Introduction

God heals and the Doctor takes the fees.

Benjamin Franklin

In today's scenario medical care is expensive and costs are zooming upwards day-by-day. A person acquires medical insurance for the same reason as other kinds of insurance - to protect oneself financially. By going in for medical insurance, you can protect yourself and your family if struck by disease. While no one wants to fall ill, the last thing one wants to worry about when is whether one will be able to afford good medical care. On the other hand, if you have been prudent enough to obtain insurance, many of your costs can be covered by a third-party payer, namely, the insurance company, thus relieving you of considerable anxiety and concern.

The traditional form of health insurance is called indemnity insurance (also known as fee-for-service), in which the insurer pays for the cost of covered health care services after they have been provided. In most indemnity insurance plans the patient is free to choose his own doctor or hospital.

In India, the insurance business is still a monopoly, so that, for all practical purposes, the only medical insurance policy available for most of us is **MediClaim**, through the subsidiaries of the General Insurance Corporation (GIC). The government does have special schemes for its employees: the ESIS (Employee State Insurance Scheme) and the CGHS (Central Government Health Scheme). Many employers now provide medical insurance as a standard perquisite to many of their employees - this is called group insurance - and the premium is less than a stand-alone personal insurance policy. In many cases, the employer pays part of the cost or all of it. Not all employers, however, offer health insurance. Your employer may not subscribe to a health insurance scheme,

especially if you work for a small business or work part-time. In such a situation, you might still be able to obtain group insurance (and thus save money) through a labor union, a professional association, club, or any other organization you belong to. However, if this is not possible, then you will need to obtain coverage for yourself (and your family) on your own by taking out a personal policy.

Given the fact that the insurance business in India is still a monopoly, the only decisions one will need to make are very simple: whom to insure (some or all the members of the family); and how much to insure for. This situation is in sharp contrast to that in the USA, where there are a wide variety of medical insurance schemes on offer --- and choosing between HMOs (health maintenance organizations) and PPOs (preferred provider organizations) can leave most patients very confused! While taking out a policy is a simple matter (after all, the insurance company is happy to earn the premium you pay!) getting reimbursement for the expenses you incur can be a tedious process; the company does not want to part with their money.

In the future, with increasing liberalization, as the insurance business in India is opened up to the private sector, many more options will become available for patients to choose from.

About Mediclaim

Ram Sharma was content he was retiring after he had saved enough for his daughter's marriage and his son's higher education that would land him a plum job abroad. Despite his happy frame of mind he couldn't help but notice the sharp chest pain. He complained to his son who rushed him to the nearest hospital that diagnosed the acute angina and recommended the cardiac bypass urgently. The surgery was successful .The cost: Rs two lakh! Mr. Sharma's wonderful dreams for his family are shattered into nightmares.

Though this is fiction, a similar situation is quite possible in any family that has not planned for sudden hospital expenses that are not negligible any more. For some the tragedy does not end there. Unable to arrange the huge amounts required for hospitalization the poor man resigns himself to his fate.

In this tragedy lies a great paradox. India is blessed with the best of hospitals having the most sophisticated equipment with our doctors having acquired skills abroad and yet the common man from India is unable to access this type of medical care only because of one reason, and that is money. The solution to this lies in the form of Mediclaim policy.

Mediclaim Policy

Medical insurance is commonly known as mediclaim in India. This type of policy covers, up to the limit contracted for, expenses with respect to hospitalisation and treatment. The expenses covered by mediclaim are room and boarding expenses, nursing expenses, fees for the surgeon, anaesthetist, medical practitioner and consultant, fees for specialists, charges for anaesthesia, blood, oxygen and the operation theatre, charges for surgical appliances, medicines and diagnostic materials and charges for X-rays, dialysis, chemotherapy and so on.

The policy works in a slightly different manner as compared with other life insurance policies. This policy can be taken for one year at a time. When you pay the premium for one year, you get a medical insurance for that year. You can renew the policy every year

as per your needs. For instance, let us assume that a person buys a Rs one lakh mediclaim policy for this year by paying a premium. In case the person is hospitalised, the insurance policy will cover the expenses. There are two ways in which the policy amount is paid. In some cases, the insurer may have a tie-up with the hospital concerned and in such cases, the expenses are settled between the insurance company and the hospital. This is called cash-less settlement. In other cases, you will have to first pay the expenses and then claim a reimbursement from the insurer.

Suitable for

This insurance policy is ideally suited for

- Each and every person aged between 5 and 75 years of age. Children aged between 3 months and 5 years have to be insured along with their parents.
- Government or private institutions for their employees.
- Clubs or associations for their bona-fide members.

Risks covered

This insurance policy protects the insured from the risks of illness or disease or accidental injury sustained.

Compensation offered

This insurance policy provides compensation for

- Hospitalisation expenses based on actuals and subject to the sum insured.
- Domiciliary hospitalisation charges based on actuals and subject to the sum insured.

Exclusions

This insurance policy does not pay any claims arising from

- Pre or post hospitalisation treatment of asthma, chronic nephritis, gastroenteritis, diabetes, epilepsy, hypertension, influenza, cough or cold, psychiatric or psychosomatic disorders, pyrexia, tonsillitis, arthritis, rheumatism or any treatment relating to any illness/ disease already in existence at the time of treatment.
- Any disease or injury within 30 days of commencement of policy except accidental injury.
- Cataract, benign prostatic hypertrophy, hysterectomy for menorrhagia on fibromyoma, hernia, hydrocele, congenital internal disease, fistula in anus, sinusitis and related disorders in the first year of cover under the contract.
- Vaccinations, inoculation, circumcision, change of life, cosmetic or aesthetic treatment, plastic surgery unless the treatment necessitating hospitalisation is necessary.
- Costs of spectacles or contact lenses or hearing aids.
- Convalescence, general debility, sterility, venereal diseases, intentional self-injury or use of intoxicants.

- Any variation of AIDS.
- Hospital/ nursing charges inconsistent or non-incidental to the diagnosis or treatment.
- Vitamins or tonics not forming part of the treatment.
- Any treatment related to pregnancy, childbirth or voluntary termination of pregnancy during the first 12 months after pregnancy.
- Nuclear or war perils.
- Naturopathy treatment.

This policy is offered by:

- National Insurance Company Ltd. (NIC)
- The Oriental Insurance Company Ltd. (OIC)
- United India Insurance Company Ltd. (UIIC)
- The New India Assurance Company Ltd. (NIAC)

Claim Procedures Under Mediclaim

Under Mediclaim, in case of hospitalisation, the policyholder should primarily ensure that the health insurance company is informed within 7 days of the hospitalisation.

The preliminary notice submitted to the health insurance company should contain the following particulars:

- Name of the insured person
- Policy number

- Nature of illness and/ or injury
- Name and address of the attending physician
- Name of the hospital or nursing home

On discharge from the hospital, the hospital issues a discharge card. The health insurance company will scrutinise the claim on the basis of this discharge card, which has to be submitted to the health insurance company.

There are other documents that have to be submitted to the health insurance company

- Hospital receipted bills
- Other documents specified in the claim form
- Ensure that all the medicines you purchase have valid prescriptions.

Third Party Administrators (TPA)

Third party administrators are the intermediaries in the sector who were introduced to benefit both the insured and the insurer. While the insured is benefited by better service, insurers are benefited by reduction in their administrative costs.

Insurers can now outsource their administrative activities, including settlement of claims, to Third party administrators, who offer such services at a cost. It may be noted that the insurers remunerate TPAs and so policy holders should welcome such a move since they receive enhanced facilities at no extra cost. Once the policy has been issued, all the records will be passed on to the TPA and all the correspondence of the insured will be with the TPA.

To put in short, the job of the TPA's is to maintain databases of policyholders and issue them identity cards with unique identification numbers and handle all the post policy issues including claim settlements. In terms of infrastructure, the TPA's run a 24-hour toll-free number, which can be accessed from anywhere in the country. And they will have full-time medical practitioners under their employment who will immediately take a decision on whether the ailment is covered under the policy.

TPA license can be granted to any company registered under the companies Act 1956. IRDA, which licenses and regulates these TPAs, has specified stiff entry norms some of which include a minimum capital requirement of 1 Crore, capping the foreign equity at 26% etc. License is usually granted for a period of 3 years.

Third party administrators regulations

Presently TPA licenses are issued to render health services. It is hoped that effectively this will lead to cash less hospitalisation services. In contrast to earlier scenario where the insured is reimbursed all the hospitalisation expenses, in the present scenario TPA would tieup with the hospitals and all the hospitalisation services would be on cash less basis. Below is an overview of the activities of TPA

- All the records of medical insurance policies of an insurer will be transferred to the TPA.
- TPA may issue identity cards to all the policyholders, which they have to show to the hospital authorities before availing any hospitalisation services.
- In case of a claim, policyholder has to inform TPA on 24 hr toll free line provided by the TPA.
- On informing the TPA, policyholder will be directed to a hospital where the TPA has a tied up arrangement. However policyholder will have the option to join any other hospital of his choice, but in such case payment shall be on reimbursement basis.
- TPA issues an authorisation letter to the hospital, for the treatment wherein the TPA will pay for the treatment.
- TPA will be tracking the case of the insured at the hospital and at the point of discharge, all the bills will be sent to TPA.
- TPA makes the payment to the hospital.
- TPA sends all the documents necessary for consideration of claims, along with bills to the insurer.
- Insurer reimburses the TPA.

To offer their services TPAs, after getting license have to forge alliances with insurers. To this extent TPAs have no role to play if they are not empanelled by Insurers. As discussed earlier TPAs will be remunerated by insurers and remuneration shall be fixed on a mutually agreeable terms. However IRDA has laid down a maximum ceiling on the commission that can be given to a TPA, which presently stands at 15% of premium amount. TPAs shall also have to tie-up with hospitals, which offer hospitalisation services. Further each TPA may tie-up with any number of insurers and like wise each insurer can empanel any number of TPAs.

The above relates to roles and activities of a TPA in case of medical insurance policies. However, in the days to come, TPA services may well be extended, but not limited, to the following:

- Documentation and policy issuing.
- Legal services and claims recovery services under subrogation rights.
- Record verification under adjustment policies
- Medical examination services for life insurance policies and overseas mediclaim policies.
- Co-insurance recovery services for both premiums and claims.
- Follow up of recoveries from reinsurance companies.
- Servicing of motor policies
- Inspection and assessment of risk prior to issuance of policy.
- Arbitration services.

Current Scenario

The current statistics on health insurance indicate that out of 1 billion population only about 2 million of population is covered by Mediclaim scheme. The reason for lack of popularity of this scheme could be several which we will discuss later. Also on the other hand the growth is there as health insurance products are greatly in demand and have sustained a growth rate of 25 per cent to 35 per cent since the last three years. While there has been an overall slow growth in life and non-life insurance products due to a slew of economic factors, the one single product that has not lost steam is Mediclaim Policies. This makes us wonder whether the claim made in terms of growth are real since medical premium in itself has undergone an upward revision and TPA's cost on account of providing cashless service has also been factored into this.

The claims ratio is 200 per cent in case of pampered corporates, especially IT companies. These companies are insured for everything such as fire insurance, marine insurance, assets such as computers and servers besides medical insurance of their employees. The insurance company makes good profit obtained as premium from these products and is so willing to bear the loss obtained from health insurance product

A spiraling rise in the claims ratio of mediclaim policy from 94 per cent in 2002 to 140 percent this year, despite health insurance's limited spread, has awakened the insurance regulator to review its two decade-old healthcare policy allegedly having widely exploited loopholes. While the policy and the products are not in tune with the times, regulation in the sector remains largely on paper, with Mumbai registering the highest claims indicating systematic malpractice.

For the review, the Insurance Regulatory Development Authority (IRDA) has recently formed a 'health insurance working group' with the assistance of USAID. The group's mandate is to suggest ways and means to increase the reach of health insurance in the hitherto neglected semi-urban and rural areas. It is also looking into the ways and means

to develop a health insurance database to enable insurers to price their policies more scientifically based on the morbidity patterns.

The provision pertaining to ‘the exclusions’ clause in existing mediclaim policies and its variants available in the market is also being examined as a large number of grievances remain pouring in where insurers blatantly reject genuine claims citing existence of 'pre-existing diseases' which is an exclusion under the policy.

Problems

Although the concept of Mediclaim is very good and beneficial to people, still there are certain hitches in the success of this policy.

Some of the reasons that make this scheme not so popular can be cited as:

- The health insurance products are generally complicated and it is suggested that GIC and its subsidiary companies who deal in non-life insurance market, which is dominated by mandated insurance such as accident, fire and marine, do not have expertise in marketing health insurance and therefore this scheme is not popular. Due to lack of marketing efforts vast section of people are not aware of this scheme.
- Health insurance also represents very small percentage of overall business of GIC and its subsidiaries hence they have also not focused their attention in this area. The GIC companies have little interest and means to monitor the scheme.
- Also because of technicalities of health service business there are number of cumbersome rules which have hampered the acceptance of the scheme. It is also reported that in number of cases the applicants of older ages have been refused to become member of mediclaim scheme due to unnecessary conservatism of the companies.
- Mediclaim has provided a model for health insurance for the middle class and the rich. It covers hospitalization costs, which could be catastrophic. But given the premium is on higher side it has remained limited to middle class, urban tax payers segment of the population

Certain interviews and research was conducted to find the various problems, which arises in Mediclaim policies. A study of these problems can help in improving the implementation of this policy and make this concept a success.

Problems Faced By the Insurer

There are reported fraud and manipulation by clients and providers, which have implications for the growth and development of this sector. Medical mal-practices by doctors, consultants and hospitals are bleeding insurance companies. Also clients indulge in malpractices by availing treatment for a person in the family who might not be covered in the policy.

The monitoring systems are weak and there are chances that if the doctor and patient collude with each other, they can do more harm to the system. There is also an element of adverse selection problem as the scheme is voluntary.

One of the major problem is that there is no regulatory body to keep a watch on healthcare providers. Also when a person buys a policy, no HIV test is done. Besides, the pre-medical tests are also minimal. As an outcome of an unregulated healthcare market in India, whether it is a cashless service or reimbursement directly to the policy holders, medical billing has gone beyond all reasonable norms and ethics of the health domain

It is noted that of the 100 per cent mediclaim policyholders, 50 per cent are individually insured, while the remaining 50 per cent are employees of corporates. Paradoxically, this employee population too contributes considerably to the loss ratio of health insurance. Severe competition has brought down the price of corporate policies, eroding the actuarial premium base. Therefore skewed claims ratio is due to corporate mediclaim policies.

Also a factor worth noticing is that Corporate mediclaim policies are offered at rates lower than the government promoted Universal Health Insurance Scheme, which public sector insurers are ready to shun stating that they are non competitive.

There is a heavy cross subsidy from Fire and Engineering portfolios of the non life insurers towards health insurance portfolio owing to the existence of a tariff regime. Corporates use health insurance as a bargaining tool while deciding to offer the more lucrative and profitable portfolios of Fire and Engineering to the insurance companies."

As a result health premium in overall quantum terms for the same numbers decrease, claims cost either remain static or increase thereby adversely affecting the claim ratio, and TPAs fees which are linked to premium gets reduced while their workload increases in view of increase in number of claims being reported.

Hospitals have learned to manipulate and health insurance is turning into a loss-making product with 80 per cent to 100 per cent being the premium percentage while 140 per cent to 200 per cent being the claims amount. If this trend continues, insurance companies will have to pay five times the premium.

The deterioration in the performance on the mediclaim portfolio was despite the incentive mechanism built into the contractual agreements between insurers and the TPAs for containing claims ratio. These incentives range between 10 per cent and 20 per cent, for claims between 60 per cent and 30 per cent respectively of the premium collection. In fact, the insurance regulator, which had pushed through the TPAs mechanism, had argued that the claims ratios in medical insurance would substantially reduce TPAs were expected to help contain these high ratios through a mechanism of filtering. However, the TPAs have failed in containing claims, two years after the entire mechanism began functioning TPAs' reluctance to pass on the customer data back to the insurers has now resulted in major problems preventing the insurers from loading the premiums to segments where the claims ratios were high.

In recent times there has been some court ruling which again imposes some regulations on insurers. A Letters Patent Appeal and Special Civil Application filed by CERS and others against three government companies — United India Insurance Company, New India Assurance Company and National Insurance Company — has led to a landmark judgement from the Gujarat High Court. Justices RK Abichandani and DA Mehta

directed the insurance companies to renew the Mediclaim policies on existing terms and conditions as a matter of course.

Briefly, the judgement says that so long as a person pays renewal premium on time, the insurer is bound to renew a Mediclaim policy without excluding any disease already covered under the existing policy, which may have been contracted when it was in force. Second, a policyholder should also be allowed to raise the insurance amount, but the company may exclude coverage on some diseases, only on the increased sum. Third, insurance companies cannot refuse to renew a policy by claiming that the cover would become onerous and burdensome, because the policyholder has contracted a disease covered under an existing policy. Fourth, they can only refuse to renew a Mediclaim policy on the grounds of misrepresentation, fraud or non-disclosure of material facts that existed at the inception of the contract. And fifth, that government insurance companies, cannot "arbitrarily cancel or refuse to renew an existing Mediclaim policy" simply because their monopoly has ended and they face competition from private players

Problems Faced by the Insured

There have been many cases reported where apart from its callousness, the insurance company appears to start out on the presumption that all policyholders are cheats, without even an investigation, interaction or background check.

Many a times the insurance claims are rejected due to some small technical reasons, which leads to disputes. Most of the time the conditions and various points included in insurance policy contracts is not negotiable and these are binding on consumers. There is no analysis on what is fair practice and what is unfair practice. Given that insurance companies are large and almost monopoly setting the consumers is treated as secondary and they do not have opportunity to negotiate the terms and conditions of a contract. Many times insurance companies do not strictly follow the conditions in all cases and this creates confusion and disputes.

The existing mediclaim covers only in-patient and hospital domiciliary expenses, thus making consumers shoulder financial burdens arising from out-patient expenses.The most important area of dispute and unfair treatment is the knowledge and implications of pre-exiting conditions. A number of cases of litigation are disagreement on these pre-existing conditions. These problems also arise because of lack of specification of number of areas and properly spelling out the conditions. This is also because some chronic conditions such as high blood pressure and diabetes can increase the risk of many other disease of organs such as heart, kidney, vascular and eyes diseases. The patients with these pre-existing conditions are denied claims for treatment of complications. This is not fair and leads to disputes.

The manner in which the GIC premiums are changed from one year to the next is clever in that it ensures that the corporation does not have to take in premiums that are persistently below claims. Even the high margin of GIC premiums over claims understates the true margins. Subsequent-year premiums are calculated on the basis of

incurred claims, not on paid claims. If the claims are eventually denied the difference would apparently go unreconciled while adjusting future premiums. Besides increasing profit margins this feature builds in an incentive for the insurers to delay payment on claims. This is one of the major complaints against the GIC's Mediclaim policy.

Health insurance is typically annual and has to be renewed yearly. Policy, which is not renewed in time lapses and a new policy has to be taken out. Medical conditions detected during the interim period are treated as pre-existing condition for the new policy, which is not fair. This is seen as major issue as it changes the conditionalities about what constitutes pre- exiting conditions. Courts, however, have ruled that even if there is delay in renewing the policies it should be considered as renewed policy. In case two doctors give different reports one favoring consumer and other insurance company, the insurance company generally follows the later opinion. There are several such consumer-related issues, which need to be addressed in health insurance.

For most policyholders, the problems become apparent only when an actual claim is made. A policyholder finds that once a claim has been made, no other insurer wants his/her business. They can only renew the policy by paying a hefty increase in premium and/or by permitting the pre-existing condition from the list of illnesses/diseases insured.

There are several social issues such as exclusions of sexually transmitted diseases, AIDS, delivery and maternal conditions etc. These are not socially and ethically acceptable. Insurance companies must take care of all the risks related to health. The companies may charge additional premium for certain conditions.

The present mediclaim policy premiums are high and do not differentiate between people living in urban and rural areas where the costs of medical care are different. Thus the present policy is less attractive to poor and rural people. The tax subsidy provided to the mediclaim is also going largely to the rich who are the taxpayers. The newer health insurance policies have to improve upon the shortcoming of the existing policies. Also the existing Mediclaim structure does not properly serve the large segment of population engaged in low-paid informal activities.

The TPA was expected to ease matters for the insured person by paying the hospital and collecting the amount from the insurance company. The services of a TPA used to add roughly 7-10 per cent to the premium, but some people were willing to pay for the convenience. But increasingly hospitals don't want to deal with TPAs and have been insisting on cash payments by the insured persons. This has meant that policyholders who paid a higher premium are not even getting the contracted service. Some of the others concerns of insured people because of TPAs are:

- It has been seen that it's really difficult to get through the telephone lines of the call centres of the TPA and even if you get through there are different persons attending to you at different times. The management of TPAs are also totally unapproachable. Even if you are able to get your phone through to the call centre, they refuse to let you speak to the managers of the TPA. Many a times the call centre representatives are ill equipped to answer the queries, and requests to talk to higher ups are always negated.
- The full claim is never settled in one shot. Frivolous reasons are given to reject amounts. Even on sorting these out, claims are not settled. Further deductions are done again and again on fresh non-specific queries. This leads to unnecessary delays, paper work and frustration to the consumer. One feels that either the representatives passing the claims are not well educated or conversant or else its sheer negligence or irresponsible behaviour on their part.

Finally, there is a lot of uncertainty about the amount an insurer or TPA will reimburse and the time within which it will do the needful. This uncertainty discourages people to get insured.

Problems to the Uninsured

The consequences of this policy is not only limited to the insurer, insured person or the TPA, but the uninsured public is also affected by it.

As the scheme reimburses charges without limit it pushes up the prices of services in the private sector. Interviews with policy providers indicates wide variation of charges for same operation in the same city. Anecdotal evidence from doctors also indicates that charges are increased if patients are insured. All these effects will tend to increase the prices of private health care thus hurting the uninsured.

Problems Faced By Hospitals

Hospitals too have problems with TPAs as each hospital has its own policies. The matter of charging a patient is between the doctor and the patient.

TPAs jumped into the bandwagon thinking it's a profit making business. The major problem faced by the hospitals is that of timely payment. Many excuses cited by TPAs are bureaucratic. They cite reasons such as miss-spelt names and hospital signatures. Many TPAs don't mention in their authorisation letter the pre-existing illnesses because of which claims will be disallowed. They don't reimburse the hospital after the patient has used our services saying it's a pre-existing illness. The level of TPA performance can be attributed to a fast turnover of employees and poor infrastructure and response time, all TPAs do not have a 24-hour helpline, which they are obliged to.

The new standardized memorandum of understanding (MoU) to be signed between the TPA's and hospitals is not acceptable to all TPAs, with many in the industry feeling it is biased in favour of medical providers and against the insurers and their TPAs. They feel that hospitals have extracted unreasonable promises from the TPA's to honor their hospital bills timely. If failed, TPAs have to pay a penal interest of 12 per cent.

Besides, the hospitals under the proposed MoU have also avoided any kind of commitment to improve their system of hospitalisation insurance such as refusal on their part to screen patients for detecting pre-existing diseases excluded under the mediclaim policy at the time a patient seeks admission to the hospital. They do not agree to provide access to clinical papers, documents to the visiting physician appointed by the TPAs, in case they visit the hospitals before discharge of the patient.

Problems faced by TPAs

The aim of a TPA is to provide quality healthcare in a cost- effective manner at a reasonable and affordable price. To reduce costs various factors have to be considered, like:

- Volume of business: Regular referral to a set of providers gives concessions, which are then passed on, to the consumers.
- Certain common conditions where people get treated: With volume package deals for common surgeries/ailments like cataract, hysterectomy can be negotiated. For surgeries like these since the cost varies from place to place, prices are negotiable by paying lump sum.
- Strict scrutiny of provider bills whether managed care or existing product. And to facilitate efficient cost reduction by managed care companies, hospitals should:
- Be more efficient for the end result to be better, less complicated and reduce hospitalisation.
- Plan proper discharge planning and proper care management.
- In critical cases managed care company can manage this and see that the patient receives best treatment. For eg, in complicated cases, it is better to have two or more doctors work out. The medical team of TPA can intervene and decide.

Though the provider and TPA are amicable, the problem faced by TPAs is the billing pattern which differs from hospital to hospital. So it is difficult to scrutinise and speed processing by way of common billing pattern.

Another problem faced by the TPAs is that most of the tertiary care hospitals don't send documents along with the bills. The patients have to be followed up and that becomes a cumbersome task for the TPA. As for claims settlement insurance companies need reports of investigation, bills, discharge card, which has to be submitted by TPA. While time is lost in processing, TPAs suffer with their money stuck till reimbursed by insurance company.

Suggestions

To overcome the problems discussed in the report, the following steps should be taken:

- Simple proposal form
- Medical check-up before acceptance of the risk
- Family package cover: Mediclaim benefits, now available only to employees, their spouses and children, may be extended to dependent adults (perhaps just grandparents initially) for a supplementary premium
- Reduced premium level for people below 30 years
- Outpatient coverage
- Limit exclusions for pre-existing conditions
- Wide publicity about the coverage / exclusions under the policy
- Advertisement – during tax season and increase visibility
- Need for information bank
- Require greater monitoring of fraud and excessive fees: The government should make it mandatory for all insurance companies to devote more resources to monitoring fraudulent claims and establishing schedules of appropriate fees for specified procedures.
- Require greater efficiency in processing of claims: One of the planks on which the insurance has been deregulated is the gain in efficiency and passing on these benefits to the consumers. It is very unrealistic to assume that insurance companies will be able to gain efficiency, which helps them to reduce the price of schemes. At least one should not be expecting this thing happening in the short-run. But providing full information to the consumer and dealing with claims in a just and expeditious manner is the minimum expected outcome of the deregulation process. Consumers should be given a time schedule so that there is no uncertainty about the amount of reimbursement and the time within which they can hope for reimbursed. Delays in prepayment and arbitrary denial of claims need to be minimized

- Consumer organizations have to play very active role in future development of the health insurance sector in India.
- Once a letter is issued, the TPAs should not back out. Mediclaim is a good concept and can benefit the middle class by enhancing their reach to good hospitals. But one improvement, which can be done, is that every hospital should standardise the doctor's fees
- Insurance company officials should get involved in the process and not abdicate just because the TPAs are in the picture now. Association of Hospitals' (AoH) decision of not allowing TPAs or any other body to conduct accreditation formalities proves that they don't want anybody to look over their shoulders.
- Finally the discount on group insurance for large employers is unrealistically large. Revising the premium schedules will make health insurance more accessible to individuals from lower socio-economic categories.

One particularly nagging question is: What action can you take if the insurance company rejects a claim that you feel is valid? If the company refuses your claim, insist on a reply in writing, so that you can appeal against such rejection, say, to the consumer forum. You need to know how to stand up for your rights! Resubmit your claim in writing and express your views as to why you feel it should not have been rejected. Ensure that your problem is stated in a clear, concise manner. Also, do forget to include all appropriate documentation with the letter, including the following details: your policy number, relevant test results, medical records and doctor's statements that back up your claim. Most importantly, clearly state what action you want your insurance company to take to solve the problem. Keep copies of all your correspondence ! Don't be afraid to ask your physician and your insurance agent to contact the insurance company on your behalf. If your problem is not solved by your initial letter, you should appeal to a higher level within the insurance company. Remember that you are dealing with a bureaucracy and you will need to be persistent! You can fight for your rights, either by tackling the company itself, or through legal action, if need be.

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Conclusion

To sum up the main problems, which have been identified, are:

Problems faced by the insured

- Absence of provider network
- Getting admission in hospital of choice without payment
- Avoidable investigations
- Inefficient TPA operations
- Ignorance about pre-existing conditions
- Liquidation of assets for payment of bills
- Less involvement of insurance companies in claim settlement

Problems faced by the insurer

- Increasing trend in incurred claim ratio
- Inadequate pre-insurance health checkup
- Proposals are not filled up properly – in many cases vital information is held up
- Inefficient TPA operations
- Reluctance by TPA to pass on the customer data
- Younger people are not interested
- There is tremendous demand for the cover from elderly and sick people
- Overstay / avoidable investigations / overbilling by hospitals

One of the main reasons for the unpopularity of the mediclaim is Mediclaim is the lack of appropriate marketing efforts in selling these products. To popularize the schemes It is important that proper marketing is done. Government has taken steps to make the scheme more acceptable by exempting the premium paid by individuals from their taxable income. This provides 20-40% subsidy on the premium to taxpayers. Still efforts need to be made by all the parties involved ie insured, insurer, TPA, hospitals, etc to make harness this scheme to its fullest and make it a success.

The TPA business is relatively new in India and that is one of the reasons for the problems faced by policyholders. We can expect that as this model settles down, there will be a marked difference in the quality and service levels

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