Report of the IRDA Committee to Evaluate the Performance of Third Party Administrators (Health Services)

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SUMMARY OF RECOMMENDATIONS

Chapter 2: Scope Of TPA Activities And Services

Certain value added services like Doctor-on call, health talks etc. are already provided by some of the TPAs and can be considered within the meaning of 'Health Services' only if it is already included by the insurers as part of the health cover made available to the insured.

Validation, investigation and fraud mitigation for health claims is already being carried out by TPAs with different intensities and hence can be concluded as within the scope of TPA services.

All the above services could be offered on bundled basis or on a standalone, a la carte basis, depending on the requirements of the insurer.

Servicing of PA policies for death and disability components in addition to its medical components can be allowed as a TPA activity.

Servicing outbound travel can also be allowed, with certain safeguards such that the same does not infringe upon another regulator's jurisdiction. One option could be to allow TPAs to link up with international service providers for outbound claims and offer seamless services to insurers within India and abroad.

Servicing Inbound travel and health from insurer/TPA outside the country can also be allowed with safeguards, and TPAs can be permitted to service international insurers with safeguards like 'hold harmless' agreements, ensuring FEMA compliance, and the TPA being required to ensure that working capital requirements of this will be additional. For servicing international TPAs, it could be decided on merits of individual requests.

Insurance Broking by a TPA or a related company is not recommended, as there is clear conflict of interest. While the regulation does not permit common directorship, this should be extended such that there is also no common shareholding interest in a broking firm and in a TPA.

It may be considered if self funded group schemes already existing without insurance for over 10 yrs can be serviced by TPAs, if the modalities of minimum fund size (e.g. 5 crores) and number of years the scheme (e.g. 10 years) are met. This service will clearly be disclosed to be at group/ corporate's risk, while all data for non-insurance business will need to be provided to data repository.

Claim processing for life/ Health companies where same TPA has done pre-insurance health check up is not recommended, as there is clear conflict of interest

The fact that an insurer or re-insurer owns a stake in any TPA should clearly be disclosed to all clients of the TPA so that the clients have an informed decision in this matter.

If a Hospital group gets into TPA business, there can potentially be a conflict of interest. This could be phased out over time, or this could be addressed by due disclosures to insurers, there not being any common directors or employees in the hospital and the TPA, and separate reporting of claims emanating from related/group hospitals.

Insurers (or the group which holds stake in the insurance company) should be allowed

to hold 26% or more stake in one TPA only and not in more than one TPA. However, minority stakes by insurers could be permissible across multiple TPAs on non-exclusive basis, which will enhance governance and confidence in TPA system.

TPA cannot have common shareholding interest / directorship / employees in unlicensed companies in the business of health claims processing or health benefit administration. Likewise, insurers should not be permitted to engage the services of unlicensed companies in the business of health claims processing or health benefit administration or other activities defined to be within the scope of services of TPAs.

Chapter 3: Best Practices And Customer Service Issues

The first task towards setting best practices for the industry would be to define service standards with acceptable TATs, which are to be universally followed by all the stake holders in the health insurance sphere, including insurers, TPAs, hospitals as well as the insured. This matrix which encompasses major aspects of the health insurance delivery pathway is provided in the report. This is a comprehensive listing of steps, and defines the maximum acceptable as also benchmark time lines and any breach of standards results in a self-regulatory penalty mechanism which would provide the deterrent to help achieve expectations.

The Committee also suggests the following standard documents in addition to the common pre-authorization form and the common claims form already under development:

- Common wording of MoU with hospitals/providers for all payors
- Standard list of documents to be enclosed with the claim form
- Standard billing formats and billing masters being used by providers

A standards-based consumer redressal system, wherein all consumers have to approach only one standard level of care, through a standard email id help@ABCtpa.com, with time-based auto-escalation for unanswered as well as for unresolved grievances.

Standardization of discharge protocol to achieve smooth and quick discharge, as also to minimize the incidence of denial of claims after grant of authorization, can be achieved by the hospital providing a “Draft billing summary” in a pre-agreed format, 24 hrs prior to the probable discharge of the patient, as also cross-checking and confirming the status at this time vis-à-vis the details filled in the preauthorization form.

There is need to create a standard Hospital Master, which will be building upon the current data on providers collectively available with the TPAs and the repository and each hospital/ provider would have a standard code which would be recognized by the industry and would remain common for all insurers/ TPAs. New providers could be allotted such standard code, which will be most appropriate if done online. This will ensure better capture and analysis of hospital-wise data across the industry.

Terminology used to identify a Claim should be commonly understood by the industry for data compilation to happen in a standard and consistent manner. A suggested standard terminology for claims is enclosed in the report. It is suggested that every attempt to register a claim is captured as an incident irrespective of the out-come i.e. whether paid or

not paid, and is also reported to the repository. It is also suggested that every claim that is reopened would open with its original claim code

The Committee also impresses upon the need for sharing of data amongst the insurers and TPAs, and such sharing could be in addition to what is required by the regulator's data repository. One initiative in this direction could be the data of Group Health Insurance (GHI) policies, wherein the insurance company and the TPA provide claims data of the GHI policies which will ultimately contribute to the sustainability of the industry and the group health insurance business.

The Committee recognizes that the member and claims data that a TPA acquires in the course of its business has to be adequately secure. The actual owner of this data is the insurance company that has issued the particular policy, and data with a TPA must be assigned access rights and the officials in the TPA should be able to view the data based on viewer rights that is restricted and defined based on each individual's role in the organisation. The data must be allowed to accumulate at a particular server that provides no general access to the TPA operating staff. All claims data of a particular policy could be transferred at the end of a pre-specified period post the occurrence of claim to the insurance company and the TPA remains agnostic to the accumulated data post the specified period after the claims being incurred.

Every TPA must establish a Fraud Mitigation cell. This cell would provide the self regulatory body with a quarterly report on its findings and list of providers found indulging in irregularities with adequate proof, for further action to be taken by the body. TPAs may also build capacity in investigation of outlier cases and cases where irregularities are being suspected.

Fraud Mitigation mechanism Stage 1 would be a simple Physical Verification wherein an Insurer or TPA send a representative for a friendly 'Get Well Soon' visit to the hospital, and also confirms that physical presence of the insured member, checks that the hospital has a positive ID of the person, and broadly verifies that the medical records are in conformity with the pre-authorization request sent by the provider. Costs for this additional service could be mutually agreed by the insurer and TPA with a per-case cost model, and we suggest that 5% of all pre-authorizations should be verified on a random sample basis. Irregularities found on such verification can trigger the investigation process

The Stage 2 of the Fraud Mitigation mechanism is investigation of medical claims wherein the TPA does have domain expertise and could actually be encouraged by an incentive structure which remunerates the TPA not on a fee model but on 'sharing' model where costs saved for the insurer are shared in a defined proportion with the TPA, and the modality for calculation of such saved costs will be as mutually decided between the two. The report of the process should be a standard structured output, and there should be defined guidelines for conduct of investigators and for their rotation and adequate cross checks by insurers/TPAs to ensure that the investigation process itself does not introduce any further irregularities in the system.

Stage 3 of the Fraud Mitigation process is to process the result of the investigation findings- the outcome- which should be shared by all entities undertaking investigation and a unified mechanism can then be worked out so that those involved in such frauds are collectively kept out of the health insurance sphere. This will provide the desired deterrent against those committing fraud.

It is suggested that all TPA have a process by which the operating system recognizes the actual file in-warded date. This will enable the correct estimate of Day zero from where the counting will begin.

It is recommended that the insurers, when they give the service mandate of a product to a TPA, must also provide the claims manual of the product immediately.

For all Hospitals and Health Providers, daily medical record of the insured member is a non-negotiable requirement of any hospital empanelled with the insurance system and this must be made available to the insurer, for which necessary terms may be incorporated in the policy document and the hospital MOU.

To prevent adverse customer experience, Council could decide to encourage corporates to renew insurance 15 days before renewal date. Cashless facilities to be only available 15 days after renewal mandate and premium are received to ensure that insurer/TPA has access to policy terms and member data.

The Committee on Health Insurance for Senior Citizens had earlier recommended a choice of TPAs which could be more feasible if implementing in the form of a choice to request change of TPA at renewal, one month before renewal date. Companies with in-house processing will be required to prominently disclose to the insured at proposal/renewal that as they do not utilize the services of TPAs, this choice will not be available.

IRDA must consider facilitating the creation of a formal association or body of Third Party Administrators where all TPAs can be represented, and which could take up various initiatives on behalf of the TPA industry.

Creation of a Common Health Insurance Industry Body, or a 'Health Insurance Development Council'. is one of the most relevant and critical recommendations of this Committee. This body will spear head the industry's initiatives for standardization across stakeholders, and for updating and maintaining such standard documents and standard 'masters', which in itself is a big task. Also, by acting uniformly against fraudulent entities, the body would create deterrents against misuse or fraud in the system. It could also be a mechanism to resolve differences between insurers and TPAs, and will create a common platform for interaction with other stake holders that are part of the health insurance system, including hospitals. The committee has enclosed a detailed concept note for this body in the report.

Chapter 4: Infrastructure And Financial Issues

There is necessity to ensure entry of serious, long term & pan-India organizations. There need to be regulations to ensure proper investments in TPA infrastructure, which includes IT, varied necessary skill sets, office & provider network. There is also a need to ensure adequate working capital availability at all times and some guidelines to protect the financial exposure of insurance companies & TPAs.

It is recommended that the Paid up Capital may be enhanced to Rs. 2 crores for a start-up TPA business. the following schedule is recommended for infusion of fresh capital with the growth in business:

Billing/ Revenue of TPA	Paid Up Capital Required
0 – 20 crores	2 crores
21- 30 crores	3 crores
31- 40 crores	4 crores
41 crores & above	5 crores

The fresh infusion of capital shall have to effected in the financial year subsequent to the year in which the billings cross the thresholds specified. Existing organisations may be given time till 31st March 2010 to comply with these conditions.

The committee also feels that there should be specific Investment guidelines for deployment of Capital. TPAs can invest only in TPA related activities & in bank deposits or approved securities. Inter corporate deposits are not permitted.

The committee feels that eligible current assets may have to be specified to a certain extent and accordingly recommends that inter-corporate deposits, even if short term, are not to be considered as current assets. Further, deposits for office space not exceeding 11 months only, & cost of bank guarantee could be considered towards current assets. Only short-term scheduled bank deposits for a less than 1 year term are to be considered as current assets.

The committee feels that there should be minimum organizational requirements prior to licensing, which include:

- the TPA should have at least 4 offices in different states in addition to its Head Office,
- web enabled software with security features
- the following minimum Skill set-
  - head office- 1 MBBS, 2 ICD coders, 1 IT professional, a 24 x 7 call centre (with appropriate number of call centre staff manning the same)
  - Every other office- 1 medical professional- otherwise, it is only to be treated as a contact point or a point of presence and not as a branch office.

To ensure proper implementation of the above guidelines, a two stage licensing could be put in place i.e. letter of intent and final license. Existing TPA's can be given time till 31st March 2010 for compliance.

To ensure the financial security of either the Insurance companies or other stakeholders, a sum of Rs 1 crore could be kept as fixed deposit with lien to IRDA. Further, TPAs may be required to purchase adequate insurance cover, with an E & O policy of 3 times fee earned in last FY with a minimum of 1 crore, and a Floater fidelity guarantee for Rs. 3 crores.

Insurance Companies may be asked to release the TPA fees on the total health premium booked in a calendar month before the end of the subsequent calendar month. The present practice of TPAs being required to raise an invoice may be dispensed with and a receipt subsequently obtained for the fee paid to the TPA. Non-compliance would require a mandatory penal interest @ 2% over the bank rate to be paid to the TPA.

Similarly, the 'Float' or funds for making payments for claims must be released within 7 days of submission of the request by the TPA, and an appropriate mechanism for reporting of delayed replenishment of float and for penalties thereupon could be devised by IRDA or the common industry body proposed later in this report.

CHAPTER 1

INTRODUCTION

1.1 Health insurance has been the fastest growing segment in the non-life insurance industry in India over the last few years, having grown 60% during 2007-08 to command a market (in non-life companies) of over Rs 5100 crores as against a level of about Rs 3200 crores in 2006-07. Between 2001-02 and 2007-08, the total health insurance premium collected by non-life insurance companies has thus grown from about Rs 700 crores to over Rs 5100 crores, which reflects a compounded annual growth rate of over 39% during this period. The Health Insurance portfolio now stands at 18% of all business transacted by the non-life insurers as of 31st March 2008. During the first half of the current financial year 2008-09 also, this total premium has grown 47% over the corresponding period in the previous year, and stood at about Rs 3350 crores.

1.2 Health insurance is thus fast emerging as an important mechanism to finance the healthcare needs of the people. However, the sector still constitutes under 3% of the total health spending in the country, and thus there still exists significant potential for growth of health insurance.

1.3 The arrival of Third Party Administrators (TPAs) as authorized entities in the Indian medical insurance market dates back to 2001, when the Insurance Regulatory and Development Authority (IRDA) notified the Regulations governing them. The Regulations came into effect from the date of their notification, i.e. 17.09.2001. The introduction of TPAs as intermediaries in the healthcare service chain was done with a view to ensure higher efficiency, standardization, providing cashless healthcare services to policyholders and increasing penetration of health insurance in the country. They are also potentially equipped to play a wider role in standardization of charges for various treatments and procedures, benefit management,

medical management, provider network management, claim administration and maintaining a database of health insurance policies.

1.4 The primary role of TPAs has been to provide health insurance member enrolment, hospital network development and claim processing services to the policyholders on behalf of their insurers. The TPAs have been paid a fee negotiated with the insurers at certain percentage of the insurance premium, and there have also been instances where the fee has been paid on a per member or per service basis. The TPAs are expected to have professional expertise as also appropriate systems and management structures in place in order to control service costs and minimize claims, while providing efficient services to the parties involved.

1.5 Regulation 23 of the IRDA (TPA) regulations, 2001, provides for constitution of Committees to look into the proper and efficient performance of TPAs. After about 7 years of the regulations coming into force, IRDA constituted the present Committee to evaluate the performance of the TPA system, vide its order dated 25th November 2008. A copy of the order is available at Annexure 1. The Committee is required to submit its report to the Authority by 30th April 2009.

1.6 The terms of reference for the Committee were:

- To examine the role of TPAs in the current health insurance market scenario and to make suitable recommendations clarifying their utility to the future growth of the health insurance industry.

- To evaluate the performance of the TPA system till date, with particular reference to the objectives behind the introduction of the TPA system and specifically with regards to the provision of Cashless facilities, data management, timely settlement of claims and reducing claim ratios.

- To suggest standards of best practices for TPAs.

- To devise customer service benchmarks for TPAs (including TAT for ID Cards, settlement of claims, etc.) with optimum and maximum time lines for different processes.

- To suggest minimum skill sets for the TPA personnel, including training in ICD-10 coding, claim and pre-authorization processing, medical and insurance knowledge etc.

- To suggest any regulatory changes needed in pursuit of the objectives of a robust health insurance system in the country.

- To deliberate on any other matter as the committee may consider relevant in the best interests of the future growth of the health insurance market, the insurers and the insuring public.

1.7 The Committee comprised of the following members:

1.	Sri S. B. Mathur, Secretary General, Life Insurance Council	Chairman
2.	Sri S. L. Mohan, Secretary General, General Insurance Council	Member
3.	Sri G Srinivasan, CMD, United India Ins. Co. Ltd.	Member
4.	Sri Sandeep Bakshi, CEO, ICICI Lombard Gen. Ins. Co. Ltd.	Member
5.	Sri V Jagannathan, CEO, Star Health & Allied Ins. Co. Ltd.	Member
6.	Sri S Krishnamurthy, CEO, TTK Healthcare TPA Pvt. Ltd.	Member
7.	Sri Anupam Gupta, COO, MD India Healthcare Services (TPA) Pvt. Ltd.	Member
8.	Sri C Chandrasekhar, representative of Apollo Hospitals Group	Member
9.	Dr. Lloyd Nazareth, representative of Wockhardt Hospital Group	Member

10.	Ms. Pushpa Girimaji, Consumer Activist	Member
11.	Sri Suresh Mathur, Joint Director, IRDA	Member
12.	Sri U S Roy, CEO, SBI Life Insurance Co Ltd	Co-opted Member
13.	Sri Kamesh Goyal, CEO, Bajaj Allianz Life Insurance Co Ltd	Co-opted Member
14.	Dr. Somil Nagpal, Special Officer- Health Insurance, IRDA	Member-Convener

1.8 The Committee undertook 6 meetings to meet the various industry stakeholders including TPAs, Hospitals, Consulting firms, Insurance Professionals etc. (list at Annexure 2), and to deliberate on the various issues before the Committee.

1.9 The meetings held by the Committee included the following:

- First Meeting: 22nd Dec 2008 in New Delhi
- Second Meeting: 20th Jan 2009 in Mumbai
- Third Meeting: 10th Feb 2009 in New Delhi
- Fourth Meeting: 19th Feb 2009 in Bangalore
- Fifth Meeting: 3rd March 2009 in Pune
- Sixth Meeting:16th March 2009 in Hyderabad

1.10 In addition to the above meetings, the Committee also constituted three sub-groups of the Committee for focused deliberations on specific areas required to be examined by the Committee, which held their separate meetings.

1.11 All insurance companies were also requested to send their inputs to the Committee through the respective Councils.

1.12 Overall, the Committee acknowledges that TPAs have played a valuable role in the health insurance system of the country by making available professional capacity for handling health insurance claims, in terms of the wide availability of cashless facility and in terms of the increasing availability

of health insurance data. It also agrees that evaluation of TPAs in terms of Claim Ratios alone is not appropriate as this also depends on underwriting and premium charged which are outside their control and thus may not completely reflect any cost control that TPAs may have achieved. While there are certainly issues over operational aspects of the TPA system including delays in pre-authorization and claim settlements, these have been studied and some recommendations have been made to address such issues.

1.13 The observations and recommendations of the Committee as detailed in the chapters which follow do go beyond TPAs alone, and encompass certain areas of the health insurance system as a whole, though with a focus on the TPA-related TORs for the Committee, as the Committee finds that these issues are closely related and need to be dealt at a systemic level.

CHAPTER 2

SCOPE OF TPA ACTIVITIES AND SERVICES

2.1 TPA has been defined as per regulation 2(e) of Regulation 2001 in terms of two specific requirements:

- it is licensed by IRDA as a TPA
- it is engaged for a fee or remuneration, by an Insurance Company to provide Health services.

TPA can, thus, work only with the Insurer, it can carry out only health services, though a TPA can service more than one Insurer and an Insurer can engage more than one TPA.

2.2 'Health Services', in turn, includes, as per Reg. 2(d), all services rendered by a TPA under an agreement with an Insurance Company in connection with Health Insurance Business, except the business of an insurance company or the soliciting of insurance business.

2.3 Further, by virtue of subsequent clarifications and circulars issued by IRDA, the scope of the services provided by a TPA includes those to a government organization, and pre-insurance medical examinations in connection with the life insurance business.

2.4 At present, the core activity of TPAs is to provide cashless services to the Insured through a network of hospitals across India. The proportion of claims settled on cashless basis has increased steadily and is now about 50% of the total claims handled by TPAs.

2.5 The Committee discussed and classified the services that can currently be offered by a TPA into 3 groups:

A. Activities currently permissible within the regulatory framework:

1. Enrollment and ID card issuance
2. Preauthorization for cashless hospitalization
3. Claim processing and payment
4. 24x7 assistance to policyholders
5. Provision of MIS reports to insurers and regulator
6. Grievance redressal mechanism
7. Providing services to health schemes of Government organizations
8. Pre-insurance medical examination for health and life companies.
9. Any value-added health services bundled by the insurer to the policy holder, including health check, health talks, preventive programmes
10. Claim processing of life insurance companies' health policies (where pre- insurance medical examination is not done by same TPA)
11. Domestic travel – administration of emergency medical assistance
12. Personal Accident policies- for medical component
13. Critical illness policy claim processing for life companies
14. Verification, Investigation, Fraud mitigation for Health claims

B. Functions clearly not permissible within the regulatory framework:

1. Any form of risk taking (regulations prohibit insurance activity)
2. Sales / broking (regulations prohibit solicitation of business)

C. Activities which required discussion and recommendations of the Committee whether those could be within the regulatory framework

1. Service PA policies for death and disability components
2. Servicing outbound travel- OMP
3. Servicing Inbound travel and health from insurer/TPA outside the country
4. Insurance Broking

2.6 In the first set A above, the points no.1 to no.7 are usually included in the MOU of insurers and TPAs, and are clearly understood by all parties concerned to be within the scope of the TPA's services, while the other functions have either been specifically permitted or were understood to be within the scope of 'health services' which the TPAs could provide. For example, certain value added services like Doctor-on call, health talks etc. are currently being provided by some of the TPAs. However these services can be considered within the meaning of 'Health Services' only if it is already included by the insurers as part of the health cover made available to the insured. Also, the last mentioned, viz. validation, investigation and fraud mitigation for health claims is already being carried out by TPAs with different intensities and hence can be concluded as within the scope of TPA service. All the above services could be offered on bundled basis or on a standalone, a la carte basis, depending on the requirements of the insurer.

2.7 In the second set B above, both the activities are clearly prohibited in the TPA regulations. These are also areas which could bring TPAs in a situation of conflict of interest with the insurance companies that they serve. The Committee does not envisage suggesting any change on these from the present situation.

2.8 In the third set C above, the activities do need clarification, and after deliberations within the Committee, the following are suggested:

Scope/Function	**Committee's Recommendation**
Service PA policies for death and disability components	This can be allowed.
Servicing outbound travel- OMP	This can also be allowed, with certain safeguards such that the same does not infringe upon another regulator's jurisdiction. One option could be to allow TPAs to link up with international service providers for outbound claims and offer seamless services to insurers within India and abroad.
Servicing Inbound travel and health from insurer/TPA outside the country	Yes, this can also be allowed with safeguards, and TPAs can be permitted to service international insurers with safeguards like 'hold harmless' agreements, ensuring FEMA compliance, and the TPA being required to ensure that working capital requirements of this will be additional. For servicing international TPAs, it could be decided on merits of individual requests.
Insurance Broking	This is not recommended, as there is clear conflict of interest.
Self funded schemes >10 yrs :	The modalities of fund size (e.g. 5 crores) and number of years the scheme (e.g. 10 years) has continued as a self-funded scheme may be considered. This service will clearly be disclosed to be at group/corporate's risk, while all data for non-insurance business will need to be provided to data repository.

Claim processing for life/ Health companies where same TPA has done pre-insurance health check up	This is also not recommended, as there is clear conflict of interest

2.9 Conflicts of interest of TPAs when other entities are in the same ownership:

A. If Insurance Company carries out its own claim processing activities there is no conflict therein, and an Insurer could also pick up a large or controlling stake in a TPA. However, such a situation can hamper competition. Also, in such a case, the fact that an insurer or reinsurer owns a stake in the TPA should clearly be disclosed to all clients of the TPA so that the clients have an informed decision in this matter.

B. If a broker is involved into TPA activities through a related entity, it is conflict of interest and should not be permitted. The regulation does not permit common directorship, but this should be extended such that there is also no common shareholding interest in a broking firm and in a TPA.

C. If Hospital gets into TPA servicing, it can also potentially be a conflict of interest. This has to be viewed from corporate governance point of view and either this could be phased out over time, or this could be addressed by disclosures to insurers, there not being any common directors or employees in the hospital and the TPA, and separate reporting of claims from related/group hospitals.

2.10 Insurers (or the group which holds stake in the insurance company) should be allowed to hold 26% or more stake in one TPA only and not in more than one TPA. However, minority stakes by insurers could be permissible across TPAs on non-exclusive basis, which will enhance governance and confidence in TPA system.

2.11 TPA cannot have common shareholding interest / directorship / employees in unlicensed companies in the business of health claims processing or health benefit administration. Likewise, insurers should not be permitted to engage the services of unlicensed companies in the business of health claims processing or health benefit administration or other activities defined to be within the scope of services of TPAs.

CHAPTER 3

BEST PRACTICES AND CUSTOMER SERVICE ISSUES

3.1 The Committee took stock of the imperfections and challenges in the current eco-system based on stakeholder interaction and the learnings gained from IRDA inspections and from the grievance system of IRDA. It found the following areas which required careful attention:

- Greater interaction amongst various stakeholders in the health insurance industry, which was currently multiple and fragmented
- Standard processes to accommodate the multiple TPA and Insurer engagement with the provider .
- Non-standard billing and payment processes between Healthcare providers and payors
- Significant variance in the cost of treatment for the same ailment across providers in different geographies.
- Limited bargaining power both for payors like TPAs/Insurers as industry itself is fragmented
- Low emphasis/ incentives for fraud control
- Leakage and lack of controls in health claims processing
- Low awareness among policyholders about the product itself and about the role and services of Insurer and TPA
- An effective grievance redressal system which leads to timely resolution of grievances needs to be put in place.

3.2 The Committee realized that a series of fundamental underlying issues contribute to the above defined issues within the ecosystem, and can be narrowed down to the fact that the industry lacked standardization on many fronts, the primary contributors being:

- Non standard transaction documents in multiple formats, each different for different payors and providers.
- Authorisation letters (AL) from the TPAs/Insurers having no defined time lines leading to dissatisfaction and anxiety both for provider and insured .
- Information sought by the payor in a non standardized manner.
- Information provided by provider in a non-standardized manner
- Time limits for information exchange were not laid down
- Non-standard terminology for claim identification
- Non-standard claim closure process, and with undefined turnaround time (TAT)
- Non- standard discharge protocols
- Non- standard payment processes
- Multiple types of MOUs existing between payors and providers
- Multiple forms of recognition/ identification/ listing of same entity.

3.3 The Committee suggests that the first task towards setting best practices for the industry would be to define service standards with acceptable TATs, which are to be universally followed by all the stake holders in the health insurance sphere, including insurers, TPAs, hospitals as well as the insured. This exercise was frozen as a simple matrix which encompasses major aspects of the health insurance delivery pathway and is provided at Annexure 3. Some of the salient features of the exercise include the fact that this is a comprehensive listing of steps in the process, it defines the maximum acceptable as also benchmark time lines so that the path for future movement of acceptable standards is also set, and suggests that any breach of standards results in a self-regulatory penalty mechanism which would provide the deterrent to help achieve expectations. It also proposes certain tolerance levels for the present, beyond which penalties could apply, with an expectation that the tolerance levels are progressively made more stringent. The penalties are proposed on a per-case basis, which could be levied on

self-reported quarterly reports or as otherwise decided by the implementing agency and the regulator, and can be higher for extreme delays. It is also suggested that the penalty amount could go to the corpus of industry body proposed later in this report, and an appeal could lie to General Insurance Council for non-life insurers and TPAs, and to Life Insurance Council for life insurers. Wherever a subsequent cross-check of any nature reveals errors in the self reported number of cases, an appropriate deterrent in the form of a higher penalty plus warning letter could be considered, though genuine errors found by the reporting entity itself can otherwise be subsequently corrected when noticed.

3.4 The Committee then set out to deliberate on standard processes as also on the standardization of documentation. The committee recognized that the smooth flow of data between the various stake holders in the service delivery system is not possible without standardized documentation. The Committee learnt that an exercise of standardization of the pre-authorization form and the claims form was already being taken up by the regulator in a multi-stakeholder forum and recommended that the same be completed at the earliest. The Committee also suggests the following standard documents:

- Common wording of MoU with hospitals/providers for all payors- whether insurers or TPAs
- Standard list of documents to be enclosed with the claim form
- Standard billing formats and billing masters being used by providers

3.5 The Committee recognized the lack of standards for grievance redressal in the health insurance delivery system and sought to address the same. The core of this task was to keep the process simple for the consumer and also guide him to the right level for the most efficient redressal of his/her grievance. This was accomplished post a detailed deliberation and the architecture of the flow of the proposed grievance system is depicted in Annexure 4. The salient features of the proposed system are that the system

is a standards-based consumer redressal system, and all consumers have to approach only one, standard level of care, which is through a standard email id of help@ABCtpa.com, requiring all TPAs to provide "help@" email id. The system proposes time-based auto-escalation for unanswered as well as for unresolved grievances.

3.6 Standardization of discharge protocol is also suggested by the Committee, after consultation with Hospitals and TPAs. The committee recognized that the discharge process is an experience that remains an un-pleasant experience both for the consumer and the provider, and found that a lack of common and simple discharge protocols was leading to this experience. Hence the committee suggests a few simple protocols to be followed to smoothen this process, mentioned in the next paragraph.

3.7 To achieve smooth and quick discharge, as also to minimize the incidence of denial of claims after grant of authorization, the hospital should be required to provide a "Draft billing summary" in a pre-agreed format, 24 hrs prior to the probable discharge of the patient. In addition, the providers have to cross-check and confirm the status at this time vis-à-vis the details filled in the preauthorization form, and either provide the changed information or confirm that there is no change in the information filled out for pre-authorization. The committee feels that a smooth and hassle free discharge process can be achieved if all the three parties conform to protocol (Provider, payor & consumer).

3.8 The Committee also emphasizes the need to create standard Hospital Master, which will be a common database building upon the current data on providers collectively available with the TPAs and the repository which could be used to create the same. Thus, each hospital/ provider would have a standard code which would be recognized by the industry and would remain common for all insurers/ TPAs and will be quoted by the provider. A system

will need to be devised where any new provider would have to provide all the data prescribed during the enrolment process and will then be allotted the standard code, and it will be most appropriate if this code allotment can be done online. Hospitals should not be empanelled without this standard enrolment code. This will ensure better capture and analysis of hospital-wise data across the industry.

3.9 Terminology used to identify a Claim should be commonly understood by the industry**.** Thus, the very question as to 'What is a claim?' needs to be understood in a common manner for data compilation to happen in a standard and consistent manner. A suggested standard terminology for claims is enclosed at Annexure 5. As mentioned therein, it is suggested that every attempt to register a claim is captured as an incident irrespective of the out-come i.e. whether paid or not paid, and is also reported to the repository, where the claim outcome is termed as financially fulfilled or not-financially fulfilled. It is also suggested that every claim that is reopened would open with its original claim code

3.10 The Committee also impresses upon the need for sharing of data amongst the insurers and TPAs, and such sharing could be in addition to what is required by the regulator's data repository. One initiative in this direction could be the data of Group Health Insurance (GHI) policies, wherein the insurance company and the TPA provide claims data of the GHI policies at the end of every eleventh month of the policy period. To protect the commercial interests of the insurer, the premium figures need not be disclosed, while availability of Claims data would result in better pricing by the industry which will ultimately contribute to the sustainability of the industry and the group health insurance business. It is envisaged that the industry uses this data judicially and contributes earnestly.

3.11 The Committee recognizes that the member and claims data that a TPA acquires in the course of its business has to be adequately secure. The actual owner of this data is the insurance company that has issued the particular policy, in which the claims have occurred. The claims data with a TPA must be assigned access rights and the officials in the TPA should be able to view the data based on viewer rights that is restricted and defined based on each individual's role in the organisation. The data must be allowed to accumulate at a particular server that provides no general access to the TPA operating staff. All claims data of a particular policy could be transferred at the end of a pre-specified period post the occurrence of claim to the insurance company that has issued the particular policy and on confirmation of receipt of such information by the insurance company, the detailed data could be auto purged from the storage systems of the TPA. This ensures the possession of the data only by the insurance company and the TPA remains agnostic to the accumulated data post the specified period after the claims being incurred.

3.12 The Committee would also like to emphasize on the need for adequate fraud mitigation measures to be taken at an industry level with the support of all stakeholders in the industry. The problem requires that the industry comes together with a single minded determination to stamp this aberration out .This would require sharing of information and creation of common caution lists. The fraud mitigation measures suggested by the Committee are detailed in the next few paragraphs.

3.13 Every TPA must establish a Fraud Mitigation cell. This cell would provide the self regulatory body with a quarterly report on its findings and list of providers found indulging in irregularities with adequate proof, for further action to be taken by the body. TPAs may also build capacity in investigation of outlier cases and cases where irregularities are being suspected. Investigation of health claims is considered by the Committee to indeed be an

activity where the TPA as an entity was in the best position to utilize its professional competence and serve to address this challenge.

3.14 The suggested Fraud Mitigation mechanism is a three stage process as detailed below. The Stage 1 is a simple Physical Verification wherein an Insurer or TPA send a representative for a friendly ‘Get Well Soon’ visit to the hospital, and also confirms that physical presence of the insured member, checks that the hospital has a positive ID of the person, and broadly verifies that the medical records are in conformity with the pre-authorization request sent by the provider. This requires staff with requisite customer friendly soft-skills. Costs for this additional service could be mutually agreed by the insurer and TPA with a per-case cost model, and we suggest that 5% of all pre-authorizations should be verified on a random sample basis. Irregularities found on such verification can trigger the investigation process discussed below.

3.15 The Stage 2 of the Fraud Mitigation mechanism is investigation of medical claims wherein the TPA does have domain expertise and could actually be encouraged by an incentive structure which remunerates the TPA not on a fee model but on ‘sharing’ model where costs saved for the insurer are shared in a defined proportion with the TPA, and the modality for calculation of such saved costs will be as mutually decided between the two. One primary requirement for this to be successful and efficient would be for software tools which can flag outliers and abnormalities from live claim data inflow. The resources used for investigation would need basic knowledge of medical terms, good soft skills, and high integrity. The report of the process should be a standard structured output, and there should be defined guidelines for conduct of investigators and for their rotation and adequate cross checks by insurers/TPAs to ensure that the investigation process itself does not introduce any further irregularities in the system.

3.16 Stage 3 of the Fraud Mitigation process is to process the result of the investigation findings- the outcome- which should be shared by all entities undertaking investigation and unified mechanism can then be worked out so that those involved in such frauds are collectively kept out of the health insurance sphere. This will provide the desired deterrent against those committing fraud. However, any such unified mechanism should be transparent and meticulously documented.

3.17 It is suggested that all TPA have a process by which the operating system recognizes the actual file in-warded date. This will enable the correct estimate of Day zero from where the counting will begin.

3.18 It is recommended that the insurers, when they give the service mandate of a product to a TPA, must also provide the claims manual of the product immediately.

3.19 For all Hospitals and Health Providers, daily medical record of the insured member is a non-negotiable requirement of any hospital empanelled with the insurance system and this must be made available to the insurer, for which necessary terms may be incorporated in the policy document and the hospital MOU.

3.20 To prevent adverse customer experience, Council could decide to encourage corporates to renew insurance 15 days before renewal date. Cashless facilities to be only available 15 days after renewal mandate and premium are received to ensure that insurer/TPA has access to policy terms and member data.

3.21 The Committee on Health Insurance for Senior Citizens had earlier recommended a choice of TPAs which could be more feasible if implementing in the form of a choice to request change of TPA at renewal, one month

before renewal date. Companies with in-house processing will be required to prominently disclose to the insured at proposal/renewal that as they do not utilize the services of TPAs, this choice will not be available.

3.22 IRDA must consider facilitating the creation of a formal association or body of Third Party Administrators where all TPAs can be represented, and which could take up various initiatives on behalf of the TPA industry. This association could also contribute its representatives to the common health insurance industry body proposed below.

3.23 **Creation of a Common Health Insurance Industry Body** is one of the most relevant and critical recommendations of this Committee as this will be required for the implementation of many other recommendations of the Committee. This body will spear head the industry's attempts at taking Initiatives for standardization across stakeholders, and updating/ maintaining standard documents and standard 'masters', which in itself is a big task. Also, by acting uniformly against fraudulent entities, the body would create deterrents against misuse or fraud in the system. It could also be a mechanism to resolve differences between insurers and TPAs, and will create a common platform for interaction with other stake holders that are part of the health insurance system, including hospitals. The Committee has enclosed a concept note on the creation of such a body after the same was deliberated by the members which is placed at Annexure 6.

CHAPTER 4

INFRASTRUCTURE AND FINANCIAL ISSUES

4.1 The infrastructure and financial aspects of the functioning of TPAs have been examined by the Committee in light of the terms of reference 5, 6 & 7 in the IRDA order constituting the Committee (dated 25th November 2008).

4.2 As regards the financial requirements from TPA's, it is noted that there is no other guideline than what is mentioned in the TPA regulations, 2001. These guidelines stipulate a minimum paid up & working capital of Rs. 1 crore. However, there is not much mention of any other issue related to finance. The committee identified some areas for improvement in the present guidelines, which include upward revision in the paid up & working capital, which at the present level of 1 crore, is inadequate for pan India operations. There needs to be prescription of certain minimum infrastructure, a clear definition of current assets, requirement for certain minimum skill-sets in TPA personnel, and some directions on cash flows for processing claims and for payment of fees. The modalities for capital deployment can also be defined.

4.3 The committee identified the potential problems which could arise as a result of inadequately defined guidelines:

- Proliferation of local/ regional entities entering the business without adequate infrastructure
- Diversion of funds received for claim payment to non core activities
- Organizations with inadequate professional resources
- No incentive for investment in skilled manpower
- Low investments in creating a robust IT platform and automation

- Poor development of adequate and transparent provider/ hospital and office networks

- Skilled manpower is deployed more for liaison with insurance companies rather than focusing on customer service

- Lack of specific guidelines leave scope for misuse of float fund

4.4 The committee observes that a critical stage is reached in the evolution of the TPA industry & it is the most appropriate time to formulate/ modify regulations comprehensively to attain the following objectives. There is necessity to ensure entry of serious, long term & pan-India organizations. There need to be regulations to ensure proper investments in infrastructure, which includes IT, varied necessary skill sets, office & provider network. There is also a need to ensure adequate working capital availability at all times and some guidelines to protect the financial exposure of insurance companies & TPAs.

4.5 It is recommended that the Paid up Capital may be enhanced to Rs. 2 crores for a start-up TPA business. Even in the case of ongoing businesses, there will be a necessity to infuse fresh capital on a continuous basis to effectively deal with the increased volume of work. Accordingly, the following schedule is recommended for infusion of fresh capital with the growth in business:

Billing/ Revenue of TPA	Paid Up Capital Required
0 – 20 crores	2 crores
21- 30 crores	3 crores
31- 40 crores	4 crores
41 crores & above	5 crores

The fresh infusion of capital shall have to effected in the financial year subsequent to the year in which the billings cross the thresholds specified.

Existing organisations may be given time till 31st March 2010 to comply with these conditions.

4.6 The committee also feels that there should be specific Investment guidelines for deployment of Capital. TPAs can invest only in TPA related activities & in bank deposits or approved securities. Inter corporate deposits are not permitted as it has the potential to be misused as a route to show capital adequacy and will also render the capital not readily available for the TPA business. An amount of Rs. 1 crore can be utilised for a 'lien' with IRDA as elaborated at a later stage in the chapter.

4.7 The present regulations use the definition of working capital from the Companies Act, 1956, which mention the same as the difference between current assets and current liabilities. The current assets are not further specified. The committee feels that eligible current assets may have to be specified to a certain extent and accordingly recommends that inter-corporate deposits, even if short term, are not to be considered as current assets. Further, deposits for office space not exceeding 11 months only, & cost of bank guarantee could be considered towards current assets. Only short-term scheduled bank deposits for a less than 1 year term are to be considered as current assets.

4.8 The present guidelines are also silent on the minimum infrastructure required for starting up a TPA business. As health insurance policies are themselves pan-India, which allow the widest choice possible to the customers and enabling them to select the service provider according to their requirements, a TPA with a single office operation or with a regional focus will not be able to cater to these requirements of policyholders. The committee feels that there should be minimum organizational requirements prior to licensing, which include:

- the TPA should have at least 4 offices in different states in addition to its Head Office,
- web enabled software with security features
- the following minimum Skill set-

  * head office- 1 MBBS, 2 ICD coders, 1 IT professional, a 24 x 7 call centre (with appropriate number of call centre staff manning the same)

  * Every other office- 1 medical professional- otherwise, it is only to be treated as a contact point or a point of presence and not as a branch office.

To ensure proper implementation of the above guidelines, a two stage licensing could be put in place i.e. letter of intent and final license. Existing TPA's can be given time till 31st March 2010 for compliance.

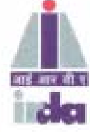
4.9 Presently there are no guidelines to ensure the financial security of either the Insurance companies or other stakeholders. Insurance companies obtain bank guarantees to protect their exposure through TPAs. Provision of bank guarantee to Insurance Companies is also a drainage of resources for the TPA. It is felt that this can be obviated to a certain extent by having a deposit with lien to IRDA which can be accessible by the stakeholders in case of default. Thus, a sum of Rs 1 crore could be kept as fixed deposit with lien to IRDA. Further, TPAs may be required to purchase adequate insurance cover, with an E & O policy of 3 times fee earned in last FY with a minimum of 1 crore, and a Floater fidelity guarantee for Rs. 3 crores.

4.10 At present there are also no directions in respect of the payment of TPA fees and the periodicity of fund replenishment for claim payments, which is often a reason for substantial delays in these areas. It is recommended that Insurance Companies may be directed to treat TPA fees on par with agency commission/ brokerage, and be asked to release the TPA fees on the total health premium booked in a calendar month before the end of the subsequent

calendar month. The present practice of TPAs being required to raise an invoice may be dispensed with and a receipt subsequently obtained for the fee paid to the TPA. Non-compliance would require a mandatory penal interest @ 2% over the bank rate to be paid to the TPA.

4.11 Similarly, the ‘Float’ or funds for making payments for claims must be released within 7 days of submission of the request by the TPA, and an appropriate mechanism for reporting of delayed replenishment of float and for penalties thereupon could be devised by IRDA or the common industry body proposed later in this report.

Annexure 1: IRDA Circular constituting the Committee



बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

023/IRDA/HI-TPA/CIR/Nov-08 **25th November, 2008**

CIRCULAR

Re: **Constitution of Committee for Evaluation of the Performance of the Third Party Administrators-Health Services (TPAs).**

In accordance with Sub-Regulation 23 of the IRDA (Third Party Administrators-Health Services) Regulations, 2001, the Authority has constituted a Committee comprising of the following members for "Evaluation of the Performance of the Third Party Administrators-Health Services (TPAs)":-

S.No.	Name	Designation
1.	Sri S. B. Mathur, Secretary General, Life Insurance Council	Chairman
2.	Sri S. L. Mohan, Secretary General, General Insurance Council	Member
3.	Sri G Srinivasan, CMD, United India Ins. Co. Ltd.	Member
4.	Sri Sandeep Bakshi, CEO, ICICI Lombard Gen. Ins. Co. Ltd.	Member
5.	Sri V Jagannathan, CEO, Star Health & Allied Ins. Co. Ltd.	Member
6.	Sri S Krishnamurthy, CEO, TTK Healthcare TPA Pvt. Ltd.	Member
7.	Sri Suresh V Karanadikar, CEO, MD India Healthcare Services (TPA) Pvt. Ltd.	Member
8.	Representative of Apollo Hospitals Group	Member
9.	Representative of Wockhardt Hospital Group	Member
10.	Ms. Pushpa Girimaji, Consumer Activist	Member
11.	Sri Suresh Mathur, Joint Director, IRDA	Member
12.	Dr. Somil Nagpal, Special Officer-Health Ins., IRDA	Member-Convener

The Committee will go into the various aspects of the performance of TPAs as per the Terms of Reference given below:-

1. To examine the role of TPAs in the current health insurance market scenario and to make suitable recommendations clarifying their utility to the future growth of the health insurance industry.

2. To evaluate the performance of the TPA system till date, with particular reference to the objectives behind the introduction of the TPA system and specifically with regards to the provision of Cashless facilities, data management, timely settlement of claims and reducing claim ratios.

1

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3. To suggest standards of best practices for TPAs.

4. To devise customer service benchmarks for TPAs (including TAT for ID Cards, settlement of claims, etc.) with optimum and maximum time lines for different processes.

5. To suggest minimum skill sets for the TPA personnel, including training in ICD-10 coding, claim and pre-authorization processing, medical and insurance knowledge etc.

6. To suggest any regulatory changes needed in pursuit of the objectives of a robust health insurance system in the country.

7. To deliberate on any other matter as the committee may consider relevant in the best interests of the future growth of the health insurance market, the insurers and the insuring public.

The Committee shall submit its Report to the Authority by 30th April, 2009.

(J Hari Narayan)
Chairman

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Annexure 2

List of TPAs, Providers and other invitees who attended the meetings of the Committee held at various places across the country

Name of person/ organisation

Hospitals and Healthcare Providers

Dr. Suhas Kate, Association of Medical Consultants
Dr. Rajeev Walavalkar, Association of Medical Consultants
Dr. Lalit Kapoor, Association of Medical Consultants
Dr. Suhas Shah, Association of Medical Consultants
Ms. Poulami Banerjee, Breach Candy hospital
Ruby Hall Clinic
Noble Hospital
Dinanath Mangeshkar Hospital
Dr. H S Kukreja, Delhi Medical Association
Mr. Avinder Berar, Fortis Healthcare Ltd
Mr. Sumanjit Chaudhry, Fortis Healthcare Ltd
Mr. Vibhu Talwar, Moolchand Hospital
Mr. Niranjan Rai, Manipal Hospital
Dr. Mudit Saxena, Wockhardt Hospitals
Dr. Davison P K, Wockhardt Hospitals
Mr. C R Radhakrishnan, Shekhar Nethralaya
T K Kumaresh Babu, Trinity Hospital and Heart Foundation
Dr. Raviraj K G, Lakeside Medical Centre and Hospital
Mr. M R Chandrasekhar, Chinmaya Mission Hospital
Dr. S K Saran, Chinmaya Mission Hospital
Dr. Madan Gaekwad, Private Hospitals and Nursing Homes' Association
Dr. Aravind Gubbi, Private Hospitals and Nursing Homes' Association
Dr. Mahendra S K, Private Hospitals and Nursing Homes' Association

TPA representatives

Mr. Felix Walder, Health India TPA Services Private Limited
Dr. Manish Wayal, Rothshield Healthcare India Private Limited
Mr. Praveen Yadav, MD India Healthcare TPA (P) Ltd.
Dr. Subodh Sirur, Paramount Health Services Private Limited
Mr. Yogesh Jariwala, Anmol Medicare Limited
Mr. Ravi Iyer, Dedicated Healthcare Services (India) Private Limited
Dr. Utpal Ray, Medicare TPA Services (I) Pvt. Ltd
Mr. Nitin Monga, Medicare TPA Services (I) Pvt. Ltd
MR. Pawan Kumar Bhalla, Raksha TPA Pvt. Ltd
Mr. Rajan Subramaniam, Vipul Medcorp Ltd
Capt. Mahesh Sharma, Safeway TPA Services
Dr. Divneet Kaur, Safeway TPA Services
Mr. G P Sureka, Universal Mediaid Services Limited
Ms. Malti Jaswal, E Meditek Solutions Limited
Mr. Gopal Verma, E Meditek Solutions Limited
Mr. Promod Khanna, Genins India Limited
Mr. Rajeev Bhatnagar, Genins India Limited
Mr. Praful Bhalerao, Focus Healthcare Pvt. Ltd
Mr. Anil Jindal, Park Mediclaim Consultants Pvt. Ltd
Mr. N K Malhotra, Park Mediclaim Consultants Pvt. Ltd

Mr. Neeraj Bali, East West Assist Private Limited
Mr. R K Kachroo, Alankit Healthcare TPA Ltd
Mr. A Rajamani, Sri Gokulam TPA
Dr. K S Rai, Sri Gokulam TPA
Mr. B Madhavan, Medi Assist India TPA Pvt. Ltd
Ms. Soumya A Kumar, Good Health Plan Ltd
Dr. Navya, Good Health Plan Ltd
Mr. L V K Suhas, Medicare TPA Services (I) Pvt. Ltd
Mr. Hari Venkataraman, Medicare TPA Services (I) Pvt. Ltd
Mr. Surendra Tiwari, Heritage Health TPA Pvt. Ltd
Dr. N R Shetty, Anyuta Medinet Healthcare TPA Pvt. Ltd
Mr. R K T Krishnan, I-Care Health Management & TPA Services Pvt. Ltd
Mr. Ninad Raje, Parekh Health Management TPA
Ms. Poonam Jethwani, Parekh Health Management TPA

Other stakeholders

Ms. Gayle Adams, Watson Wyatt Consulting
Mr. Anurag Sunda, Watson Wyatt Consulting
SK Mahapatra, Ex-chairperson, GIPSA
Ms Melissa Tzouralus, Ingenix
Mr. Vishal Malik, Ingenix
Mr Swaraj Krishnan, Bajaj Allianz General Insurance
Dr Shreeraj Deshpande, Bajaj Allianz General Insurance
Shri Anuj Gulati, ICICI Lombard General Insurance

In addition, the feedback of non-life and life insurers was also obtained by the respective Councils, which were represented on the Committee.

Annexure 3: Process TAT's

For TPA

Activity	optimum TATs	Maximum TAT	Penalty	Elaboration
card issuance	15 days from the date of policy start date	30 days from the date of policy start date	**to be decided**	**maximum TAT is 30 days to the insured, the days to be adjusted between TPA and insurer**
Pre Authorization	3 hours to 6 hours in case of emergency and 6 hours to 12 hours in planned from receipt of request	12 hours from receipt of completely filled request	**to be decided**	**The envisaged compliance band will be 60: 80**
Shortfall or query to be raised	within 6 hours of receipt of request	within 12 hours of receipt of request	**to be decided**	**the envisaged compliance band will be 80:95**
Validity of Authorization	Minimum of 7 days	validity expires after 15 days	**to be decided**	
Claim processing	9 days from receipt of complete claim documents from the policy holder, for all reimbursement claims and NW claims	14 days from receipt of complete claim documents from the policyholder, for all reimbursement claims and NW claims	**to be decided**	**This includes the process of raising a float request with the Payor**
Release of Payment	3 days from completion of claim processing for all reimbursement claims, and the agreed upon credit period for all NW claims against the pre-authorizations given	7 days from completion of claim processing for all reimbursement claims, and the agreed upon credit period for all NW claims against the pre-authorizations given	**to be decided**	
Shortfall Letter	3 days from receipt of claim	5 days from receipt of claim	**to be decided**	
First Reminder	10 days after first letter	15 days after first letter	**to be decided**	

Second reminder	10 days after first reminder	15 days after first reminder	**to be decided**	**It is suggested that the second reminder is sent through registered post**
closure letter cum final reminder	10 days after second reminder	15 days after second reminder	**to be decided**	
Claim suspension		90 days from the receipt of claim	**to be decided**	**The TPA suspends the claim for non-response and forwards the information to insurer**
For Providers				
Activity	**0ptimum TATs**	**Maximum TAT**	**Penalty**	
Pre Authorization request	At least 24 hrs before any planned hospitalization and within 3 hrs from time of admission for all emergency / Unplanned hospitalisations	At least 10 hrs before any planned hospitalisation and within 3 hrs from time of admission for all emergency / Unplanned hospitalisations	**to be decided**	
Query Answer	12 hrs from receipt of query	24 hrs from receipt of query	**to be decided**	
Submission of claim bills	7 days from date of discharge. No claim will be accepted beyond 30 days after discharge from hospital and the authorisation given will stand null and void.	7 days from date of discharge. No claim will be accepted beyond 30 days after discharge from hospital and the authorisation given will stand null and void.	**to be decided**	
For Insurance Company				
Payor	**0ptimum TATs**	**Maximum TAT**	**Penalty**	
Payment to TPA	5 days from receipt of complete information from TPA in agreed formats	10 days from receipt of complete information from TPA in agreed formats	**to be decided**	

Payment to beneficiary (direct) or Provider	5 days from receipt of complete claim documents from the policy holder, for all reimbursement claims and NW claims	10 days from receipt of complete claim documents from the policy holder, for all reimbursement claims and NW claims	**to be decided**	
Repudiation	3 days to confirm repudiation	15 days to confirm	**to be decided**	
Providing policy details to TPA	7 days from issuance of policy mandate to TPA	15 days from issuance of policy mandate to TPA	**to be decided**	
		For insured		
Insured	**0ptimum TATs**	**Maximum TAT**	**Penalty**	
Claim submission - Main Hospitalization	30 days from day of discharge	45 days from day of discharge	Any claim file submitted after 45 days from Discharge could be repudiated unless customer gives justified reasons for delay.	
Pre and Post Hospitalization charges	15 days from the end of period of coverage as per the policy terms and conditions	45 days from the end of period of coverage as per the policy terms and conditions	Any claim file submitted after 45 days after such period ends could be repudiated unless customer gives justified reasons for delay.	

Annexure 4: Grievance Redressal Matrix

Guidelines for Customer usage

All TPA to have a common format of grievance mail post

help@abctpa.com

Primary Contact:
Call on toll free number /Email in case you have any query/complaint. (specific grievance ID of the TPA is generated against every interaction)
Turnaround time for response: 8 Hours
Turnaround time for resolution: 48 hrs since receipt of complaint

Escalation Level 1
If the query remains **unanswered** for 8 hrs then the mail gets auto escalated to the next level (a designated Manager for Redressal)
Turnaround time for response: 24 Hours
Turnaround time for resolution: 96 hrs since receipt of complaint

Escalation Level 2
If the query remains **unanswered** for 24 hrs then the mail gets auto escalated to the next level (suggested to have a senior management like a COO)
Turnaround time for response: 48 Hours
Turnaround time for resolution: 5 days since receipt of complaint

Escalation Level 3
Post 48hrs the customer is guided to approach (Grievance officer @ the insurance company where policy is issued)
Turnaround time: 7 days
Turnaround time for resolution since receipt of complaint: 15 days

If after having followed Steps 1, 2, 3 and 4 your issue remains unresolved, you may approach the Insurance Ombudsman for Redressal.
Enclosed: List of Insurance Ombudsman offices.

Annexure 5: Claim Terminology

1. What is a Claim?

A claim arising out of any disease or as a result of suffering from Any one illness** or any bodily injury due to an accident and if such a disease, illness, accident or injury would require any such insured, upon the advice of a medical practitioner to incur hospitalization or domiciliary hospitalization expenses.

2. Any one illness:** Whenever referred, this term would mean a continuous period of illness that includes relapse within 45 days from the date of last consultation with the hospital/nursing home where the treatment may have been taken. However, if the same illness recurs (whether as a relapse or not) after 45 days, it would qualify as a separate episode of illness.

3. Pre and post Hospitalization: The term pre-hospitalization means relevant medical expenses incurred during a period up to "X" (norm is 30 days) days prior to hospitalization/domiciliary hospitalization for a disease, illness or sustained injury.

The term post-hospitalization means relevant medical expenses incurred during period upto X (norm is 60 days) days after the date of discharge from hospitalization due to a disease, illness, or sustained injury due to an accident.

4. Registered claim: When the potential claimant gives all the medical history and submits all the documents in order to make a claim. When these documents are received, the claim is **registered** by the insurance company.

Registered claim is recorded as either of two entries in the common system:

- Payable claim – reason YYYY

- Non payable claim -reason NNNN

It is suggested that every attempt to register a claim is captured as an incident irrespective of the out-come and is reported to the repository. The claim outcome is termed as financially fulfilled or not-financially fulfilled.

5. Re-opening and closing of a claim: A claim could get closed due to deficient documentation and no reverts to queries by the insurer/TPA, or where it is not lodged within a defined and agreed timeline. The same could then get reopened on receipt of deficient documents, when reverts on queries raised are received albeit later than expected, or after the receipt of the delayed claim documents, a decision is taken to accept the same.

It is a suggested that every claim that is reopened would open with its original claim code.

Annexure 6: Concept Note on Formation of Common Industry Body

Suggested name: "Health Insurance Development Council"

Background

The Insurers- both life and non-life, as also the Third Party Administrators and Service Providers are keen on setting up a Self Regulatory Industry Body with a multi-faceted role in the developmental issues surrounding the health insurance industry today. As one of its roles, this body could look at initiatives for standardization and maintain standard documents and standard 'masters' to be used in the industry, as also take steps to bring about uniformity in the processes of handling pre-authorization, Health claims etc. As a second role, the body will create strong deterrents against misuse or fraud in the system, which will include a role for the body in maintaining a database of fraudulent entities, as also investigate or otherwise legally pursue cases of suspected or reported fraud brought to the attention of the body by the industry, and to suggest common action against such entities which the entire industry would follow. The Body could be collectively set up by the Insurance Industry with representation of Non-life and Life Insurers, Third party Administrators and with representation from Providers (hospitals) for collectively servicing the health insurance business.

Legal Provisions applicable for Forming such a Self Regulatory Industry body

The Insurance act as per Section 64 R (1) which defines the General powers of Life *Insurance Council and General Insurance Council*

"64R (1) For the efficient performance of its duties, the Life Insurance Council or the General Council, as the case may be , may

…..

> *(d) With the previous approval of the Authority, make regulations for*

…..

> *(v) The regulation of any other matter which may be necessary for the purpose of enabling it to carry out its duties under this Act. "*

In view of the above provision in the Insurance Act, there is no limitation for the General Insurance council and Life Insurance Council to initiate measures for effective management of the Insurance business.

Formation of the Self Regulatory Industry body

The Self Regulatory body can be formed as an "Association not for Profit" as defined under Section 25 of the Companies Act. The formation of the body shall be subject to the approval of IRDA and Central Government.

The Self Regulatory entity being a Non profit oriented organization can also be formed as per the provisions of the Indian Trust Act.

Objectives of Self Regulatory Association

To provide Health Insurance cover to the customer with high service standards and undertake standardization initiatives including those for the claim handling and settlement process to the benefit of the members and the general public who have availed the Health Insurance cover. To help the industry formulate common forms, processes and definitions. Monitor compliance to ethical and efficiency standards agreed upon. Enforce strict vigilance on attempts to defraud the insurance system and take effective and concrete action thereupon.

Agreement

The representatives of General Insurance Council (GIC), Life Insurance Council (LIC), Third Party Administrators (TPAs), IRDA, Consumer representatives and Providers (Hospitals) as part of the IRDA-constituted Committee for Evaluation of Performance of TPAs have agreed upon the objectives and have also recommended the formation of the Self Regulatory Association.

Membership of Self Regulatory body

All the Insurance Companies who are carrying on or propose to carry on the Health Insurance Business, whether Life Insurance companies or Non-life Insurance companies or Companies doing Health and Allied Insurance business, and registered with IRDA will be members of the self-regulatory body. The members will nominate their representatives to the governing body as described below.

Income and Expenditure

The expenses of the Self Regulatory Association shall be shared by all the insurance companies in proportion of the health insurance claims settled by them during the previous year. The body may also seek grants from the regulator and from the government for carrying out its functions effectively.

Administration of the Self Regulatory Association

The Administration of the pool shall be carried out by the governing body which shall comprise of a 12 member body as stated below. The Composition of 12 member governing body is proposed as

- 3 representatives of Non-life Insurance companies
- 2 representatives of Life Insurance companies
- 2 representatives of Third Party Administrators, through a formal Association
- 1 representative of Stand alone Health Insurance Company
- 1 representative from Consumer Groups nominated by Insurance Regulatory Development Authority
- 2 representatives of the Providers (Hospitals) nominated by DGHS/ Industry Chambers

The minimum Quorum for taking a decision shall be 7 (seven) members and the chairperson shall either be the Secretary General of Life Insurance Council or General Insurance Council by rotation. The members of the Governing body will have a term of 2 years, though re-election as a member can be considered for another term.

Proposed Departments

To ensure active participation of the Member in the efficient operation of the **Self Regulatory body,** the following departments are proposed to be formed as a permanent support structure to the body :

- Departments for Standards and Quality initiatives
- Department for Legal matters and Fraud Control
- Accounts Department
- Administration Department

Code of Conduct

It is proposed that the members of the Self Regulatory Association shall be governed by a fixed set of Code of conduct which shall be framed by the governing body from time to time and any violation of the Code of Conduct by the members will be subject to prosecution by the Governing body.

Accounts

The accounting year for the Self Regulatory Association will be from 1st April to 31st March of the year. Accounts will be rendered on membership fees and contribution received and expenses incurred.

The Governing Body shall render the accounts to all Members at such frequency and within such time as the Members may decide from time to time.

Acknowledgements

At the outset, the Committee would like to place on record its sincere appreciation for Shri J Hari Narayan, Chairman, IRDA and Members of IRDA, for setting up this Committee at an important stage in the evolution of the Health Insurance industry and the TPA system in our country.

The Committee gratefully acknowledges the valuable inputs given by the organizations and individuals with whom the Committee had the opportunity to interact directly or indirectly.

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