like that yeah. Number 3 is claims and processing what I just said that claims processing.

You can say that processing of the entire health insurance or is just claims processing and or you know I will keep it separately first before claims processing I will say that selling the policies and managing the processes, post sales processes. Number 4, claims processing. Number 5, data management because they need to share the data like in terms of the hospitals, in terms of the pricing, in terms of this how much is being.

What is the difference between the cost during approval and during billing, what is the rejection rate that which are the health insurance schemes which have not been approved you know for those treatment coverage. So what is the rejection rate, what is the time taken for every process you know which are the general which are the hospitals where the prices are really bumpy, what is the difference in price across the hospitals for the same kinds of services.

All this data they need to keep and they need to share. This is the data about the patients, their patient profiles, their disease profiles, their socio-economic background profiles, everything they need to keep. Number 6, the distribution service, so distribution service is again networking or the process distribution across all these 3 stakeholders, the patients or the customers, the health care providers as well as the health insurance companies.

Number 7 is provider network management which is very much aligned with this you know distribution services but not all the time provider and network management that they in order to make sure that the rates are standardized, they have to form a network across the providers, they have to bring them together, they have to bring, they have to you know moderate consensus so that a consensus comes in in terms of this pricing.

So they are the ones who otherwise face troubles, so they have to you know work towards that and then the number 8 or the last one is complete solution for particular subject areas. Complete solutions for a particular health insurance schemes yeah. So these are all about the services a third party administrator you know extends towards us.

So the advantages we have found again is it not only increases the efficiency but with the efficiency or not only increases the management with this efficiency in terms of the managing a particular health insurance schemes they insure several things. Number 1, it reduces the time. It reduces time of a particular health insurance process, times of claims approval, pre-approval.

It improves the insurance turnover, it improves the number of policies, it of course reduces the cost and yeah. So it brings the standardization at least tries to bring a standardization across the health care providers but the customer is satisfied and because they have knowledge now, so that knowledge awareness generation is also a very important part they play in and the competitiveness is also there.

Because now they are pushing for the you know standardized rate across the health care providers. So they bring the hospitals in a competitive mode, so that the price is similar and then they have to be better in terms of the service delivery, so that they get a larger number of patients and certainly it ensures the legal requirements and you know wipes out the confusions in terms of the hospitals, health insurance organizations as well as the customers.

At the same time, TPA you know they are actually the heart of this entire health insurance business. So and they are connecting 3 completely different islands you know separated islands that it is not a very easy task. It is a very challenging task and when it comes to a developing market like India. So what they primarily do or what kind of problems they primarily face?

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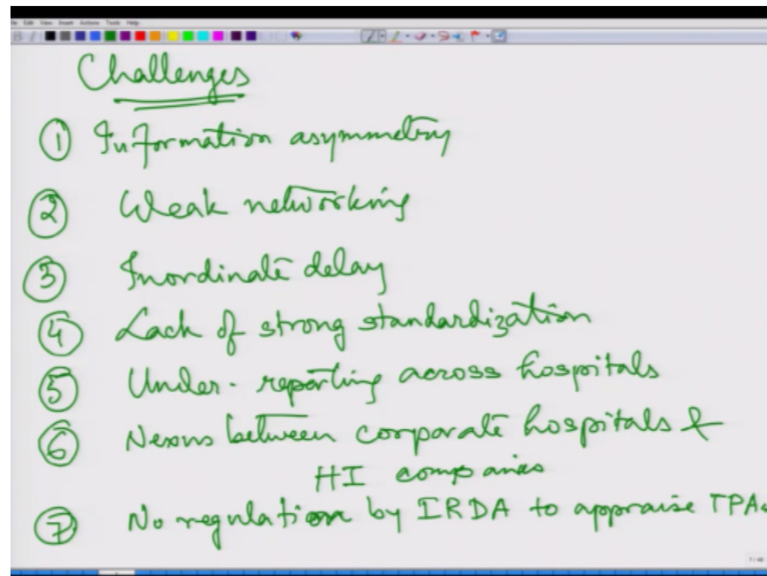

The first one is information asymmetry. I am talking about the challenges here that people do not have idea about the third party administrator at all that you know we do not have idea, we think that star health insurance is an insurer, no they are a third party administrator. You know similarly Vidal, TTK, Max Bupa, Birla Health Insurance, so many of them just work as third party administrator.

Some of them you know they are the health insurers as well as they have their own third party administrator group who can also work for other insurance companies. So one is that information asymmetry about the work or the existence of the third party administrator, number 1 information asymmetry about the hospitals providing certain services, information asymmetry about the among the patients about which are the hospitals, what kind of services they do provide.

And you know what kind of services my insurance covers and all this. Number 2 is weak networking among the hospitals, weak networking between the hospitals and the patients and the weaker the network is the more the confusions are, the more the challenges or you know

the time, inefficiency everything increases, cost finally and then the number 3 is inordinate delay you know because here TPAs can only push.

But then it is upon the hospitals, it is upon the say upon the health insurance companies, say certain documents has to be sent by the hospitals to health insurance companies. If they do not send those documents, the health insurance companies cannot make the payment towards the patients in case of a reimbursement but the hospitals can take a lot of time. So IRDA has its regulations you know 24 hours, 48 hours so on and so forth which is bringing the scenario in a better structure.

But still we face delays from these parts you know. Number 4 you know lack of strong standardization. So they really face a lack of strong standardization. They really face the music when the insurance companies or the patients ask that why you know the patient's coverage can be 60,000 rupees and because of the hospital charges exorbitantly highly and then the patient's coverage increases to 90,000 rupees.

And then the rest 30,000 rupees is not covered by the insurance company and then the patient has to pay that 30,000 rupees. So there is a lack of strong standardization across the hospitals which they have to ensure. In my family for a particular operation two top tier corporate hospitals in Bangalore, one said 1 lakh rupees, one said 70,000 rupees. So and this 30,000 rupees you know it is often challenging that whether my insurance companies will cover that or not.

And then we ask our insurance companies and we did not ask our insurance companies, we asked our third party administrator and then they have to find the answer and we never got a very convincing answer though because of weak networking because they also did not have a very convincing answer for themselves because of this weak networking. Number 5 is under reporting across hospitals.

Under reporting of cases what they face, under reporting in terms of diagnostic facilities or the services they have rendered you know. Number 6 nexus between the corporate hospital and health insurance companies. Yes, this is a not a very healthy nexus because you know they follow a low claim ratio for the individual cases that it is an individual case so they do not give proper attention.

So you know individual insurance case so they may reject that whereas for a group insurance case or you know expensive insurance case, they will cover that, so high claim ratio for you know for a corporate insurance or a group insurance because they value that and then they will forward that to the health insurance companies. In that way both these health insurance companies and the hospital both of them are actually setting a win-win condition.

Number 7 is no regulation by IRDA to appraise the TPAs, so the TPAs may also get involved into wrongdoings you know there are plenty of TPAs in the market. So the TPAs can also get involved into some wrongdoings.

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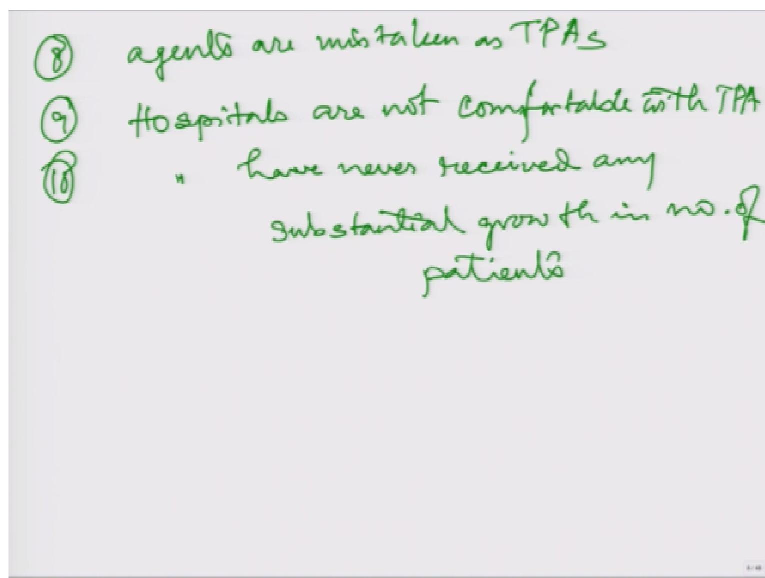

So you know often what happens again when we talk about the awareness the patients they mistake the agents as the TPAs, mistaken as TPAs and then the agents do not have proper information because they are not the guys who are connected. You know policyholders have little knowledge about the impaneled hospitals, holders little knowledge. We have already talked about impaneled hospitals; about the services are being given or covered under their health insurance schemes.

And the standardization have often been like not having a standardized mechanism, have often been problem to the patients as well because they have the answer and they do not know how to answer them the third party administrators and you know the hospital administrators experience significant problem while they have to deal with the TPAs. So hospitals are not really comfortable to deal with TPAs.

Because they face too many questions and too many you know regulatory or comfortable with TPAs and then the last one is the hospitals never faced a substantial, hospitals have never received any substantial growth in number of patients that is the TPAs or having TPAs really did not increase their business. So it has not been beneficial for the hospitals to increase their business.

So TPAs are good but in a developing country like India developing market like India, it has been extremely challenging for them. Thank you.