



**Third Party Administration
In The
Provision of In-Patient Health Insurance**

An Indian Case Study

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1 Executive summary

Whilst there have been significant efforts by the public and private sector in India to provide the poor with access to healthcare, the Indian poor remain largely un-served by effective health insurance.

Demographics show that the population is growing at around 2% per annum, and the existing public healthcare structure often lacks the capability to keep up, or even catch up, with the national demand for healthcare.

Although donors and the government have made significant investments in public services, healthcare infrastructure is heavily biased towards the private sector which undertakes the vast majority of treatment. In turn this means that the poor need access to cash in order to access services which often means borrowing or selling assets at punitive terms which means that the poor go with out access to timely health services.

To enable the poor to access the in-patient healthcare they demand, there is a need for effective, affordable insurance. To implement this there are numerous challenges to overcome including provision of a network of hospitals , access to generic medication, administration of enrolment, quality treatment, controlling fraud through claims process, and finding underwriters who are willing to provide the right product at the right price.

As well as providing an administration solution that will be capable of scaling up to handle millions of clients, any insurance product must overcome the problem of fraud, both by the supplier of healthcare services and by the patient.

Since 2000, the insurance industry in India has been liberalised to encourage development of the private insurance sector, and third party administrators have been licensed to handle administration within the healthcare industry. This has opened up the way to design in-patient products that are relevant to the poor, low cost, scalable, effectively managed, and transparent throughout the process.

MicroEnsure has partnered with SHARE Microfin a leading microfinance organisation in India serving over 1,700,000 borrowers; Medicare a Kolkata based third party administrator, and the United India Insurance Company to design and implement an in-patient health insurance product for the India micro market.

MicroEnsure has designed the policy which is compulsory for borrowers of the MFI, cashless at point of service, covers the borrower as well as spouse and children, has minimal exclusions and covers maternity and pre-existing conditions from day one of the policy. MicroEnsure has also negotiated with the insurance company to secure one of the lowest cost policies in India, written the operations manual, and undertakes on-going training and education for the MFI's field staff and borrowers. Finally, MicroEnsure acts as the project manager holding together all the stakeholders and solving problems as they arise.

Microcare TPA provides the hospital network, and handles all the administration of enrolment, diagnosis, treatment, claims payment and client service, providing transparency through provision of real time information to all parties throughout the process.

The purpose of this paper is to discuss the product, challenges faced and unique aspects of the project from which we hope others can learn.

2 Background to health provision in India

The population of India has passed 1.1 billion, and it is growing at 2% per year. Reasons for this growth include a declining infant mortality, eradication of diseases such as polio and hepatitis, and increasing life expectancy (by 2025, an estimated 189 million will be 60 or older). A full 26% of the population are living below the poverty line and the illiteracy rate stands at 35%.

It takes just a few basic statistics to appreciate the tremendous burden this places on the healthcare infrastructure. The public healthcare system is under siege and many independent experts suggest that it is inadequate to meet the needs of the Indian population. As a result, the private sector accounts for more than 80% of total healthcare spending, but only a little more than 1% of the population are covered by private healthcare insurance (Price Waterhouse Coopers, Healthcare in India, Emerging market report 2007). The first medical insurance scheme to be introduced, 'Janarogya Yojana', was provided on a reimbursement basis and involved a lengthy claims process. Whilst a number of cashless insurance schemes have since been introduced, many lack a suitable network of hospitals near enough to the users or lack an efficient cashless mechanism which means that the users are forced to pay cash and seek reimbursement, effectively putting them out of reach of the poor who simply don't have the resources to pay cash at the time of treatment.

This situation was highlighted by Arvind Panagariya, Professor at Columbia University and Non-resident Senior Fellow at Brookings Institution:

"To make improvements in the delivery of health services, at least three reforms are urgently required. First, it is time to accept the fact that the government has at best limited capacity to deliver health services and that a radical shift in strategy that gives the poor greater opportunity to choose between private and public providers is needed.

"This can be best accomplished by providing the poor cash transfers for out-patient and insurance for in-patient care. Once this is done, a competitive price must be charged for services provided at public facilities only in hard to reach regions where private providers may not emerge."

The Economic Times, 24 January, 2008

Without access to health insurance, the poor need to take on debt or sell assets in order to meet the cost of hospital care. It has been estimated that 20 million people a year, or 24%, of those receiving medical treatment, end up below the poverty line as a result of the high cost of treatment (World Bank, 2002).

The public healthcare infrastructure has not kept up with economic growth in India, and cannot adequately meet the current demand. It is estimated that 40% of in-patient care and 60% of out-patient care is in the hands of private companies (Price Waterhouse Coopers, Healthcare in India, Emerging market report 2007) There is reluctance by doctors to practice in remote and rural areas, and where they do so there is a tendency for them to devote much of their time to private practice which has a negative impact on government health care. Most public health services provide only basic care. The result is that when they have funds the majority of patients opt for private healthcare in order to reduce the time taken and increase the level of care received.

In addition to a lack of doctors in the public system, there is often a lack of medicines available through government healthcare, especially in the rural areas.

The liberalisation of the Indian healthcare insurance sector by the passing of the Insurance Regulatory Development Authority Bill in 1999 was designed to allow the private insurance market to emerge. However, there has been little experience of administering large volumes of healthcare claims effectively since then and the opportunity for misuse has not been eliminated.

Post liberalisation, some companies have been licensed as third party administrators (TPAs) of health services with the aims of bringing more professionalism into claims management, and facilitating cashless payment. This has made it easier for health insurance to be offered on a cashless payment basis for in-patient treatment.

Because the poor are likely to require medical treatment several times a year, the take-up of health insurance when it is made available is likely to be high. But although health insurance is in great demand, for many reasons it is perhaps the most difficult product to deliver.

Experience demonstrates that around 5% of the population require in-patient treatment every year whereas 95% of the population will require access to out-patient care. Out-patient care is better addressed through cash flow and a client's savings, whereas the relatively infrequent but severe in-patient care is better financed through insurance.

Never-the-less, the shortcomings of the public healthcare system, the high costs of healthcare, and a large demand opens up the possibility of developing insurance products to bring effective and affordable means to provide the poor with in-patient healthcare; until a clear government policy develops.

The question is how to design, administer, and implement such an insurance product which also maximises client impact.

3 Overcoming challenges in the market

When MicroEnsure was seeking to enter India, it quickly identified that its core model of entering a country with a basic life insurance product sold to microfinance borrowers would not work in that country. There were two reasons for this thinking; firstly, the Life Insurance Company of India (LIC) has access to significant Government funding which it uses to subsidise the rates charged to microfinance borrowers. Any private insurer wanting to offer a life insurance product in this market has to accept it will not be competitive on price so it has to differentiate in terms of service level. The second reason is that most low-income households think of “life insurance” not as a product which responds to mortality but as a product that provides an investment return after five or more years. MicroEnsure quickly identified that entering India and selling short term life insurance policies would not be a successful business model.

Having completed our assessment of the market, it seemed clear to the senior team that there was a significant opportunity to provide health insurance through microfinance lenders. In order to be successful in providing health insurance, MicroEnsure would need to be able to provide a better coverage and higher level of service than was currently available in the market; this would be no easy task. In this section we attempt to set out the challenges we faced and the solutions we came up with.

3.1 *Finding the right underwriters*

Following the liberalisation of the Indian insurance market in 1999; the Indian insurance market is bifurcated into the “private insurers” and the “public insurers” or PSUs (Public Sector Undertakings). Whilst there are some notable exceptions, the perception of these two groups is broadly homogeneous especially amongst the senior management of the MFI’s.

The private insurance companies are seen as being extremely innovative and aggressive in their marketing but many MFI’s report having received poor service from the private insurers. Many private insurers have a policy of cancelling or restricting cover once the loss ratio starts to become adverse; this has had a significant negative effect on the MFI’s reputations with borrowers blaming the MFI when cover is cancelled half way through loans. In addition the private insurers have recently started to take the claims management function (or TPA) in-house but they have failed to build sufficiently deep networks of hospitals meaning that MFI borrowers have to either travel significant distances to reach a networked hospital or else they have to pay cash for treatment and seek reimbursement from the private insurer which can be problematic.

By contrast the four sister public sector insurers (PSUs) are seen as being less innovative in product design and marketing but at least they have a strong commitment to the social sector which means that they will not cancel a program because the loss ratio is adverse. Their significant branch networks and strong relationship with the TPAs also allows them to provide a deeper network of hospitals and service points which make them more accessible to the MFI branch staff and borrowers. The PSUs have a reputation of slow claims servicing due to a high level of procedures and bureaucracy; many hospitals have refused to allow PSU clients to avail of cashless service fearing slow claims settlement. So whilst a cashless system is in place, the borrowers are unable to use it and are forced to pay cash and seek reimbursement which is not optimal.

As MicroEnsure evaluated the market there seemed to be an opportunity to differentiate the service we offered by combining the best of the private and public sectors. What we wanted to achieve was to take the innovate products and claims-payment-speed offered by the private sector, combine it with the “commitment to the poor and willingness to make a loss whilst the program stabilised” of the public sector.

Our solution was to locate a public sector insurer who was willing to allow MicroEnsure to control the claims payment service through the use of an escrow account which was pre-funded to pay claims. After visiting with the management of the PSU's a decision was taken to work in conjunction with United India Insurance Company (UIIC); they quickly understood the issue and were keen to work in a partnership to serve the poor.

3.2 Claims handling

With over 3,500,000 lives covered through its subsidiaries in Africa and Asia; MicroEnsure has made its ability to provide a high level of claims servicing a key competitive differentiator in the market. However, the challenge with providing health insurance lies in being able to process a significant volume of claims compared to say life or property insurance. MicroEnsure was clear that in order to provide a quality service it would need to secure a world class third party administrator (TPA) capability.

MicroEnsure management were convinced that whilst they had a sophisticated IT system, providing claims management for health insurance required a different level of functionality. The search was started for a suitable partner who could provide a system that would allow clients to access healthcare on a cashless basis, control the inevitable misuse and do all this at a very low cost per family. A number of different options were considered and in the end the team opted to partner with a Kolkata based TPA called Medicare.

3.3 Controlling misuse

Misuse is one of the major issues that have a negative effect on providing an effective system of healthcare for the poor. The existing system is open to misuse by both patients and the service providers. Many patients are confused by a state system that often lacks doctors to treat them. This situation can lead to misuse on the part of doctors who demand illegal payments before they will provide treatment.

Many of the poor do not have adequate or official identity documents which can provide them with opportunities to claim treatment under a false identity. A prerequisite for the elimination of misuse is a simple and secure ID verification system. In order for any in-patient healthcare system (where transactional costs are necessarily high) to work properly, it must guarantee transparency in all areas of its administration. Put simply, a failure to control misuse on the part of users or healthcare providers will result in failure of the health insurance program.

3.4 Client education

At present there is confusion and mistrust of the healthcare system. Patients, and especially the poor, need to understand the healthcare that they are able to access and build trust in its proper practices and administration. To a large degree, the existing perception is that insurance is not a solution to in-patient treatment needs of the poor, with the often devastating consequences discussed above.

There is a need to offer a simple product offering as a first step, and to provide education to clients in order that they can make informed decisions on selecting the most appropriate healthcare solutions. Many healthcare programmes have demonstrated the positive effect of disease prevention (i.e. provision of malaria nets) and client education on both the claims ratio and the health of the low-income family. This is a future step for MicroEnsure.

SHARE Microfin Client: Nagpur Branch

During February a team of MicroEnsure head office staff visited with clients of SHARE Microfin's Nagpur branch to better understand their needs. During the focus group discussions one lady stood up and described how she had recently benefitted from using this product when her daughter fell sick with Tuberculosis (TB).

The client described how she happy that she had access to a private hospital when her daughter fell sick because she received treatment promptly and the medications were immediately available. Her daughter remained in the hospital for ten days and was treated as a cashless patient; the patient went to lengths to express her happiness with how she was treated and the medical attention that her daughter received.

However, the client went on to complain that her daughter now needed to attend out-patient clinics for one year and receive drugs and this out-patient care was not covered by the insurance. Because she had utilized the private hospital when her daughter was critically ill she had continued using the private hospital for the out-patient care and she could not afford the cost of consultations or the drugs.

When it was explained to her that the Government provided subsidized TB consultation and drugs but in order to access this care she needed to attend the public hospital she was both relieved and surprised. The client was happy to use the private hospital for critical care when it was needed most but their ability to pay means they have no choice but to use the public hospitals when they have transitioned to out-patient care.

MicroEnsure learnt from this experience that the clients would prefer to use private hospitals when their budget allows, but they need to be educated about when to use private and when to use public services.

4 Claims management.

4.1 The need for third party administration

Claims management is perhaps the most important aspect of providing effective in-patient healthcare for the poor because it is the intersect of misuse control and client service. The partnership between MicroEnsure and Medicare TPA is designed to provide a mechanism to administer large scale in-patient healthcare that provides an efficient, low-cost solution for the poor and eliminates opportunities for misuse by patient and healthcare provider.

4.2 MicroEnsure's role

MicroEnsure has designed the cashless insurance policy that has been made as simple as possible. It is compulsory for borrowers of the MFI and coverage includes the policy holder, spouse and children. Pre-existing illnesses are covered with just a few exceptions for the first year. Maternity is covered without a waiting period which was an innovation in the Indian market. It works on a floater basis so that the sum insured may be used in any way between all the insured on the policy.

MicroEnsure secures underwriter approval, in this case the United India Insurance Company, a PSU pre-funding payments with a 6-day target for claims settlement. In addition to negotiating a product that provided better cover than existing products in the market, MicroEnsure was able to negotiate with UIIC for premiums to be paid on a weekly basis rather than upfront which reduces the burden on the poor. In order to achieve this product innovation, MicroEnsure had to provide cash deposit equal to one month of the expected premiums because the regulations in India require premiums to be paid upfront before coverage is in force. The provision of the cash deposit was the solution

Other responsibilities of MicroEnsure include preparation of the operations manual, training of the MFI's loan officers and developing client education materials such as comic books, and organising training of Centre leaders at the MFI branches. Each of these branches has 75 to 100 centres, with each centre having about 40 borrowers organised into groups of five.

4.3 Medicare TPA's role

Medicare TPA is one of India's leading third party administrators, and with a presence in more than 260 cities and towns, is well positioned to handle the claims mechanism a very large in-patient health insurance scheme across a wide geographical area.

The TPA provides the hospital network of over 4,000 hospitals around India. Patients need to attend a network hospital with their identity card in order to avail themselves of the cashless facility. The third party administrator handles all the administration of claims providing online real time information to all concerned parties including the policyholder, provider and insurance company. Managing large numbers of clients and a large claims volume necessitates a highly efficient administration system capable of speedy and accurate response to clients' hospitalisation needs.

Medicare TPA issues ID cards to each family, verifies the claim very quickly and pays the hospital so clients do not have to find cash for the treatment. In cases where patients have received treatment in a non-network hospital, Medicare TPA reimburses the expenses on production of appropriate receipts.

4.4 The microfinance organisations role

The first MFI that MicroEnsure partnered with in India for the health insurance was SHARE Microfin which is one of India's largest MFI's with over 1,700,000 active borrowers nationwide. SHARE Microfin acts as the "front office" for policy implementation maintaining the direct relationship with the low-income household. They are responsible for explaining the importance of health insurance in the branch Centre meetings, and sensitising clients on the methodology and benefits of insurance.

SHARE Microfin's loan officers assist borrowers to fill out the one page application form which lists names of family members covered and their ages. The loan officer takes a photograph of the family members using a digital camera supplied by MicroEnsure and the photograph is submitted on a weekly basis. Initially MicroEnsure requested that each insured member of the family be photographed individually but it soon emerged that this was not possible as photos of family members would be submitted over a course of weeks and it was hard to then match up all members of a single family. Eventually it was decided to take a single photo of the family and to use this on the ID card. This change required some IT system manipulation but was accommodated.

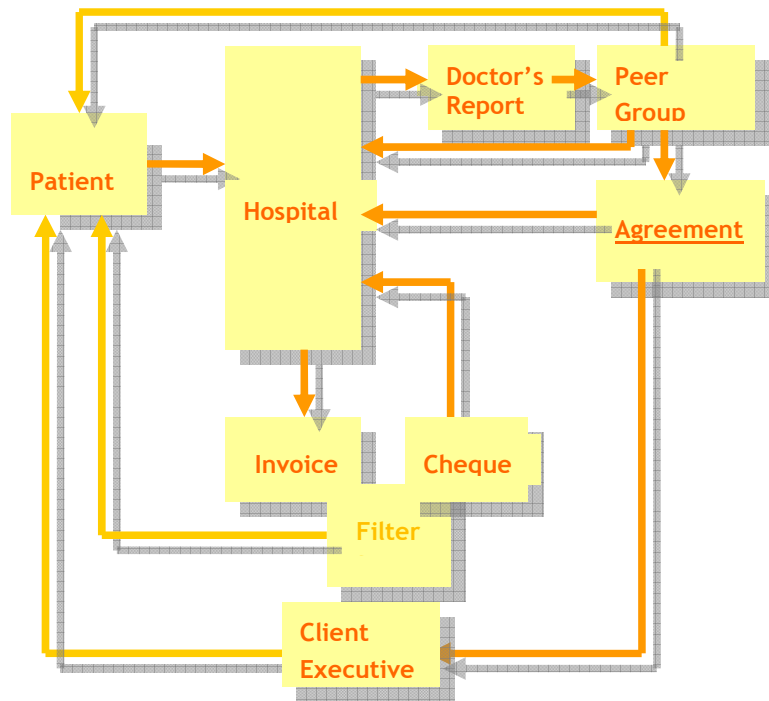
4.5 The health insurance workflow

Enrolment of clients is the first step which is completed by the microfinance organisation; in this case it was SHARE Microfin. The borrower is asked to complete a one page application form in local language as part of the loan application process; the MFI loan officer has been provided training on how to assist the borrower complete the form correctly. A photograph of the insured family members is taken and submitted on a CD with others enrolled at the branch.

The use of a simple ID card addresses the problem of client verification. The MFI is provided with digital cameras to assist loan officers capture the families' image. The ID card is produced by Medicare TPA and each insured family member is given a unique ID number. The photograph and ID number is printed on an identity card that is presented when a client attends an empanelled hospital for in-patient treatment. This card enables access to cashless treatment. The enrolment details, including a soft copy of the photograph, are sent to MicroEnsure by email, with hard copies following later. MicroEnsure then digitises the data and transfers it to the TPA for production of the ID cards.

When a patient requires hospital treatment, he or she attends an empanelled hospital (which will have a minimum of 15 beds), and presents the ID card. There is an examination of the patient there by a doctor or consultant who writes a consultation report of his diagnosis, this diagnosis is then submitted to the TPA via fax. As soon as it arrives at the TPA it is scanned immediately and reviewed by doctors employed by the TPA to perform a peer review. This peer review is normally conducted within an hour. The peer reviewer has the option to send the report back to the hospital electronically if there are any questions on the report, which ensures transparency throughout the consultancy process.

Figure 1: Schematic showing how the Third Party Administrator works



THIRD PARTY ADMINISTRATION

When the peer reviewer is satisfied with the consultation report, an agreement is automatically generated detailing the agreed treatment and costs per item. This agreement also contains the patient's photograph and identification details. The agreement is faxed back to the hospital as authorisation for the treatment. Simultaneously, the agreement is also sent to a client executive who is employed by the TPA and who will visit the patient whilst they are in hospital on a random basis to ensure that the person being treated is in fact the insured and also that the level of service being provided by the hospital is adequate.

The hospital issues a bill to Medicare TPA. At this point the hospital's bill is run through six claims filters to ensure the hospital bill is valid, these include; legitimacy of the coverage, the treatment protocol, and correct drug patterns. Once the bill has been approved, a cheque is issued to the hospital - the target payment period is six days so that the hospital cannot complain that they are suffering from cash flow issues and hence deny treating future cashless clients. Medicare TPA can also contact the client directly by SMS to discuss any issues regarding treatment, drug usage, etc. providing another level of transparency.

The whole process is designed to provide security against fraud by both patient and service provider. The system is web-based with access to management reports and the details of individual client cases to any authorised person.

5 Conclusion

Providing the poor with access to affordable health insurance is hugely challenging. In order to succeed a product which is affordable, has minimal exclusions so it is easy to understand, provides access to cashless treatment, at a range of hospitals that are easy to reach, in a way which controls fraud from the healthcare provider and user alike and in a manner which can handle the huge volume of claims. The challenges are clear but research has demonstrated to us that access to health insurance is the number one priority of the poor, not just in India.

The poor are looking for good value for money from their purchases and health insurance is a product that they perceive they will get benefit from; as one client so elegantly put it “I visit the doctor several times a year, I will only die once and I do not know anyone who has experienced a fire in their home”. Demand and usage / perceived usage are clearly linked.

For MicroEnsure the key to success was finding a willing underwriter and capable Third Party Administration (TPA) system; without either it would not be possible to provide a product. The cost of the TPA mechanism was absolutely key in being able to deliver a low cost product. With health insurance the “risk premium” is relatively easy to calculate using data on the average cost of a treatment and the ailments that are most common, the cost to the client will be heavily inflated if the TPA mechanism is too expensive or fails to control the misuse and as a result it becomes a key linkage in providing a successful and affordable health product.

For MicroEnsure, their partnership with Medicare TPA is one which is in the process of expanding rapidly with plans to start offering similar products in Africa during 2009 in partnership. In order to do this MicroEnsure has also had to bring underwriting capacity to the market which it is currently doing through the creation of cell captives which are funded by commercial insurance companies that allow MicroEnsure to design products and cede risk to the cell captive on their behalf.

MicroEnsure believes that health insurance is a product which will have the greatest impact on the lives of the poor. We are grateful for our partnerships with organisations such as SHARE Microfin, United Insurance India and Medicare TPA.

For more information please visit www.microensure.com or write to info@microensure.com

6 Appendix: Details of the product

6.1 Eligibility

Health insurance is compulsory to all clients of the Microfinance Organisation (MFI) taking loans so long as they meet all eligibility requirements set out below.

- The health insurance applies to all borrowers.
- Maximum age at entry is 65 years for all family members. The minimum age of entry is 3 months for family members.
- It is compulsory for MFI customers to enrol all their children in the scheme so long as they meet all the eligibility requirements.

6.2 Exclusions

Exclusions have been kept to a minimum. Claims will not be paid for medical costs arising directly or indirectly from the following diseases in the first year of the policy:

- Cataract
- Benign Prostatic Hypertrophy
- Hysterectomy
- Hernia
- Hydrocele
- Fistula of anus
- Piles
- Sinusitis and related disorders

Other exclusions that apply:

- Injury or disease directly or indirectly arising from or attributable to invasion, act of foreign army or war like operations
- Circumcision unless necessary for treatment
- Vaccination or inoculation
- Cost of spectacles, lenses and hearing aids
- Dental treatment or surgery of any kind (except accidental injury requiring hospitalization)
- Intentional self injury
- Use of intoxication drugs or alcohol
- Sterility, venereal disease, convalescence
- Any condition of a similar kind commonly referred to as AIDS
- Expenses for vitamins and tonics unless forming part of approved treatment
- Injury or disease caused by nuclear weapons or materials
- Naturopathy
- Committing, attempting or provoking a criminal offence, or participating in a riot

6.3 Payment of benefits

Payment of a benefit under this product is triggered by the customers admitted to network hospitals for treatment for at least 24 hours.

The policy covers hospitalisation expenses for illness and disease or injury sustained by the insured person and the members of their family who are covered.

Medicare TPA will pay the hospital or nursing home by cheque upon receipt of correct claim documentation, for such expenses as are admissible under the policy but not exceeding the sum Insured. This is a cashless facility.

The sum Insured for each family is Rs 20,000 per year on a floater basis. And coverage for pre-existing diseases is provided.

The sum Insured covers:

- Room/boarding expense as provided by the hospital/nursing home
- Nursing expenses
- Surgeon, anaesthetist, medical practitioner, consultants, specialists
- Anaesthetist, blood, oxygen, operating theatre, surgical appliances, medicines and drugs, diagnostic materials and x-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker

Expenses are paid on hospitalisation for a minimum of 24 hours. However this minimum time does not apply to treatments for dialysis, chemotherapy, eye surgery, lithotripsy, D&C, tonsillectomy taken in the hospital

Hospitals and nursing homes include those empanelled by Medicare.

Maternity benefits and child care are included.

Reasonable transportation charges up to Rs 100 with submission of receipt.

Customers who seek medical treatment before they receive their ID card will not have the cashless facility available to them. They will be required to submit original receipts and claim form to their MFI Loan Officer who will forward the documents to MISPL Chennai for processing.