

Comprehensive Health Insurance Scheme (CHIS) in Kerala: Some Issues of Comprehensiveness and Equity

Parvathy Sunaina

The Comprehensive Health Insurance Scheme (CHIS) was implemented in Kerala from October 2, 2008 on the lines of the Rashtriya Swasthya Bima Yojana (RSBY). While RSBY caters to those Below the Poverty Line, CHIS envisages bringing within the insurance fold a larger population. This paper attempts to discuss how successful the scheme has been in providing “comprehensive” insurance coverage and also some issues of equity that it brings in its wake. It examines the implementation of CHIS, especially with reference to comprehensiveness and equity.

Although CHIS provides financial access to services to the beneficiaries, it does so only to a limited extent. The shortfalls of the scheme with respect to enrolment of beneficiaries, empanelment of service providers, coverage of costs, quality of service delivery, etc., not only undermine access to quality health care but may also lead to the perpetuation of inequality in delivery of health care across regions and providers. Quality of health care can be ensured only when such demand-side financing alternatives are initiated along with supply-side interventions which focus on improving the quality of service. It was assumed that the competition between the public and private sectors for the revenue out of CHIS claims will motivate them to strive for better standards of service. But it is seen that the public sector driven by the revenue-incentive model of CHIS is moving towards the profit-oriented mode of functioning of the private sector. It needs to be seen whether instead of allowing public funds to flow to the private sector comprising of the private hospitals as well as private insurer, more money should be pumped for improving the public health care delivery system.

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Health Insurance in India: Factors Affecting Synergy among Insurers and Healthcare Providers

Rohit Kumar and K Rangarajan

In the last decade several key incidents have occurred in the Indian health insurance arena and it is important to develop synergy among the two most important and critical players, i.e., the insurers and healthcare providers. The relationship between them governs the service delivery model. Its study is critical for the current and future growth of the industry. The study suggests that there are multiple factors that can either develop or destroy synergy among insurers and healthcare providers. They may be categorized into different synergy buckets (INSECT Framework) and can help to develop strategies for synergy.

Introduction and Background

Private health insurance called “Mediclaim Policy” was introduced in 1986 in India by the government-owned insurance companies. However, its performance has not been very encouraging. Though penetration of health insurance has increased recently, the pace is below expectation (Rao 2004, Ahuja 2005). Health insurance has gained importance since the privatization of the insurance sector. The entry of stand alone insurance company has triggered the growth in this area. Only about two per cent of total health expenditure is funded by public/social health insurance, while 18 per cent is funded by government budget (Bhat and Mavalankar 2000).

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Private health sector was estimated to be worth ₹ 69,000 crore and expected to double to ₹ 156,000 crore by 2012, besides an additional ₹ 39,000 crore if health insurance picked up (CII-McKinsey 2004). It was estimated that the proportion of in-patient care would go up to 47 per cent largely due to lifestyle ailments like cancer and cardiovascular diseases. This growth is likely to require an additional 750,000 beds, 520,000 doctors and an overall investment of ₹ 100,000-150,000 crore, of which 80 per cent has been projected as the share of the private sector. With liberalization and entry of private companies in insurance, the Indian insurance sector has started showing signs of significant change. Within a short span of time, private insurance has acquired 13 per cent of the life insurance market and 14 per cent of non-life market (Bhat *et al.* 2005). The National Commission of Macroeconomics and Health observed, "The health system in India consists of a public sector, a private sector and an informal network of providers of care operating within an unregulated environment, with no controls on what services can be provided by whom, in what manner, and at what cost, and no standardized protocols to help measure the quality of care. There are wide disparities in access, further worsened by the poor functioning of the public health system" (Rao 2005).

Opening of Insurance Market

General insurance sector in India was nationalized with effect from January 1, 1973. There were more than 100 general insurance companies operating at the time. They were assigned to four subsidiaries of the General Insurance Corporation.¹ There were several reasons for this course of action. The Malhotra Committee noted that the behaviour of the general insurance employees was not customer-friendly (Malhotra 1994, Chapter II, Section 2.22, p. 15). Gupta Indrani (2002) studied 500 households in Delhi and found a wide disparity across sections on willingness to participate. Challenges for the new system included: (a) pooling of individuals across risk and economic status categories, (b) setting up a multi-tier system to meet the objectives of equity and efficiency in health care delivery and (c) to keep health insurance separate from other non-health insurance business by planners and regulators.

Third Party Administrators (TPAs) were introduced in the Indian health insurance market in 2001. The number of TPAs had increased to 29 as on January 2011. The most important service offered by them is the cashless hospitalization services. Its primary objective is that the insured patient is able to get treatment in a cashless mode, i.e., he is not required to pay out-of-pocket in

¹ The General Insurance Corporation of India was incorporated as a holding company in November 1972 and it commenced business on January 1, 1973. Its four subsidiaries were: (1) National Insurance Company; (2) New India Assurance Company; (3) Oriental Insurance Company and (4) United India Insurance Company with head offices in Calcutta (now Kolkata), Bombay (now Mumbai), New Delhi and Madras (now Chennai) respectively.

case of hospitalization (in-patient treatment in few cases covers day care surgery). The price which insurance companies pay to the TPA for the above listed services is some five to six per cent of the premium amount. However, even at this price there are few insurance companies which are developing their own in-house teams for extending cashless hospitalization services. Does this mean that the TPAs are not able to meet their objectives or deliver services as expected by the insurance companies? Or, have the insurance companies lost their trust in the TPA model? The answers to these questions are important not only for the TPAs but also for hospitals (hereafter called providers) and for the growth of health insurance industry in India.

As could be seen in Table 1, the claim paid ratios have increased from 83 per cent to 96 per cent in the year 2009-2010 when compared with year 2003-2004. In 2007-2008 and 2008-2009 the claim paid ratio was 105 per cent and 103 per cent respectively. There are twofold reasons for high claim ratio, viz., the premium (which is linked to the underwriting activity), and the other claims, linked to the payment made to the providers and insured by means of cashless benefit or through reimbursement mechanism. Since premium is linked with the past claims history, the study linked to claims is of more importance. The reasons for high claim ratio linked with the claims could be because of multiple factors.

As per IRDA Annual Report (2003-2004), insurance companies have no interface with hospital establishments in determining the reasonableness of charges relative to quality of medical care provided. There are neither benchmarks nor standards for billing these services. The cost of health care delivery is passed on to the policyholder. Owing to the hidden costs in health care delivery system without any audit or authentication of their reasonableness, health insurance comes with a big price tag.

Table 1: Claim Paid Ratio (2003-2010)

Years	Premium (Cr.)	Claims Paid (Cr.)	Claims Paid Ratio
2003-2004*	944	785	83 %
2004-2005*	987	948	96 %
2005-2006*	1947	1777	91 %
2006-2007*	2820	2198	78 %
2007-2008*	2758	2904	105 %
2008-2009*	3976	4087	103 %
2009-2010 **	7803	7456	96 %

* Policies serviced by TPAs only.

** Summary figure of policies serviced by TPAs and directly by insurers.

Source: IRDA- Tariff Advisory Committee, Data Repository.

Additionally, there is no mechanism to check these against established standards and benchmarks have not been attempted or established. Establishment of a database in the health sector would also provide access to critical

information which is currently not available to stakeholders. The system could provide information about patients with the service providers to ensure portability.²

If this trend continues, there is a probability that the insurers would not find this sector lucrative enough and would keep on off-loading cost to the customers. This can result in higher premium rates and would, in turn, act as a barrier for the growth of health insurance industry. The high claim ratio can also force the insurance companies to take myopic steps like blaming the providers and restricting the access in case of cashless benefits. The IRDA explicitly admitted similar concerns in its annual report, "Health insurance is another area of concern for the industry. The legislative intent of laying special emphasis on "health", while framing the regulations was to facilitate access of the health care facilities to the insurable population through the medium of insurance. However, three years down the lane, there has been no appreciable progress. While the potential is huge, the impediments to growth need to be addressed. Although positive signals have emanated in this segment of insurance business, much more needs to be done."³

The Working Group on Health Insurance constituted by the IRDA with representatives from various stakeholders looked into areas related to the promotion and development of health insurance. A host of initiatives are being rolled-out with the objective of promoting the growth of health insurance market.

However, one area which has not attracted attention is research. There is not much research to generate evidence and to identify solutions to the current and future problems. Even with the current initiatives, there is a lack of framework which can be used to measure the level of synergy among the insurers and providers within the health insurance industry. To develop any framework, it is important to identify different factors which affect the phenomenon under consideration. For this it is important to first define synergy and look into research methodology.

Defining Synergy

The word Synergy comes from the Greek word synergia, meaning joint work and cooperative action. As per the common definition, synergy is found when the result is greater than the sum of parts. It is created when things work together in concert to create an outcome that is in some way of more value than the total of individual inputs.

If used in business application, it means that teamwork will produce an overall better result than if each person was working towards the same goal individually. The term is also defined as the interaction of two or more forces so

² In 2011 IRDA had rolled out guidelines on health insurance portability which shall be applicable for existing health insurance contracts and new contracts with effect from 1st July 2011.

³ 3rd Annual Report, IRDA (2002-2003).

that their combined effect is greater than the sum of their individual effect. This means implementing (or collaborating in implementation) of more than one intervention in an area with the expectation that the 'combined effect' of multiple components will result in greater positive impact than that of any one components.

In the area of health insurance, synergy may be assumed not to exist:

- i. When an insured customer decides to go for reimbursement instead of cashless benefit.
- ii. When a customer decides not to buy health insurance product because he does not see value in it.
- iii. When the insurer denies pre-authorization.
- iv. When the industry has high claim ratio.
- v. When the insurer, provider or the customer is not satisfied with cashless hospitalization services.

Research Methodology

The research framework was developed on the basis of comprehensive literature survey, process flow, discussion with players in the health insurance industry and design school of thought in the area of strategic management. To identify factors affecting synergy among insurers and providers, both quantitative and qualitative methods were used. Under qualitative methods, the focus was on the stakeholders in the Indian health insurance industry. Qualitative methods used for data collection are given below:

- Interviews
- Focus Group Discussion (FGD)
- Observations and
- Open-ended questions- these questions were asked during the time of survey conducted to collect data for second research objective (*see* Table 2).

Table 2: List of Stakeholders Interviewed (In-depth Interviews)

Doctors- 15	Brokers- 5
IRDA- 2	Government Bodies- 2
TPA- 3	Re-Insurers- 2
Providers - 14	NGOs- 3
Insured Customers - 25	Medical Staff- 5
Insurance Companies - 12	Teaching Institutes- 3
Pharmaceutical Companies- 2	Medical Equipment and Information Technology - 2

Note: The numbers represent the sample size.

These interactions were in the form of interviews, discussions and observations. In-depth interview was used as a source for data collection. The theoretical roots of in-depth interviewing are in what is known as the

interpretative tradition. According to Taylor and Bogdan (1984), in-depth interviewing is 'repeated face-to-face encounters between the researcher and informants directed towards understanding informants' perspectives on their lives, experiences, or situations as expressed in their own words.' This definition underlines two essential characteristics of in-depth interviewing: one, it involves face-to-face, repeated interaction between the researcher and his or her informant(s); and two, it seeks to understand the latter's perspectives. Because of repeated contacts and hence extended length of time spent with an informant, it is assumed that the rapport between a researcher and informant will be enhanced, and that the corresponding understanding and confidence between the two will lead to in-depth and accurate information. Semi-structured questionnaires are used for interviews to collect the data.

Field visits were made to providers, TPAs and insurance companies. To help in achieving the research objective, the stakeholder analysis as listed out by Freeman (1984) has been followed. Broadly, a grounded theory approach was followed in the analysis of qualitative data, apart from analyzing the data captured through field investigations.

The factors which came out in common from different stakeholders were considered more important while doing the analysis as they represented common concerns. Specialised questionnaires were used to re-validate the findings. All the factors identified during the course of the study were presented in the form of a questionnaire (*see* Annexure-I) and experts were asked to rate each factor on a scale of one to five based on its ability to either develop or destroy synergy among insurers and network hospitals. To seek inputs from the experts, e-mail was used. It was preceded (in few cases) as well as followed by telephonic discussion. It was decided to remove the factors with average score of 2.5 or less.

Findings of the Study

The findings of the field study suggest that the awareness level regarding policy terms and conditions is low among the insured population and most people do not care for the cost of treatment. The providers increase their rates frequently and prefer the middle income group for extending cashless benefits. The TPA model has not been successful in bringing down the claim cost but has helped in providing unbiased services including cashless benefits. The price structure of healthcare services is linked to the room rent category and most of the insured patients, who are more demanding, prefer staying in higher category rooms (Figure 1a, 1b and 1c).

Taking into account developments in and outside the insurance sector, showcasing developments in the field of insurance, including developments specific to health insurance with brief summaries, are given in a chronological order since the introduction of mediclaim policy in 1986 (Table 3).

Figure 1a: Findings of the Hospital Survey

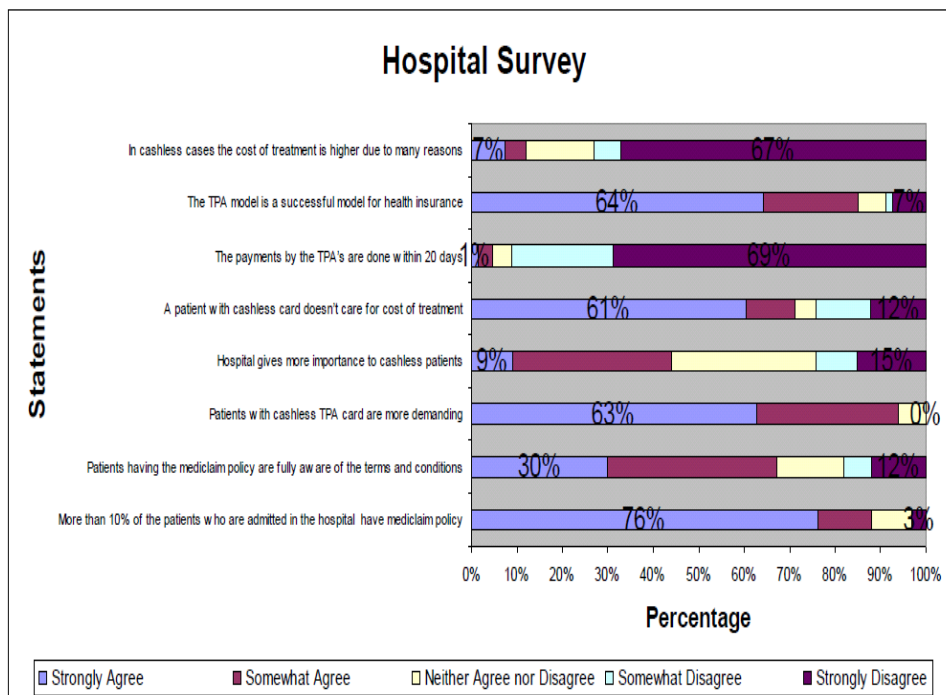


Figure 1b: Frequency of Increase in Hospital Charges by the Providers

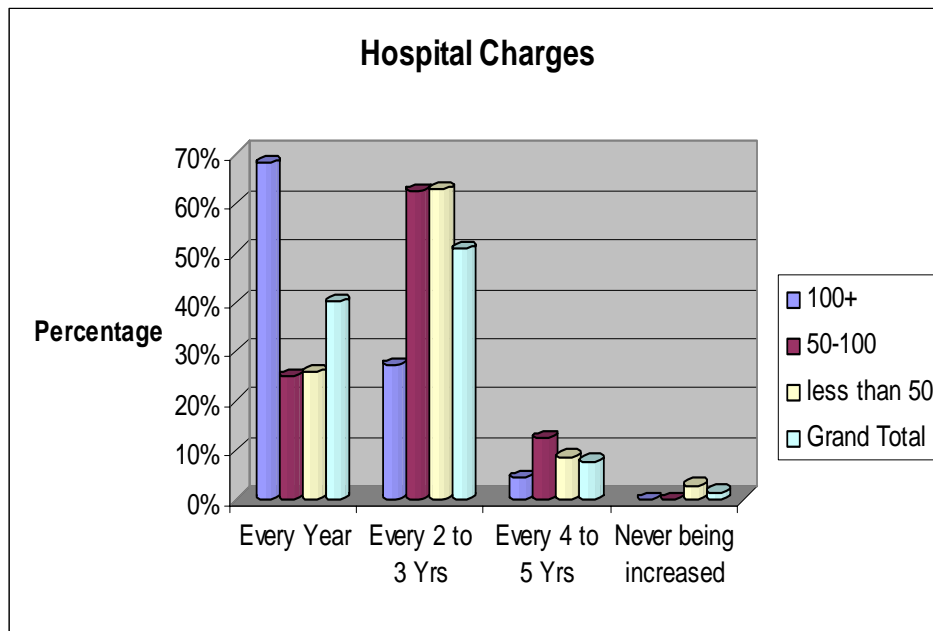
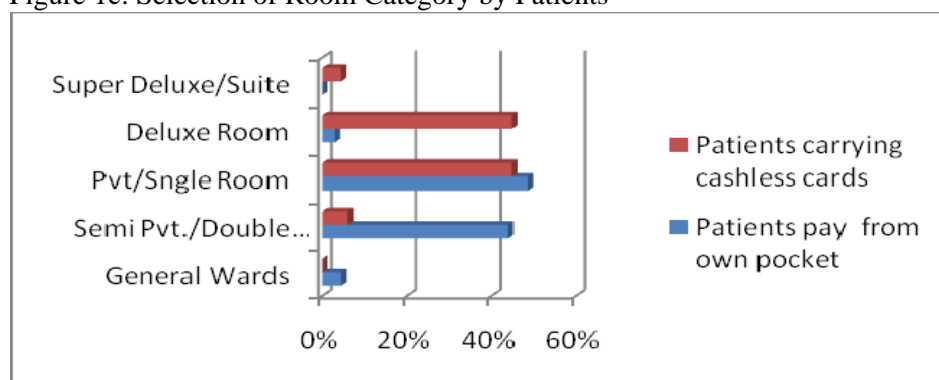


Figure 1c: Selection of Room Category by Patients



Source: Rohit Kumar, K. Rangarajan, and Nagarajan Ranganathan (2011), "Health Insurance in India—A Study of Provider's Perceptions in Delhi and the NCR," *Journal of Health Management*, 13: 259-277.

Table 3: Health Insurance in India (chronology: 1912- 2011)

YEAR	Important Developments
1986	General Insurance Corporation of India (GIC) introduced mediclaim insurance policy.
1999	Insurance Regulatory and Development Authority (IRDA) Act was passed.
2001	IRDA introduced several insurance regulations including provisions for Third Party Administrators (TPAs) system in health insurance. Nine private general insurance companies were registered with IRDA.
2003	IRDA set up a National Health Insurance Working Group, with Sub-group on data, standalone health insurer and product innovation. This Committee was formed with the objective of identifying the existing problems in the health insurance industry and to make recommendations to enable and encourage companies to participate in the growth of insurance in health financing.
2006	First Standalone Health Insurance Company commenced business with a capital requirement of ₹ 100 crore. The guidelines on file and use requirements for general insurance products were issued which superseded the earlier IRDA guidelines.
2007	The insurance market was de-tariffed. Earlier 70 per cent of the general insurance business was driven by tariffs prescribed by the Tariff Advisory Committee (TAC), established under Sec. 64 UM of Insurance Act to control and regulate the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business.
2008	Insurance Information Bureau set up by IRDA (primarily working on health and motor data). General Insurance Council for the first time defined the "Pre-existing" clause and made it standard across the industry.
2009	The renewability of health insurance policies circular was issued on 31st March, 2009. It advises non-life insurers not to generally decline renewals except for specified reasons. Detailed instructions on Health Insurance for Senior Citizens stipulate that all health insurance products filed on or after 1st July, 2009 must allow entry up to 65 years of age, and to make adequate dissemination of product information on websites. The FICCI report on Health Insurance was released in July 2009. It includes Standard Treatment Guidelines for 21 common causes of hospitalization.
2010	The Preferred Provider Network (PPN) of hospitals was introduced in July 2010 to offer cashless medical treatment following the initiative taken by the four public insurers to bring discipline on the pricing of hospital services. The health insurance market continues to be dominated by the four state-owned general insurers which together accounted for almost 60 per cent of the premiums.
2011	A key development was the announcement of portability of health insurance policies by IRDA. The regulator has issued guidelines for the arrangement to be effective from 1 July, 2011 which will allow policy-holders to switch providers on the same policy terms, particularly without losing the credit gained for pre-existing conditions in terms of waiting period. Circular on "De-Listing of Hospitals" and guidelines on "Distance Marketing" was also rolled out.

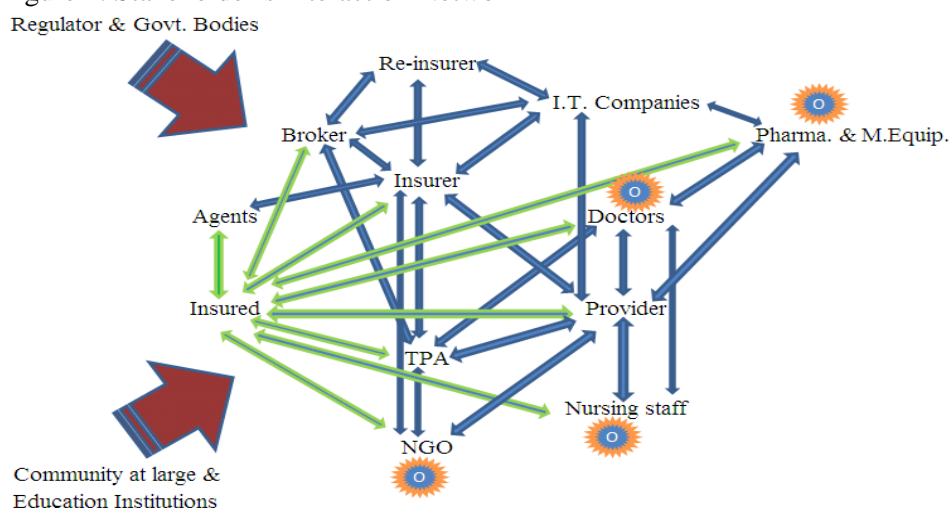
Stakeholders Analysis

During our investigations and interactions with the stakeholders, factors were identified which either could help develop or destroy synergy among insurers and providers. For a better understanding, the findings of the key stakeholder groups are clubbed under five categories, i.e., insured, government and regulatory bodies, health care professionals (doctor and nursing staff), intermediaries (agents, brokers and TPAs) and others (NGOs, educational institutions, pharmaceutical cos., etc.). This is followed by summarizing the key factors identified during the stakeholder analysis.

Insured Customers

Insured customers are one of the most important stakeholders when it comes to identify the strategy for synergy between the insurers and providers. They are the major link between the insurers and providers. The relationship of other stakeholders with the insured customer could be seen in Figure 2.

Figure 2: Stakeholder's Interaction Network



In the Indian context, the insured customers can be classified into three categories. The first category is of retail customers. They either purchase the insurance policy for self or for families. The product offerings are not as comprehensive as in other categories like group policies, but options are available. This section of insured population is currently low because of multiple reasons like less importance given to health insurance over areas like education, home, vehicle, children's marriage and alike; problems with claim processing; limited product coverage; limited options for doctors and hospitals; agent and

payment related issues; cost considerations; complicated policy document and limited awareness. However, this segment is seen as a big opportunity by most of the upcoming health insurance companies and efforts are being made to lure the retail customers.

The second category is of corporate clients where the insured are the employees of a corporation or business entity. In few cases, in addition to the employees, their dependents are also covered. The dependents may be defined as the immediate family members (self, spouse and children) or can include extended family (self, spouse, children and parents). Since this segment traditionally buys the health insurance cover in bulk, the products offerings are more comprehensive. Additional benefits like the maternity and outpatient are covered which lack in the retail segment. Because of its size, this segment is often further broken into special categories like Small and Medium Enterprises (SME), gold, silver and platinum clients. This categorization may not be necessary based on the health insurance premium, but could be on the overall health insurance premium generated by the corporate clients. The latter are more exposed to the concept of health insurance and often have a department responsible for managing the health insurance piece.

The third category is of government-sponsored scheme commonly termed as "Mass" business. At times this category falls under the definition of micro-insurance schemes. The insured are associated or members of a special group. This group has individuals of the same occupation like weavers, artisans or others below the poverty line. One example of this category is the RSBY policy where the BPL individuals and their families get cover for health insurance.

Recently the IRDA has asked general insurance companies and the standalone health insurance companies to submit the break-up of health insurance data for 2009-2010 for individuals, corporate groups and government-sponsored schemes.

For current study the focus was on three types of insurance customers, i.e., one who is a potential customer, insured customer (with claim experience) and insured customer (without any claim experience). Interestingly, there were few factors which were common across all the categories of customers like lack of awareness. It was found that the level of awareness about insurance, policy terms and conditions, cashless hospitalization process and details about network hospitals was poor for both potential customers as well as customers without any claim experience. Customers who had experienced submitting a claim with either a TPA or an insurance company were found to have a fair idea about the TPAs and the cashless hospitalization process. However, their awareness about the policy terms and conditions was found to be poor (for a summary of findings about the level of awareness, *see* Table 4).

During the interview, different sets of questions were asked and responses noted. Similarities were found in the need for purchasing health insurance by different categories of customers. The expectations of the insured customers with past claim experience were higher than those of potential customers. This group

suggested that the providers charge higher in case of cashless hospitalization. The overall experience was different for customers without any claim history from that for customers who had lodged either a claim with the insurers or had availed of the cashless services. Sample of the interactions are presented in Table 5.

Table 4: Stakeholder Analysis- Customer Awareness

Awareness	Potential Customer	Insured Customer without any Claim Experience	Insured Customer with Claim Experience
About Insurance	Poor	Poor	Average
Policy T&C	Poor	Poor	Poor
Cashless Hospitalization	Poor	Poor	Average
TPA	Poor	Average	Good
Insurance Company	Poor	Average	Average
Network Hospitals	Poor	Poor	Average

Source: Summarized on the basis of Focus Group Discussions (FGDs) of different categories of Insured Customers.

Table 5: Stakeholders' Analysis-Customer Group

	Potential Customer	Insured Customer without any Claim Experience	Insured Customer with Claim Experience
Why have you purchased/ not purchased health insurance?	<i>Don't need...., Never thought about buying...., No one had come to sell...., Don't know about health insurance...., Don't have time...., I am healthy...., From where to get it.</i>	<i>Peace of mind...., To pay for hospital bills...., My Parents asked me to...., To cover risk...., Got a good deal.</i>	<i>Security...., Peace of Mind...., Payment of medical bills...., Everybody does not have ready cash for emergency treatment.</i>
What are your expectations from your health insurance policy?	<i>Can't say...., Should cost less...., Cover all diseases...., Transparent...., Good client service.</i>	<i>Value added services...., Should pay in case I get admitted to a hospital...., Card should reach in time...., No premium loading next year.</i>	<i>Network hospital should accept the card...., No delay in payments...., Unnecessary query should not be raised...., TPA should not cheat...., should be customer friendly.</i>
Does hospital charge more in case the person is covered through insurance?	<i>What is cashless...., Can't say.</i>	<i>May be...., Not sure...., Can't say...., Might be.</i>	<i>Yes, they increase by 30%...., no, can't say...., Yes, we have felt the same.</i>
What has been your experience?	NA	<i>Good...., Still have not got the cards...., The TPA doesn't respond...., The agent was good.</i>	<i>Cashless got denied...., TPA asked us to make the payment...., was good, policy terms and condition were explained...., Don't have hospital near to where I live...., I have submitted the papers long back but have not heard from the TPA.</i>

Source: Compiled from Focus Group Discussions (FGDs) of different categories of Insured Customers.

Government and Regulatory Bodies

Some critics argue that the government intervention in the market place brings social benefits which would not occur otherwise. For example, the health insurance policy benefit the BPL family which gets covered for a sum insured of ₹ 30,000 by just paying a fee of ₹ 30. Here, the total premium paid to the insurance company per BPL family is somewhere around ₹ 800, where the balance of ₹ 760 is paid by the Central and State governments (Central share is 75 per cent and State share 25 per cent). Had the government not initiated this policy, the BPL families would not have secured the health insurance cover. However, just paying a major chunk of the premium does not ensure real improvement in the health of a BPL family. It is an important area of research, to see if schemes like RSBY improve the health status of families who get benefit from such health insurance schemes.

The insurance regulator has taken multiple initiatives for the orderly growth of health insurance industry. For example, it has formed a joint working committee to look into the area of health insurance. It has licensed standalone health insurance companies and is looking into the recommendation of reducing the working capital requirement for standalone health insurance companies. The insurance regulator has done a fair job in handling customer grievances. Recently, it has opened a call centre, where a customer can lodge his complaints.

Based on the current investigations, it was found that major areas of interest for the government are awareness, trust and transparency on the one hand and to improve the health infrastructure of the country on the other hand. The key themes and factors which emerge are discussed below.

Lack of Access

One of the concerns raised was the lack of access for the insured customer when it comes to accessing cashless benefit at hospitals. Currently only private hospitals are included in the list of insurers and most providers have profit motives. Besides, the latter are primarily in the urban areas. This limits the access to those insured persons and families who live in rural and semi-urban areas. If health insurance fails to provide access to hospital care for treatment of illness covered under health insurance, then one of its key benefits is lost. The reasons which lead to lack of access are: unavailability of hospitals in a region, absence of network tie-up by the insurance company in a given region, non-availability of hospital beds in the hospital, denial of admission or non-acceptance of health insurance card by the provider, etc. To make health insurance successful, there is a need for both insurers and providers to come together on the one side and to provide access to the care and cashless benefit to all sections of the society on the other hand.

Need to Improve Trust and Transparency

There is a pressing need to develop trust and transparency within the health insurance system. Comments are made that at times the parties are not fair in their approach. This observation was validated in one such instance where some public sector insurers stopped cashless facility in metro cities due to losses in their health insurance portfolio without consulting the providers. Both the insurers and providers questioned the honesty of each other. The insurers thought that the providers were not honest in their dealings and charged more money from the insured patients. On the other side, the providers believed that the insurers were out to make profit and did not care either about them or about the customers. It is important that both of them work together to develop trust and transparency. This will help in the growth of the health insurance industry.

Improve Existing Health Infrastructure

According to government and regulatory bodies, medical infrastructure is poor in our country and in most of the rural areas the private facility is almost negligible. It was thought that if insurers and providers came together, it would help build the health infrastructure. The example of RSBY was given to justify the same. It was evident that the government has the powers to influence the current relationship between the insurers and providers not merely by introducing new schemes for the general population who can't afford to pay the health insurance premium, but also by bringing changes in the current regulatory regime. The insurers and providers must make efforts to influence the public policy in a way that helps to develop synergy between them.

Healthcare Professionals (Doctors, Hospital Administrators and Nursing Staff)

Health professionals are one of the key stakeholders in the relationship between insurers and providers. This group delivers actual service to the insured customer and determines the cost of care. Without this group neither the hospitals nor insurers (providing health insurance benefit) can survive. The interactions with this group were both interesting and insightful. This may be because they are at the centre of activities linked to health insurance claims. It is on the advice of the treating doctors that the cashless benefit is triggered. The treating doctor decides the line of treatment for the insured patient and not the insurer. Nursing staff provides care to the insured patient and not the sales staff of an insurance company. Thus, the power of this group to influence customer satisfaction is the highest.

The key themes and factors which were brought into light include: Lack of ownership by the insurers and TPAs, delays in provider payments, lack of referral system, poor doctor and insurer relationship, criteria for selection of

providers, lack of standardization, training issues and the need to have a robust grievance handling mechanism for addressing provider issues. These factors are discussed in the subsequent section.

Lack of Ownership

During our interaction with the healthcare professionals, it was said that both the insurers and TPAs do not own the patient at the time of need. There are situations where the patient is asked to speak to different parties to get the cashless claim processed. During our interview with the doctors, it was mentioned that the insurance regulator does not visit and meet network providers and seek their feedback for insurance companies and TPAs, i.e., to understand problems faced by the providers and take corrective action. Some of them suggested that there is no ownership by the TPAs (the issue linked to lack of ownership is discussed separately). Few of them pointed out that they are not able to control cost, are just profit-making agencies without focusing on service, have poor quality of manpower and are involved in fraudulent practices and sharing data with competitors.

Delay in Provider Payments

The providers do not receive payments in time and that it is perceived as a critical factor by them while evaluating the services of the TPAs and insurance companies. Delays in payment to providers are at times used as an excuse for charging more money from the insured patients. If payments to providers are made within the agreed timeframe, it would help to build confidence in them for the services promised by the insurers. This will also affect the level of services offered to the insured patients. For example, when asked why the providers take advance deposit from insured patients the reason given was that there were instances where the payments were delayed by either the insurers or the TPAs.

Lack of Referral System

We don't follow referral system in the private space. This has a direct impact on the hospital occupancy rate and cost of treatment. Even for normal cold and fever, the insured visits a super specialty hospital and gets consultation from a super specialist. Even though the percentage of business from health insurance was low, there is an opportunity to have close network policies to control the flow of patients to providers and also the concept of gatekeeper was thought to be a workable solution. Since it's not easy to change the behaviour of customers, some steps may be taken to ensure that there is a balance between the demand and supply of healthcare.

Poor Doctor-insurer Relationship

The doctor and patient relationship is strong in the Indian context. However, there is hardly any relationship between the doctors and insurers. It is either the hospitals or the TPAs which interact at regular intervals and have some sort of on-going relationship. It is either the TPA desk or the accounts team of the hospital that interacts with the insurance companies. Currently there are many doctors who work on freelance basis and are not exclusively tied-up with any specific provider. They have no incentive to reduce the cost of care for insured patients. If the insurance company can initiate building relationship then it might help to manage the health insurance claims cost. For example, there are many hospitals where the consultant's charges are not fixed. It is up to him to decide how much he will charge and from whom. If the insurance company can tie-up with consultants and work towards a fixed consultant charge (*in lieu of patient flow*), then this would help to minimize the claim cost. It was felt that building the doctor and insurer relationship will bring more transparency in the system and benefit both the providers and insurers.

Criteria for Selection of Providers

There is a common perception that the providers are not selected fairly. It is the discretion of the TPAs or the insurance company and there is no standard process followed for undertaking this activity. It is also suggested that there are few TPAs which take kickbacks from the providers for getting into their panel. There is a pressing need to follow a standard process for the selection of providers and it should be transparent so that the providers know the reasons for not getting included for extending cashless benefit.

Lack of Standardization

There is a lack of standardization in both treatment as well as the processes followed by the insurer and TPAs. There is no standard treatment guideline followed by most of the providers. By implementing it, there could be more transparency in the existing system. However, it was argued by the doctors that there are cases which are complex and involve multiple line of treatment and one cannot have standard guidelines (like multiple organ failure). It, therefore, will also restrict the freedom of doctors in deciding the line of treatment.

An example of the lack of standardization in the processes is that most TPAs have their own SLA agreement and thus it becomes extremely difficult for providers to measure and monitor the same. Hospital administrators argue that the benefits of standardization of SLA and inclusion of common industry benchmarks will focus the expectation from the service provider, whether they are the TPAs, providers or insurers.

Training Issues

It was a common feedback from the healthcare professionals that there is a lack of training given to them either by the TPAs or the insurance companies. The study found that this is because of lack of funds, dearth of trained manpower (trainers), shortfall in infrastructure, focus on just selling and not focusing on quality of sale, health insurance being a loss-making portfolio, and so expenses on training are never treated as an investment. In the case of providers, there is attrition at the insurance desk. By providing training to healthcare professionals on health insurance and its processes, more synergy could be developed among insurers and providers.

Lack of Robust Grievance Handling Mechanism for Providers (Hospitals)

The current grievance handling mechanism of the insurers to handle provider query and complaints are not robust. There are many instances when the issues highlighted by the providers and/or doctors are not addressed by the insurers. Also, there are delays in responses received from the insurers and TPAs. There are payment issues which are been resolved for years. A robust grievance handling mechanism will help to build confidence in the minds of the providers and would help develop synergy.

Intermediaries (Agents, Advisors, Brokers, TPAs)

The intermediaries are an important stakeholder group as they not only help in sales and distribution but also in servicing of health insurance policies. The key themes and factors highlighted by the intermediaries were in the area of provider tariff, communication, underwriting, product innovation and health insurance fraud. The summary of the same is presented below:

Dual Provider Tariff

There was a common complaint that most providers follow a dual tariff, i.e., one for patients who pay out-of-pocket and the other for insured patients. Such practices hamper the relationship between insurers and providers. They had started with the introduction of cashless services by the insurance companies. Because of such instances the TPAs and insurance companies are coming up with their own package rates. Even in a mass scheme like RSBY, standard package rates are followed. Such practices destroy synergy among insurers and providers.

Improvement in Communication among Parties

There are opportunities to improve communication among all the parties involved in the health insurance mechanism and working on them would help develop synergy between insurers and providers.

Lack of Prudent Underwriting

It becomes difficult for the intermediaries to understand few conditions in the policy which are incorporated at the time of underwriting. For example, if the policy document simply says that there is a room rent capping of, say, 10 per cent, then it is not clear if the hospital should ask the insured patient to pay 10 per cent of the room rent charge or all the charges which are associated with room rent. So at the time of underwriting adequate care should be taken while writing any special conditions so that it is clearly understood by the providers. Pricing of health insurance products does not take into account medical inflation. Prudent underwriting guidelines are hardly followed by the insurance companies due to market pressure, lack of available data on morbidity and past claim history.

Inadequate Cover and Product Innovation

There is inadequate cover and product innovation in health insurance. The problem with limited cover is that it restricts the provider to offer services and makes it troublesome for the insured (as well as the provider) to understand the If's and But's of the policy. There is a perception among the insured population that insurance companies want to cover only young and healthy people so that they can make huge profits. This thinking is fuelled by the fact that most insurance companies don't extend cover if a person is more than 80 years old. In the course of the study the need for product innovation was highlighted and its impact on synergy among insurers and providers reflected.

Health Insurance Fraud

Occurrence of fraud in health insurance business was acknowledged. There are different types of frauds in the market. For example, lodging of fraudulent reimbursement claims, mis-representation of material fact at the time of policy issuance, manipulation of claim documents including bills and receipts, kickback from providers and intermediaries, etc. Concepts like 'rent a patient', 'unbundling', 'up-coding', etc., are emerging in the area of provider fraud. Insured patients are made to stay more than patients who pay out-of-pocket. They are also prescribed high-end diagnostic tests like CT scan and MRI even when the same are not linked to treatment. There are cases where fixed commission is paid to the prescribing doctors by the diagnostic centres. Since the

providers invest large sums in buying the latest technology, they tend to use the technology on patients for regular income flow and decreasing the idle time of the equipment. There was a common feeling that the saving brought about by mitigating health insurance fraud risk will not only benefit the insurers, but other stakeholders in the industry too.

Others (NGOs, Educational Institutions, Pharmaceutical Companies, etc.)

Key themes raised by the remaining stakeholders (i.e., NGO's, educational institutions, etc.) were in the area of value creation, training, co-payment and deductibles and linked to insurance cover (over and under-insurance). A brief summary of these is presented below:

Lack of Value Creation: There was a common feedback that there is a lack of value creation in multiple areas. These include activities like the health insurance product development, cashless processing and customer service (both for insurer and provider, etc.). The level of customer satisfaction may be increased by creating value for the customer by reducing the premium of health insurance products and offering care with quality of international standards.

Lack of Specialized Training Institutions and Courses: There is lack of specialized training institutions and courses designed to address the training needs of the Indian health insurance market. As the health portfolio was bleeding with high claim ratio, it was never thought a good idea to spend money in training. The NGOs and educational institutions were more vocal on this issue. A pressing need to develop course curriculum based on the needs of the health insurance industry was pressed. Through these specialized training institutions and courses, the industry would be able to produce trained manpower required to sustain the current growth level of health insurance.

Co-payment and High Deductibles: The NGOs were of the opinion that insurance companies had started putting co-payment and deductible clauses in their products to safeguard themselves from financial loss. But such activities are completely against the customers. It becomes difficult for a poor patient to pay out-of-pocket when he is covered through insurance. Such activities are not welcomed by him and should be stopped.

Over and Under-Insurance: The NGOs were of the opinion that over and under-insurance is not customer-friendly. What is the value for the customer if he is under-insured? If the sum insured is less than the treatment cost, then what is the fun in buying a health insurance cover? Over-insurance is that where the customer is offered higher sum-insured but it is not that prevalent in the Indian scenario due to in capacity to pay higher premium. Also, it becomes difficult for the providers to process claims where the total treatment cost is not paid by the insurers.

Thus, there are multiple factors which can affect synergy between insurers and providers. Each stakeholder group has an interest in the relationship between

insurer and provider, and can affect the implementation of potential strategies for synergy. However, if the identified factors and issues are kept in mind while developing strategies for synergy, the chances of failure for implementation would be minimized.

The INSECT Framework and Validation

An attempt had been made to evolve a sector-specific framework that addresses different factors and strategy buckets that will not only help in bringing synergy among insurers and providers, but also help in implementing and evaluating different strategies. The different synergy buckets in the INSECT framework are: the Insured, Need for care and cover, Standardization, Existing relationship, Claims and cost, and Trust and technology. The study was validated and re-validated by undertaking expert interviews and using the INSECT framework in the form of an expert-questionnaire. The findings suggest that all the factors identified under different synergy buckets in the INSECT framework have the ability to either develop or destroy synergy among insurers and network hospitals (Refer to Annexure II for average scores and ranking).

Limitations of the Study

This study has identified factors affecting synergy among insurers and providers in the Indian health insurance market for the first time. The final outcome of this study is the formation of different strategies that could be adopted for bringing synergy among insurers and providers.

Conclusion

The Indian health insurance industry is growing at a fast pace and so are the issues and challenges linked to bringing in synergy within the system. The two most important players in providing health insurance benefits and services to the insured customer are the insurers and providers. It is the relationship between them that governs the service delivery model and its analysis is critical for the current and future growth of the industry. In the Indian context not much has been studied in the area of insurer-provider relationship. It is, therefore, prudent to understand this relationship by also studying the stakeholders involved.

The study suggests that there are multiple factors which can either develop or destroy synergy among insurers and healthcare providers. They may be categorized into different synergy buckets which can help to develop strategies for synergy at the insured, firm and the industry levels. The INSECT framework not only reflects the different synergy buckets and its components, but also helps both practitioners and policy-makers in understanding the complex inter-relationship of multiple factors that has the potential to either develop or destroy synergy between insurers and providers.

Annexure I: Expert Opinion Questionnaire

Name	Designation
Total Years of Experience (in Yrs):	Age (in Yrs):
Organization Name:	
Address:	State:

Instruction: Rate the below listed factors between 1-5 on their ability to either develop or destroy synergy among insurers and network hospitals (**where, 1= minimum affect and 5= maximum affect**). These factors are being identified based on extensive field investigations undertaken by us and is an outcome of both qualitative and quantitative analysis.

Note: For brief details about the below listed factors, refer to the separate document entitled- **Factor Description**. Name of the respondent shall be kept confidential.

INSURED	POINTS	NEED (Care and Cover)	POINTS
• Awareness		• Referral system	
• Ownership		• Existing Infrastructure	
• Value creation		• Underwriting and enrolment	
• Access		• Inadequate cover and product innovation	
		• Over and Under-insurance	

STANDARDIZATION	POINTS	EXISTING RELATIONSHIP	POINTS
• Selection of providers		• Provider Tariffs and business volume	
• Service Level Agreement		• Trust and transparency	
• Standard treatment guidelines		• Provider payment	
• Standard forms and format		• Relationship with Intermediaries	
		• Grievance handling mechanism	

CLAIM & COST	POINTS	TECHNOLOGY and TRAINING	POINTS
• Co-payment and deductibles		• Training issues	
• Health insurance fraud and misuse		• Specialized training institutions and courses	
• Selection of room category		• Use of information technology	
• Outcome-based payment system		• Efficiency and Effectiveness	
• TPA vs In-house claim processing		• Communication between parties	

Remarks (If any):	
Signature:	Location:

Annexure II: Factors Average Score and Ranking

Factors	Factor Group	Total Score	Avg. Score	Rank within synergy bucket
Awareness		176	4.19	1
Ownership	INSURED	135	3.21	4
Value creation		139	3.31	3
Access		149	3.55	2
Referral System		145	3.45	2
Existing infrastructure		153	3.64	1
Underwriting and enrolment	NEED (Care and Cover)	140	3.33	4
Inadequate cover & product innovation		144	3.43	3
Over and under-insurance		135	3.21	5
Selection of providers		149	3.55	3
Service level agreement	STANDARDIZATION	146	3.48	4
Standard treatment guidelines		164	3.90	1
Standard forms and format		160	3.81	2
Provider tariff and business volume		158	3.76	4
Provider Payment	EXISTING RELATIONSHIP	176	4.19	1
Relationship with intermediaries		171	4.07	2
Grievance handling mechanism		129	3.07	5
Trust and transparency		162	3.86	3
Co-payment and deductibles		148	3.52	4
Health insurance fraud and misuse		171	4.07	1
Selection of room category	CLAIM and COST	153	3.64	3
Outcome-based payment system		141	3.36	5
TPA Vs In-house claim processing		157	3.74	2
Training issues		158	3.76	3
Specialized training institutions and courses	TECHNOLOGY and TRAINING	144	3.43	5
Use of information technology		187	4.45	1
Efficiency & effectiveness		147	3.50	4
Communication among parties		171	4.07	2
N= 42				

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