Implementing Health Insurance through Micro-credit: A Case Study of SKS Microfinance, India

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This report is an output from an ongoing study to evaluate the impact of providing health insurance combined with micro-credit. This project is being undertaken jointly by the Centre for Micro Finance, Abdul Latif Jameel Poverty Action Lab and SKS Microfinance Pvt. Ltd. For more information on this study, please visit http://ifmr.ac.in/cmf/research/iehi.html.

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1. BACKGROUND AND SIGNIFICANCE

Health shocks are among the biggest and least predictable forms of uncertainty that a poor family faces (Gruber-Gertler 2002). For households without insurance or access to credit, periods of poor health may sharply lower consumption in the short-term (Townsend 1994) or decrease investments in very productive assets (Rosenzweig and Wolpin 1993). The World Bank 2004 World Development Report describes health shocks as a potential endemic source of poverty: "Illness pushes households into poverty, through lost wages, high spending for catastrophic illnesses, and repeated treatment for other illnesses."

Globally, less than six percent of the extremely poor hold health insurance (Banerjee and Duflo 2006). Within India, a recent survey of Hyderabad "slums" found that none of its urban poor had health insurance (Banerjee and Duflo 2006). Lacking alternative financing mechanisms, 98 percent of households turn to "out-of-pocket" expenditures for health care (Ruchismita, Ahmed, and Rai 2007).

The provision of formal health insurance is likely limited by health insurers' concerns about superfluous or fraudulent claims and an adversely-selected group of clients—concerns often heightened in the developing world. There is very little systematic evidence on how the rural poor might respond to the availability of health insurance. Just as loans were once thought to be infeasible, health insurance has not been seriously considered as means of mitigating financial shocks for the rural poor.

This study captures the experience of SKS Microfinance Pvt. Ltd., India's third-largest microfinance institution,[2] in launching a mandatory catastrophic health insurance policy in the state of Karnataka, India, and expanding that product across other branches. In February 2007, SKS tested the policy at a single branch in northern Karnataka.[3] A year later, SKS is in the process of rolling out the product to 600 branches.

SKS's goal was to create a product that was beneficial to all stakeholders involved: to the client, to the insurer, and to SKS. This report documents the steps involved in SKS' development of the health insurance product from conceptualization to rollout to operational processes and challenges. Additionally, it provides an interesting case study of implementation of a particularly promising mechanism for insuring the rural poor in developing countries. Insights into SKS's successes and challenges in implementing this product will assist other microfinance institutions with design and rollout of their own insurance products.

This report is part of a larger impact evaluation research project currently undertaken in collaboration with the Abdul Latif Jameel Poverty Action Lab and SKS Microfinance. The research aims to evaluate the impact of providing health insurance combined with micro-credit on various household economic, social and health outcomes.

[2] According to MIX Market, a global microfinance information system, SKS was India's third-largest microfinance institution in 2007, in terms of gross loan portfolio and in terms of number of active borrowers.
[3] Please see Appendix I for a timeline of the development of this product.

2. PRODUCT DESCRIPTION

In 2007, SKS Microfinance introduced "Swayam Shakti," a health insurance cover for catastrophic illnesses. SKS requires all members taking new loans to enroll in health insurance which provides maternity, hospitalization, and accident benefits. SKS partnered as an agent with a private insurance company to provide the product.

2.1 Benefits and premiums

Benefits cover the actual cost of health-related expenses from hospitalization for over 24 hours due to any major health event affecting the household, such as a catastrophic illness, an accident, or the birth of a child. The policy provides coverage for the period of one year. Members and their dependents receive the same benefits.[4]

Conditions excluded from coverage included HIV/AIDS, reproductive health, drug- or alcohol-induced conditions, and conditions not requiring hospitalization.[5]

While the insurance is mandatory for all clients taking a new loan, the client can choose to cover up to three additional family members, with the premium adjusted accordingly. Depending on the level of coverage, the client pays a premium of 1.9-2.5% of the total sum assured for the insurance policy. The client pays an additional 0.8-1.5% of the total sum assured to SKS as an administrative fee. (See Table 1 below for details.)

Table 1. "Swayam Shakti" Health Insurance Plan Options

Plan	Family Members Covered	Premium (as % of total sum assured)	Administrative Fee (as % of total sum assured)	Total Price to Client (Premium + Administrative Fee, as % of total sum assured)
Plan 1	Member	2.5	1.5	4.0
Plan 2	Member + Spouse	1.6	0.8	2.4
Plan 3	Member + Spouse + 1 additional member of family	1.8	0.8	2.5
Plan 4	Member + Spouse + 2 additional members of family	1.9	0.9	2.6

SKS management chose not to require a co-payment or deductible, believing that such a requirement would decrease the popularity of the product among clients.

Premiums are not age-dependent, though all individuals are required to be 70 years of age or under at time of enrollment to be eligible. Thus, members' parents are typically excluded as dependants.

[4] Please see Appendix II for the full listing of covered conditions and benefits.
[5] At the time of this writing, SKS and the insurer have no formal system in place to document pre-existing conditions and partial disability at the time of enrollment. Please see Appendix III for the full listing of conditions excluded from coverage.

2.2 Using benefits

There are two ways which an insured member can claim benefits. If she or an insured dependent receives treatment at a "network" hospital, she can receive "cashless" benefits, without paying any cash out-of-pocket towards covered expenses. Alternatively, an insured individual could receive treatment at an "out-of-network" hospital, but would have to pay for treatment upfront, submit claims documentation to SKS, and wait for reimbursement in 45-90 days.[6] "Cashless" benefits become effective 15 days after enrollment, while "out-of-network" benefits become effective immediately.

When an insured individual seeks treatment at a network facility, the hospital is required to submit a pre-authorization letter to the insurer. The provider is expected to give authorization to the facility quickly, usually occurring within two hours. However, treatment may begin before the authorization is received. In case of emergency, pre-authorization is not required, though the facility is responsible for submitting a request for authorization within 48 hours of the members' hospital admission.

Members receive a list of network hospitals at enrollment. They are responsible for presenting their health card or their loan passbook at the time of treatment to receive cashless services. The policy mandates that network hospitals cannot deny treatment to an insured individual, even if a hospital had previously rejected them for lack of ability to pay.

SKS and the insurer selected a few hospitals in each district as network hospitals where clients could use their insurance policy. In this case, the insurer reimburses the hospital directly.

For treatment at out-of-network hospitals, clients submit their claims forms to SKS loan officers along with all bills and details of treatment. SKS, in turn, submits claims to the insurer. Reimbursements are then sent from the insurer to SKS headquarters, which disburses reimbursement amounts to branch offices. After reimbursements arrive at the branches, loan officers reimburse clients in cash. The insurance reimburses clients on an event-by-event basis, that is, each hospital admission requires separate claims even when related. Pre-authorization is not required at out-of-network hospitals.

At the time of this writing, the insurer—not SKS—made determinations of whether claims were approved or rejected. An appeals process is in place where SKS and the insurer meet to discuss cases where they differ on their view of the amount of reimbursement.

3. DESIGNING THE PRODUCT

SKS and the insurer conceptualized the insurance product over a period of 5-6 months. The key factors they considered are described below.

3.1 Choosing an appropriate insurance company for partnering

[6] Please see Appendices IV and V for flowcharts explaining the "cashless" and "out-of-network" reimbursement schemes in more detail.

SKS selected an insurer based on responsiveness, value of benefits, and cost of package. SKS talked to five private and government insurers. Three insurers made it to the later rounds of consideration. SKS rejected the insurers who were unwilling to implement a "cashless" network system, hesitant to work in the domain of health insurance, or provided too few benefits with too high premiums. SKS estimates that the process of choosing an insurance company partner took about six weeks.

3.2 Choosing appropriate coverage

SKS began negotiations with a "wish list" of items it wanted covered, including pre-natal and post-natal care and chronic conditions such as blood pressure; the insurer approached negotiations with a list of items generally excluded from coverage. SKS considered moving some of these items which it deemed important for clients from the "excluded" to the "covered" list. For each health condition, SKS took into account (a) the frequency of its occurrence among SKS clientele and (b) whether providing coverage for it would lead to "moral hazard"—a change in the behavior of an insured party, such as an increase in risky behavior, due to the presence of the insurance. For example, SKS negotiated with the insurer to cover cataracts, believing that coverage for this condition would encourage more usage among clients and their families. However, even though SKS believed its clients would find hysterectomy coverage useful, SKS chose not to cover that condition in the first year because of potential overuse and abuse.

Adding items to the insurer's "stock" list of coverage did not increase the price of the premium, because SKS and the insurer had already agreed upon a pricing structure at the time of negotiations. Interestingly, months after the rollout of the coverage, SKS reported that few clients had sought claims for the conditions that SKS had lobbied to be moved to the "covered" list.

SKS conceptualized the product as one that would provide wide breadth of coverage specifically targeted to women. For example, they added maternity coverage to benefit the three-quarters of their clientele between the ages of 18 and 40, as well as their female family members. Additionally, SKS expanded the definition of "family member" to include not just children and siblings, but also daughter-in-laws.

3.3 Pricing the premiums

In negotiations with the insurer, SKS sought a premium which was affordable and sustainable. To determine affordability, SKS surveyed clients' willingness-to-pay. To ensure that the premium was sustainable, SKS came to an informal agreement with the insurer that SKS would enroll at least 10,000 clients. To meet this goal while avoiding adverse selection, SKS made its product mandatory for all clients receiving new loans.

SKS believes a lower premium might have been negotiable; however, it would have come at the cost of fewer benefits to clients, which would threaten the popularity and the use of the product. SKS decided that a slightly higher premium was worth ensuring the product's long-term sustainability.

SKS approached the negotiations table with quotes that it had received from other insurers. Additionally, SKS referred to a benchmark from SKS's internal group health insurance

provider, examined the premiums in insurance schemes that other microfinance institutions had used, and evaluated client needs and potential benefits.

SKS and the insurer provided no subsidies for the premium.

3.4 Determining eligibility

When SKS conceptualized the health insurance product, SKS wanted to make the product mandatory for *all* its current clients. However, SKS found that existing clients had greater resistance to the product than new clients, causing delay in enrollment. SKS went through several rounds of discussions with clients to determine reasons for resistance. Consequently, SKS modified the product so that it became compulsory only at the time of taking a new loan or renewing an existing loan.

SKS chose to make clients eligible to use out-of-network benefits immediately after enrollment.[7] Generally, insurance schemes have a two-week to one-month "cooling period" to allow for enrollment information to travel from the member to the insurance company. SKS, however, chose to put in place immediate eligibility because it increased client confidence with the product: clients felt they were immediately receiving service for the premium which they paid upfront. When a client wants to use her health insurance before enrollment data is transferred to the insurer, the insurer calls SKS to verify enrollment.

3.5 Designing the reimbursement process

Though SKS allows reimbursements at out-of-network hospitals and no 'black list' of hospitals and providers currently exists, SKS encourages all its clients to seek "cashless" benefits at network hospitals. SKS and the insurer chose a "cashless" reimbursement scheme because it would

- guarantee at least a standard level of treatment for clients within benefit limits;
- reduce the burden on the client for out-of-pocket expenses at the time of a major health shock;
- guarantee a price for services which is often lower than what clients could negotiate for themselves;
- reduce the paperwork burden on clients; and
- dispose of the wait for reimbursements.

The networked scheme is also beneficial to the insurer, as it reduces the likelihood of fraud. In the absence of pre-negotiated prices, doctors may artificially inflate the price for a service, particularly if she has insurance. Typically, claims ratios are higher at network than non-network hospitals.

However, reimbursement claims at out-of-network hospitals allows clients to use their benefits elsewhere. Clients may prefer out-of-network hospitals because they are located closer to their residences than network hospitals; they have sought treatment there in the past; or other reasons. The trade-off is that servicing out-of-network claims is more expensive and

[7] "Cashless" benefits at network hospitals became effective 15 days after enrollment.

staff-intensive, requires the client to pay upfront for services, results in a wait of 45-90 days for reimbursement, and more vulnerable to fraud and abuse.

3.6 Implementing a Reserve Fund

As part of the administrative fee that it charges clients, 5% of every client's total health insurance payment goes towards a Reserve Fund. A designated SKS management team considers disbursing reimbursements from this fund in two situations:

- SKS will consider reimbursement when the insurer has denied a claim due to SKS error, particularly as the product is still being rolled out. Should a data management error prevent a client from receiving approval for treatment, for example, SKS would consider reimbursement from the Reserve Fund.

- Under extenuating circumstances, SKS will consider reimbursement from the Reserve Fund when an insured individual requires treatment for a life-threatening condition that is not covered. For example, SKS is considering reimbursement of treatment for a client and her spouse, both of whom were hospitalized at the same time for conditions which are excluded in the first year of coverage.

4. THE "PRE-PILOT"

In February 2007, SKS tested the product in a single branch in northern Karnataka. Using feedback from this "pre-pilot," SKS modified its product before relaunching it in a formal pilot phase in May 2007. Changes included shifting the trigger for enrollment from membership in SKS to taking a new loan; moving from an installment to an upfront payment of premiums; and asking clients, rather than SKS staff, to nominate network hospitals.

4.1 Trigger for enrollment

In the "pre-pilot," all clients, regardless of when they had taken a loan, were enrolled in the product. Clients met this "mandatory for everyone" policy with some resistance. For the formal pilot, SKS changed the enrollment policy to be mandatory upon taking a new loan. SKS found that this new policy, which is still in place, also eased tracking of insurance coverage, as coverage consistently ended two weeks after a client's loan repayment schedule.

4.2 Premium cost and payment

In the "pre-pilot," clients paid a premium through weekly installments which were tacked onto their existing loan. In the formal pilot, SKS was able to lower the premium by moving to an upfront payment policy. The rate was lower because (1) SKS no longer had to charge interest; and (2) SKS no longer had to "pad" the rate to ensure that the weekly installments fell into whole numbers.[8]

[8] SKS's management information system was incapable of handling *paisa*—1/100 of a Rupee. As SKS As a result, SKS increased the premium to an amount that would was neatly divisible by 50, ensuring a weekly installment that was a whole number.

Since the rollout, SKS has required upfront premium payment in nearly all cases. Under this policy, clients paid for the premium from their own savings and before receiving any loan disbursements.

After SKS changed its policy of premium payment from weekly installments to upfront payment, it also modified its management information system accordingly. This modification resulted in a gap of two months between the pre-pilot and the formal pilot of the health insurance product.

4.3 Identification of network hospitals

For the "pre-pilot," SKS staff conducted on-site visits and in-depth survey of hospitals to determine whether they should be part of the network. Since the pilot, SKS has depended on SKS clients to nominate hospitals which are close, frequently used, and have a good reputation. In both pilot and the final rollout, the insurer has retained final responsibility for assessing network suitability.

5. THE PILOT

In May 2007, SKS launched a formal pilot of its product in two districts in northern Karnataka with the goal of enrolling 10,000 clients.

By August 2007, though it neared its goal, SKS found that the initial results of the pilot were not strong to indicate whether the product was viable for scale-up across all of SKS's branches. For example, in August 2007, the product had a claims ratio of 180%. SKS wanted further evidence of the viability of the product, so it extended and expanded the pilot phase across 32 branches with the goal of enrolling 50,000 clients.

On December 31, 2007, SKS enrolled its 50,000 client. With a claims ratio of 110%, SKS deemed the product sustainable and decided it was ready for rollout across all of its branches in 15 states.

6. PREPARING FOR ROLLOUT AT THE BRANCH LEVEL

At every branch where it rolls out its product, SKS undertakes marketing and client education; training for SKS loan officers; establishment of management information systems; and identification of network hospitals.

6.1 Marketing the product to clients

SKS invested funds, staff, and time into developing materials and processes which would effectively explain the product to its clients, a population with little or no experience with insurance.

- SKS developed a 20-minute video in Kannada, the local language. The insurer funded the video production and the Institute for Financial Management and Research's Centre for Insurance and Risk Management administered the project. Initially, SKS

depended on this video as its primary marketing tool. SKS loan officers screened the video to clients and their husbands at centre meetings. The video met with mixed success. In some situations—for example, at centre meetings where only half the members spoke Kannada—not all clients understood the video. As a result, SKS has since redesigned its marketing efforts to revolve around a presentation and discussion that health associates, loan officers, or other branch staff lead, using the videos only in cases where there is high resistance to the product.

- Group presentations and discussions, which have replaced the video as SKS's primary marketing tool, begin fifteen days before enrollment. SKS developed a five-minute script to facilitate these discussions and standardize information shared to members across centres.

- SKS developed a 16-page guidebook, written in Kannada, which presents all necessary information for the client with simple language and, for the benefit of illiterate clients, simplistic graphics. The last page of the guidebook features contact information for local network hospitals and SKS health associates.

- SKS loan officers use the submission and disbursement of claims at centre meetings as opportunities to further educate clients about the product.

6.2 Training SKS staff on product

Much of SKS's staff is as new to the health insurance product as their clients. SKS management developed a multi-pronged approach to bring them up to speed as quickly as possible.

- Prior to rollout, SKS created a mandatory, two-day off-site training workshop for loan officers. Health associates—SKS's staff devoted to health insurance—deliver the training, which uses a standardized Powerpoint presentation to walk through product basics and loan officer responsibilities in marketing, enrollment, and claims disbursement.

- SKS distributes a Health Insurance manual to staff, which is a "one-stop shop" to answer all questions that a loan officer may have about the product. Included are answers to "frequently asked questions" that clients may ask during centre meetings.

- Though designed as a marketing tool for clients, the video is also an instructional tool for staff. Vikram Akula, SKS's Founder and Chief Executive Officer, is featured in the video, which may provide additional motivation to staff.

6.3 Establishing management information systems

To track enrollments and claims, SKS needed to implement new management information systems.[9] For enrollments, SKS worked with in-house developers to create an add-on module to its existing information system. The claims system has not yet been developed,

[9] Please see Appendix VI for SKS's minimum data requirements in implementing these management information systems.

but will be built in as a module to its new overhauled company-wide system. Until then, SKS is tracking claims through Excel spreadsheets.

6.4 Identifying network hospitals

Though the insurer maintained final responsibility for determining suitability for networking, SKS staff provided the initial identification of hospitals because its employees knew the pilot area better than the insurer.[10] SKS staff looked for hospitals which had

- At least 12 beds;
- At least one doctor with an established history of medical service provision to some clients in that particular geographical region;
- A location preferably close to a bus stand or railway station; and
- A location within 35 km of the most distant centre in the area. (However, if no hospitals in the region qualified to become a network hospital, that range could be increased.)
- Additionally, the availability of a fax machine at the hospital was also considered.

Network hospitals tended to be those that were most accessible to clients. Additionally, clients demonstrated preferences for these hospitals when loan officers asked them at centre meetings to identify which hospitals they used.

Aside from the network hospitals, SKS and The insurer created a "white list"—a secondary list of hospitals recommended for members if they were unable to go to a network facility—for the geographic area covered by the health insurance product. There was no "black list" of hospitals; however, SKS and The insurer chose not to provide coverage for *Unani*, a traditional Greco-Arabic form of medicine.

6.5 Developing a management structure for continual rollout

As SKS planned for a quick scale-up of its product, it developed a management structure which allowed for continual rollout while still providing high-quality service to clients. Within every state, the health insurance program has a state manager and 1 health associate for every 3-4 branches. With this structure, SKS plans to cover an additional 50 branches every month until March 2009, when its product will have reached 600 branches.

7. SERVICING CLIENTS

7.1 Enrollment and Identification Cards

SKS loan officers are responsible for enrolling clients in the health insurance product when they sign for a new loan. Registration takes place during the weekly repayment meeting, in

[10] Please see Appendix VII for a list of the network hospitals in the pilot area.

front of fellow group members. Clients are required to provide the names and a group photograph of household members who will be covered.

SKS loan officers then note that the client has enrolled in the health insurance on the loan record sheet and in the client's book. This information is passed to the branch, which then shares enrollment information with SKS headquarters. SKS, in turn, shares enrollment information with the insurer. In total, it takes about two weeks for a client to appear in the insurer's systems. During that time, if she needs to use her insurance, she can request that the insurer verify her information with SKS. Clients have made use of their insurance in their initial two weeks of coverage, calling their health associate to facilitate the process.

After enrollment, SKS issues health insurance identification cards to clients. SKS initially funded their production, but after October 2007, the insurer agreed to pay for them. However, clients do not need identification cards to receive treatment and may use their passbooks with an attached family or household photograph instead. Initially, clients were unclear that they could use their passbooks instead of the health insurance card and this led to some confusion among clients on how to claims benefits at a network hospital. In recent months, SKS has taken steps to clarify to clients that they may use their passbook for coverage.

As enrollment is tied to the signing of a new loan, it takes place throughout the year on an ongoing basis. SKS allows clients to delay acceptance of a further loan—and the accompanying mandatory health insurance—indefinitely. Therefore, a client could wait until she or someone in her family became pregnant, and then enroll in insurance to have coverage for the delivery. To prevent such occurrences, SKS is considering implementing a time limit within which clients must renew their loans and purchase insurance

Enrollment data is sent from SKS's branches to its head office, and then to the insurer. The insurance is a bulk insurance policy in the name of SKS, and is not broken up into individual policies in the clients' names.

7.2 Collecting annual premiums

At the weekly repayment meetings, SKS loan officers collect the annual premium upfront. The loan officer then records this payment and the client's health insurance status on the client's loan record sheet. To this extent, it would be interesting to track renewals of health insurance and loans[11].

7.3 Hiring additional staff to provide customer service for health insurance

SKS uses a "facilitation model": when an insured individual seeks treatment, SKS staff provide in-person assistance to process the claim. First, an insured individual calls SKS at a designated "helpline" number that is widely publicized during enrollment and listed on the back of the guidebook. Next, a SKS health associate visits the client in person at either the network or out-of-network hospital to assist with claims. SKS and the insurer do not use a third party administrator. For treatment at a network hospital, the health associate helps the

[11] As a part of the larger research project, renewal and drop out rates are tracked regularly to identify and understand drop-outs, if any.

hospital process the paperwork. At an out-of-network hospital, the health associate brings a checklist of documents that the client needs to obtain to claim reimbursement. SKS found that the facilitation model helped maintain relations with both hospitals and clients; however, it greatly drives up staffing costs.

7.4 Administering claims and reimbursements

At the weekly repayment meetings, SKS loan officers collect claims from and disburse reimbursements to members who received services from an out-of-network hospital. Additionally, SKS loan officers are responsible for explaining to the member why their claims might have been rejected.

8. KEY CHALLENGES GOING FORWARD

SKS's primary obstacles include minimizing fraud; ensuring a high level of service for "cashless" treatments; working with an insurance company whose infrastructure is struggling to keep pace with SKS's expansion; and determining the actual cost of the product per client.

8.1 Minimizing Fraud

SKS believes minimizing fraud is primarily the responsibility of the insurer. However, SKS believes it has a moral and "cultural" responsibility to minimize fraud. Examples of fraud include document fraud or members being admitted for more than 24 hours to a hospital when they did not require such treatment.

SKS's steps taken to minimize fraud include

- Encouraging the insurer to create its own facilitator position. The insurer has recently dispatched its first such employee.

- Implementing layers of repetitive document scrutiny. Loan officers check documents upon receipt at centre meetings; health associates check documents at the area level; and SKS headquarters checks documents again before sending them to the insurer for processing.

- Encouraging an increase in use of network hospitals, which do not require documents and therefore minimizes incidence of document fraud; and

- Using loan officers as "eyes and ears" on the ground to report incidences of fraud.

SKS is also considering conducting random audits of claims.

8.2 Ensuring high level of service for "cashless" treatment at network hospitals

As SKS expands its product, it is finding maintaining a high level of service at network hospitals a challenge. Since network hospitals are locked into a contract, some have had difficulty reaching a profit without large numbers of clients. Additionally, some hospitals

lack a fax machine to facilitate authorization, resulting in all transactions conducted by phone.

8.3 Encouraging insurance company infrastructure

SKS's insurance company partner is having some difficulty rolling out its infrastructure at the same pace as SKS's planned expansion. The insurer, new to rural environments, has had to adapt its business practices accordingly. Additionally, in some areas, it must open new offices.

8.4 Uncertainty about Cost

Due to large indirect costs (office infrastructure, staff time, administration, etc.), determining the exact cost of the health insurance product is very difficult. As a result, right now SKS is unsure whether it is profiting, breaking even, or losing money on the health insurance product. However, with the limited information that it has, SKS views the current price structure as appropriate and sustainable. SKS estimates that *direct* costs (guidebooks, management information system, etc.) are about USD $2.00-$2.13 per insured client.[12] SKS estimates that the remaining $1.63-$1.75 of the administrative fee would go towards SKS's indirect costs.

Generally, for the costs it can measure, SKS's actual costs do not vary greatly from its estimates. Where SKS did vary from its costs were in staffing and marketing. Though SKS had estimated high staffing costs, it still found staffing costs higher than expected, as the pilot and initial rollout phases both required extensive travel. Marketing costs, however, were lower than expected. SKS found that the video, which SKS had planned to use as its primary marketing tool, received a mixed response. SKS moved to a cheaper communication and discussion group strategy, which was more effective as a marketing tool.

9. CURRENT STATUS

9.1 Client Use and Satisfaction with the Product

As of late January 2008, about 210,000 SKS clients in 79 branches across Karnataka and the neighboring state of Andhra Pradesh had enrolled in the health insurance product. About 80% of clients had chosen to enroll in Plan 4, which provides coverage to the member and three additional family members.

Overall, clients raised a total of 1,143 claims in the last 12 months.[13] At the time of this writing, SKS had settled about 60% of all claims with an average payout of USD $78.75. One-third of settled claims took place at out-of-network hospitals.

The heaviest users of the product—more than two-fifths of all with settled claims—were women between 16-30 years. However, the patients with the highest settled claims were males between 16-30 years, with an average payout of $152.45.

[12] Please see Appendix VIII for the breakdown of some of SKS's direct costs.
[13] Please see Appendix IX for more detailed claims information.

SKS's goal was to achieve a claims ratio of less than 100% within one year of operation. It achieved this goal in February 2008.

In focus groups, the primary concern of clients has been the wait for reimbursements—up to three months with bottlenecks at both SKS and The insurer. SKS management is aware of this concern.

9.2 Expansion

At the time of this writing, SKS has expanded the product throughout Karnataka and part of the neighboring state of Andhra Pradesh and is beginning expansion in Orissa. SKS plans to bring the product to all of its branches in fifteen states across India by March 2009, rolling it out in fifty branches every month. SKS has chosen areas of expansion according to

- Proximity to branches already covered by insurance, thereby reducing travel, translation, and other administrative costs.

- Strength of clientele base.

- Hospital presence. As SKS wants to encourage use of network hospitals, it is attempting to launch the product in areas where an appropriate hospital can be found.

- Insurer presence. SKS is rolling out the product in Orissa because The insurer has an office in West Bengal which can service the area.

10. LESSONS LEARNED

SKS has been able to expand its health insurance product because it designed a product and processes appropriate to the needs of its clientele.

- SKS intentionally designed the product to meet the needs of its clients. SKS felt strongly that some aspect of the product should "speak" to the client—in SKS's case, the maternity benefit.

- SKS changed its enrollment policy after clients did not react favorably in the pilot to mandatory enrollment for all clients, regardless of when they took a loan. Under its new policy enrollment is mandatory only upon taking a new loan—SKS has increased client satisfaction.

- SKS shifted from an installment to an upfront premium collection policy to lower the price of the premium for its clients.

- SKS took steps to ensure that clients, many of whom had little or no experience with insurance, had a strong understanding of the product. Initially, SKS invested in a video for client education and marketing. When the video met with mixed success, SKS moved to a group discussion strategy. Finally, SKS developed a guidebook with simplistic

graphics and language to communicate all the necessary information in a format that was comprehensible to clients.

- SKS invested in the "facilitation model," which closely navigated clients through usage of benefits.

APPENDIX I: TIMELINE OF EVENTS

Feb 2007	SKS launches "pre-pilot" test of health insurance product in a single branch in northern Karnataka
May 2007	SKS launches pilot of product, with certain key changes from "pre-pilot," in two districts in northern Karnataka with goal of reaching 10,000 clients
Aug 2007	SKS decides to extend pilot phase to 32 branches and 50,000 clients
Sep 2007	SKS enrolls 10,000th client
Dec 2007	SKS enrolls 50,000th client; SKS decides to expand product across all branches
Jan 2008	SKS begins rollout of product in Andhra Pradesh and southern Karnataka
Mar 2008	SKS begins rollout of product in Orissa
Sep 2008	SKS begins rollout of product in Maharastra
Mar 2009	SKS completes rollout of product across 600 branches in 15 states (projected)

APPENDIX II: CONDITIONS COVERED BY SKS HEALTH INSURANCE PRODUCT

Maternity

- Coverage is provided for one delivery every year for up to USD $62.50.

- The member can only use this if the delivery takes place in a hospital/nursing home. Deliveries at home or clinics are not covered.

- The newborn child is automatically covered for the policy term without additional premium. To ensure coverage, the member must report the date of birth and name of the newborn within 90 days of birth.

Hospitalization

- Coverage is provided for
    - inpatient treatment of more than 24 hours for illness, disease, injury and accidents; and
    - specified day procedures: dialysis, lithotripsy (kidney stone removal), chemotherapy, cancer-related radiotherapy, eye surgery, coronary angiography, cardiac catheterization, and coronary angioplasty.

- Covered costs include room and boarding charges; surgeon, anesthesiologist, medical practitioner and consultant specialist fees; medical consumables and medicines; diagnostic tests, ventilator, ICU and related charges; and nursing expenses.

Accidents

- Coverage is provided for
    - death within a period of twelve months from the date of bodily injury, where the injury is the main cause of death; and
    - total and irrecoverable disability resulting from injury within twelve months of its occurrence.

- Benefits for accidents are provided according to the table below:

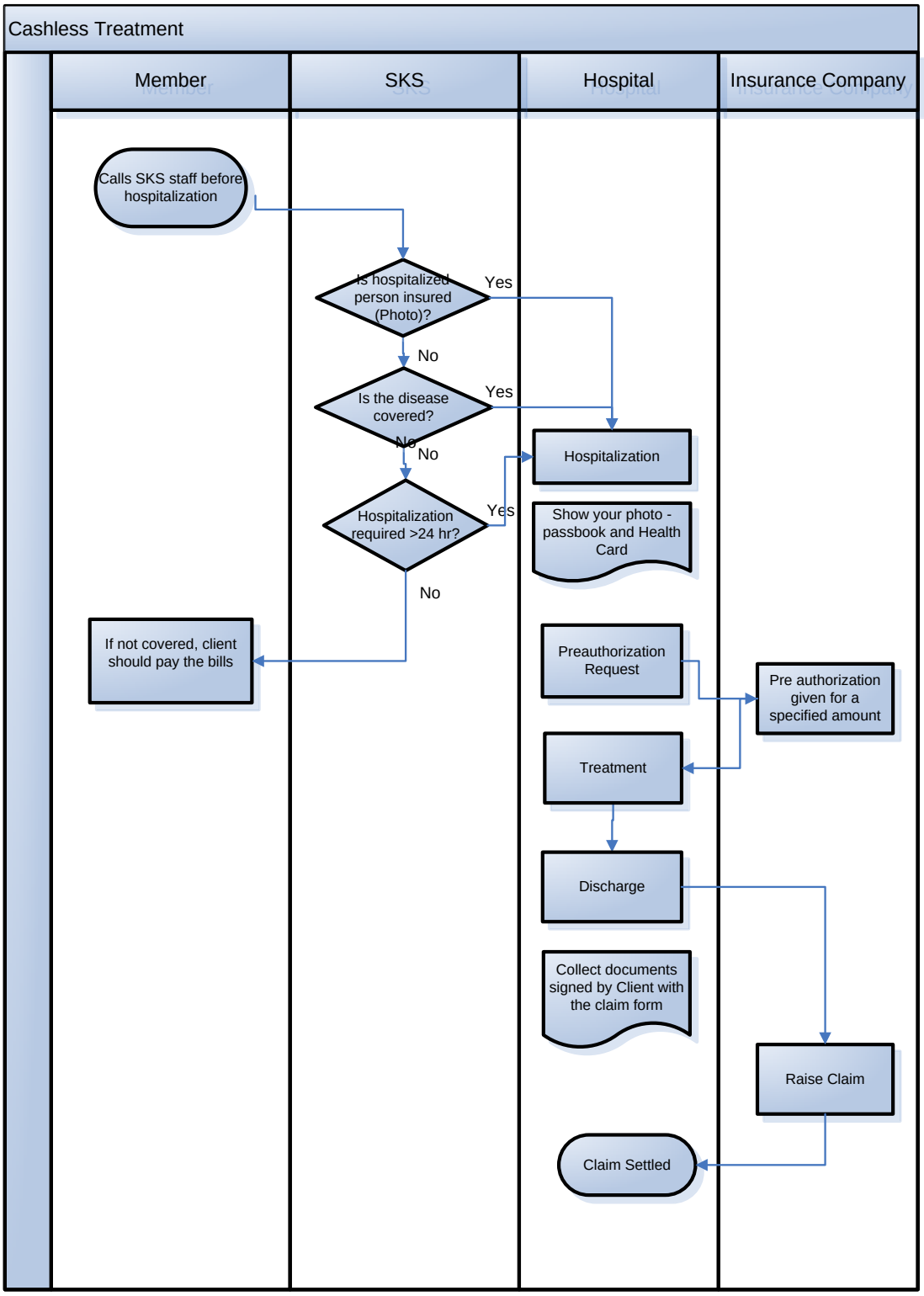
Loss due to Accident	Benefit Amount	
	% of Sum Assured	In USD
Accidental Death only(not normal death)	100%	Plan 1: $250 Plans 2-4: 250
Both hands or feet or sight	100%	Plan 1: 250 Plans 2-4: 250
One hand and one foot	100%	Plan 1: 250 Plans 2-4: 250
Either hand or foot and sight of one eye	100%	Plan 1: 250 Plans 2-4: 250
Hearing of Both ears	100%	Plan 1: 250 Plans 2-4: 250
Speech	100%	Plan 1: 250 Plans 2-4: 250
Either Hand or Foot (loss or Loss of Function)	50%	Plan 1: 125 Plans 2-4: 125
Loss of function of one hand and one foot without separation	50%	Plan 1: 125 Plans 2-4: 125
Sight of One Eye	50%	Plan 1: 125 Plans 2-4: 125
Quadriplegia (All four limbs paralyzed)	100%	Plan 1: 250 Plans 2-4: 250
Paraplegia (Both legs paralyzed)	100%	Plan 1: 250 Plans 2-4: 250
Hemiplagia (Hand and leg of one side of the body paralyzed)	100%	Plan 1: 250 Plans 2-4: 250

APPENDIX III: CONDITIONS EXCLUDED BY SKS HEALTH INSURANCE PRODUCT

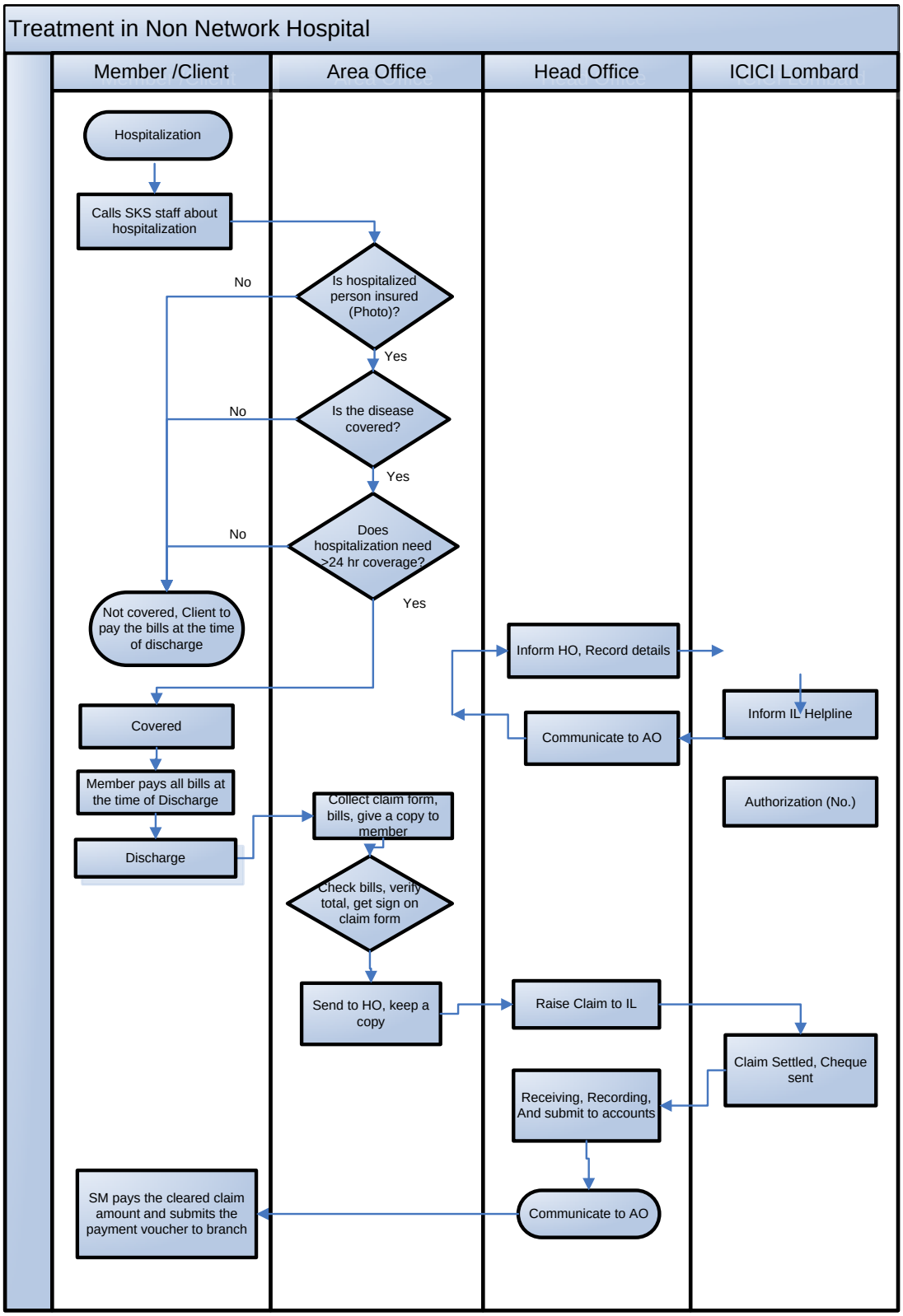
Conditions excluded from coverage included

- Conditions not requiring hospitalization,
- Conditions treated at home, and
- Conditions where the client is hospitalized due to
    - Congenital external diseases
    - Fertility, sub fertility or assisted conception operation or sterilization procedure
    - Drug and alcohol-induced illness
    - HIV/AIDS
    - Vaccination
    - Sexually transmitted diseases
    - War or nuclear invasion
    - Experimental and unproven treatment
    - Ambulance and non medical expenses
    - Cosmetic surgery
    - Dental treatment
    - Suicide/self-injury
    - Pre-post hospitalization
    - Disabilities
    - Occupational accidents like participating in a circus, car racing, parachute gliding or military activity or accidents arising out of them
    - Injury or death due to child birth or pregnancy.

APPENDIX IV. FLOWCHART OF PROCESS TO RECEIVE "CASHLESS" CLAIMS THROUGH A NETWORK HOSPITAL



APPENDIX V. FLOWCHART OF PROCESS TO RECEIVE REIMBURSEMENT CLAIMS AT AN OUT-OF-NETWORK HOSPITAL



APPENDIX VI. MINIMUM DATA REQUIREMENTS FOR HEALTH INSURANCE MANAGEMENT INFORMATION SYSTEMS

Minimum data requirements included

- eligibility for new loan
- repayment of loan
- health insurance enrollment status of client
- family members enrolled
- number of major health events within household
- use of health insurance for coverage
- use of network versus non-network facilities
- claims reimbursement rates
- drop-out rates
- loan delay rates
- take-up of mid-term loans.

SKS's basic data collection at the centre and branch level included loan disbursal, claims information, and member repayment. Branch managers, rather than loan officers, were responsible for entering these data in their databases and received training from SKS's head office on financial management. SKS planned to work with centres to ensure collection of other data to assess the impact of mandatory health insurance on loan take-up, loan delay, drop-out rates, and claims.

Hospitals do not have access to the insured patient's data; they only have access to the member's health insurance card. Thus, they cannot view the client's health or repayment history. Both the client and the loan officer maintain formal records on loan repayment and insurance status.

SKS explored the possibility of using "smart cards"—not just for the health insurance for all of its financial services—because they would greatly help record-keeping and claims processing. However, SKS ultimately decided against them because of the prohibitive cost. Additionally, hospitals lacked the necessary infrastructure to use them.

APPENDIX VII. LIST OF NETWORK HOSPITALS IN PILOT AREA

	Name of Hospital	Location
1	Basaveshwara Hospital	Gulbarga
2	Sangameshwara Hospital	Gulbarga
3	KBN Hospital	Gulbarga
4	Kiran Meternity Hospital	Shahpur
5	Harikrishna Hospital	Shahpur
6	Maruthi Medical Centre	Yadgir
7	Gurunanak Hospital	Bidar
8	APEX Hospital	Bidar
9	Prayavi Hospital	Bidar
10	Matoshri Hospital	Bidar
11	Dr. Suryamshi Hospital	Bidar
12	Basnel Hospital	Basavakalyan
13	Basaveshwar Hospital	Basavakalyan

APPENDIX VIII. ESTIMATES FOR DIRECT COSTS FOR THE PILOT AND EXPANSION TO OTHER BRANCHES

Below are estimates for some of SKS's direct fixed and variable costs for its pilot and its expansion of the product to other branches. For a complete estimate on costs, we also require indirect costs—such as usage of utilities and office space shared with other SKS program units—which are not easily calculated.

As shown below, cost per client for both fixed and variable direct costs decreased as the number of clients enrolled increased from 10,000 to 50,000.

- The cost per client for the premium to the insurance company decreased as an increasing number of clients chose insurance plans with slightly lower premiums. In September 2007, 68% of clients were enrolled in Plan 4, the plan with the highest premium. By December 2007, however, only 60% of clients were enrolled in Plan 4. As more clients enrolled in the less expensive plans, SKS's cost per client for the premium to the insurance company dropped.

- Other costs decreased as the number of enrolled clients increased because SKS took advantage of economies of scale. For example, the cost per client for health insurance cards and guidebook printing decreased as SKS was able to place a larger order and bargain for better prices.

PRE-IMPLEMENTATION COSTS

Production of marketing video[14]	$1,250
Staff costs (including salaries, conveyance, travel, lodging, phone, and daily allowance)	11,183

IMPLEMENTATION COSTS

	Cost per client insured (USD)	
	At 10,000 enrolled clients (Sept 2007)	At 50,000 enrolled clients (Dec 2007)
Premium to insurance company	$4.18	$2.68
Staff costs (including salaries, conveyance, travel, lodging, phone, and daily allowance)	0.14	0.08
Incentive to loan officers working in areas enrolling clients in health insurance (0.13 for each new enrolled client, 0.25 for each enrolled client if all clients in a centre are enrolled)	0.17	0.11
Loan officer training	0.30	0.05
Reserve Fund	0.09	0.06

[14] The insurer funded production of the marketing video.

Health insurance cards	0.22	0.05
Guidebook printing	0.03	0.01

Overall, cost per client for direct costs for launching health insurance: $2.00-$2.13

Overall, total direct costs for launching health insurance across all 210,000 enrolled members (as of January 2008): $420,000-$446,250

APPENDIX IX. REFERENCES CITED

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