ROLE OF THIRD PARTY ADMINISTRATORS IN SETTING UP MANAGED HEALTH CARE SYSTEMS: A CASE OF HENNER GROUPE KENYA

BY

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DECLARATION

STUDENT'S DECLARATION

This research project is my original work and has not been presented for a degree at any other university.

Signed ....   Date 09|11|2012.

Georgina Bundi

L50/64003/2010

SUPERVISOR'S DECLARATION

This research project has been submitted for examination with my approval as the candidate's University Supervisor.

Signed ....

Date.....9/11/2012

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DEDICATION

This is dedicated to my parents, Mr. and Mrs. Bundi

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LIST OF ABBREVIATION

AD&D- Accidental Death and Dismemberment

ANOVA - Analysis of Variance

API   - Assurances & Prévoyance Internationales

COB   - Coordination of Benefits

EPO   - Exclusive Provider Organization

FDI   - Foreign Direct Investment

GMC   - Garantie Médicale & Chirurgicale

GO   - Garantie Obsèques

HMO - Health Management Organization

ID   - Identity

IOM   - Institute of Medicine

IRA   - Insurance Regulatory Authority

IRDA - Insurance Regulatory and Development Authority

IT   - Information Technology

MIP   - Medical Insurance Plan

NGO   - Non-Government Organization

NHIF - National Health Insurance Fund

PPO   - Preferred Provider Organization

SI   - Sum Insured

SPSS - Statistical Package for Social Sciences

TPA   - Third Party Administrator

UN   - United Nations

UNDP - United Nations Development Programme

UNEP - United Nations Environmental Programme

WFP   - World Food Programme

WHO   - World Health Organization

ABSTRACT

This study attempted to establish the role of TPA in setting up managed health care systems with special reference to Henner Groupe Kenya. The study adopted a descriptive research design targeting the member organization/clientele at United Nations Environmental Programme (UNEP); United Nations Development Programme (UNDP); World Food Programme (WFP) covered by Henner Group Kenya. Using stratified sampling technique, a sample size of 480 respondents was selected, proportionately, from the target population. Questionnaires were used as the main instrument of data collection. Descriptive statistics was adopted to analyze the data (means, standard deviation, frequency and percentages). Multiple regression analysis was used determine the significance of the relationship. The study's findings shows that GMC/Henner Groupe have adopted a healthcare financing system whereby it covers part of the medical cost for both inpatient and outpatient medical expenses. The TPA reimburses the policyholders' claims whenever they pay for their medical cost. GMC/Henner Group monitors and collects necessary information, documents and bills pertaining to the policyholders' treatment, thus, eases healthcare insurance workload both administrative and money costs. GMC/Henner Group are efficient in policy-related enquiries and makes arrangements for ambulance, helicopter evacuation, medicines supplies, information on health facilities available among others. The study, therefore, recommends that TPAs have enhanced healthcare systems through its reimbursement, medical cost containment and call centre support. The study recommends that policymakers create environment both legislatively and monetarily favourable for TPAs so as to improve the healthcare management system in Kenya.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Insurance provides protection against risks or uncertain events and is based on the principle that what is highly unpredictable to an individual is predictable to a group of individuals. Health insurance protects against the cost of illness, mobilizes funds for health services, increases the efficiency of mobilization of funds and provision of health services, and achieves certain equity objectives (Mills, 2000). Various forms of health insurance can be broadly categorized (based on ownership of scheme) as follows: state-based systems, market-based systems, member organisation (NGO or cooperative)-based systems, and private household-based systems (Jutting 1999).

A third party administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity (Bhat and Babu, 2003). That is, a company that administers self-funded employee benefit plans (such as health, welfare, workers' compensation, and retirement plans) on behalf of an employer or plan sponsor. Alison (2008) defines TPA as a company that administers self-funded employee benefit plans (such as health, welfare, workers' compensation and retirement plans) on behalf of an employer or plan sponsor.

TPA as a state-licensed organization that adjudicates claims and provides administrative services on behalf of another organization's self-funded benefit plan. A TPA may administer a variety of health and workers' compensation benefits including: medical, dental, vision, life, disability, voluntary benefits, consumer-directed health plans, and

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flexible spending plans. TPAs can also assist their clients with designing and implementing benefit plans, managing plans, and with billing/collecting of funds (or premiums) for distribution to the vendors involved.

TPAs work on behalf of employers or plan sponsors as administrators and facilitators to outside vendors such as managing general underwriters, direct stop-loss writers, Preferred Provider Organization (PPO) networks, Exclusive Provider Organization (EPO) networks, Point of Service (POS) providers, utilization review companies, pharmacy benefit managers, specialty pharmacies, home healthcare agencies, re-insurers, case managers, dental providers, life insurance companies, long- and short-term disability providers, nurse lines, customer service centers, specialty sub-acute care hospital networks, and other ancillary providers. TPAs may be independently owned and operated or can be owned by an insurance company, multi-employer group, or association (Alison, 2008).

This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company itself. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA. An insurance company may also use a TPA to manage its claims processing, provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent (Bhat and Babu, 2003).

From a service standpoint, the most significant difference between a TPA and a claims department f an insurance company is that a TPA provides claims services with a variety of service lengths, ranging from twelve months to the life of the claim. TPAs also handle many aspects of other employee benefit plans such as the processing of retirement plans and flexible spending accounts. Many employee benefit plans have highly technical aspects and difficult administration that can make using a specialized entity such as a TPA more cost effective than doing the same processing in house. TPAs have substantial experience in claims handling, and they usually have access to other supporting services such as actuarial, loss control, managed care, and return-to work programs. Thus, a TPA is generally regarded as the centerpiece of many self-insured programs.

Third party administrators are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process. They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, enrollment and other administrative activities. A hospital or provider organization desiring to set up its own health plan will often outsource certain responsibilities to a TPA.

TPAs have been set up to ensure better services to policyholders and to mitigate some of the negative consequences of private health insurance. However, given the demand and supply-side complexities of private health insurance and healthcare markets, insurance intermediaries face immense challenges. Insurance Regulatory and Development Authority (IRDA) has defined the role of TPAs as one of managing claims and reimbursement. Their role in controlling costs of healthcare and ensuring appropriate quality of care is not fully-defined.

1.1.1 Henner Groupe Kenya

HENNER Groupe is a French company established in 1964 as associations of several entities: Garantie Médicale & Chirurgicale (GMC); Garantie Obsèques (GO); and insurance brokerage company Assurances & Prévoyance Internationales (API). HENNER Group, leader in social coverage, manages 460 millions Euros of premiums, has a turnover of 62 millions Euros and employs 660 persons. With more than 4 millions beneficiaries, Groupe Henner works with 15,000 companies or groups of clients. It is present abroad by insuring 93,800 expatriated beneficiaries in 155 countries and develops its action worldwide through an international network of professionals.

GMC Services International which was created in 1947 offering companies modular medical coverage schemes associated with a single direct-settlement system accredited with selected healthcare professionals. Being a leader in covering expatriate populations, GMC Services offers healthcare plans, assistance and repatriation services, group life programs and retirement plans for more than 129,000 multi-nationals in 190 countries. In 2009, GMC was awarded the administration of Medical Insurance Plan (MIP) plan. The MIP is a self-funded Benefits Plan which has been specifically designed by the United Nations Environmental Program me (UN) for its local employees. GMC is responsible for adjudicating claims and paying covered health claims according to the rules of the MIP Plan as set forth by the UN. GMC Services International is located in Luxembourg, Switzerland, Nairobi, Singapore, Brazil, Tunis and France. GMC Services Kenya is GMC Services International subsidiary located in Landmark Plaza Nairobi.

GMC Services Kenya provides organizations with analysis of their specific needs; review of existing policies; finding solutions with its partners; setting up contracts;

administration of the policies by dedicated professional teams in the legal and actuarial fields; maintaining an updated file of plan member; adjudicating and paying claims; resolving claims disputes; preparing claims report; providing case management; conducting hospital bill audits; providing access to a large network of providers; facilitating direct billing for hospitalization; expediting reimbursement for members claims; helping organizations to monitor health care costs and avoid fraud or abuse.

1.2 Problem Description

This section is divided into two parts; first, dealing with background of the problem and the second with statement of the problem.

1.2.1 Background of the Problem

English proverb; "Health is Wealth" is not a meaningless saying as it defines a very important fact of life. However, an estimated 1.3 billion people worldwide lack access to effective, affordable healthcare, while more than 150 million people in 44 million households worldwide every year face financial ruin as a direct result of large medical bills (International Conference on Social Health Insurance in Developing Countries, 2005). Healthcare has always been a problem area for developing countries in general and Kenya in particular, a nation with a fairly large population and a substantial portion living below the poverty line. Consequently, healthcare access and equity become important issues and health insurance has yet to be developed for poor people.

Today's labor market streams with employees who are either insured or uninsured. For the uninsured employees, the extraordinary costs of receiving healthcare without insurance strongly discourages them from seeking out medical care until it's too late or

the ailment has worsened. This in-turn lowers their productivity in the organization. In contrast, for insured employees, the coverage helps them get timely medical care and improve their lives and health (Bovbjerg and Hadley, 2007). Indeed, the Institute of Medicine (IOM) estimate that lack of coverage is associated with about 18,000 extra deaths per year among uninsured adults and reduced employee productivity in organizations (Mcrill, 2001 and IOM, 2002).

A country of approximately 37 million people, Kenya has struggled to build a health system that can effectively deliver quality health services to its population. Access to health care varies widely throughout the country and is determined on numerous factors, though in particular, major divides exist between the moneyed elite and the poorer masses. In Kenya, the poorer masses—those living below the national poverty line—constitute approximately 52% of the population. These do not have resources to cater for their health bill when they fall ill and health insurance would be a means of achieving this (United Nations Development Programme, UNDP, 2009). Estimation of average life expectancy at 54 years for both sexes below a global average of 68 years stresses the need of a proper managed health care system especially insurance to cushion the poor (World Health Organization, 2007). However, in Kenya 36% of health expenditure originate from households, "mainly through out of pocket spending" with the remainder originating from National Health Insurance Fund (NHIF), government or donors (Ministry of Public Health and Sanitation, 2008).

1.2.2 Statement of the Problem

Considering this challenging health landscape, utilization of health services is a key factor in improving health outcomes for Kenyans, in both the short- and long-term. While TPA's role is to manage employees' health insurance on behalf of the employers, no study has been done in Kenya to determine their role in bring about a well-managed health care system. This study sought to fill-in this knowledge gap by investigating the role of TPA in setting up managed health care systems with special reference to Henner Groupe Kenya

1.3 Objectives of the Study

1.3.1 General Objective

This study sought to determine the role of TPA in setting up managed health care systems with special reference to GMC Services Kenya/Henner Group

1.3.2 Specific Objectives

From the general objective above, the study sought to determine how TPAs in Kenya have been effective and/or efficient in reimbursement of claims management, call centre support to policyholders and medical cost management. Thus, the specific objectives became to:

i. Determine the efficiency of TPA in the reimbursement of claims in setting up managed healthcare systems.

ii. Determine the effectiveness of TPA in medical cost management in setting up
   . managed healthcare systems.

iii. Assess the role of TPAs' call centre support to policyholders in setting up managed healthcare systems.

1.4 Research Questions

The study sought to answer the following research questions:

i. How efficient are TPAs' reimbursement of claims in setting up managed healthcare systems?

ii. How effective are TPAs' in medical cost management in setting up managed healthcare systems?

iii. What is the extent of TPAs' role in call centre support to policyholders in setting up managed healthcare systems.?

1.5 Significance of the Study

The purpose of this study was to investigate role of TPA in setting up managed healthcare systems. The management of Henner Groupe Kenya may benefit from the in-depth report on their roles in setting up managed health care systems. Thus, this can make them understand their relevance in the healthcare sector.

The study can be of significance to the government and financial sector regulators such as Insurance Regulatory Authority (IRA) and Ministry of Labour in Kenya. Policymakers may make improved and informed decisions on policies regarding these TPAs since they would be better placed to make such crucial decisions regarding TPAs role in healthcare management. This can help in the penetration of TPAs in Kenya, thus, bringing about better management of healthcare care systems.

The study would also aid researchers and students on the role of TPA in setting up managed health care systems by contributing to the existing body of knowledge in the area. Academicians may use findings for further research as a reference point. The study would, thus, help researchers to do further research on issues raised in the study.

1.6 Scope of the Study

The study sought to establish the role of TPA in setting up managed health care systems. Towards this end, the study looked at claims/reimbursement management; medical cost management; and, call centre support to policyholder role of TPA and sought to establish how this contributes towards ensuring a well managed healthcare system in Kenya.

The main focus of this study was GMC Services Kenya's headquarter. Data was specifically collected from member organizations that are covered by third party health insurance administration. Thus, they were in a good stead to provide the most reliable information.

1.7 Limitation of the Study

The researcher could encounter the following difficulties in carrying out the research:

Suspicion: the respondents were not willing to give information for two reasons. They did not comprehend why the researcher was carrying out the study in the work area and what the information would be used for. This was mitigated by explaining to the respondents the purpose of the study.

Fear of Victimization: The respondents feared that the information they were to give out would be used to publish negative information about TPAs hence lead to their

victimization. As a remedy, the study sought introductory letter from the University which was presented to the respondents.

Bureaucracy: Due to bureaucracy, the necessary permits and permissions to get access to the information, from the GMC Services Kenya's management, posed a big problem. Much time was wasted seeking for permission to access and ask questions. However, the study sought the help of the managing director to expedite access.

1.8 Definition of Terms

Call Centre Support - Customer interaction centre or telephone service facility set-up to handle a large number of in-bound and out-bound calls, in this case, related to the medical insurance plan

Cost Management - the process of planning and controlling the budget incurred by employer organization in the administration of medical insurance plan under TPA management

Healthcare - Prevention, treatment and management of illness and the preservation of mental and physical well-being through the services offered by medical and allied health profession

Insurance - Promise of compensation to protect the financial well-being of an individual, company or other entity in the case of unexpected loss

Reimbursement - To repay, refund or compensate for expenses incurred in settling medical bills for illness covered by medical insurance plan

Third Party Administration - organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.

1.9 Organization of the Study

This chapter presents the background of the study, statement of the problem, objectives of the study and the research questions. It also gives the justification for the study together with its limitations and scope. The next chapter is literature review which discusses the theoretical orientation regarding third party administration and the literature there-of. Chapter three contains the methodology that was followed in doing the research. Chapter four analyzes data and discusses the findings of the study on each objective. Chapter five summarizes the key findings, presents the conclusions and recommendations there-to.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the various literature that has been done on the subject matter; role of TPA in insuring a well-managed healthcare system. The specific areas covered here are theoretical review, conceptualization and empirical review.

2.2 Financial Intermediation Theory

Financial intermediaries are firms that pool the savings or investments of many people and lend or invest the money to other companies or people to earn a return. Financial intermediaries include banks, investment companies, insurance companies, and pension funds. Insurance companies pool the premiums of the insured to pay for the losses of a few of the insured, thereby preventing a financial catastrophe for the sufferers. The assets and liabilities of financial intermediaries are primarily financial instruments. Loans, stocks, bonds, and other investments are their assets while the deposits and payment obligations, such as the insurance company's obligation to pay for a loss. Financial intermediaries make a profit from the difference from what they earn on their assets and what they pay in liabilities (Fama, 2008).

Financial intermediaries provide valuable services that cannot be obtained by direct lending or investing. Insurance companies provide financial protection in case of a loss, even if that loss is much greater than the premiums paid by the insured. Intermediation reduces the risk of information asymmetry, where the receiver of the funds knows more about their financial condition and their intentions than do the giver of those funds.

Financial intermediaries have expertise in assessing the risk of the applicant for funds that reduces adverse selection and moral hazard. They have easy access to various databases that provide information on both individuals and businesses, and they have expertise in doing their own research and monitoring (Alison, 2008).

TPAs are confronted with the informational asymmetry problems of adverse selection and moral hazard. TPAs solves the problem of adverse selection by screening applicants—verifying information in the application, checking the applicant's history, and by applying restrictive covenants in the insurance contract, such as not covering a pre-existing condition. Adverse selection is also reduced by grouping—placing the healthcare insurance applicant into specific classes where there is a difference in claims history for the group, then charging the appropriate premium. One controversial example is the use of credit scores for determining insurance premiums, since several studies have shown that people with lower credit scores file more claims than those with higher scores (Gupta, 2007).

However, criticisms exist on the theory. In the traditional Arrow-Debreu model of resource allocation, firms and households interact through markets and financial intermediaries play no role. When markets are perfect and complete, the allocation of resources is Pareto efficient and there is no scope for intermediaries to improve welfare. Moreover, the Modigliani-Miller theorem applied in this context asserts that financial structure does not matter: households can construct portfolios which offset any position taken by an intermediary and intermediation cannot create value (Fama, 1980).

2.3 Self-Funded Benefit Schemes

TPAs administer self-funded benefits for employers. Employers that elect to offer benefits to employees have two options for paying, or funding, those benefits. The two funding arrangements are:

Self-Funded Benefits: In this arrangement the employer (assisted by a consultant, agent, broker, or TPA) creates, defines and establishes a benefit plan (schedule of benefits) for its employees. Employee payroll deductions and employer contributions that would normally be used to pay an insurance policy premium are placed in a special fund for the sole purpose of paying employees' medical bills and fees as they are incurred. In this arrangement the employer assumes the financial risk, as it must pay the medical bills of its employees that fall within the scope of the plan. The employer must calculate and create reserves to support the benefit plan. Technically speaking, "self-funded" is a term that describes an employer that is responsible for 100% of the medical bills of its employees (Alison, 2008).

Partially Self-Funded Benefits: In this arrangement the employer self-funds, but purchases aggregate stop-loss coverage or specific stop-loss coverage to protect against cases of catastrophic employee injury or illness which might create medical bills that are in excess of the funding that the company has on hand, and aggregate stop-loss to maximize the total exposure of the health plan. Additionally an employer may choose to self-fund or partially self-fund dental and prescription drug benefits while opting to provide fully insured coverage for life, Life and Accidental Death and Dismemberment (AD&D), and other ancillary benefits (Alison, 2008).

Self-funding differs from fully-insured benefits (insurance policies) in many ways. Fully insured policies require monthly premiums to an insurance company in exchange for a predefined (and limited) set of services, such as healthcare. Typically the employer deducts money from an employee's pay to cover some or all of the premium costs. In this arrangement the employer assumes no financial risk, beyond premium payments, for the healthcare or benefits provided to its employees (Bhat and Babu, 2003). Companies tend to choose a funding arrangement for their benefits based on what option provides the most amount of coverage for the least expense. Generally companies with less than 100 employees find that fully insured benefits are the most cost-effective route, while companies with over 100 employees have an economy of scale that can make partial self-funding a more cost-effective option. And companies with thousands of covered lives tend to find that fully self-funding their health plan is the most cost effective option (Jutting, 1999).

2.2 Efficiency of TPAs in Reimbursement of Claims

The basic role of the TPA is to function as an intermediary between the insurer and insured and facilitate cash less service to the insured. However as per practice the following is done by the TPAs or the following steps followed by TPAs from the initiation until settling the claims: All the records of medical insurance policies of an insurer will be transferred to the TPA once the insurance company has given the business to a TPA then the TPA will issue identity cards to all policyholders, which they have to show to the hospital authorities before availing any hospitalization services, in case of a claim, policyholder has to inform the TPA on a 24-hour toll-free line provided by the

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latter; on informing the TPA, policyholder will be directed to a hospital where the TPA has a tied up arrangement (Bhat, Maheshwari and Saha, 2005).

However, the policyholder will have the option to join any other hospital of their choice, but in such case payment shall be on reimbursement basis after which, TPA issues an authorization letter to the hospital for treatment, and will pay for the treatment. TPA will track the case of the insured at the hospital and at the point of discharge; all the bills will be sent to TPA. TPA will also make the payment to the hospital and sends all the documents necessary for consideration of claims, along with bills to the insurer then the Insurer reimburses the TPA (Gupta, 2007).

TPAs receive a commission of 5.5% of premium amount from the insurance company for all the services rendered. The core product or services of a TPA is ensuring cashless hospitalization to policyholders. Intermediation by TPAs ensures that the policyholders get the hassle-free services; insurance company pay for efficient and cost-efficient services and the healthcare get their reimbursement on time. It is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs, developing protocol to minimize unnecessary treatment/investigations, improve quality of services and ultimately leads to lower insurance premium. However, the system is currently going through teething troubles. Cash less policy, where the insurers directly pay the hospital bills to healthcare providers (Kalyani, 2004).

TPAs were introduced as intermediaries to facilitate the claim settlement between insurers and insured. The agreement between TPAs and insurance companies provide for monitoring and collection of necessary information, documents and bills pertaining to the treatment of the insured. All these documents are examined by the TPAs and after

processing sent to the insurance companies for reimbursement. Here the TPAs play the role as defined by IRDA by fulfilling the responsibility of claims settlement, getting reimbursement from the insurance company and paying to the healthcare providers. This leads to achievement of simplicity in claim process and streamlining the claim process as mandated by the IRDA (Mills, 2000).

A claim is essentially the information submitted by the provider of healthcare services to a healthcare plan or claims administrator, such as a TPA or insurance carrier, for payment of services rendered. A "clean" claim fully details the patient's demographic information, benefits information, the date of service, and coding which represents patient's diagnosis and the type of treatment received by the employee. In addition, a clean claim is unencumbered by coordination of benefits (COB), subrogation, or other issues. Once a healthcare provider submits a claim to the TPA, the TPA adjudicates the claim by taking the following action. They review it for accuracy of information, current coverage including eligibility verification, provider status, and contracted rates. They then verify other information such as pre-certification requirements and medical records. The process of adjudication also includes clarification of information presented on the claim (Subramaniam, 2005).

Most TPAs use computer programs that check all the information needed to adjudicate the claim. If no irregularities are found, the claim is paid promptly. Regardless of the process within each TPA, the end result remains that the TPA adjudicates the claim and then notifies the employer of their funding responsibility. The client then "funds" the claim by releasing payment for it (Sigma, 2001). Then the claims auditing which will act on qualitative or quantitative review of services rendered or proposed by a health

provider. Most audits are retrospective and may be a comparison of patient records with any of the following: claim-form information, a patient questionnaire, a review of hospital or practitioner records, a pre- or post-treatment clinical examination of a patient, or fee verification. Investigating all circumstances, events, and facts surrounding an illness or injury. Claims investigators compile detailed reports that may include reports from attorneys, physicians, insurance experts, or other qualified experts, to help resolve the claim. Fraud and medical necessity are the primary reasons for claim investigation (Subramaniam, 2005).

Typically, claim investigation is most widely used to determine liability in workers compensation and disability claims. Repricing is then done in a variety of ways, but the three most prominent are automatic at-point-of-claim adjudication, internet re-pricing, and vendor repricing which is the process of converting (applying discounts or adjusting for predetermined rates) the initial billed charges into the amount to be paid. When a TPA is taking over an employer group from another TPA, they may adjudicate the run-in claims (those incurred prior to the transfer date, but received after that date). Likewise, if a self-funded group were to convert to a fully insured plan, the run-out claims (those incurred before the transition date) would continue to be administered by the TPA (Sigma, 2001).

Claims Subrogation: The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable for the claim incurred. For example, where one insurer pays damages that may also be covered by another insurer's policy, the paying insurer will obtain a subrogation right from the insured to pursue the claim against the insurer who has not yet paid (WHO, 2005).

2.2. Effectiveness of TPA in Medical Cost Management

TPAs sort out health care providers by setting up a network with hospitals, general practitioners, diagnostic centres, pharmacies, dental clinics etc. They sign a memorandum of understanding with insurance companies under which they let policyholders know about the various healthcare delivery facilities and the methods for settling claims. The agreement between TPA's and healthcare facilities includes the collection of documents and bills concerning the treatment. Documents are assessed and sent to the insurance company for reimbursement. TPA's also procure reimbursements from the insurance company and pay the healthcare provider. TPA's usually have in-house specialists comprising of medical practitioners, insurance consultants, legal experts and IT professionals. The mainstay of TPA's is information management system. The value added services provided by TPAs include ambulance service, medicines and supplies, information about health facilities, hospitals, bed availability, 24 hour help line (Ekman, 2007).

The introduction of TPAs is of great help and relief to the insurance companies, which have been searching for ways and means to get their management expenses in line with the specifications laid down by the IRDA. The job of TPAs is to maintain a database of policyholders and issue identity cards with unique identification numbers to them. They also handle all the policy- related issues, including claim settlements for the policy holders Insurance companies (insurers) can now outsource their administrative activities, including settlement of claims, to third party administrators, who offer such services for a cost. The insurers remunerate the TPAs; hence, policyholders receive enhanced facilities at no extra cost (Carrin, Evans and Xu, 2007). Once the policy has been issued, all the

records will be passed on to the TPAs and all further correspondence of the insured will be with the TPAs and not with the insurance companies (Bhat, Maheshwari and Saha, 2005). The TPA's are expected to provide value-added services to the consumers, like arranging ambulance services, medicines and supplies, guiding policy holders for specialized consultation, and providing information about 24- hour help lines, health facilities, bed availability, organization of lifestyle management and well- being programs. With the advent of TPA, the insurance companies aim at ensuring higher efficiency, standardization of charges, greater awareness and penetration of health insurance to a larger section of the people (Anand, 2011).

High Claim Ratio (110% +) has made medical insurance unviable and unprofitable. TPA's play a major role in cost containment and last 3 years, the average cost/incidence is controlled. ICR also has shown a downward trend. Service provider to built cost structure keeping in mind the Sum Insured (SI) (Higher SI can absorb higher costs), policy terms and conditions (Capping etc.) Standardized rates offered by TPAs/Insurer, improving volumes with optimal cost mix is a win solution, although, the customers are not required to pay any extra charges for the services of TPAs, yet they are indirectly paid in the form of higher premium charged by the insurance company (Subramaniam, 2005). No doubt, the claims ratio is coming down and the insurance companies are getting freed of their workload both in the form of money and other administrative cost, still this savings are not passed to customers in the form of additional benefits rather charged with higher premium (Carrin, Evans and Xu, 2007).

TPAs are expected to provide cashless facilities which will increases the capacity of policyholders to incur higher costs at the time of illness, and therefore have a tendency to

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inflate the demand for high-cost care. This could be limited to a certain extent only with the presence of a system of co-payments. But this is ultimately defeating the vary purpose of introduction of TPAs; that is, to minimize the cost of healthcare (Bawa and Verma, 2011).

Cost of management also increases because of inability of the TPAs to make enough profits. Various studies reveal that TPAs are dissatisfied with the 5.5% commission. Moreover there is lot of variation in calculating break-even among the TPAs on account of their in-built costs. As the breakeven in metro at Rs 20 crore of premium business will account for Rs 8 crore in non-metro. Some TPAs are out rightly admitting that they are incurring losses because of high management cost and lesser commission and would not be able to carry out activities and functions as per defined framework (Bhat and Babu, 2003).

2.3 Role of TPAs in Call Centre Support to Policyholders

Third Party Administrator (TPA) is an important link between Insurance companies' policyholders and healthcare providers (hospitals). A TPA's role is to provide administrative support to the insurance companies for servicing their insurance policies. this include cashless hospitalization: Each policy holder is provided with a list of empanelled hospitals where he or she can avail cashless hospitalization, ID card TPA provides ID cards to all their policy holders in order to validate their Identity at the time of admission, Claims Management: On behalf of insurance companies TPA administers and settles claims to hospitals and policyholders and 24 Hour Customer Support Services: TPA provides assistance through its 24 hour call centre. Information regarding

policyholders' data, provider network, claim status, benefits available with existing cardholder, etc are furnished on request (Mills, 2000).

The call center is always open for the policy holders and its only policy holders (those who have medical insurance) that can avail the cashless service from TPAs. Insurance call centre only helps the policyholders in getting cashless approval from TPAs after which guarantee approvals or reimbursement will take place. Policyholder can be hospitalized in an emergency after showing their Insurance card or policy copies and are supposed to fill an undertaking form at the reception. They should complete any pre-authorization formality filled by the concerned doctor. TPA will issue an authorization letter for the coverage as per the policy to the insurance company. The response will come from TPA in the form of authorization letter. Policy holders can directly approach the hospital admission counter for admission with the ID Card and one copy of the authorization letter will be given to the Admission/IP billing department. Hospital will extend cashless treatment to the policyholder up to the authorized amount (United Nations Development Programme, 2009). In case the authorized limit gets exhausted get in touch with Insurance help desk, they will try to get an enhancement. An enhancement may require a few hours to process. At the time of discharge, the policyholder will inform the Insurance desk and may be required to sign a claim form.

2.5 Conceptual Framework

Conceptual framework is a diagrammatical presentation of the independent and dependent variables and the relationship among themselves. This enables the reader to not only have a snapshot but clear understanding of what the study seeks to establish. From the literature discussed above and the research objectives, the independent variables

are claims/reimbursement management; medical cost management; and, call centre support to policyholders. The dependent variable would be well managed healthcare system. The conceptual framework is thus presented:

Figure 1: Conceptual Framework

Moderating Variables

| Technological Use |
| Working |
| Environment |

| Efficiency of TPA |
| in Reimbursement |
| of Claims |

| Effectiveness of TPA |
| in Medical Cost |
| Management |

| TPA (Healthcare |
| System Management) |

| TPA's Role in Call |
| Centre Support to |
| Policyholders |

Dependent Variable

Independent Variables

| Regulatory Framework |
| Competition from |
| Insurance |
| Companies/HMOs |

Intervening Variables

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2.6 Empirical Review

Mahal (2002) analyzed whether the regulatory steps in the IRA bill will influence the progress towards achieving health policy goals of India or not; and also described the regulatory structure currently existing in India in relation to health care provisions, private health insurance and its ability to promote national health policy goals. The study concluded that private health insurance is likely to have an impact on equity in the financing of health care, cost and quality of health care. The private health insurance may turn out to be more inequitable than social insurance of comparable coverage. However an informed and well defined, regulated and implemented insurance regime will ameliorate the bad outcomes of private health insurance.

Parekh (2003) examined the training aspects of the TPAs and concluded that there is a dearth of knowledge and training in the TPA community and training for the leadership team alone is inadequate. The lack of training at most insurance companies is also woefully insufficient and alarming. So the study suggested that IRDA should arrange for adequate training facilities for TPAs which will enhance their knowledge and the ultimate benefit will be reap by the community. Sureka (2003) conducted a study on the TPAs and its regulator and concluded that TPAs are forced to provide service to the policyholder for an obsolete product – the Mediclaim policy which was introduced at least almost two decades ago. Beside this if the policyholder is made to pay for the services he is availing, then why is the insurer imposing a TPA on the policyholder? The study provided that a policyholder should have the right to accept or refuse the services of a TPA for such absolute products.

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Gupta, Roy and Trivedi (2004) examined the role of TPAs and the issues that required to be taken into consideration while evaluating their usefulness and functioning in India. The study based on a series of meetings, discussions and interviews with various TPAs, insurance companies and providers. No doubt the TPAs face different barriers in terms of capital, capacity and connections, but still they are providing cashless transaction at the time of service delivery to the customers. The IRDA and Health Ministry should come together so as to ensure TPAs which in turn will ensure active role of the TPAs in Community and Universal Health Insurance Schemes.

Bhat and Babu (2004) provided that introduction of IRDA has paved the way for (TPAs) third party administrators who are playing the role of insurance intermediaries in setting up of managed health care systems. The objective behind setting up of TPAs was to ensure better services to policy holders and to mitigate the negative consequences of private health insurance. However the TPAs face immense challenges in the health sector because of demand and supply side complexities of private health insurance and health care market. IRDA has defined the role of TPAs as insurance intermediary in the management of claims and reimbursement, but at the same time their role is not well defined in controlling the cost of health care and ensuring appropriate quality of care.

Mohapatra (2005) provided that TPAs form a vital link between insurers, healthcare service providers and policyholders. Beside this also provided that for a smooth functioning of the system, the TPAs should be judiciously governed and meticulously regulated. Under the present dispensation, the issues of standardization/ governance between the TPA and the providers is left to the vagaries of market forces, the respective parties flexing their muscles to browbeat one another, forcing the TPAs to negotiate local

agreement. Further it is recommended that IRDA constitute a consultative mechanism consisting of representative from providers, insurers, TPAs and consumer bodies to attack the various issues affecting smoother governance. If need be, necessary changes can be brought about in the regulatory compliances.

Bhat, Maheshwari and Saha (2005) ascertained the experiences and challenges faced by hospitals and policyholders in availing the services of TPA in Ahmedabad, Gujarat. The results of the study shown that only a small percentages of respondents have knowledge about existence of TPA, there is substantial delay in settlement of claims between TPAs and health care providers, administrators of hospital perceive burden in terms of efforts and expenditure after the introduction of TPA. The study concluded there is no mechanism to appraise the performance of TPAs and regulatory body need to focus attention on developing mechanism, in order to strengthen the TPAs so as to ensure smooth delivery of TPAs services in the emerging health insurance market.

Ruchismita, Ahmed and Rai (2007) highlighted the challenges in financing health in India and examined the role of health insurance in addressing these challenges. The study provided with an operational framework for developing sustainable health insurance model under national rural health mission which will respond to the contextual need of different states. Moreover innovative pilots of partner agent model led micro insurance could give useful insights for designing a national level programme, led by an apex body could systematically impact the health system in the country.

Jaswal (2010) examined the cashless hospitalization which was evolved during the last decade, as an integral part of health insurance claim offering, making claim under health insurance policy indeed a customer friendly process. The study concluded that the

practice to pay claims through physical cheques is quite outdated and inefficient; it would benefit all, if newer methods of payment like electronic fund transfer were to be implemented. Moreover, Indian medical industry being unregulated, there are no standard treatment guidelines or uniform medical protocols which are followed by medical professional all over the country, in all hospitals.

Various studies revealed that the Indian healthcare scenario is composed of high out-of-pocket payment; health insurance availed by small portion of population; uncontrolled expansion of the private health sector; allowance of FDIs in the Insurance sector; and falling standards of government healthcare facility in term of both accessibility and availability. This lead to the situation in which lot of confusion exist about, "are the reforms in the insurance sector are equally appreciable and effective"? Moreover what should be the ideal set of reforms for next agenda for development in the insurance sector specifically for health insurance? However to a large extent this was very much clear at that the health insurance sector needed to expand for greater coverage, at least for catastrophic illnesses (Bovbjerg and Hadle, 2007).

Moreover it is also found that there is considerable confusion on the role and usefulness of third party administrators (TPAs) in India. The Insurance Regulatory and Development Authority (IRDA) defines TPA as „an insurance intermediary licensed by the Authority who, either directly or indirectly, solicits or effects coverage of, underwrite, collect, charge premium from an insured, or adjust or settle claims in connection with health insurance, except as an agent or broker or an insurer (Bhat, Maheshwari and Saha, 2005). "Basically, a TPA plays a triangular role of service integrator between the insurer, the insured and the health service provider. Keeping into mind such an important role being

assigned by the IRDA, there is dire need to study the role actually played by them. So the study was conducted with a broad objective to examine the conditions, code of conduct/role defined by IRDA for TPAs and role actually played them and finally to come out with the parameters of parity and deviation between role defined and role played (Bovbjerg and Hadle, 2007).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology that was used to carry out the survey, what informed the selection of the research design, the target population, sampling method used, data collection instrument, how data was analyzed, interpreted and presented.

This study is approached from a positivism philosophy point of view. The positivism school of thought is based on the philosophy that only one reality exist though can only be known imperfectly due to human limitations and researchers can only discover this reality within the realm of probability (Reichardt and Ralli, 1994). This school also holds that the researcher and the subjects were independent; didn't influence each other or outcome. Thus, the researcher upheld objectivity by remaining neutral to prevent values and biasness from influencing outcome. This study achieved this by applying scientific research approaches from sampling to analysis and interpretation (Guba and Lincoln, 1994). Positivism approaches vouch for experimental methods of data collection which can be modified as it is challenging to subject human to conditions.

3.2 Research Design

Descriptive research is used to obtain information concerning the current status of the phenomena to describe "what exists" with respect to variables or conditions in a situation. Descriptive research design was developed to provide further insight into the research problem by describing the variables of interest. A descriptive study is concerned with

determining the frequency with which something occurs (Bryman and Bell, 2003). This design was aimed at determining the role of third party administrators in setting up managed health care systems. According to Mugenda (2008), a descriptive study is concerned with finding out the what, where and how of a phenomenon. This approach enabled this study achieve its objectives.

3.3 Target Population

Target population is the complete set of individual's cases or objects with some common characteristics to which the research wants to generate the results of the study (Kothari, 2004). In this study, the target population was the member organization/clientele covered by Henner Group Kenya. From Henner Groupe Kenya 2011 report, the TPA covers, among other organizations: United Nations Environmental Programme (UNEP); United Nations Development Programme (UNDP); World Food Programme (WFP). The study targeted the active staff and retirees of these three main clients (Table 3.1):

Table 3.1: Target Population

Organization	Population	Percentage
UNEP	3,000	62.5
UNDP	1200	25.0
WFP	600	12.5
Total	4,800	100.0

Source: Henner Groupe Kenya (2011)

3.4 Sampling Technique and Sample

The study adopted stratified random sampling technique to come up with the sample. This is based on the target population being heterogeneous (consisting of three

organizations that requires representation). Stratified random sampling technique was used as it ensured that the three organizations are represented in the sample. According to Mugenda and Mugenda (2003), stratified technique is advantageous as it samples each subpopulation (stratum) independently by grouping members of the population into relatively homogeneous subgroups before sampling. This improves the representativeness of the sample by reducing sampling error. The target population was stratified into the three organizations and random sampling technique used to select samples from the stratum (Table 3.2). Random sampling technique was used within the stratum as it accorded all the members of a population equal probability of being included in the sample. This enhances representation and eliminates biasness making the technique scientific (Mugenda and Mugenda, 2003). Proportionate sample size (10% of the target population) was selected from each organization. Mugenda and Mugenda (2003) vouched for a target population of 10 to 30% as representative.

Table 3.2: Sampling Frame

Organization	Population	Sample	Percentage
UNEP	3,000	300	10.0
UNDP	1200	120	10.0
WFP	600	60	10.0
Total	**4,800**	**480**	**10.0**

3.5 Data Collection Instrument and Procedure

The data was gathered through questionnaires. Gall *et al.,* (1996) points out that, questionnaires are appropriate for studies since they collect information that is not directly observable as they inquire about feelings, motivations, attitudes,

accomplishments as well as experiences of individuals. They further observed that questionnaires have the added advantage of being less costly and using less time as instruments of data collection.

The questionnaire was semi-structured (have both open and close-ended questions). While the close-ended questions guided the respondents' answers within the choices given, the open-ended ones was useful in obtaining a more detailed response essentially in cases where the researcher has no pre-determined options. The questionnaire addressed the three research objectives. The first section of the questionnaire enquired general information about the respondents; the rest of the sections dwelt on efficiency of reimbursement of claims; effectiveness of medical cost management; and, extent of call centre support to policyholders.

After designing the questionnaire and before actual data collection, a pilot study was conducted on 20 members covered under Henner Groupe Kenya. Data collected during the pilot study was not used in the final data analysis. The purpose of the pilot study was to establish the accuracy and appropriateness of the research design and instrumentation. After the pilot study the main survey followed.

3.5.1 Validity Test

According to Shanghverzy (2003), validity is the degree by which the sample of test items represents the content the test is designed to measure. To establish the validity of the research instrument the research sought opinions of experts in the field of study especially the researcher's supervisor. This facilitated the necessary revision and modification of the research instrument thereby enhancing validity.

3.5.2 Reliability Test

According to Shanghverzy (2003), reliability refers to the consistency of measurement and is frequently assessed using the test–retest reliability method. Reliability is increased by including many similar items on a measure, by testing a diverse sample of individuals and by using uniform testing procedures. The pilot study allowed for pre-testing of the research instrument. The clarity of the instrument items to the respondents was established so as to enhance the instrument's validity and reliability. The pilot study enabled the researcher to be familiar with research and its administration procedure as well as identifying items that require modification. The result helped the researcher to correct inconsistencies arising from the instruments, which ensured that they measure what is intended. Thereafter, the data was collected using questionnaires that were hand delivered to the respondents.

3.6 Data Analysis Methods

With the data having been collected, the filled-in questionnaires were coded to enable the responses to be grouped into various categories and entries made into Statistical Package for Social Sciences (SPSS version 17). Descriptive statistics such as means, standard deviation, frequency distribution and percentages were used to analyze the data. Tables were used to present the data collected for ease of understanding and analysis. This generated quantitative reports through tabulations, percentages and measure of central tendency.

Multiple regression analysis was conducted to determine the relationship between dependent (Healthcare System Management) and independent variables (reimbursement of claims, cost management and call centre support). The regression model, thus, became:

$$HCM = \beta_0 + \beta_1 RC + \beta_2 MCM + \beta_3 CCS + \varepsilon$$

Whereby: β_0 is the regression intercept; β_1, β_2 and β_3 are the regression coefficients; HCM is the dependent variable (Healthcare System Management); RC is reimbursement of claims; MCM is medical cost management; and, CCS is call centre support. From the analysis, the contribution of third party administration (TPA) towards healthcare management was determined using Pearson's Correlations (R); the significance of the model and the variables, there-to, were determined using analysis of variance's (ANOVA) F-test and regression coefficient's t-test.

3.7 Operationalization of Variables

Operationalization is the process of strictly defining variables into measurable factors. It involves finding a measurable, quantifiable, and valid index for the variables (both independent and dependent variables) in such a way that fuzzy concepts are defined allowing them to be measured, empirically and quantitatively (Shuttleworth, 2008).

Table 3.3: Operational Definition of Variables

Variable	Indicators	Measurement	Measuring Scale	Type of Analysis	Tool of Analysis
Managed Healthcare	Affordable Healthcare Employee Health/ Wellness Healthcare Access	Cashless Hospitalization Optimal Treatment (providing access to a large network of providers) Reduce Sick Leave Days Reduce Employee Death Workers Compensation system Timely medical care	Ratio	Descriptive Inferential	Frequencies Mean Regression Correlation
Reimbursement of Claims	Fraudulent claim mitigation Timely claim payment	Adjudicating and paying claims Resolving claims disputes Preparing claims report Expediting reimbursement for members claims Avoid fraud or abuse of health insurance	Ordinal	Descriptive Inferential	Frequencies Mean Regression t-test
Medical Cost Management	Medical cost containment Reduce indemnity losses Helping organizations to monitor health care costs	Costs of receiving healthcare Conducting hospital bill audits Facilitating direct billing for hospitalization Annual medical ceiling Stop loss, Hardship clause	Ordinal	Descriptive Inferential	Frequencies Mean Regression t-test
Call Centre Support to Policyholders	Setting up contracts with Healthcare providers Administration of the insurance policies Policy Enrolment Confirmation	Review of existing policies Finding medical care solutions with its partners Maintaining an updated file of plan member Emergency guarantee of payment	Ratio	Descriptive Inferential	Frequencies Mean Regression t-test

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents the data analysis, presentation and interpretation on the role of third party administrators in setting up managed health care system the case study being Henner Groupe Kenya. The findings answer the research questions. Data collected was analyzed and reports produced in form of tables.

4.2 Response Rate

The researcher targeted 480 respondents who are member organizations/clientele covered by Henner Group Kenya. Four hundred and eighty (480) questionnaires were distributed to the respondents. However, 440 out of 480 target respondents filled in and returned the questionnaire contributing to 92% response rate. This conformed to Mugenda and Mugenda (2003) who recommended that for simplification a response rate of 50% is sufficient for scrutiny and exposure, 60% is good and a response rate of 70% and over is excellent.

This response rate can be attributed to the data collection procedure, where the researcher employed research assistants to administer questionnaires as they wait for respondents to fill-in the questionnaires. The 8% questionnaires that were not returned were due to rationale like, the respondents were not accessible to fill them in at that time and with various follow-ups there were no constructive responses from them. The response rate demonstrates willingness of the respondents' to partake in the survey.

Table 4.4: Response Rate

	Frequency	Percentage
Filled in Questionnaires	440	91.7
Unfilled Questionnaires	40	8.3
Total	**480**	**100.0**

4.3 Demographic Information

This section presents the findings on the respondents' demographic information. This was useful in determining the general characteristics on the study's respondents and in determining their appropriateness for the study.. This include the gender, organization they worked for and work experience in the organization, monthly contribution in the medical scheme, dependants coverage in the Scheme and the types of illnesses covered.

Table 4.5: Organization

Organization	Frequency	Percentage
WFP	50	11.4
UNDP	100	22.7
UNEP	290	65.9
Total	**440**	**100**

The Table 4.5 shows the various organizations that the respondents work for and as depicted from the study majority that is 65.9% work for the United Nations Environmental Programme (UNEP), 22.7% work for the United Nations Development

Programme (UNDP) while the least of the respondents work for the World Food Programme thus 11.4%.

Table 4.6: Gender of the Respondents

Gender	Frequency	Percentage
Male	250	56.8
Female	190	43.2
Total	**440**	**100.0**

The study sort to find out the gender of the respondents and as shown in the figure above; a bigger number of the respondents were male making 56.8% of the respondents while their female counterparts were 43.2%.

Table 4.7: Duration Worked for the Organization

Duration (Year)	Frequency	Percentage
Less than 1 Year	45	10.2
1 to 5 Years	50	11.4
6 to 10 Years	155	35.2
11 to 15 Years	100	22.7
Over 15 Years	90	20.5
Total	**440**	**100.0**

The Table 4.7 shows the duration the respondents have worked in the organization since it is of significance to know the duration thus determining their level of experience with TPA. Majority have worked for their various organizations for 6-10 years making 35.2% followed by those who have worked for 10-15 years having 22.75. Respondents who have worked for over 15 years had a percentage of 20.5 while those who have worked

between 1-5 years had 11.4%. The minority of the respondents who have worked for their various organizations for less than 1 year had a percentage of 10.2%.

Table 4.8: Contribution per Month towards Medical Health Care Insurance

Amount	Frequency	Percentage
Ksh1000 or Less	0	0
Ksh1001 - 2000	80	18.2
Ksh2001 - 3000	130	29.5
Ksh3001 - 4000	100	22.7
More than Ksh4000	130	.29.6
Total	440	100

The study sought to establish the monthly contributions that the respondents made towards the medical insurance healthcare scheme. Table 4.8 shows that 29.5% of the respondnets pay Kshs 2001-3000 or at least 29.6% of the respondents pay more than Kshs 4000 per month; 22.7% of the respondents claimed that they made a monthly contribution of Kshs 3000-4000 while 18.2% made a monthly contribution of Kshs 1001-2000. No respondnet made a monthlky contribution lesss than Ksh1,000. This depicts that majority of the GMC Services Kenya's cleints contribute at least Kshs2,000 monthly.

Table 4.9: Dependents and Insurance Cover

	Yes%	No%
Whether dependents are covered in the health care insurance plan	97.7	2.3
Whether insurance covers both in-patient and outpatient medical care expenses	68.2	31.8

On whether dependents are covered by the health care insurance plan the respondents stated who stated yes were 97.7% while those who stated no were 2.3%. On the question

whether the insurance covers in-patient and outpatient medical expenses, 68.2% stated yes while 31.8% stated no.

Table 4.10: Illnesses Covered

	Yes (%)	No (%)
Optical illnesses	97.7	2.3
Dental illnesses	90.9	9.1
Cancer illnesses	11.4	88.6
HIV/AIDS related illness	10	90
Dermatological (skin) related illness	79.5	20.5
Chronic diseases	93.9	6.1
Theatre/operations	45.5	54.5
Over the counter medication	100.0	0.0

The study sort to find out the illnesses that are covered in the health insurance plan and as shown in the Table 4.10 above: Optical illnesses had the highest percentage together with over the counter medication thus 100% and 97.7% respectively followed by chronic illnesses having 93.9% then Dental 90.9%, Dermatological 79.5%, theater operations 45.5% while lastly cancer and HIV/AIDS which had the least cover thus 11.4% and 10% respectively.

4.4 Effectiveness of TPA in Reimbursement of Claims

This section presents the findings on the effectiveness of the TPA in reimbursement of claims. The section looks at medical schemes terms regarding reimbursement and efficiency in claims reimbursement.

Table 4.11: Reimbursement of Claims

	Yes (%)	No (%)
As per policy of insurance scheme whether required to pay part of the medical bill	75.0	25.0
In case of personal medical expenses whether reimbursement is done	97.7	2.3
Whether satisfied by the way claims are handled by third party administrators	92.7	7.3
During claim processing whether GMC/Henner Group monitor and collect necessary information, documents and bills pertaining to treatment	93.9	6.1
In comparison to other TPA's, whether GMC/ Henner group has achieved simplicity in claim process and streamlining the claim process	88.2	11.8
Whether erroneously deducted at one point for medical health care services not received	9.1	90.9

The respondents are required to pay part of the medical bill as per the policy of insurance scheme, the respondents that stated yes were 75% and in case of personal medical expenses whether reimbursement is done 97.7% responded yes. On the point whether the respondents are satisfied by the way claims are handled by TPA, 92% stated satisfaction indeed. During claim processing 93.9% stated that GMC/Henner Group monitors and collect necessary information, documents and bills pertaining to treatments. Lastly was on the point whether the respondents have ever been erroneously deducted for medical health care services not received and the response was 9.1% saying yes.

Level of Satisfaction with Reimbursement of Personal Claims

On whether the respondents were satisfied with the time take to reimburse personal claims, 6.8% of those surveyed were very satisfied, 18.2% were satisfied while 18.2% were very dissatisfied. Majority of the respondents were indifferent at 34.1% while 22.7% were dissatisfied.

Table 4.12: Level of Satisfaction with Reimbursement of Personal Claims

Satisfaction	Frequency	Percentage
Very Satisfied	30	6.8
Satisfied	80	18.2
Indifferent	150	34.1
Dissatisfied	100	22.7
Very dissatisfied	80	18.2
Total	**440**	**100**

4.5 Effectiveness of TPA in Medical Cost Management

This section presents the findings on the effectiveness of TPA in medical cost management. It looks at TPA's role in medical cost saving, administrative efficiency and respondents' knowledge on cost related clauses in the policy.

Table 4.13: Medical Cost Management

	Yes %	No %
Owing to third party administration by GMC/ Henner Group whether healthcare access has improved owing to paying of incidences irrespective of health illnesses	93.2	6.8
Whether GMC/Henner group has freed organizations from health care insurance workload both administrative and money costs	46.1	53.9
In cost management of medical insurance plan whether members are aware of 'stop loss' or 'hardship clause'	93	7

Owing to third party administration by GMC/ Henner Group whether health care access has improved owing to paying of incidences irrespective of health, 93.2% of the respondents stated that it has improved while on the point whether GMC/Henner group

has freed organizations from health care insurance workload both administrative and money costs, 46.1% stated yes while 53.9% stated no. On whether aware of 'stop loss' or 'hardship clause' in cost management of medical insurance plan, 93% said they are aware while 7% said they are not aware.

Table 4.14: Effect Henner/GMC group has on saving costs of healthcare in terms of expenses incurred

Effect	Frequencies	Percentage
Increased cost saving effect	200	45.5
Reduced cost saving effect	190	43.1
No change in cost saving	50	11.4
Total	**440**	**100.0**

On the effect that Henner/GMC group has on saving costs of healthcare in terms of expense incurred 45.5% of the respondents stated it has increased, 43.2% stated it has reduced wile 11.4% stated no change.

4.6 Effectiveness of TPA in Call Centre Support to Policyholders

This section presents the findings on the effectiveness of TPA in call centre support to policyholders. It looks at TPA's role in sending updates to the clients, confirmation of enrolment, efficiency in responding to the insured enquiries and accuracy of the information received.

Table 4.15: Support to Shareholders

	Yes	No
Whether Henner/GMC group sends quarterly reports on updated medical health care service providers	93.2	6.8
Whether medical facilities networks are available all over the country (Kenya)	92.5	7.5
After seeking medical treatment whether you receive statements of explanation of benefits (EoB)	93.9	6.1
Whether GMC/Henner group maintains an updated file on dependents	95.5	4.5

On whether Henner/GMC group sends quarterly reports on updated medical health care service providers, 93.2% stated it does while on the point whether medical facilities networks are available all over the country (Kenya) 92.5% stated yes. After seeking medical treatment 93.9% of the respondents stated to receive statements of explanation of benefits EoB and finally 95.5% of the respondents suggested that GMC/Henner group maintains an updated file on dependents.

Table 4.16: How Frequent Statements Of Explanation Of Benefits Are Received

Frequency	Percentage
Monthly	9.1
Annually	22.7
When a claim is made	68.2
Total	**100**

The frequency by which the statement of explanation of benefits was received by the respondents was of interest to the study and as shown in the table above: those who stated to receive when claims were made was at 68.2%, those who received annually had 22.7% while those who received monthly had 9.1%.

Table 4.17: Whether GMC/Henner Group sends Confirmation of Enrollment

Response	Frequency	Percentage
Yes	400	90.9
No	40	9.1
Total	**440**	**100.0**

Ninety Percent (90.9%) of the respondents are of the idea that GMC/Henner Group sends them confirmation of enrollment while 9.1% of the population disagrees with this.

Table 4.18: Channels through which Confirmation of Enrollment is received

Channels of communication	Frequency	Percentage
Email	300	68.2
Postal mail	70	15.9
SMS's	50	11.4
Telephone	20	4.5
Total	**440**	**100.0**

Various channels are used to send confirmation of enrollment into the medical insurance plan and the most popular according to the respondents is E-mail at 68.2% followed by post 15.9% then SMSs 11.4% and lastly telephone 4.5%.

Table 4.19: Rate on the Accuracy Of Information Contained In The Confirmation Of Enrollment

Rating	Frequency	Percentage
Accurate	350	79.5
Very accurate	25	5.7
Perfect	25	5.7
In accurate	15	3.4
Erroneous	25	5.7
Total	**440**	**100**

The study sort further for the respondents to rate the accuracy of information contained in the confirmation of enrollment: 90.9% rated it accurate while 9.1 rated it quite inaccurate.

Table 4.20: Efficiency of GMC/Henner Group to Enquiries

	Frequency	Percentage
Efficient	380	86.4
Very efficient	40	9.1
Inefficient	20	4.5
Total	**440**	**100.0**

The Table above shows the results of the respondents on how they thought GMC/Henner group responds to policy related enquiries that are made; some stated that they are quite efficient thus 86.4% while others termed it as being eficient having 9.1%. Inefficiently had the least percentage of 4.5%.

Table 4.21: Provision of Value Added Services

	Yes	No
Arranging ambulance services	87.3	12.7
Arranging medicines and supplies	93.2	6.8
Guiding policyholders for specialized consultation	79.5	20.5
Providing information about 24- hour help lines	92.5	7.5
Guiding on health facilities and bed availability	79.5	20.5
Organization of lifestyle management and well-being programs	93.2	6.8

The provision of value added services was also brought to question by the study and as shown in the figure 4.6 above: 87.3% of the respondents said that ambulance services are arranged, Arranging medicines and supplies and guiding policy holders for specialized consultation had both positive response of 93.2% and 79.5% respectively. 92.5% also stated that the company provides information about 24- hour help lines while it also provides guidelines on health facilities and bed availability thus 79.5%. The organization also provides lifestyle management and well-being programs since 93.2%.

4.7 Regression Analysis

The study sought to establish the influence third party administrators in health care systems management.

Table 4.22: Model's Goodness of Fit Statistics

R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
.745ᵃ	.555	.509	.19610	1.874

a. Predictors: (Constant), Reimbursement of Claims, Medical Cost Management, Call Centre Support to Policyholders
b. Dependent Variable: Managed Health Care Systems

Table 4.22 shows that there is a good linear association between the dependent and independent variables used in the study. This is shown by a correlation (R) coefficient of 0.745. The coefficient of determination as measured by the adjusted R-square presents a moderately strong relationship between dependent and independent variables given a value of 0.509. This depicts that the model accounts for 50.9% of the total observations while 49.1% remains unexplained by the regression model.

Durbin Watson test was used as one of the preliminary test for regression which to test whether there is any autocorrelation within the model's residuals. Given that the Durbin Watson value was close to 2 (1.874), there was no autocorrelation in the model's residuals.

Table 4.23: Analysis of Variance (ANOVA)

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	1.389	3	.463·	12.043	.011[a]
Residual	1.115	29	.038		
Total	2.505	32			

a. Predictors: (Constant), Reimbursement of Claims, Medical Cost Management, Call Centre Support to Policyholders
b. Dependent Variable: Managed Health Care Systems

The ANOVA statistics presented in Table 4.23 was used to present the regression model significance. An F-significance value of $p = 0.011$ was established showing that there is a probability of 1.1% of the regression model presenting a false information.

Table 4.24: Regression Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	3.606	.433		8.336	.213
Reimbursement Of Claims	.158	.078	.282	2.031	.042
Medical Cost Management	.646	.126	.967	5.133	.002
Call Centre Support	.096	.075	.241	1.273	.023

a. Dependent Variable: TPA (Healthcare Management Systems)

The following regression result was obtained:

TPA = 3.606 + 0.158*RC + 0.646*MCM + 0.096*CCS   P = 0.011

From the model, when other factors (reimbursement of claims, medical cost management, call centre support to policyholders) are at zero, the effectiveness of TPA in managed health care systems will be 3.606 (p<0.213). Holding other factors constant (medical cost management and call centre support), a unit increase in TPA efficiency in reimbursement of claims would lead to a 0.158 increase in bringing about a well managed health care system. This relationship was significant at 95% confidence level (p=.042).

When reimbursement of claims and call centre support are kept constant a unit increase in TPA's effectiveness in medical cost management would lead to a 0.646 increase in bringing about a well managed health care system. This was established at p = 0.002 error margin (significant at 95% confidence level). Besides, holding reimbursement of claims and medical cost management constant, a unit increase in TPA's role in call centre support to policyholders would lead to a 0.096 increase in bringing about a well managed health care system. This was significant at 95% confidence level. These results show that TPAs are very instrumental in enhancing the healthcare management system of a country.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSION AND

RECOMMENDATIONs

5.1 Introduction

This chapter presents the summary on the analysis on the role of third party administrators in setting up managed health care system the case study being Henner Group Kenya. The conclusions and recommendations are drawn there to. The chapter is structured into discussion, conclusions, recommendations and area for further research.

5.2 Findings

The study is well justified and concrete considering the response rate; the findings have provided a very concrete platform when it comes to the services rendered by TPA entities and the outcome thereof. Majority of the respondents have worked for their various organizations for quite a long time implying that they have enough information pertaining to how the various organizations run their medical insurance health plans making the data and information gathered quite valid. Majority of respondents pay premiums ranging from Ksh1001-4000 per month depending on the cover that they have taken implying variance and the variety of health care plans provided by the TPA entity and their ability to cover the organization entrusted to them.

The study established covered optical illnesses, over the counter medication, chronic illnesses, dental, dermatological, theatre operations. However, AIDS and Cancer were least covered in the policy owing to the high cost of medicine and related treatments

associated these diseases. The insurance policy covers both inpatient and outpatient medical expenses and well as the employees' dependents. The TPA maintains an updated file on dependents.

On reimbursement of claims, the study established that the policyholders were required to pay part of the medical bills and reimbursed whenever they paid the medical bills. GMC/Henner Group monitors and collects necessary information to this effect. The findings indicate that GMC/Henner Group has simplified claim process and streamlining the claim process and rarely were the policyholders erroneously deducted.

On medical cost management, the study established that healthcare access has improved owing to paying incidences irrespective of health illnesses. GMC/Henner Group had freed organizations from healthcare insurance workload both administrative and in money costs. The 'stop loss' or 'hardship clauses' benefits both the employer and policyholders owing to the latter varied needs.

On Call Centre Support to policyholders, the study established that Henner/GMC group sends: quarterly reports on updated medical healthcare service providers; statements of explanation of benefits (EoBs) both annually and whenever a claim is made; and, Confirmation of Enrollment whenever an employee is registered in the scheme. GMC/Henner Group, efficiently and effectively, responds to policy-related enquiries through their 24- hour help lines; and, arrange for ambulance services and medicine supplies.

The study established a good linear dependence between TPA and healthcare management ($R = 0.745$) which was significant at 95% confidence level ($P = 0.011$). The

regression result shows that TPAs though their roles of reimbursement of claims (P = 0.042), medical cost management (P = 0.002) and call centre support (P = 0.023) enhance healthcare management systems in Kenya.

5.3 Discussions

The study established that the TPA maintains an updated file on policy holders and their dependents and sends Confirmation of Enrollment whenever an employee is registered. This concurs with Alison (2008) assertion that one of the TPAs' job is to maintain a database of policyholders and issue identity cards with unique identification numbers to them. Kalyani (2004) observed that intermediation by TPAs ensures that the policyholders get the hassle-free services; insurance company pay for efficient and cost-efficient services and the healthcare get their reimbursement on time. This assertion is in agreement with the study's finding that GMC Groupe facilitates reimbursement whenever policyholders met the expenses or medical bills. Towards this end, the TPA monitors and collects necessary information, documents and bills pertaining to the policyholders' treatment; it ensures that policyholders are not erroneously deducted. In concurrence Allison (2008) established that TPAs and insurance companies monitor and collects necessary information, documents and bills pertaining to the treatment of the insured. These are then examined by the TPAs and after processing sent to the insurance companies for reimbursement. The TPAs review the information received for accuracy, current coverage including eligibility verification, provider status, and contracted rates. The study established that the information received from GMC/Henner Groupe is very accurate.

The study established that, in comparison with the previous TPAs, GMC/Henner Groupe has achieved simplicity in claim process and streamlining the claim process, which agrees with Allison's (2008) findings. The study established that healthcare access has improved owing to paying of incidence besides TPAs having freed organizations from healthcare insurance workload both administrative and money costs. This concurs with Anand (2011) findings that TPAs have ensured higher efficiency, standardization of charges, greater awareness and penetration of health insurance to a larger section of the people. According to Bhat, Maheshwari and Saha (2005), policyholders receive enhanced facilities at no extra cost as they provide value-added services to the consumers. These include: ambulance service, medicines and supplies, information about health facilities, hospitals, bed availability and 24 hour help line. They further state that TPA's play a major role in cost containment and control the average cost/incidence. Subramaniam (2005) also concurs by establishing that the standardized rates offered by TPAs, improving volumes with optimal cost mix, is a win solution, although, the customers are not required to pay any extra charges for the services of TPAs. However, Bawa and Verma's (2011) findings disagrees with this.

Bawa and Verma established that TPAs provide cashless facilities which increases the capacity of policyholders to incur higher costs at the time of illness. Subramaniam (2005) state that service provider build cost structure keeping in mind the Sum Insured (SI), (Higher SI can absorb higher costs), policy terms and conditions (Capping, Stop Loss and Hardship Clause). In cognizance, GMC Groupe has enasured that cost management though keeping in mind diverse needs through its 'stop loss' or 'hardship' clauses.

Just as Gupta (2007) asserted, the study established that GMC/Henner Groupe arranges for policy holders: ambulance services, medicines, guide policy holders for specialized consultation, and providing information about 24-hour help lines, health facilities to attend. Besides, TPAs have roles in providing administrative support to the insurance companies for servicing their insurance policies. This includes: information regarding policyholders' data, provider network, claim status, benefits available with existing cardholder, *et cetera* are furnished on request (Mills, 2000). The study established that Henner/GMC Groupe sends quarterly reports on updated medical health care service providers. Besides, GMC Groupe sends statements of explanation of benefits (EoBs) after the policyholders have sought medical treatment. This contradicts Bihari (2010) assertion that Explanation of Benefits (EOB) should be sent to the policyholder by insurance company after they have received a healthcare service.

5.4 Conclusions

GMC/Henner as a Third Party Administrator is ranked among the best providers of medical insurance plan in Kenya considering the response that have been good when it comes to the services that they offer.

The satisfaction that has been demonstrated by the respondents shows the level of confidence and trust that the organizations under study have with the TPA, who offers them medical health care plan. As preempted and suggested by the study the TPA plan has been a strong pillar in planning and management of the cost and organization spends on the health budget plan.

5.5 Recommendation

Based on the findings, the study recommends that policy makers to look at ways of encouraging TPAs in health care cover since they cut on costs and are very effective. On reimbursement of medical claims, the study recommends that TPA's (Henner Groupe) should speed-up the reimbursement of medical cost incurred by the insured so as to uptake of healthcare services. It is also suggested that Henner Group Kenya should extend its network of healthcare facilities so that the insured in upcountry can access timely effective healthcare services at affordable cost.

5.6 Suggestions for Further Studies

The study suggests that similar studies can be done to appraise the role of management health organizations that are market based (private insurance companies) and state-based, National Health Insurance Fund (NHIF), owing to their extensive coverage of employed and the unemployed. Alternatively, other studies can be done on the effectiveness of outpatient cover on healthcare system management in NHIF and private insurance companies in Kenya. The study can be extended to cover other countries.

REFERENCES

Alison, A. (2008). The Role of the TPA in Self-funding. *Standard Directory of Third Party Administrators*, 2008 Edition

Anand, C. (2011). Effectiveness of Third Party Administrators in context to Indian Health Insurance. This paper was submitted for eINDIA 2011 conference

Bawa, S.K., & Verma, R. (2011). Third Party Administrators (TPAs) In India: An Insight Into Role Defined And Role Played With Reference To IRDA. *International Journal of Multidisciplinary Research*, 1(3), July 2011,

Bhat, R., & Babu, S.K. (2003). Health Insurance and Third Party Administrators: Issues and Challenges. *Economic and Political Weekly* 39(28), pp. 3149-3159

Bhat, R., Maheshwari, S., & Saha, S. (2005). Third Party Administrators and Health Insurance in India: Perception of Providers and Policyholders.

Bihari, M. (2010). *Explanation of Benefits - Understanding Your EOB: How to Decipher Your Explanation of Benefits.* Retrieved April 25, 2012, http://healthinsurance.about.com/od/healthinsurancebasics/a/understanding_EOB. htm

Bovbjerg, R.R., & Hadle, J. (2007). Why Health Insurance Is Important. *The Urban Institute*, DC-SPG no.1, November 2007

Bryman, A., & Bell, E. (2003). *Synthesizing Research: A guide for Literature Reviews, 3rd ed.* Sage: Thousand Oaks

Carrin, G., Evans, D., & Xu, K. (2007). Designing health financing policy towards universal coverage. *Bull World Health Organ*; 85(9): 652

Ekman, B. (2007). The impact of health insurance on outpatient utilization and expenditure: evidence from one middle-income country using national household survey data. *Health Research Policy and Systems*, 5:6

Fama, E.F. (1980). Banking in the theory of finance. *Journal of Monetary Economics*, 6, 39-58.

Gupta, H. (2007) "The role of insurance in health care management in India", International Journal of Health Care Quality Assurance, 20(5), pp.379 – 391

IOM. (2002). *Care without Coverage: Too Little, Too Late*.

Jutting, J. (1999): Strengthening Social Security Systems in Rural Areas of Developing Countries. *ZEF Discussion Paper on Development Policy*, Center for Development Research, Bonn.

Mcrill, D. (2001). Importance of Health Care Insurance. *eHow*

Mills, A. (2000): Health Insurance: Implications for the Demand and Supply of Health services. *Presentation at Two Day Conference on 'Health Insurance in India'*, Indian Institute of Management March 18-19, 2000

Ministry of Public Health and Sanitation. (2008). Annual Health Sector Statistics Report. Division of Health Management Information Systems. Nairobi: 18.

Mugenda, A.G. (2008). *Social Science Research: Theory and Principles*. Nairobi: Arts Press.

Mugenda, O., & Mugenda, A. (2003). *Research Methods: Qualitative and Quantitative Approaches*. Nairobi: Africa Centre for Technology Studies (ACTS) Press.

Shuttleworth, M. (2008). *Operationalization.* Retrieved October 27, 2012, http://explorable.com/operationalization.html

Sigma (2001). World insurance in 2000: another boom year for life insurance; return to normal growth for non-life insurance. *Sigma Series* No. 6/2001, Swiss Re.

Subramaniam, R. (2005). Role of Third Party Administrators (TPA). *Vipul MedCorp TPA Pvt Ltd,* August 4, 2005

United Nations Development Programme (2009). Population Living Below the National Poverty Line, 2000-2006.". Human Development Reports. Retrieved on March 12, 2012, http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_KEN.html

WHO. (2005). International Conference on Social Health Insurance in Developing Countries, Berlin, 5-7 December. Retrieved on December 20, 2011, www.who.int/contracting/berlin/ en/index.htm.

World Health Organization (2007). Kenya Health Profile. Retrieved on March 12, 2012, http://www.who.int/ gho/countries/ken.pdf.

APPENDICES

Appendix I: Introduction Letter

P.O Box 55455 – 00200,

Nairobi, Kenya.

To Whom it May Concern,

Dear Sir/Madam,

RE: DATA COLLECTION

I am a postgraduate student of Nairobi University pursuing a Master of Arts in Project Planning and Management. I am currently collecting data for my research project entitled **"Role of Third Party Administrators in Setting up Managed Health Care Systems: a Case of Henner Groupe Kenya".**

In view of the above, I am humbly requesting you to cooperate in answering the questionnaire/responding to the questions which I will provide/ask. Kindly read the accompanying instructions and respond to the questions as provided for. This will help me collect the necessary data which will assist in carrying out the analysis in order to achieve the objectives of the study.

The information that you will provide will remain confidential and will be used exclusively for this research and not for any other purpose whatsoever. Your response and cooperation in this matter will be highly appreciated. Thank you in advance

Yours Faithfully,

Georgina Bundi - L50/64003/2010

Appendix II: Questionnaire for Insured members

Instructions: (*Please read the instructions given and answer the questions as appropriately as possible*). It is advisable you answer or fill in each section as provided. Make an attempt to answer every question fully and correctly.

1) Name   of   your   organization?

....

2) What is your Gender?

Male   [ ]   Female   [ ]

3) For how long have you worked for the organization?

Less than 1 year   [ ]   1-5 years   ‹ ·   [ ]
6-10year   [ ]   10-15years   [ ]
Over 15years   [ ]

4) Approximately, how much do you contribute per month towards your medical health insurance?

Less than Ksh1000   [ ]   Ksh1001 - 2000   [ ]
Ksh2001 – 3000   [ ]   Ksh3000 – 4000   [ ]
More than Ksh4000   [ ]

a. Are your dependants covered by the healthcare insurance plan?

Yes   [ ]   No   [ ]

5) Does this insurance plan cover both in patient and out-patient medical care expenses?

Yes   [ ]   No   [ ]

a. What kind of illnesses are covered by the scheme? (Tick all that applies)

Optical illnesses   [ ]   Dental illnesses   [ ]
Cancer illnesses   [ ]   HIV/AIDS related illness   [ ]
Dermatological (skin) related illness [ ] Chronic diseases   [ ]
Theatre/operations   [ ]   q11   [ ]
Any   ₐ   other   illness   (please   indicate):

....

....
....
....

SECTION B: EFFECTIVENESS OF TPA IN REIMBURSEMENT OF CLAIMS

6) As a policy for the insurance scheme, are you required to pay part of the medical bills?

   Yes   [ ]   No   [ ]

7) In case you incur medical expenses, are you reimbursed for it?

   Yes   [ ]   No   [ ]

   a) Are you satisfied with the way the claims are handled by the third party administrators?

   Yes   [ ]   No   [ ]

8) During claim processing does GMC/Henner Group monitor and collect necessary information, documents and bills pertaining to your treatment?

   Yes   [ ]   No   [ ]

   a. Comparing with other TPAs you know of, do you think that GMC/Henner Group has achieved simplicity in claim process and streamlining the claim process?

   Yes   [ ]   No   [ ]

9) Have you ever been erroneously deducted for medical healthcare services you did not receive?

   Yes   [ ]   No   [ ]

10) What was your level of satisfaction with the time taken for reimbursement of these personal claims?

   Very dissatisfied   [ ]   Dissatisfied   [ ]
   Indifferent   [ ]   Satisfied   [ ]
   Very Satisfied   [ ]

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SECTION C: EFFECTIVENESS OF TPA IN MEDICAL COST MANAGEMENT

11) Owing to third party administration by GMC/Henner Group, has your healthcare access improved, owing to paying incidence, irrespective of the illness?

Yes   [ ]   No   [ ]

12) Do you think that GMC/Henner Group free of your Organization of health insurance workload both in the form of money and other administrative cost?

Yes   [ ]   No   [ ]

13) In your own opinion, what effect has Henner Group/GMC Services had on saving cost of healthcare, in terms of the expenses you incur?

Reduced   [ ]   No change   [ ]
Increased   [ ]

14) In cost management of medical insurance plan, are you aware of 'stop loss' or 'hardship' clause?

Yes   [ ]   No   [ ]

SECTION D: EFFECTIVENESS OF TPA IN CALL CENTRE SUPPORT TO POLICYHOLDERS

15) Does Henner Group/GMC send you quarterly reports on updated medical healthcare service providers?

Yes   [ ]   No   [ ]

a. Are the medical facilities networks available to you all over the country, Kenya?

Yes   [ ]   No   [ ]

16) After seeking medical treatment, do you receive statements on explanation of benefits (EoB)?

Yes   [ ]   No   - [ ]

a. How frequently do your receive this?

Daily   [ ]   Weekly   [ ]
Monthly   [ ]   Quarterly   [ ]
Annually   [ ]   When claim is made   [ ]

17) In your opinion, does Henner Group/GMC Services maintain an up-to-date file on your and dependants?

Yes   [ ]   No   [ ]

18) Does GMC/Henner Group send you confirmation of your enrolment?

Yes   [ ]   No   [ ]

a. If yes to the question above, through which channels do you receive confirmation of your enrolment?

E-mail   [ ]   SMSs   [ ]

Telephone [ ]   Postal Mail [ ]

b. How would you rate the accuracy of information contained in the confirmation of enrolment?

Erroneous   [ ]   Quit Inaccurate   [ ]

Accurate   [ ]   Very Accurate   [ ]

Perfect   [ ]

19) How efficiently does GMC/Henner Group respond to policy related enquiries you make?

Very Inefficiently   [ ]   Inefficiently   [ ]

Efficiently   [ ]   Very Efficiently   [ ]

20)   In your own opinion, how would you rate the effectiveness of GMC's/Henner
       Group's call centre support?

       Very Ineffective   [ ]   Ineffective   [ ]

       Effective   [ ]   Very Effective   [ ]

21)   In your opinion does GMC service provide the following value-added services to
       the consumers,

       Arranging ambulance services   [ ]
       Arranging medicines and supplies   [ ]
       Guiding policy holders for specialized consultation   [ ]
       Providing information about 24- hour help lines   [ ]
       Guiding on health facilities and bed availability   [ ]
       Organization of lifestyle management and well- being programs   [ ]

22)   In your own words, kindly indicate what GMC/Henner Group doesn't do to leave
       up to your expectation? What do you recommends to be done?

       ....
       ....
       ....
       ....
       ....

THANK YOU FOR PARTICIPATING IN THE QUESTIONNAIRE