CHAPTER 21

HEALTH INSURANCE CLAIMS

Chapter Introduction

In this chapter we will discuss about claim management process in health insurance, documentation required and the process of claim reserving. Apart from this we will also look into claims management under personal accident insurance and understand the role of TPAs.

Learning Outcomes

A. Claims management in insurance
B. Management of health insurance claims
C. Documentation in health insurance claims
D. Claims reserving
E. Role of third party administrators (TPA)
F. Claims management – personal accident
G. Claims management- Overseas travel insurance

After studying this chapter, you should be able to:

a) Explain the various stakeholders in insurance claims
b) Describe how health insurance claims are managed
c) Discuss the various documents required for settlement of health insurance claims
d) Explain how reserves for claims are provided for by insurers
e) Discuss personal accident claims
f) Understand the concept and role of TPAs

A. Claims management in insurance

It is very well understood that insurance is a '**promise**' and the policy is a '**witness**' to that promise. The occurrence of an insured event leading to a claim under the policy is the true test of that promise. How well an insurer performs is evaluated by how well it keeps its claims promises. One of the key rating factors in insurance is the claims paying ability of the insurance company.

1. Stakeholders in claim process

Before we look in detail at how claims are managed, we need to understand who are the interested parties in the claims process.

Diagram 1: Stakeholders in claim process

Customer	The person who buys insurance is the first stakeholder and 'receiver of the claim'.
Owners	Owners of the insurance company have a big stake as the 'payers of the claims'. Even if the claims are met from the policy holders' funds, in most cases, it is they who are liable to keep the promise.

Underwriters	Underwriters within an insurance company and across all insurers have the responsibility to understand the claims and design the products, decide policy terms, conditions and pricing etc.
Regulator	The regulator (Insurance Regulatory and Development Authority of India) is a key stakeholder in its objective to: ✓ Maintain order in the insurance environment ✓ Protect policy holders' interest ✓ Ensure long term financial health of insurers.
Third Party Administrators	Service intermediaries known as Third Party Administrators, who process health insurance claims.
Insurance agents / brokers	Insurance agents / brokers not only sell policies but are also expected to service the customers in the event of a claim.
Providers / Hospitals	They ensure that the customer gets a smooth claim experience, especially when the hospital is on the panel of the TPA the Insurer to provide cashless hospitalization.

Thus managing claims well means managing the objectives of the each of these stakeholders related to the claims. Of course, it may happen that some of these objectives can conflict with each other.

2. Role of claims management in insurance company

As per industry data- "the health insurance loss ratio of various insurers ranges from 65% to above 120%, with major part of the market operating at above 100% loss ratio". Most companies are making losses in health insurance business.

This means that there is a great need to adopt sound underwriting practices and efficient management of claims to bring better results to the company and the policyholders.

Test Yourself 1

Who among the following is not a stakeholder in insurance claim process?

I. Insurance company shareholders
II. Human Resource Department
III. Regulator
IV. TPA

B. Management of health insurance claims

1. Challenges in health insurance

It is important to understand the peculiar features of the health insurance portfolio in depth so that health claims can be effectively managed. These are:

a) Majority of the policies are for hospitalization indemnity where the subject matter covered is a human being. This brings forth emotional issues that are not normally faced in other classes of insurance.

b) India presents very peculiar patterns of illnesses, approach to treatment and follow up. These result in some people being excessively cautious with some others being unworried about their illness and treatment.

c) Health insurance can be purchased by an individual, a group such as a corporate organization or through a retail selling channel like a bank. This results in the product being sold as a standard commodity at one extreme while being tailored to satisfy needs of the customer at the other.

d) Health insurance depends on the act of being hospitalized, to trigger a claim under the policy. However, there is great difference in the availability, specialization, treatment methods, billing patterns and charges of all health service providers whether doctors, surgeons or hospitals which make it very difficult to assess claims.

e) The discipline of healthcare is the fastest developing one. New diseases and conditions keep occurring resulting in development of new treatment methods. Examples of this are key-hole surgeries, laser treatments, etc.
This makes health insurance more technical and the skills to handle the insurance claims for such procedure needs constant improvement.

f) More than all these factors, the fact that a human body cannot be standardized adds a completely new dimension. Two people could respond differently to the same treatment for the same illness or require different treatments or varying periods of hospitalization.

The portfolio of health insurance is growing rapidly. The challenge of such rapid growth is the huge number of products. There are hundreds of health insurance products in the market and even within a company one can find many different products. Each product and its variant has its peculiarity and therefore needs to be studied before a claim can be handled.

Growth of the health portfolio also brings about the challenge of numbers – a company selling 100,000 health policies to retail customers covering say, 300,000 members under these policies, has to be prepared to service about 20,000 claims at least! With the expectation of cashless service and speedy

settlement of claims, organizing health insurance claims department is a significant challenge.

Typically health insurance policies written in India cover hospitalization anywhere within the country. The team handling claims must understand the practices across the country to be able to appreciate the claim presented.

The health claims manager meets these challenges using expertise, experience and various tools available to him.

In the final analysis, health insurance offers the satisfaction of having assisted a person who is in need and is undergoing the physical and emotional stress of illness of himself or his family.

Efficient claims management ensures that right claim is paid to right person at the right time.

2. Claim process in health insurance

A claim may be serviced either by the insurance company itself or through the services of a Third Party Administrator (TPA) authorized by the insurance company.

From the time a claim is made known to the insurer / TPA to the time the payment is made as per the policy terms, the health claim passes through a set of well-defined steps, each having its own relevance.

The processes detailed below are in specific reference to health insurance (hospitalization) indemnity products which form the major part of health insurance business.

The general process and supporting documents for a claim under fixed benefit product or critical illness or daily cash product etc. would be quite similar, except for the fact that such products may not come with cashless facility.

The claim under an indemnity policy could be a:

a) Cashless claim

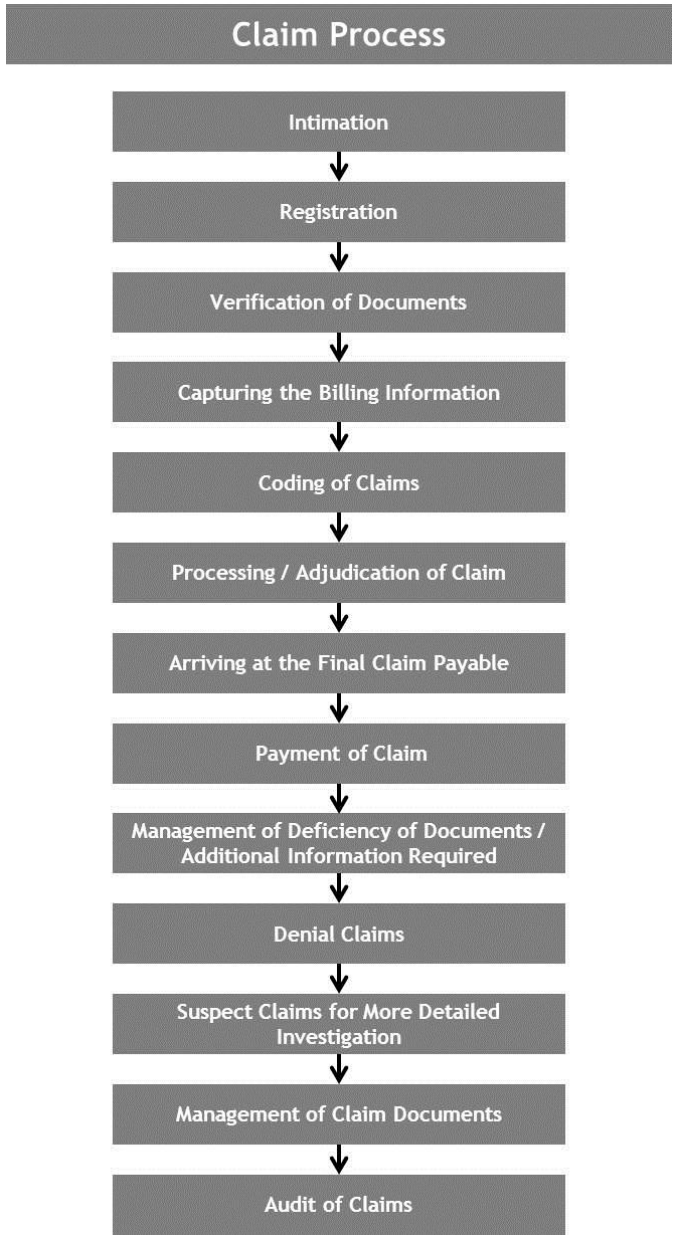
The customer does not pay the expenses at the time of admission or treatment. The network hospital provides the services based on a pre-approval from the insurer/TPA and later submits the documents to the insurer/TPA for settlement of the claim.

b) Reimbursement claim

The customer pays the hospital from his own resources and then files his claim with Insurer/TPA for payment of the admissible claim.

In both cases, the basic steps remain the same.

Diagram 2: Claim process broadly comprises of following steps (not in exact order)



a) Intimation

Claim intimation is the first instance of contact between the customer and the claims team. The customer could inform the company that he is planning to avail a hospitalization or the intimation would be made after the hospitalization has taken place, especially in case of emergency admission to a hospital.

Till recently, the act of intimation of a claim event was a formality. However, recently insurers have started insisting on the intimation of claim as soon as practicable. Typically it is required before hospitalization in case of planned admission, and within 24 hours of hospitalization in case of an emergency.

The timely availability of information about hospitalization helps the Insurer/TPA to verify that the hospitalization of the customer is genuine and there is no impersonation or fraud and sometimes, to negotiate the charges.

Intimation earlier meant 'a letter written, submitted and acknowledged' or by fax. With development in communication and technology, intimation is now possible through call centres run by insurers/TPAs open 24 hours as well as through the internet and e-mail.

b) Registration

Registration of a claim is the process of entering the claim in the system and creating a reference number using which the claim can be traced any time. This number is called Claim number, Claim reference number or Claim control number. The claim number could be numeric or alpha-numeric based on the system and processes used by the processing organization

Registration and generation of a reference no. is usually done once the claim intimation is received and the correct policy number and insured person's particulars are matched.

Once a claim is registered in the system, a reserve for the same would be created simultaneously in the accounts of the insurer. At the time of intimation/registration, the exact claim amount or estimate may not be known. The initial reserve amount is therefore a standard reserve (mostly based on historical average claim size). Once the estimate or expected amount of liability is known, the reserve is revised upward/downward to reflect the same.

c) Verification of documents

Once a claim is registered, the next step is to check for the receipt of all the required documents for processing.

It must be appreciated that for a claim to be processed following are the most important requirements:

1. The documentary evidence of the illness
2. Treatment provided
3. In-patient duration
4. Investigation Reports
5. Payment made to the hospital
6. Further advice for treatment
7. Payment proofs for implants etc.

Verification of documents follows a checklist which the claim processor checks out. Most of the companies ensure that such checklists are part of the processing documentation.

The missing documentation is noted at this stage – while some processes involve requesting for the documents not submitted by the customer / hospital at this point, most of the companies first complete the scrutiny of all the documents submitted before requesting for additional information so that the customer is not inconvenienced.

d) Capturing the billing information

Billing is an important part of the claim processing cycle. Typical health insurance policies provide for indemnifying expenses incurred in the treatment with specific limits under various heads. The standard practice is to classify the treatment charges into:

- ✓ Room, board and nursing expenses including registration and service charges.
- ✓ Charges for ICU and any intensive care operations.
- ✓ Operation theatre charges, anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and any medical expenses incurred which is integral part of the operation.
- ✓ Surgeon, anaesthetist, medical practitioner, consultant's, specialists fees.
- ✓ Ambulance charges.
- ✓ Investigation charges covering blood test, X-ray, scans, etc.
- ✓ Medicines and drugs.

Documents submitted by the customer are examined to capture information under these heads so that the settlement of claims can be done with accuracy.

Though there are efforts being made to standardize the billing pattern of hospitals, it is common for each hospital to use a different method for billing and the challenges faced in this are:

- ✓ Room charges can include some non-payables such as service charges or diet.

- ✓ Single bill can include different headings or a lump-sum bill for all investigations or all medicines.
- ✓ Non-standard names being used – e.g. nursing charges being called service charges.
- ✓ Use of words like "similar charges", "etc.", "allied expenses" in the bill.

Where the billing is not clear, the processor seeks the break up or additional information, so that the doubts on the classification and admissibility are resolved.

To address this issue, IRDAI issued Health Insurance Standardization Guidelines which have standardized the format of such bills and the list of non-payable items.

Package rates

Many hospitals have agreed package rates for treatment of certain diseases. This is based on the ability of the hospital to standardize the treatment procedure and use of resources. In recent times, for treatment at Preferred Provider Network and also in case of RSBY, package cost of many procedures has been pre-fixed.

Example

a) Cardiac packages: Angiogram, Angioplasty, CABG or Open heart surgery, etc.

b) Gynaecological packages: Normal delivery, Caesarean delivery, hysterectomy, etc.

c) Orthopaedic packages

d) Ophthalmological packages

Additional costs due to complications after surgery are charged separately on actual basis if incurred over and above these.

Packages have the advantages of certainty of the cost involved and standardization of the procedures and so such claims are easier to handle.

e) Coding of claims

The most important code set used is the World Health Organization (WHO) developed **International Classification of Diseases (ICD) codes.**

While ICD is used to capture the disease in a standardized format, procedure codes such as **Current Procedure Terminology (CPT) codes** capture the procedures performed to treat the illness.

Insurers are relying on the coding increasingly and Insurance Information Bureau (IIB), which is part of Insurance Regulatory and Development Authority (IRDAI), has started an information bank where such information that can be analyzed.

f) Processing of claim

A reading of the health insurance policy shows that while it is a commercial contract, it involves medical terms that define when a claim is payable and to what extent. The heart of claims processing in any insurance policy, is in answering two key questions:

- ✓ Is the claim payable under the policy?
- ✓ If yes, what is the net payable amount?

Each of these questions requires understanding of a number of terms and conditions of the policy issued as well as the rates agreed with the hospital in case treatment has taken place at a network hospital.

Admissibility of a claim

For a health claim to be admissible the following conditions must be satisfied.

i. The member hospitalized must be covered under the insurance policy

While this looks simple, we come across situations where the names (and in more cases, the age) of the person covered and person hospitalized do not match. This could be because of:

It is important to ensure that the person covered under the policy and the person hospitalized is the same. This kind of fraud is very common in health insurance.

ii. Admission of the patient within the period of insurance

iii. Hospital definition

The hospital where the person was admitted should be as per the definition of "hospital or nursing home" under the policy otherwise the claim is not payable.

iv. Domiciliary hospitalization

Some policies cover domiciliary hospitalization i.e. treatment taken at home in India for a period exceeding 3 days for an ailment which normally requires treatment at hospital/nursing home.

Domiciliary hospitalization, if covered in a policy, is payable only if:

- ✓ The condition of the patient is such that he/she cannot be removed to the Hospital/Nursing Home or
- ✓ The patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein

v. Duration of hospitalization

Health insurance policies normally cover hospitalization exceeding 24 hours as an in-patient. Therefore the date and time of admission as well as discharge becomes important to note if this condition is satisfied.

Day-care treatments

Technological developments in the healthcare industry have led to simplification of many procedures that earlier required complex and prolonged hospitalization. There are a number of procedures carried out on day care basis without need for hospitalization exceeding 24 hours.

Most of the day care procedures are on pre-agreed package rate basis, resulting in certainty in costs.

vi. OPD

Some policies cover treatment/consultations taken as an out-patient also, subject to a specific sum insured which is usually less than the hospitalization sum insured.

The coverage under OPD varies from policy to policy. For such reimbursements, the clause for 24 hours hospitalization is not applicable.

vii. Treatment procedure/line of treatment

Hospitalization is typically associated with Allopathic method of treatment. However, the patient could undergo other modes of treatment such as:

- ✓ Unani
- ✓ Siddha
- ✓ Homeopathy
- ✓ Ayurveda
- ✓ Naturopathy etc.

Most policies exclude these treatments while some policies cover one or more of these treatments with sub-limits.

viii. Pre-existing illnesses

Definition
Pre-existing illnesses refer to "Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to his/her health policy with the company whether explicitly known to him or not."

The reason for excluding pre-existing illnesses is due to the fundamental principles of insurance that a certainty cannot be covered under insurance.

However, application of this principle is quite difficult and involves a systematic check of the symptoms and treatment to find out whether the person had the condition at the time of insuring. As medical professionals can differ in the opinions of duration of the illness, the opinion of when the disease first showed up is carefully taken before applying this condition to deny any claim.

In the evolution of health insurance, we come across two modifications to this exclusion.

- ✓ The first is in the case of group insurance where the entire group of people is insured, with no selection against the insurer. Group policies covering, say all government employees, all families below poverty line, all families of employees of a major corporate group, etc. are treated favorably as compared to a single family opting to cover for the first time. These policies often deleted the exception, with exception adequate price built in.
- ✓ The second modification is that pre-existing illnesses are covered after the a certain period of continuous coverage. This follows the principle that even a condition is present in a person, if it does not show up for a certain period of time, it cannot be treated as a certainty.

ix. Initial waiting period

A typical health insurance policy covers illnesses only after an initial 30 days (except accident related hospitalization).

Similarly, there are lists of illnesses such as:

✓ Cataract, ✓ Benign Prostatic Hypertrophy, ✓ Hysterectomy, ✓ Fistula, ✓ Piles,	✓ Hernia, ✓ Hydrocele, ✓ Sinusitis, ✓ Knee / Hip Joint replacement etc.

These are not covered for an initial period that could be one year or two years or more depending on specific insurance company's product.

The claim processor identifies if the illness is one of these and how long the person has been covered to check if it falls within this admissibility condition.

x. Exclusions

The policy lists out a set of exclusions which in general can be classified as:

- ✓ Benefits such as maternity (though this is covered in some policies).
- ✓ Outpatient and Dental treatments.
- ✓ Illnesses which are not intended to be covered such as HIV, Hormone therapy, obesity treatment, fertility treatment, cosmetic surgeries, etc.
- ✓ Diseases caused by alcohol/drug abuse.
- ✓ Medical treatment outside India.
- ✓ High hazard activities, suicide attempt, radioactive contamination.
- ✓ Admission for tests/investigation purpose only.

In such a case it is extremely important for the claims handler to specifically explain the circumstances so that the specialist opinion is exactly to the point and will stand the scrutiny in a court of law, if challenged.

xi. Compliance with conditions with respect to the claims.

The insurance policy also defines certain actions to be taken by the Insured in case of a claim, some of which are important for admissibility of the claim.

In general, these relate to:

- ✓ Intimation of claim within certain period – we have seen the importance of intimation earlier. The policy could stipulate a time within which such intimation must reach the company.

- ✓ Submission of claim documents within a certain period.

- ✓ Not being involved in misrepresentation, misdescription or non-disclosure of material facts.

g) Arriving at the final claim payable

Once the claim is admissible, the next step is to decide the the amount of claim payable. To compute this we need to understand the factors that decide the claim amount payable. These factors are:

i. Sum insured available for the member under the policy

There are policies issued with individual sum insured, some issued on floater basis where the sum insured is available across the family or policies which are on floater basis but with a limit per member.

ii. Balance sum insured available under the policy for the member after taking into account any claim made already:

While calculating the balance of sum insured available after deducting claims already paid, any later cashless authorization provided to the hospitals will also have to be noted.

iii. Sub-Limits

Most policies specify room rent limitation, nursing charges etc. either as a percentage of sum insured or as a limit per day. Similar limitation could be in force for consultant fee, or ambulance charges, etc.

iv. Check for any limits specific to illness

The policy could specify a certain amount or capping for maternity cover or for other diseases say, cardiac illness.

v. Check whether entitled or not to cumulative bonus

Verify whether the insured is entitled to any no-claim bonus (in case the insured has not claimed from his policy in the previous year/s). No-claim bonus often comes in the form of additional sum insured, which in fact increases the sum insured of the patient/insured. Sometimes, the cumulative bonus may also be wrongly stated as claims intimated towards the end of the previous year may not have been taken into account.

vi. Other expenses covered with limitation:

There could be other limits e.g. if treatment is undertaken under Ayurvedic system of medicine, usually the same has a much lower limit. Health check-up costs are only up to a certain limit after four years of the policy. Hospital cash payment also has a per day limit.

vii. Co-payment

This is normally a flat percentage of the assessed claim before payment. The co-pay could also be applicable only in select circumstances – only for parent claims, only for maternity claims, only from second claim onwards or even only on claims exceeding a certain amount.

Before the payable amount is adjusted to these limits, the claim amount payable is computed net of deductions for non-payable items.

Non-payable items in a health claim

The expenses incurred in treating an illness can be classified into:

- ✓ Expenses for cure and
- ✓ Expenses for care.

Expenses for curing an illness comprise of all the medical costs and the normal related facilities. In addition, there could be costs incurred to make the stay in a hospital more comfortable or even luxurious.

A typical health insurance policy attends to the expenses for curing an illness and unless stated specifically, the extra expenses for luxury are not payable.

These expenses can be classified into non-treatment charges such as registration charge, documentation charges, etc. and to items that can be considered if directly relating to the cure (e.g. protein supplement during the inpatient period specifically prescribed).

Earlier every TPA/insurer had its own list of non-payable items, now the same has been standardized under IRDAI Health Insurance Standardization Guidelines.

The order of arriving at the final claim payable is as follows:

Table 2.1

Step I	List all the bills and receipts under the various heads of room rent, consultant fee, etc.
Step II	Deduct the non-payable items from the amount claimed under each head
Step III	Apply any limits applicable for each head of expense
Step IV	Arrive at the total payable amount and check if it is within sum insured overall
Step V	Deduct any co-pay if applicable to arrive at the net claim payable

h) Payment of claim

Once the payable claim amount is arrived at, payment is done to the customer or the hospital as the case may be. The approved claim amount is advised to the Finance / Accounts function and the payment may be made either by cheque or by transferring the claim money to the customer's bank account.

When the payment is made to the hospital, necessary tax deduction, if any is made from the payment.

Where the payment is handled by the Third Party Administrator, the payment process may vary from insurer to insurer. A more detailed insight into working of TPAs is provided later on.

Payment updates in the system are crucial for handling customer inquiries. Typically these details will be shared through the system with the call centre / customer service team.

Once payment is made, the claim is treated as settled. Reports have to be periodically sent to the company's management, intermediaries, customers and IRDAI for number and amount of settled claims. The typical analysis of settled claims includes the % settled, amount of non-payables as a proportion, average time taken to settle claims, etc.

i) Management of deficiency of documents / additional information required

Processing of a claim requires the scrutiny of a list of key documents. These are:

- ✓ Discharge summary with admission notes,
- ✓ Supporting investigation reports,
- ✓ Final consolidated bill with break up into various parts,
- ✓ Prescriptions and pharmacy bills,
- ✓ Payment receipts,
- ✓ Claim form and
- ✓ Customer identification.

Experience shows that one out of four claims submitted has a suffer from being incomplete in terms of the basic documents. It is therefore required that the customer is advised of the documents not submitted and is given a time limit within which he can attach them to his claim.

Similarly, it may happen that while a claim is being processed, additional information may be required because:

i. The discharge summary provided is not in the correct format as prescribed by IRDAI or does not capture some details of the diagnosis or the history of the illness.

ii. Treatment given has not been described in enough detail or requires clarification.

iii. The treatment is not in line with the diagnosis as per discharge summary or medicines prescribed are not related to the illness for which treatment was provided.

iv. The bills provided do not have the required break up.

v. Mismatch of age of the person between two of the documents.

vi. Mismatch in date of admission / date of discharge between discharge summary and the bill.

vii. The claim requires a more detailed scrutiny of the hospitalization and for this, the hospital's indoor case papers are required.

In both the cases, the customer is informed in writing or through email detailing the requirement of additional information. In most cases, the customer will be able to provide the information required. However, there are circumstances where the information required is too important to be overlooked but the customer does not respond. In such cases, the customer is sent reminders that the information is needed to process the claim and after three such reminders, a claim closure notice is sent.

In all correspondence relating to a claim when it is in process, you will see that the words "Without Prejudice" are mentioned on top of the letter. This is a legal requirement to ensure that the right of the insurer to reject a claim after these correspondences remains intact.

Example

The insurer may ask for indoor case papers to study the case in detail and may come to a conclusion that the procedure / treatment does not fall within the policy conditions. The act of asking for more information should not be treated as an act that implies that the insurer has accepted the claim.

Managing shortfalls in documentation and explanation and additional information required is a key challenge in claims management. While the claim cannot be processed without all the required information, the customer cannot be put to inconvenience by frequent requests for more and more information.

Good practice requires that such request is raised once with a consolidated list of all information that may be needed and no new requirement is raised thereafter.

j) Denial claims

The experience in health claims show that 10% to 15% of the claims submitted do not fall within the terms of the policy. This could be because of a variety of reasons some of which are:

i. Date of admission is not within the period of insurance.
ii. The Member for whom the claim is made is not covered.
iii. Due to Pre-existing illness (where the policy excludes such condition).
iv. Undue delay in submission without valid reason.
v. No active treatment; admission is only for investigation purpose.
vi. Illness treated is excluded under the policy.
vii. The cause of illness is abuse of alcohol or drugs
viii. Hospitalization is less than 24 hours.

Denial or repudiation of a claim (due to whatever reason) has to be informed to the customer in writing. Usually, such denial letter clearly states the reason for denial, narrating the policy term / condition on which the claim was denied.

Most insurers have a process by which a denial is authorized by a manager senior to the one authorized to approve the claim. This is to ensure that any denial is fully justified and will be explained in case the insured seeks any legal remedy.

Apart from the representation to the insurer, the customer has the option, to approach the following in case of denial of claim:

- ✓ Insurance Ombudsman or
- ✓ The consumer forums or
- ✓ IRDAI or
- ✓ Law courts.

In case of each denial the file is checked to assess if the denial will stand the legal scrutiny in the normal course and the documents are stored in a safe location, should a need to defend the decision arise.

k) Suspect claims for more detailed investigation

Insurers have been trying to handle the problem of fraud in all lines of business. In terms of sheer number of fraud claims handled, health insurance presents a great challenge to the insurers.

Few examples of frauds committed in health insurance are:

i. Impersonation, the person insured is different from person treated.

ii. Fabrication of documents to make a claim where there is no hospitalization.

iii. Inflation of expenses, either with the help of the hospital or by addition of external bills fraudulently created.

iv. **Outpatient treatment converted to in-patient / hospitalization** to cover cost of diagnosis, which could be high in some conditions.

With newer methods of frauds emerging on a daily basis, the insurers and TPAs have to continuously monitor the situation on the ground and come up with measures to find and control such frauds.

Claims are chosen for investigation based on two methods:

- ✓ Routine claims and
- ✓ Triggered claims

A TPA or an insurer may set an internal standard that a specific percentage of the claims be physically verified; this percentage could be different for cashless and reimbursement claims.

Under this method, claims are chosen using random sampling method. Some insurers stipulate that all claims above a certain value be investigated and a sampled set of claims which are below that limit are taken up for verification.

In the second method, each claim goes through a set of checkpoints which if not in line, trigger investigation such as

i. a high portion of the claim relating to medical tests or medicines
ii. customer too eager to settle
iii. bills with over-writing, etc.

If the claim is suspected to be not genuine, the claim is investigated, however small it is.

n. Cashless settlement process by TPA

How does the cashless facility work? At the heart of this is an agreement that the TPA insurer enters into, with the hospital. There are agreements possible with other medical service providers as well. We shall look at the process used for providing cashless facility in this section:

Table 3.1

Step 1	A customer covered under health insurance suffers from an illness or sustains an injury and so is advised admission into a hospital. He/she (or someone on his/her behalf) approaches the hospital's insurance desk with the insurance details such as: i. TPA name, ii. His membership number, iii. Insurer name, etc.

Step 2	The hospital compiles the necessary information such as: i. Illness diagnosis ii. Treatment, iii. Name of treating doctor, iv. Number of days of proposed hospitalization and v. The estimated cost This is presented in a format, called the **cashless authorization form.**
Step 3	The TPA studies the information provided in the *cashless authorization form*. It checks the information with the policy terms and the agreed tariff with the hospital, if any, and arrives at the decision on whether the cashless authorization could be provided and if so, for how much amount it should be authorized. The TPA could ask for more information to arrive at the decision. Once the decision is made, it is communicated to the hospital without delay. Both forms have now been standardized under IRDAI Health Insurance Standardization Guidelines; refer to Annexure at the end).
Step 4	The patient is treated by the hospital, keeping the amount authorized by the TPA as credit in the patient's account. The member may be called on to make a deposit payment to cover the non-treatment expenses and any co-pay required under the policy.
Step 5	When the patient is ready for discharge, the hospital checks the amount of credit in the account of the patient approved by the TPA against the actual treatment charges covered by insurance. If the credit is less, the hospital requests for additional approval of credit for the cashless treatment. TPA analyses the same and approves the additional amount.
Step 6	Patient pays the non-admissible charges and gets discharged. He will be asked to sign the claim form and the bill, to complete the documentation.

Step 7	Hospital consolidates all the documents and presents to the TPA the following documents for processing of the bill: i. Claim form ii. Discharge summary / admission notes iii. Patient / proposer identification card issued by the TPA and photo ID proof. iv. Final consolidated bill v. Detailed bill vi. Investigation reports vii. Prescription and pharmacy bills viii. Approval letters sent by the TPA
Step 8	TPA will process the claim and recommend for payment to the hospital after verifying details such as the following: i. The Patient treated is the same person for whom approval was provided. ii. Treated the patient for the same condition that it requested the approval for. iii. Expenses for treatment of excluded illness, if any, is not part of the bill. iv. All limits that were communicated to the hospital have been adhered to. v. Tariff rates agreed with the hospital have been adhered to, calculate the net payable amount.

The value of cashless facility is not in doubt. It is also important for the customer to know how to make the best use of the facility. The points to note are:

i. Customer must make sure that he/she has his/her insurance details with him/her. This includes his:

   - ✓ TPA card,
   - ✓ Policy copy,
   - ✓ Terms and conditions of cover etc.

   When this is not available, he can contact the TPA (through a 24 hour helpline) and seek the details.

ii. Customer must check if the hospital suggested by his/her consulting doctor is in the network of the TPA. If not, he needs to check with the TPA the options available where cashless facility for such treatment is available.

iii. He/she needs to make sure that the correct details are entered into the pre-authorization form. This form has been standardized by IRDAI as per

Guidelines on Standardization in Health Insurance issued in 2013. If the case is not clear, the TPA could deny the cashless facility or raise query.

iv. He/she needs to ensure that the hospital charges are consistent with the limits such as room rent or caps on specified treatments such as cataract.

In case he/she wants to spend more than what is allowed by the policy, it is better to know, in advance, what would be his/her share of expenses.

v. The customer must inform the TPA in advance of the discharge and request the hospital to send to the TPA any additional approval that may be required before discharge. This will ensure the patient does not wait unnecessarily at the hospital.

It is also possible that the customer requests and takes an approval for cashless treatment at a hospital but decides to admit the patient elsewhere. In such cases, the customer must inform and ask the hospital to communicate to the TPA that the cashless approval is not being used.

If this is not done, the amount approved could get blocked in the customer's policy and could prejudice the approval of the subsequent request.

C. Documentation in health insurance claims

Health insurance claims require a range of documents for processing, as explained earlier. Each document is expected to assist in answering the two key questions – admissibility (Is it payable?) and extent of claim (how much?).

This section explains the need for and content of each of the documents required to be submitted by the customers:

1. Discharge summary

Discharge summary can be termed as the most important document that is required to process a health insurance claim. It details the complete information about the condition of the patient and the line of treatment.

As per IRDAI Standardization Guidelines the contents of a standard Discharge Summary are as follows:

1. Patient's Name
2. Telephone No / Mobile No
3. IPD No
4. Admission No
5. Treating Consultant/s Name, contact numbers and Department / Specialty
6. Date of Admission with Time
7. Date of Discharge with Time
8. MLC No / FIR No
9. Provisional Diagnosis at the time of Admission
10. Final Diagnosis at the time of Discharge
11. ICD-10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis
12. Presenting Complaints with Duration and Reason for Admission
13. Summary of Presenting Illness
14. Key findings on physical examination at the time of admission
15. History of alcoholism, tobacco or substance abuse, if any
16. Significant Past Medical and Surgical History, if any
17. Family History if significant/relevant to diagnosis or treatment
18. Summary of key investigations during Hospitalization
19. Course in the Hospital including complications if any
20. Advice on Discharge
21. Name & Signature of treating Consultant/ Authorized Team Doctor
22. Name & Signature of Patient / Attendant

A well written discharge summary helps the claim processing person immensely to understand the illness / injury and the line of treatment, thereby speeding up the process of settlement. Where the patient unfortunately does not survive, the discharge summary is termed **Death Summary** in many hospitals.

The discharge summary is always sought in original.

2. Investigation reports

Investigation reports assist in comparing the diagnosis and the treatment, thereby providing the necessary information to understand the exact condition that prompted the treatment and the progress made during the hospitalization.

Investigation reports usually consist of:

a) Blood test reports;

b) X-ray reports;

c) Scan reports and

d) Biopsy reports

All investigation reports carry the name, age, gender, date of test etc. and typically presented in original. The insurer may return the X-ray and other films to the customer on specific request.

3. Consolidated and detailed bills:

This is the document that decides what needs to be paid under the insurance policy. Earlier there was no standard format for the bill, but IRDAI Standardization Guidelines provide format for consolidated and detailed bills. The student is advised to understand the details available on the IRDAI website.

While the consolidated bill presents the overall picture, the detailed bill will provide the break up, with reference codes.

Scrutiny of non-payable expenses is done using the detailed bill, where the non-admissible expenses are rounded off and used for deduction under the expense head to which it belongs.

The bills have to be received in original.

4. Receipt for payment

Being a contract of indemnity, the reimbursement of a health insurance claim will also require the formal receipt from the hospital of the amount paid.

While the amount paid must correspond to the total of the bill, many hospitals do provide an element of concession or discount in the payable amount. In such a case, the insurer is called to pay only the amount actually paid on behalf of the patient.

The receipt should be numbered and or stamped and be presented in original.

5. Claim form

Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer. The claim form has now been standardized by IRDAI and broadly consists of:

a) Details of the primary insured and the policy number under which the claim is made.
b) Details of the insurance history

c) Details of the insured person hospitalized.

d) Details of the hospitalization such as hospital, room category, date and time of admission and discharge, whether reported to police in case of accident, system of medicine etc.

e) Details of the claim for which the hospitalization was done including breakdown of the costs, pre and post-hospitalization period, details of lump-sum/cash benefit claimed etc.

f) Details of bills enclosed

g) Details of bank account of primary insured for remittance of sanctioned claim

h) Declaration from the insured.

Besides information on disease, treatment etc., the declaration from the insured person makes the claim form the most important document in the legal sense.

It is this declaration which applies the **"doctrine of utmost good faith"** into the claim, breach of which attracts the misrepresentation clause under the policy.

6. Identity proof

With the increasing use of identity proof across various activities in our life, the general proof of identity serves an important purpose – that of verifying whether the person covered and the person treated are one and the same.

Usually identification document which is sought could be:

a) Voters identity card,

b) Driving license,

c) PAN card,

d) Aadhaar card etc.

Insistence on identity proof has resulted in a significant reduction of impersonation cases in cashless claims as the identity proof is sought before hospitalization, making it a duty of the hospital to verify and present the same to the insurer or the TPA.

In reimbursement claims, the identity proof serves a lesser purpose.

7. Documents contingent to specific claims

There are certain types of claims that require additional documents apart from what has been stated above. These are:

a) Accident claims, where FIR or Medico-legal certificate issued by the hospital to the registered police station, may be required. It states the cause of accident and if the person was under the influence of alcohol, in case of traffic accidents.

b) Case indoor papers in case of complicated or high value claims. Indoor case paper or case sheet is a document which is maintained at the hospital end, detailing all treatment given to patient on day to day basis for entire duration of hospitalization.

c) Dialysis / Chemotherapy / Physiotherapy charts where applicable.

d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked.

The claims team uses certain internal document formats for processing a claim. These are:

i. Checklists for document verification,

ii. Scrutiny/ settlement sheet,

iii. Quality checks / control format.

Though these formats are not uniform across the insurers, let us study the purpose of the documents with a specimen of the usual contents.

Table 2.2

1.	**Document verification sheet**	It is the simplest of all, a check mark placed on the list of documents received to note that these have been submitted by the customer. Some insurers may provide a copy of this as an acknowledgement to the customer.
2.	**Scrutiny/process sheet**	It is usually a single sheet where the entire processing notes are captured. a) Name of the customer and id number b) Claim number, date of receipt of the claim papers c) Policy overview, Section 64VB compliance d) Sum insured and utilization of sum insured e) Date of hospitalization and discharge f) Diagnosis and treatment g) Claim admissibility / processing comments with reason thereof h) Computation of claim amount i) Movement of the claim with dates and names of people who processed
3.	**Quality checks / control format**	Final check or quality control format for checking of claim by person other than claim handler Besides check list and claim scrutiny questionnaire, the quality control/audit format shall also include information relating to: a) Settlement of claim, b) Rejection of claim or c) Requesting for additional information.

Test Yourself 2

Which of the following document is maintained at the hospital detailing all treatment done to an in-patient?

I. Investigation report
II. Settlement sheet
III. Case paper
IV. Hospital registration certificate

D. Claims reserving

1. Reserving

This refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims. While this looks very simple, the process of reserving requires enormous care – any mistake in reserving affects the insurer's profits and solvency margin calculation.

Processing systems today have built in capability to compute the reserves as at any point of time.

Test Yourself 3

The amount of provision made for all claims in the books of the insurer based on the status of the claims is known as _____.

I. Pooling
II. Provisioning
III. Reserving
IV. Investing

E. Role of third party administrators (TPA)

1. Introduction of TPAs in India

The insurance sector was opened to private players in the year 2000. Meanwhile, the demand for healthcare products was also growing with new products being launched. A need was therefore felt for the introduction of a channel for post-sale services in health insurance. This offered the opportunity for professional Third Party Administrators to be introduced.

Seeing this, the Insurance Regulatory and Development Authority allowed TPAs to be introduced into the market under license from IRDAI, provided they complied with The IRDAI (Third Party Administrators – Health Insurance) Regulations, 2001 notified on 17th Sept 2001.

Definition

As per Regulations,

"Third Party Administrators or TPA means any person who is licensed under the IRDAI (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

"Health Services by TPA" 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.

Thus the scope of TPA services starts after the sale and issue of the insurance policy. In case of insurers not using TPAs, the services are performed by in-house team.

2. Post sale service of health insurance

a) Once the proposal (and the premium) is accepted, the coverage commences.

b) If a TPA is to be used for servicing the policy, the insurer passes on the information about the customer and the policy to the TPA.

c) The TPA enrolls the members (while the proposer is the person taking the policy, members are those covered under the policy) and may issue a membership identification in the form of a card, either physical or electronic.

d) The membership with the TPA is used for availing cashless facility as well as processing of claims when the member requires the support of the policy for a hospitalization or treatment that is covered.

e) TPA processes the claim or cashless request and provides the services within the time agreed with the insurer.

The cut-off point from which the role of a TPA begins is the moment of allocation of the policy in the name of the TPA as the servicing entity. The servicing requirement continues through the policy period and through any further period that is allowed under the policy for reporting a claim.

When thousands of policies are serviced, this activity is continuous, especially when the same policy is renewed and the same TPA is servicing the policy.

3. Objectives of third party administration (TPA)

The concept of Third Party Administration in health insurance can be said to have been created with the following objectives:

a) To facilitate service to a customer of health insurance in all possible manners at the time of need.

b) To organise cashless treatment for the insured patient at network hospitals.

c) To provide fair and fast settlement of claims to the customers based on the claim documents submitted and as per procedure and guidelines of the insurance company.

d) To create functional expertise in handling health insurance claims and related services.

e) To respond to customers in a timely and proper manner.

f) To create an environment where the market objective of an insured person being able to access quality healthcare at a reasonable cost is achieved and

g) To help generate/collate relevant data pertaining to morbidity, costs, procedures, length of stay etc.,

4. Relationship between insurer and TPA

Many insurers utilize the services of the TPA for post-sale service of health insurance policies while few insurers, especially from the life insurance sector also seek assistance of a TPA for arranging pre-policy medical check-up service.

The relationship between an insurer and the TPA is contractual with a host of requirements and process steps built into the contract. IRDAI Health Insurance Standardization guidelines now lay down guidelines and provide a set of suggested standard clauses for contract between TPA and insurance company,

The services that an insurer expects out of the TPA are as follows:

A. Provider networking services

The TPA is expected to build a relationship with a network of hospitals across the country, with the objective of providing cashless claim payments for health claims to the insured persons. The recent guidelines by IRDAI require the relationship to be tri-partite including the insurer and not just between the TPA and the provider.

They also negotiate good scheduled rates for various hospitalization procedures and packages from such network hospitals reducing costs to insureds and also insurers.

B. Call centre services

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

a) Coverage and benefits available under the policy.

b) Processes and procedures relating to health claims.

c) Guidance relating to the services and cashless hospitalization.

d) Information on network hospitals.

e) Information on balance sum insured available under the policy.

f) Information on claim status.

g) Advice on missing documents in case of claims.

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.

C. Cashless access services

Definition

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
To provide this service, the requirements of the insurer under the contract are:

a) All policy related information must be available with the TPA. It is the duty of the insurer to provide this to the TPA.

b) Data of members included in the policy should be available and accessible, without any error or deficiency.

c) The insured persons must carry an Identity Card that relates them to the policy and the TPA. This Identity Card must be issued by the TPA in an agreed format, reach the member within a reasonable time and should be valid throughout the policy period.

d) TPA must issue a pre-authorization or a Letter of Guarantee to the hospital based on the information provided for requesting the cashless facility. It could seek more information to understand the nature of illness, treatment proposed and the cost involved.

e) Where the information is not clear or not available, the TPA can reject the cashless request, making it clear that denial of cashless facility is not to be construed as denial of treatment. The member is also free to pay and file a claim later, which will be considered on its merits.

f) In emergency cases, the intimation should be done within 24 hours of admission and the decision on cashless communicated.

D. Customer relationship and contact management

The TPA needs to provide a mechanism by which the customers can represent their grievances. It is usual for health insurance claims to be subjected to scrutiny and verification. It is also noted that a small percentage of the health insurance claims are denied which are outside the purview of the policy terms and conditions.

In addition, almost all health insurance claims are subject to deduction on some amount of the claim. These deductions cause customer dissatisfaction, especially where the reason for the deduction or denial is not properly explained to the customer.

To make sure that such grievances are resolved as quickly as possible, the insurer requires the TPA to have an effective grievance solution management.

E. Billing services

Under billing services, the insurer expects the TPA to provide three functions:

a) Standardized billing pattern that can help the insurer analyze the use of coverage under various heads as well as decide the pricing.

b) Confirmation that the amount charged is relevant to the treatment really required for the illness.

c) Diagnosis and procedure codes are captured so that standardization of data is possible across all TPAs in accordance with national or international standards.

This requires trained and skilled manpower in the TPA who are capable of coding, verifying the tariff and standardizing the billing data capture.

F. Claim processing and payment services

This is the most critical service offered by the TPAs. Claim processing services offered by the TPA to the insurer is usually end-to-end service from registering intimation to processing to recommending approval and payment.

Payment of claims is done through the funds received from the insurer. The funds may be provided to the TPA in the form of advance money or may be settled directly by the insurer through its bank to the customer or to the hospital.

The TPA is expected to keep an account of the monies and provide periodic reconciliation of the amounts received from the insurance company. The money cannot be used for any other purpose except for payment of approved claims.

G. Management Information Services

Since the TPA performs claim processing, all information relating to the claims individually or collectively is available with the TPA. The insurer requires the data for various purposes and such data must be provided accurately and on a timely basis by the TPA.

Thus the scope of a TPA's services can be stated as end-to-end service of the health insurance policies issued by the insurers, could be restricted to few activities, depending on requirements and MOU with particular insurer.

H. TPA Remuneration

For these services, the TPA is paid a fee on one of the following basis:

a) A percentage of the premium (excluding service tax) charged to the customer,

b) A fixed amount for each member serviced by the TPA for a defined time period, or

c) A fixed amount for each transaction of the service provided by the TPA – e.g. cost per member card issued, per claim etc.

Thus through services of TPA, insurers gain access to:

i. Cashless services

ii. Data compilation and analysis

iii. A 24 hour call centre and assistance for the customers

iv. Network of hospitals and other medical facilities

v. Support to major group customers

vi. Facilitation of the claims interaction with the customer

vii. Negotiation of tariffs and procedure prices with the hospitals

viii. Technology enabled services to ease customer service

ix. Verification and investigation of suspect cases

x. Analysis of claim patterns across companies and provision of crucial information on costs, newer methods of treatment, emerging trends and in controlling frauds

xi. Expansion of reach of services quickly

F. Claims management – personal accident

1. Personal accident

Definition

Personal accident is a benefit policy and covers accidental death, accidental disability (permanent / partial), Temporary total disability and may also have add-on coverage of accidental medical expenses, funeral expenses, educational expenses etc. depending on particular product.

The peril covered under the PA policy is "Accident".

Definition

Accident is defined as anything sudden, unforeseen, unintentional, external, violent and by visible means.

Claims manager should mark caution and check following areas on receipt of the notification of the claim:

a) Person in respect of whom the claim is made is covered under the policy

b) Policy is valid as on date of loss and premium is received

c) Loss is within the policy period

d) Loss has arisen out of "Accident" and not sickness

e) Check for any fraud triggers and assign investigation if need be

f) Register the claim and create reserve for the same

g) Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.

2. Claims investigation

If any red alert is noticed in the claim intimation or on receipt of the claim documents, claim may be assigned to a professional investigator for verification simultaneously.

Example

Examples of red alerts for personal accident claims (for purpose of further investigation, but does not indicate positive indication of fraud or claim being fraudulent):

- ✓ Close proximity claims (claim within a short time of start of insurance)
- ✓ High weekly benefit amount with longer period of disability
- ✓ Discrepancy in the claim documents
- ✓ Multiple claims by same insured
- ✓ Indication of alcohol
- ✓ Suspected suicide
- ✓ Late night Road Traffic Accident while vehicle was being driven by insured
- ✓ Snake bite
- ✓ Drowning
- ✓ Fall from height
- ✓ Suspected sickness related cases
- ✓ Poisoning
- ✓ Murder
- ✓ Bullet injury
- ✓ Frost bite disappearance
- ✓ Homicide etc.

The main objectives of investigation are:

a) Examine the cause of loss.

b) Ascertain the extent and nature of loss.

c) Collection of evidence and information.

d) To ascertain if there is element of fraud or exaggeration of claim amount.

Please note: the objective of investigation is to verify the facts of the case and gather necessary evidence.

It is important that Claims examiner guides the investigator as to the focus of investigation.

Example

Example of case guideline:

Road traffic accident

i. When did the incident take place – exact time and date place? Date and time

ii. Was the insured a pedestrian, traveling as passenger/pillion rider or driving the vehicle involved in accident?

iii. Description on the accident, how did it take place?

iv. Was the insured under the influence of alcohol at the time of accident?

v. In case of death, what was the exact time and date of death, treatment provided before death, at which hospital etc?

The possible reason for the accident:

Mechanical failure (steering, brake etc. failure) of the insured's or opponent vehicle, due to any sickness (heart attack, seizure etc.) of the driver of the vehicle, influence of alcohol, bad road condition, weather condition, speed of the vehicle etc.

Some examples of possible fraud and leakage in personal accident claims:

i. Exaggeration in TTD period.

ii. Illness presented as accident e.g. backache due to pathological reasons converted into a PA claim after reported 'fall/slip' at home.

iii. Pre-existing accidents are claimed as fresh, by fabricating documents- Natural death presented as accidental case or pre-existing morbidity leading to death after accident

iv. Suicidal deaths presented as accidental deaths

Discharge voucher is an important document for settlement of personal accident claim, especially those involving death claims. It is also important to obtain nominee details at the time of proposal and the same should form part of policy document.

3. Claim documentation

Table 2.3

Death claim	a) Duly completed Personal Accident claim form signed by the claimant's nominee/family member b) Original or Attested copy of First Information Report. (Attested copy of FIR / Panchnama / Inquest Panchnama) c) Original or Attested copy of Death certificate. d) Attested copy of Post Mortem Report if conducted. e) Attested copy of AML documents (Anti-money laundering) - for name verification (passport / PAN card / Voter's ID / Driving license) for address verification (Telephone bill / Bank account statement / Electricity bill / Ration card). f) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized

Permanent Total Disability (PTD) and Permanent Partial Disability(PPD) Claim	a) Duly completed Personal Accident claim form signed by the claimant. b) Attested copy of First Information Report if applicable. c) Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
Temporary Total Disability(TTD) Claim	a) Medical certificate from treating doctor mentioning the type of disability and disability period. Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer. **b)** Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

The above list is only indicative, further documents (including photographs of scar marks, site of accident etc.) may be required depending on particular facts of the case, especially the cases with suspected fraud angle to be investigated.

Test Yourself 4

Which of the following documents are not required to be submitted for Permanent Total Disability claim?

I. Duly completed Personal Accident claim form signed by the claimant.
II. Attested copy of First Information Report if applicable.
III. Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
IV. Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

G. Claims management- Overseas travel insurance

1. Overseas travel insurance policy

Though Overseas travel insurance policy has many sections covering non-medical benefits, its underwriting and claims management has traditionally been under health insurance portfolio because medical and sickness benefit is the main cover under the policy.

The covers under the policy can be broadly divided into following sections. A specific product may cover all or few of the below mentioned benefits:

a) Medical and sickness section

b) Repatriation and evacuation

c) Personal accident cover

d) Personal liability

e) Other non-medical covers:

i. Trip Cancellation
ii. Trip Delay
iii. Trip interruption
iv. Missed Connection
v. Delay of Checked Baggage
vi. Loss of Checked Baggage
vii. Loss of Passport
viii. Emergency Cash Advance
ix. Hijack Allowance
x. Bail Bond insurance
xi. Hijack cover
xii. Sponsor Protection
xiii. Compassionate Visit
xiv. Study Interruption
xv. Home burglary

As the name suggests, the policy is intended for people travelling abroad, it is natural that loss would happen outside India and claims would need to be serviced appropriately as and when reported. In case of overseas travel insurance the claim servicing usually involves a **Third Party service provider** (Assistance Company) who has established a network for providing necessary support and assistance all over the world.

Claims services essentially include:

a) Taking down the claim notification 24*7 basis;
b) Sending the claim form and procedure;
c) Guiding customer on what to do immediately after loss;
d) Extending cashless services for medical and sickness claims;
e) Arranging for repatriation and evacuation, emergency cash advance.

2. Assistance companies – Role in overseas claims

Assistance companies have their own offices and tie ups with other similar providers world over. These companies offer assistance to the customers of insurance companies in case of contingencies covered under the policy.

These companies operate a 24*7 call centre including international toll free numbers for claim registration and information. They also offer the following services and charges for the services vary depending on agreement with the particular insurance company, benefits covered etc.

a) Medical assistance services:

i. Medical service provider referrals
ii. Arrangement of hospital admission

iii. Arrangement of Emergency Medical Evacuation
iv. Arrangement of Emergency Medical Repatriation
v. Mortal remains repatriation
vi. Compassionate visit arrangements
vii. Minor children assistance/escort

b) Monitoring of Medical Condition during and after hospitalisation

c) Delivery of Essential Medicines

d) Guarantee of Medical Expenses Incurred during hospitalization subject to terms and condition of the policy and approval of insurance company.

e) Pre-trip information services and other services:

i. Visas and inoculation requirements
ii. Embassy referral services
iii. Lost passport and lost luggage assistance services
iv. Emergency message transmission services
v. Bail bond arrangement
vi. Financial Emergency Assistance

f) Interpreter Referral

g) Legal Referral

h) Appointment with lawyer

3. Claims management for cashless medical cases

Claims management approach differs for cashless medical cases, reimbursement medical cases and other non-medical cases. Again, cashless medical claims management differs in US than cashless medical in other countries. We shall now study step by step process

a) Claim notification

As and when loss happens, the patient takes admission into the hospital and shows the insurance details to the admission counter. Assistance Company receives notification of a new case from hospital and/or from patient or relatives/friends. Claim procedure is then explained to the claimant.

b) Case management steps:

These may vary from company to company, common steps are listed below:

i. Assistance Company case manager verifies the benefits, sum insured, policy period, name of the policy holder.

ii. Case manager then gets in touch with the hospital to obtain clinical /medical notes for an update on the patient's medical condition, billing information, estimates of cost. Assistance Company receives the clinical notes and estimate of medical cost and send an update to the Insurer.

iii. Admissibility of the claim is determined and Guarantee of payment is placed to hospital subject to approval from Insurance Company.

iv. There can be scenario where investigation may be necessary in India (local place of insured) and/or in loss location. Process of investigation is similar to what is explained in personal accident claims section. Investigator abroad is selected with the help of Assistance Company or through direct contact of insurance company.

v. Assistance Company's case manager continues to monitor the case on a daily basis to provide Insurer with a clinical and cost update, progress notes, etc. in order to obtain authorization for continuation of treatment.

vi. Once the patient is discharged, case manager works diligently with the hospital to confirm final charges.

vii. Assistance Company ensures that the bill is properly scrutinized, scrubbed and audited. Any error found is notified to the billing department of the hospital for rectification.

viii. Final bill is then re-priced as per the rates agreed between the provider and Assistance Company or its associate reprising agent. The earlier the payment assurance made to hospital, better discount through re-pricing is possible.

Re-pricing is typically characteristic of US healthcare and as such, is not applicable for non US cases. This is a major difference between cashless medical case in US and non-US cases.

c) Claims processing Steps:

i. The claims assessor receives the re-priced/original bill, verifies and ensures that coverage was in place for the dates of service and treatment rendered. The bill received by the Assistance Company is audited by the claims department to ensure the charges are in line and as per the treatment protocol. The discount is re-confirmed and the bill is processed.

ii. The bill is then sent to Insurer for payment accompanied by re-pricing notification sheet and explanation of benefits (EOB).

iii. Insurance company receives the bill and authorizes immediate payment to Assistance Company.

d) Payment process steps:

i. Assistance Company receives authorization from Insurer to release payment to the hospital via local office.

ii. The finance department releases the payment

e) Hospitalization Procedures

i. The system in overseas countries, especially US and Europe are quite different from the hospitals in India since majority of population has universal health coverage either through private insurance or through government schemes. Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid health or overseas travel insurance policy.

In most countries treatment is not delayed for want of confirmation of insurance coverage or cash deposit.

Hospitals start the treatment immediately. If there is insurance cover the insurance policy pays or the patient person has to pay. The hospitals tend to inflate charges since payments are delayed.

If payment is immediate, hospitals tend to offer very high discounts for immediate payment. Re-pricing agencies generally negotiate with hospitals for discounts for early settlement of hospital bills.

ii. Information regarding network hospitals and the procedures is available to the insured on the toll free numbers provided by the assistance companies.

iii. In event of the necessity of a hospitalization the insured needs to intimate the same at the call centre and proceed to a specified hospital with the valid travel insurance policy.

iv. Hospitals usually contact the assistance companies/insurers on the call centre numbers to check the validity of the policy and verify coverage's.

v. Once the policy is accepted by the hospital the insured would undergo treatment in the hospital on a cashless basis.

vi. Some basic information required by the insurer/assistance provider to determine admissibility are

1. Details of ailment

2. In case of any previous history ,details of hospital, local medical officer in India:

- ✓ Past history, current treatment and further planned course in hospital and request for immediate sending of
- ✓ Claim form along with attending physicians statement
- ✓ Passport copy
- ✓ Release of medical information form

f) Reimbursement of medical expenses and other non-medical claims:

Reimbursement claims are normally filed by insured after they return to India. Upon receipt of the claim papers, claim is processed as per usual process. Payments for all admissible claims are made in Indian Rupee (INR), unlike in cashless claims where payment is made in foreign currency.

While processing the reimbursement claims, currency conversion rate is applied as on date of loss to arrive at quantum of liability in INR. Then the payment is made though cheque or electronic transfer.

i. **Personal accident claims** are processed in similar fashion as explained in personal accident claims section.
ii. **Bail bond cases and financial emergency cases** are paid upfront by Assistance Company and later claimed from insurance company.
iii. **Claims repudiation** of untenable claims follows the same process as for all other claims.

g) Claim documentation for Medical Accident and Sickness Expenses

i. Claim form
ii. Doctor's report
iii. Original Admission/discharge card
iv. Original Bills/Receipts/Prescription
v. Original X-ray reports/ Pathological/ Investigative reports
vi. Copy of passport/Visa with Entry and exit stamp

The above list is only indicative. Additional information/documents may be required depending on specific case details or depending upon claim settlement policy/procedure followed by particular insurer.

Test Yourself 5

_____ are paid upfront by Assistance Company and later claimed from insurance company.

I. Bail bond cases
II. Personal accident claims
III. Overseas travel insurance claims
IV. Untenable claims

Summary

a) Insurance is a 'promise' and the policy is a 'witness' to that promise. The occurrence of insured event leading to a claim under the policy is the true test of that promise.

b) One of the key rating parameter in insurance is the claims paying ability of the insurance company.

c) Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.

d) In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer / TPA and later submits the documents for settlement of the claim.

e) In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer / TPA for payment.

f) Claim intimation is the first instance of contact between the customer and the claims team.

g) If a fraud is suspected by insurance company in case of insurance claim, it is sent for investigation. Investigation of a claim could be done in-house by an insurer/TPA or be entrusted to a professional investigation agency.

h) Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

i) In case of a denial, the customer has the option, apart from the representation to the insurer, to approach the Insurance Ombudsman or the consumer forums or even the legal authorities.

j) Frauds occur mostly in hospitalization indemnity policies but Personal accident policies also are used to make fraud claims.

k) The TPA provides many important services to the insurer and gets remunerated in the form of fees.