The Influence of Third-Party Administration and IRDAI on Indian Health Insurance Policies

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Abstract

With the growing demand of regulatory supervision, the Indian health insurance market has experienced substantial changes over the years. The Insurance Regulatory and Development Authority of India (IRDAI) has an intricate role in developing health insurance policy, which is explored in this study. By highlighting the regulatory inadequacies that made the creation of IRDAI necessary, the historical context explains how health insurance has evolved.

Examining the regulations critically reveals the careful rules that IRDAI established in an effort to strike a balance between consumer protection and innovation. The paper emphasises how crucial the IRDAI's robust complaint and dispute resolution procedures in guaranteeing ensuring and open business practices.

IRDAI's impact stretches beyond legal compliance to the domains of innovation and product development. The paper focuses at how IRDAI protects policyholder interests while promoting industry dynamism. It explores the difficulties and ethical issues raised by market behaviour, highlighting IRDAI's diligence in preventing malpractices with strict guidelines and penalties.

The concluding portion of the paper addresses the difficulties IRDAI experienced and provides suggestions for future regulatory framework enhancements. It considers the changing role of IRDAI in influencing these developments as well as the future directions in health insurance.

Keywords: IRDAI, Health Insurance, Cashless, TPAs.

I. Third-Party Administrator (TPA) Evolution: A Conceptual Framework

After the insurance industry's nationalisation in 1956, this development was regarded as a turning point towards India's adoption of a socialistic social structure.[1] The public and private health insurance companies have worked hard to ensure that people have access to quality health insurance coverage since the Insurance Regulatory and Development Authority (IRDA) bill was passed by the parliament in 2000. This has allowed a number of private insurance companies to enter the insurance market. Since their home markets were nearly saturated and emerging nations had low insurance penetration rates and strong growth rates, global insurance companies also had a significant interest in the developing insurance sector.

The insurance sector was disorganised, mismanaged, and uncontrolled prior to appropriate regulation. Without strong control, healthcare costs would surely rise, disproportionately affecting the poor and middle class as treatment became nearly expensive. Systems of high cost and bad quality healthcare delivery were distributed unequally. Additionally, the insurance companies' new policies were not so attractive.

Earlier, the whole health insurance market was controlled by the only four public sector companies. And the most well-known, General Insurance Company (GIC), with its four subsidiaries, was providing Mediclaim policies. Under these policies, the policyholder had to pay hospital bills, submit the bill to the insurance company, and then wait to get reimbursed—a process that could take a while because of the bureaucratic procedures involved.

People expected insurance firms to deliver hassle-free medical care and cashless services. But at the time of hospitalization, they first pay for the expenses and were only later reimbursed, depending on the sum insured and the coverage of diseases. Insurance companies deal with unregulated healthcare providers (hospitals) that operate in a setting absence of standards, benchmarks for quality, and treatment protocols. [2]

There were many obstacles to overcome in order to provide the policyholders with efficient and reasonably priced services, such as having a network of hospitals, general medication availability, enrolment diagnosis administration, high-quality treatment, fraud

[1]Nagendranath Abhijit, Chari Pallavi, 6th Sep (2002), p.5, Health Insurance in India: The Emerging Paradigms, [Online] IIFT School of International Business Management New Delhi. Available from: http://www.karmayog.org/communityhealth/upload2548/health%20insurance %India.pdf .

[2] Bhatt Ramesh, Babu K. Sumesh (2003), p.3, Health Insurance and Third-Party Administrators: Issues and Challenges; IIM working paper No. 2003-05-02, 3

control through the claims process, an administration capable of managing millions of clients, [3] and settling claims between insurance companies and hospitals.

In 2001, the Insurance Regulatory and Development Authority (IRDA) issued a notification on TPA health services regulations, which aimed to address these issues by introducing Third Party Administrators (TPAs) as intermediaries to facilitate claims settlement between insurance companies and healthcare providers (hospitals).

The Insurance Regulatory and Development Authority (IRDA) defines a Third-Party Administrator (TPA) as an individual who is currently licenced by the Authority and provides health services[4] to insurance companies under a name that may be specified in the agreement for a fee or remuneration. The Insurance Regulatory and Development Authority (IRDA) has granted Third Party Administrators (TPAs), independent companies, a licence to handle the administration and implementation of health insurance programmes. They serve as a nodal organisation, facilitating communication between insurance providers, covered parties, and medical facilities in order to provide consumers with better services, hassle-free claim settlement, and cashless hospitalisation.[5]

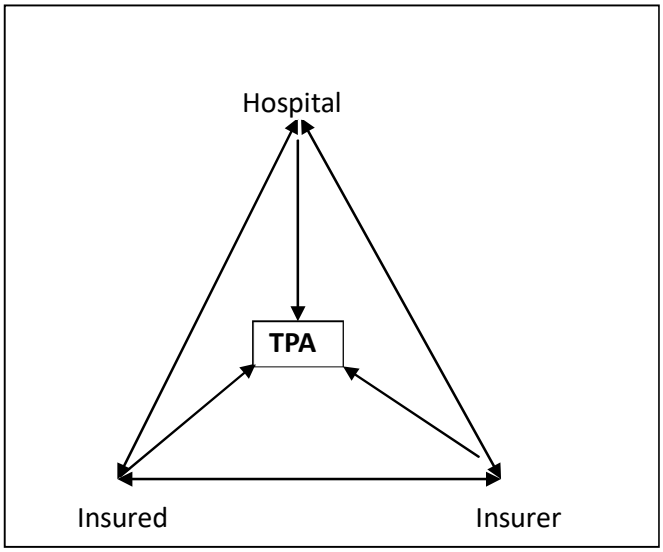

Figure 1. Relationship between the TPA, Insurer, Insured and the Hospital

[3] Lomas Peter, March (2009), p.2, Third Party Administration in the Provision of In-Patient Health Insurance, An Indian case study, VP Communications andPublic Relations, Micro Ensure.
[4] IRDAs Regulations and Guidelines for Third Party Administrators (TPAs),Sep 17 (2001), New Delhi.
[5] Agarwala Rakesh, (2009), p.44, Health Insurance in India: A Review 1st ed. The Insurance Times, Kolkata.

In order to comply with certain standards and follow a code of conduct for best practices, Third Party Administrators (TPAs) must follow regulatory guidelines issued by the Insurance Regulatory and Development Authority (IRDA). Brokers and agents used to play a very similar role, but the IRDA allowed TPAs to formally enter the market with set rules and regulations, something that the agents and brokers did not have. The agents and brokers charged the policyholders on their own initiative by engaging in unfair trade practices, processing and producing false documents, and filing claims against the records of actual members.

In 2001, the Insurance Regulatory and Development Authority (IRDA) issued a notification regarding TPA health services. Till date, around 21 TPAs[6] are authorise to operate in India. After their establishment, policyholders were no longer required to pay their hospital bills in full before filing a claim with the insurer; rather, the insurers, with the assistance of TPAs, settled the hospital bills on behalf of the policyholders, allowing them to leave for home at no further cost.

II. Meaning/Characteristics of Third-Party Administrators (TPAs)

The intermediaries between insurance companies, policyholders, and healthcare service providers (hospitals and nursing homes) are known as Third Party Administrators, or TPAs. They provide policyholders with cashless services during hospital stays, handle claims administration and settlement on behalf of insurance companies for both hospitals and policyholders, and support insurance companies administratively as they service their policies. [Figure3.2.1]

[6] https://irdai.gov.in/list-of-tpas (Visited on 11/01/2024).

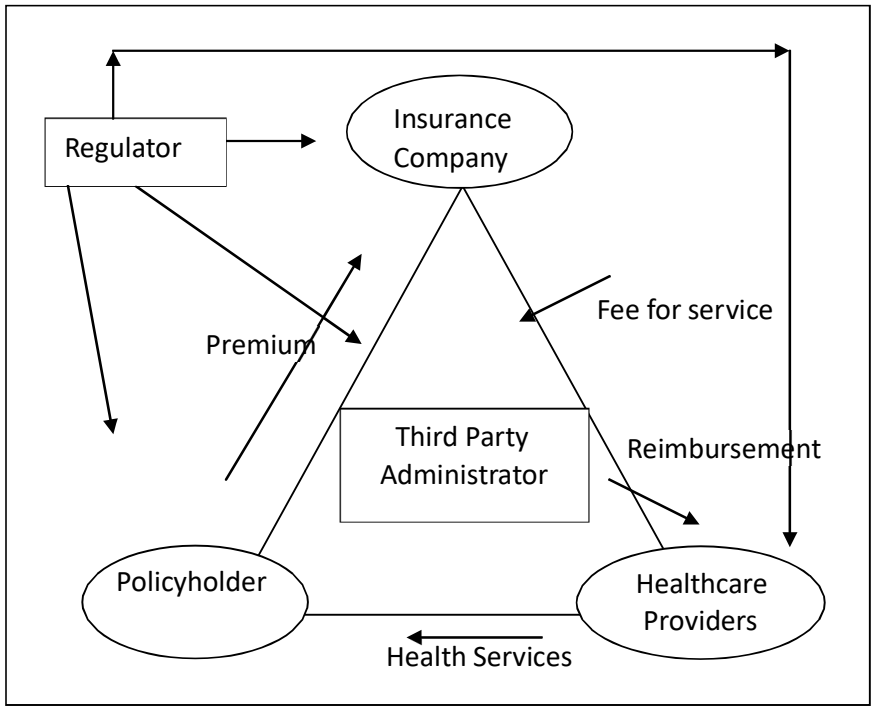

Figure 2. Working Environment of TPAs

Third Party Administrators are defined as "an insurance intermediary licenced by the authority who, either directly and indirectly, solicits or effects coverage of, underwrite, collect charge premium from an insured, adjust or settle claims in connection with health insurance, except as an agent or broker or an insurer" by the Insurance Regulatory and Development Authority (IRDA).

"Health Insurance by TPA"[7] means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

The Insurance Regulatory and Development Authority (IRDA) published the regulations governing Third Party Administrators (TPAs) in 2001, marking the entry of TPAs as authorised firms in the Indian health insurance market. The regulation became operative on September 17, 2001, the day it was notified. In order to assure improved efficiency, standardisation, cashless healthcare services for policyholders, and a greater percentage of the population having health insurance, TPAs were introduced as middlemen in the healthcare service chain.[8] Additionally,

[7]Insurance Regulatory and Development Authority (Third Party Administrators-Health Services) (Second Amendment) Regulations, 2013

[8] Anita, J. (2008). Emergine Health Insurance in India.10th Global conference of Actuaries.

they could be able to contribute more broadly to the standardisation of fees for different medical treatments and operations, claim administration, provider network management, benefit management, medical management, and maintenance of a database of health insurance policies.

The primary responsibilities of TPAs is to facilitate cashless services and act as an intermediary for the policyholder and the insurance provider. They are also in the position of offering extremely specialised services to an insurance company in order to support the management and administration of the company's health insurance products. On behalf of their insurers, they also offer policyholders enrolment number, hospital network growth, and claim processing services. They receive fee in the form of a set percentage of the insurance premium as commission for this service. Currently, this commission is set at a minimum of 6% of the premium amount, although companies are free to increase it following negotiations with Third Party Administrators (TPAs). [Figure3.2.1]

The goal of introducing TPAs into the health insurance market was to lower high claim ratios by getting rid of fraudulent cases. Although, it is anticipated that TPAs relationships with doctors and hospitals will significantly lower claims, the insurance companies will also benefit from enhanced customer relations as a result of TPAs.

Previously, the patients pay for the hospital services in advance and then file claims with their insurance company to get reimbursed back. With the advent of TPAs, clients may now obtain services on schedule by providing the required paperwork. The TPAs handle and resolve the claim; they do this by directly paying the hospitals and obtaining payments from the insurance companies.

When TPAs were introduced in 2002, the Mediclaim policy went cashless. Benefit of hospitalisation with direct payment to medical providers. Before TPAs entered the market, patients who wanted reimbursement had to send their bills to their insurance company directly in order to get paid. By using cashless hospitalisation, the TPA was able to free patients of the hassle of submitting claims by providing a future payment assurance to the hospital.

A minimum capital requirement of Rs.10 million and a ceiling of 26% foreign equity are essential requirements for a Third-Party Administrator as specified by the Insurance Regulatory and Development Authority (IRDA)[9]. A licence is often given out for a minimum of three years.

[9] IRDAs Regulations and Guidelines for Third Party Administrators (TPAs),Sep 17 (2001), New Delhi.

In an ideal world, hospitals and Third-Party Administrators (TPAs) would work together to provide cashless hospitalisation services to patients. The insurance companies, who have been looking for ways to bring their management costs into compliance with the guidelines established by the Insurance Regulatory and Development Authority (IRDA), are greatly relieved by the arrival of Third-Party Administrators (TPAs).

The insurance companies' contract with Third Party Administrators (TPAs), who provide these services on a fee basis, to handle their administrative tasks, which includes settling claims. The policyholders obtain enhanced facilities at no additional expense because the insurers pay the Third-Party Administrators (TPAs). Upon the issuance of the policy, all documentation is transferred to the Third-Party Administrators (TPAs), who handle all further correspondence with the insured party rather than the insurance company.

It is expected that Third Party Administrators (TPAs) will offer value-added services to their clients, such as scheduling ambulance services, prescription drugs, and supplies, assisting policyholders with specialist consultations, and giving information on 24-hour toll-free hotlines regarding medical facilities, hospitals, bed availability, and setting up lifestyle management and wellness initiatives.

The insurance companies hope that the entry of Third-Party Administrators (TPAs) into this market will result in increased efficiency, standardisation of rates, public awareness, and penetration of health insurance among a wider demographic.

III. Role of Third-Party Administrators (TPAs)[10]

The intermediaries known as Third Party Administrators (TPAs) are important to the health insurance industry because they connect the various players in the healthcare system, including doctors, hospitals, clinics, long-term care facilities, and pharmacies. In India, health insurance entered the next phase with the establishment of this new category of intermediaries. These Third-Party Administrators (TPAs) provide medical expense management, claim and reimbursement administration, cashless services in hospitals, and policyholder call centre support. Third Party Administrators (TPAs) create networks, manage finances, and provide clients with the right healthcare services.[11]

Through the use of Third-Party Administrators (TPAs), insurance companies can pay for effective and efficient services, policyholders and healthcare providers receive timely

[10] The Insurance Regulatory and Development Authority (Third Party Administrators - Health Services) Regulations, 2001.

[11] https://www.easypolicy.com/health-insurance/articles/role-and-importance-of a- tpa-in-health-insurance.html.

reimbursements, and policyholders receive hassle-free services. By doing this, it is expected that Third Party Administrators (TPAs) will create suitable management structures and systems with the goal of reducing costs, creating procedures to reduce ineffective examinations and treatments, enhancing service quality, and eventually lowering insurance premiums.[12]

Following are the Primary Role of Third Party Administrators (TPAs):-

a. Enrolment and issuance of member ID Card.

b. 24 hours call centre services.

c. Pre-authorization and organizing cashless treatment.

d. Claims-management.

a. Enrolment and issuance of member ID Card

The insurers send the policies and member information to the Third-Party Administrators (TPAs). After processing this data, they provide the covered member with an ID card so that their identification may be verified upon admission.[13]

b. 24 hours call centre services.

The TPA is usually expected to maintain a call centre accessible at all times including nights, weekends and holidays i.e. 24*7*365. The call centre of the TPA will provide information relating to:

- Coverage and benefits available under the policy.
- Processes and procedures relating to health claims.
- Guidance relating to the services and cashless hospitalization.
- Information on network hospitals
- Information on balance sum insured available under the policy.
- Information on claim status.
- Advice on deficiency of documents.

The call centre should be accessible through a national toll-free number and the customer service staff should be able to communicate in the major languages normally spoken by the customers. These details are of course governed by the contract between the insurers and their TPAs.

[12] IC 36, Health Insurance Claims Management, Insurance Institute of India, 2013 (Reprint 2021).
[13] https://www.bankbazaar.com/health-insurance/third-party-administrators.html

c. Pre-authorization and organizing cashless treatment.

Pre-authorization is a procedure wherein a Third-Party Administrator (TPA) or an insurer guarantees payment to the treating healthcare practitioner for services delivered to enrolled members of a pre-defined benefit plan, therefore approving the course of treatment.

The main objective of pre-authorization is cashless treatment for the enrolled member and to guarantee high-quality care while keeping costs under control to protect the patient from any possible risks. By determining whether the treatments are medically necessary and offered at a minimal expensive level of care, Third Party Administrators (TPAs) try to keep expenses under control.

Therefore, a pre-authorization is a document that specifies the maximum amount of medical treatment that can be covered by an insurance policy and is provided by the insurance company or Third-Party Administrators (TPAs). The policyholder must submit a properly completed pre-authorization form, which is available at the hospital or through Third Party Administrators (TPAs), in order to obtain a pre-authorization.[14]

An authorization or guarantee to pay the provider for the cost of treatment provided to the enrolled member is known as cashless treatment. By using cashless services, members can avoid paying the healthcare provider upfront for treatments that are covered by their benefit plan. Once the authorization has been granted, the administrator pays the patient's bill directly. At the time of hospitalisation, the patient is not required to pay the hospital expenses in full; instead, Third Party Administrators (TPAs) will handle this payment. In the event that the policy is in effect, the policyholder only needs to present their ID card at the hospital. The Third-Party Administrator (TPA) will then make arrangements to pay the hospital directly, up to the policy's maximum covered value. This is called cashless hospitalisation. The policyholder will have to pay for the remaining amount out of pocket.

d. Claims-management

Hospitals and policyholders have claims that are managed and settled by Third Party Administrators (TPAs) on behalf of the insurance companies. Outsourcing of healthcare and accuracy in health insurance claims processing are the most important elements in improving turn-around time and claims throughput. This is achieved through outsourcing high-potential

[14]http://www.medindia.net/patients/insurance/tpa-for-claims-and-cashlesshealth-insurance benefits.html

healthcare segments, such as processing health insurance claims, to Third Party Administrators (TPAs).

The goal is to control the primary sources of processing costs and provide significant financial gains for the overall plan performance of the insurers. The services for processing health insurance claims are driven by transactional efficiency. The Third-Party Administrators (TPAs) facilitate the achievement of optimal automation in the procedures related to claims resolution. They use the current legacy system to support new product and services.

Healthcare outsourcing and claims management activities and processes depend on cost and advanced process engineering savings, which are ensured by outsourcing claims processing to Third Party Administrators (TPAs). A team of medical specialists and technical personnel work for Third Party Administrators (TPAs) to manage claims for members who are enrolled with the insurance company. The following features are generally offered by Third Party Administrators (TPAs) in claims management:

a) Offering claims-management services that comprise data entry, adjudication, and a thorough review of every claim.

b) Facilitating improved control and monitoring of claims funding processes

c) The programme records every piece of information on the claim form for comprehensive information reporting.

d) Claim access, eligibility, enrollment, and processing in accordance with insurance company requests.

e) Utilization and Case Management.

To file a claim under a health insurance coverage, we have two options:

1. Cashless/ Planned Hospitalization

2. Non- Cashless/ Emergency Hospitalization

- **Cashless/ Planned Hospitalization**

1. If a hospitalisation is planned, the policyholder must notify the insurance company or Third-Party Administrators (TPAs) at least four to five days in advance about the date of admission, providing their policy number and health ID card**.**

2. The form for notifying Third Party Administrators (TPAs) and obtaining pre-authorization for Cashless claims services are available at the hospital admission counter.

3. The patient must carefully complete the form because failure to do so could result in the pre-authorization being denied.

4. The attending physician fills out any paperwork pertaining to the patient's medical condition or the need for any surgical procedures. Correct information regarding the patient's history must be provided to the doctor; otherwise, it could result in the denial of pre-authorization by Third Party Administrators (TPAs).

5. New policies will not cover any pre-existing conditions. "Pre-existing diseases are conditions, illnesses, or injuries for which the policyholder experienced symptoms, obtained a diagnosis, or sought medical advice or treatment within 48 months (4 years) before obtaining their first insurance policy from the insurer. These illnesses are the result of any prior ailment that was diagnosed before the member's enrolment and that has ever required or would require hospitalisation or medical treatment. Pre-existing conditions usually covered after three to four years of continuous coverage with the same insurance provider.[15]

Therefore, the policyholder must ensure that the doctor did not disclose any conditions that could make one to believe they were pre-existing while signing the pre-authorization form.

6. The completed form is subsequently forwarded by the hospital administration to the relevant Third-Party Administrators (TPAs) of the company in order to obtain pre-approval of the claim amount for hospitalisation.

7. After carefully scrutinising all the information, including the policy number, validity of the policy, sum assured, waiting time, and pre-existing diseases, among other factors, the Third-Party Administrators (TPAs) submit the authorization of amount directly to the hospital once they are satisfied.

8. After their complete satisfaction, Third Party Administrators (TPAs) will provide the hospital or nursing home with a pre-authorization letter or guarantee of payment stating the amount assured as payable as well as the condition for which the patient is requesting admission.

9. After their complete satisfaction, Third Party Administrators (TPAs) will provide the hospital or nursing home with a pre-authorization letter or guarantee of payment stating the amount assured as payable as well as the condition for which the patient is requesting admission.

10. Finally, the doctor attends to the patient or policyholder until discharge and forwards the treatment bill and discharge voucher, along with the related expenses, to the Third-Party

[15] Prof. M.N. Mishra, Law of Insurance, 19th Edition, Central Law Agency, 2017.

Administrators (TPAs) upon completion of the treatment. After submitting the claim to the insurance provider, the Third-Party Administrator (TPA) gets the money back. This is called Cashless Hospitalization or Cashless Services.

11. A hospital will not accept a cashless claim unless the Third-Party Administrators (TPAs) provide the pre-authorization letter. Therefore, in order to get the authorization letter, the insured must actively pursue communication with the Third-Party Administrators (TPAs).

12. The insured must first pay for the costs out of pocket before filing a claim with the Third-Party Administrator (TPA) or insurance company if the letter from the TPAs is not received or if they reject it.

13. Since the insured has enough time to follow up with the Third Party Administrators (TPAs), obtaining pre-authorization in the event of a planned hospitalisation is simpler. Emergency hospitalisation presents a dilemma. Here, time is of essence. Without approval from Third Party Administrators (TPAs) or payment from the insured, the hospital will not begin treatment.

14. This causes a panic, and frequently the insured are compelled to pay out of pocket before claiming the money from the insurance company or Third-Party Administrators (TPAs) in the regular order of events because of an emergency. Third Party Administrators (TPAs) have been observed to frequently postpone the permission procedure in order to force customers to pay out of pocket before requesting reimbursements.

15. Generally, authorization is given by the Third Party Administrators (TPAs) for a specific sum. If the patient's costs for treatment are more than that, they must come out of their own pockets. If the insurance company reimburses them, they will do so as long as their claims stay within the policy's limits.[16]

The insurance company or Third-Party Administrators (TPAs) will grant authorization if the hospital where the patient is being admitted is on their approved list. This indicates that the hospital has been given the go-ahead to treat the patient and submit the bills for payment to them. This is a cashless settlement instance.

They will grant permission to proceed with treatment at the hospital if the facility where hospitalisation is scheduled is not on the approved list. In this case, the insured pays the invoices and then sends them to the Third-Party Administrators (TPAs) in order to get

[16] Agarwala Rakesh, (2009), p.34-35, Health Insurance in India: A Review 1st ed. The Insurance Times,Kolkata.

reimbursed. It indicates that while the course of treatment is authorised, a cashless settlement is not required.

❖ **Non-Cashless/Emergency Hospitalization:-**

In an emergency, the insured should be taken to any hospital as soon as possible for treatment in order to save his life. Within seven days of being admitted to the hospital, the insured or his friends or family have an obligation to speak with the insurance company or Third-Party Administrators (TPAs) by phone or in writing on the claim. Included in the notice ought to be the following:

a. Name of the patient
b. Policy number
c. Health ID card number
d. Address of patient
e. Name of the attending doctor
f. Name of hospital
g. Nature of illness/injury

The patient may need to be transferred to a hospital that has been approved by Third Party Administrators (TPAs) as and when doctors approve. Third Party Administrators (TPAs) generally believe that treatment shouldn't take place in a hospital with less than 15 beds since the facilities might not be enough.

Thus, in this case, Third Party Administrators (TPAs) have two options: either they ask the insured to pay the hospital directly and submit the invoices for reimbursement, or they can pay the hospital directly where the patient was admitted in an emergency. The hospital's cost will be paid directly by the Third-Party Administrators (TPAs) if the patient is transferred to one of their approved hospitals after a few days. Additionally, the final claim must to be filed with the business within 30 days following the insured's discharge.

Along with the company's prescribed claim form, the following documents must be attached:

1. Original prescription of doctor.
2. Prescription of doctor advising for hospitalization/tests.
3. Original reports of all diagnostic tests along with the original bills like X-rays, ECG, Scan, MRI, Pathology etc.
4. Detailed itemized bill from the hospital for bed charges, OT charges (Operation Theatre), Medicines and details of any other charges that the hospitals have levied.
5. Surgeons certificate stating nature of operation along with bill.
6. All bills for medicine purchased during the previous 30 days before

hospitalization and after discharge.

7. Hospital/Receipts/Bills/Cash memos in Original (Copies of charge slips if payment is made by credit card) duly stamped.
8. Discharge certificate from hospital.
9. Certificate from the doctor that the patient is fully cured and is able to resume his work.
10. A certified nurse's report from visiting the patient at home, backed up by a doctor's certificate, in the event of a domiciliary hospitalisation.
11. Copy of current insurance policy and previous policy.
12. F.I.R. in case of accidental injury.
13. The claim form needs to be completed accurately, with no information overlap, or else the claim could be denied.
14. The claim form needs to be completed accurately, with no information overlap, or else the claim could be denied.
15. The policyholder must retain a copy of the claim form and the original papers filed with it, since the original documents are submitted with the claim form. In order to verify that the documents were submitted, he needs to get an acknowledgement from the insurance copy at the time the claim form is submitted.
16. The policyholder is required to check in with the insurance company periodically to inquire about the claim's status, as the insurance company might need additional documentation or explanations from the hospital regarding the charges.
17. If the insurance company finds everything is in order, the claim will be paid. Frequently, it subtracts certain amounts from the bill that are either not permitted by the policy or appear to be excessive.

The cost of using Third Party Administrators (TPAs) is borne by the insured and is covered by the insurance company's premium. If the policyholder agrees to submit claim bills directly to the insurance company and does not require Cashless facility through Third Party Administrators (TPAs), certain insurance companies will offer a discount on premiums of 5-6%.

IV. Pre and Post Hospitalization Expenses:-

Pre-hospitalization charges are defined as appropriate medical costs incurred up to 30 days prior to a patient is admitted to the hospital/ domiciliary hospitalization for a condition requiring more than a 24-hour stay.

Post-hospitalization expenses are defined as appropriate medical costs resulting from a disease, illness, or accident that are incurred within 60 days following the date of hospital discharge.

The medical treatment of policyholder will not be covered by the plan if they have a critical illness or condition while they are taking out a health insurance. For the first year of the coverage, there are some significant surgical operations that are not covered by health insurance.[17]

The hospital will receive payments from the policyholders for any expenses that exceed the permitted limit set by Third Party Administrators (TPAs). When admitting a patient to a non-network hospital, the insured must confirm that the hospital meets the necessary requirements. A hospital or assisted living facility is often required to have fifteen inpatient beds, a fully furnished operating room, and personnel who are fully qualified.

V. Network/Non-Network Hospitals:-

Network hospitals are those which have a tie-up arrangement for cashless claim processes with insurance companies and Third-Party Administrators (TPAs). The insurance company or TPA pays the insured directly when they receive cashless care at any of these network hospitals.

The hospitals that do not have a cashless tie-up arrangement with the insurance company or TPA are known as non-network hospitals. An insured patient must pay for any care received at non-network hospitals on their own and then submit all necessary paperwork to the insurance company or Third-Party Administrators (TPAs). After the procedure, the claim amount is then refunded in accordance with the terms and conditions of the policy.

Large claims are denied due to a pre-existing condition, whether the insured is aware of it or not. When providing information regarding their prior medical history to their consulting physician, the insured should use caution. The claim can be denied if the physician mentions any pre-existing disorders or diseases in their notes.

[17] https://www.irdai.gov.in/

The policyholders are protected under Insurance Regulatory and Development Authority (IRDA) policyholder protection regulation 2002. Within 30 days of receiving all the documentation requested by the insurance company, they must either approve or deny the claim.

If the insurance company refuses to pay a claim, customers have two options: they can file a grievance with the Insurance Regulatory and Development Authority (IRDA) or complain to the insurance ombudsman. Since Third Party Administrators (TPAs) have not approved investigations, evaluations, or health check-ups, policyholders should not insist on being admitted to the hospital for these purposes alone.

VI. Issues & Challenges before Third Party Administrators (TPAs)

Third Party Administrators (TPAs), insurance intermediaries, have been made possible by the Insurance Regulatory and Development Authority (IRDA). TPAs are anticipated to be essential in the establishment of managed care systems. Third Party Administrators were established to guarantee improved services for subscribers and to reduce the drawbacks associated with private health insurance. However, Third Party Administrators confront tremendous difficulties due to the supply and demand side complexity of the healthcare and private health insurance sectors. The Insurance Regulatory and Development Authority of Indai (IRDAI) initially defined the function of Third-Party Administrators (TPAs) as managing claims and reimbursements; their role in regulating healthcare costs and guaranteeing proper quality of care is still unclear.[18]

When it comes to handling claims and payments, Third Party Administrators (TPAs) are only as good as their bargaining strength when it comes to healthcare service providers. It is anticipated that Third Party Administrators (TPAs) will be able to adopt better monitoring systems and negotiate better deals with hospitals and doctors, which will result in reduced claim ratios.[19] However, Third Party Administrators actually confront a great deal of difficulties in accomplishing these objectives. Revenue generation for Third Party Administrators (TPAs) is inevitably impacted by managing claims and reimbursements in highly fragmented, unregulated markets and interacting with numerous small-sized healthcare service providers. It will be necessary for Third Party Administrators (TPAs) to hire managers and medical management specialists who are skilled at negotiating with a wide range of healthcare service providers. It will be difficult to negotiate prices and levels of service quality because healthcare

[18] IC 27, Health Insurance, Insurance Institute of India, 2013 (Reprint 2021).
[19] Asis Kumar Bandyopadhyay, Health Insurance in India:- Problem and Prospects, Scholar Press, 2013.

providers are not subject to regulations and there is no information available on numerous operational aspects of healthcare facilities, such as occupancy rates, duration of stay, etc.

There are undoubtedly problems with the TPA system's operational features, such as the wait times for claim settlements and pre-authorization approval. A wide range of challenges await Third Party Administrators (TPAs), including but not limited to upholding a delicate balance between insurance companies, healthcare providers, and policyholders; intense pressure from the insurance companies to maintain a low claim ratio; significant disputes with healthcare service providers; and the investigation and reduction of false claims.

Third Party Administrators (TPAs) are prohibited from marketing health insurance products in accordance with IRDAI norms. This creates a conflict of interest between TPAs and policyholders as well as between TPAs and the insurance companies.

The operating risk for Third Party Administrators (TPAs) to achieve the economies of scale required to break even is significant. Volumes are important since the number of policies Third Party Administrators (TPAs) take on to administer determines how much money they make. Since the insurance company requires the Third-Party Administrators to administer and process less claims, there is a serious conflict of interest between TPAs and the companies. On other side, the Third-Party Administrators attempt to file more claims in order to receive their commission, which is determined by a fixed percentage of the policy premium.

Lack of uniform standards for geographically dispersed healthcare providers and the inability to set standards of care without their involvement make it difficult for Third Party Administrators (TPAs) to obtain information on disease management and cost/pricing policies. A significant portion of consumers have been shown to be unaware of the terms and features included in the policies. When taking medication, people attempt to make claims for which they are not eligible, which causes disputes between policyholders and insurance companies.

Since TPAs act as guarantors of facilities and reimbursements between the insurer and the provider of healthcare services, the Insurance Regulatory and Development Authority (IRDA) has the authority to revoke the license of TPAs if their financial performance declines at any point of time.

The social responsibility component of IRDAI requires health insurance companies to establish a sizable presence in rural areas. Therefore, Third Party Administrators (TPAs) would be mandated by the insurance companies to establish infrastructure in rural areas and manage the health needs of the rural population by giving them convenient access to medical care, prescription drugs, and treatment for a range of illnesses. Third Party Administrators will have a difficult time handling the rural market.

Third Party Administrators (TPAs) are expected to have an impact on changes in the health sector, as evidenced by their recent expansion and performance. The extent of their effect will depend on their roles and responsibilities towards clients and insurance companies. The Insurance Sector still has difficulties institutionalizing TPA services despite the TPAs' offerings, and there is a lot of room for development.[20]

Conclusion

In order to guarantee improved services for insurance companies, healthcare providers, and insured patients, the IRDAI developed TPAs as a new insurance service provider and management system. The IRDAI specifies the roles and codes of conduct that they must follow. It is the TPA who provide cashless facilities to the insured on behalf of the insurance companies and regulated by the IRDAI. Thus, the purpose of this study was to investigate the function of TPAs. The study assessed how TPAs offer a range of basic and value-added services, rationalize and streamline the claims procedure, manage information storage, offer medical professional services, offer no additional costs, etc. However, there are some failures as well. These include low TPA awareness of policy exclusions and inclusions, delays in claim settlement, claim rejection, poor service quality, additional indirect costs to customers that result in higher insurance premiums and healthcare costs, a variety of issues that policyholders face related to or connected to TPAs, and increased management costs. However, overall, based on primary and secondary statistics, it can be said that TPAs are a successful service management model and perform better than insurers in the constructed system when it comes to offering a variety of services linked to health care. But in order to address various issues pertaining to the TPA system's operation, some changes and enhancements must be made in order to raise its efficacy and efficiency.

[20] Bhat Ramesh, et al. Jan (2005), p.2, *Third Party Administrators and HealthInsurance in India: Perception of Providers and Policyholders.* [Online] IIM Ahmedabad. Available from: http://www.iimahd.ernet.in/Publications/data/2005-01-02.pdf.