Modified Cashless Health Insurance: VimoSEWA's Experience

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Manila

Structure of presentation

- Background
- The Health Insurance Product
- The Modified Cashless System
- Reasons for it being a **Modified** Cashless System
- Challenges
- Learnings

Self Employed Women's Association (SEWA)

- National union of 1.56 million poor self-employed women workers (in the informal economy) started in 1972
- Headquartered in Gujarat, India - operations in 8 states
- SEWA's objectives are full employment and self-reliance for its members
- Activities include livelihood promotion, banking, advocacy for workers' rights, social security

Some SEWA Members

VimoSEWA

- Insurance started in 1992
- Registered as a cooperative in 2009
- Bundled and unbundled products – life, accident, hospitalization, and asset loss
- Members include women, spouses and children
- Membership in September 2010 -**103,362**

Health Insurance Products

Premium (Rs.)	**Coverage (Rs.)**
175 (bundled)	**2000**
375 (bundled)	6000
400	10,000
1000	25,000

VimoSEWA's Health Insurance

- Voluntary enrolment
- 24 hours hospitalization
- Primary insured SEWA member; spouse and children can be insured
- Entry before 55 yrs of age
- Coverage upto 70 years of age

Reimbursement vs Cashless

Reimbursement Method

- Member has choice of hospital
- Member pays out of pocket and is reimbursed on submission of documents (TAT: < 1 month)

Cashless Method

- Member has to use one of selected hospitals
- Member is paid health care costs while in hospital (24-48 hrs)

Objectives of Cashless System

To provide improved access to health care

- Poor faced difficulties such as
  - Borrowing/selling assets to pay costs
  - Difficulty with required documents
- Further,
  - Empanelment of hospitals helps monitor quality, prevent collusion
  - Thrust on govt. and trust hospitals helps contain cost of care

Steps for claim settlement - 1

1. Insured member goes to empanelled hospital

2. After admission, phones extension worker on mobile

3. Extension worker visits hospital - meets member and doctor

4. Extension worker checks if member has paid premium, is eligible for claim etc.

Steps for claim settlement - 2

5. If “yes”, then member paid first installment in cash after 24 hours. Second installment (cash) paid at time of discharge.

6. Direct payment to 10 out of 30 hospitals .

7. Documents collected from patient and submitted to insurance company .

8. Insurance company approves claims and tops up fund at VimoSEWA for claim reimbursement.

Benefits of ‘Cashless’-1

- For members
  - Reduced indebtedness
  - Immediate reimbursement
  - Improved quality of care

- For programme
  - Greater efficiency – e.g. lower claim rejection rate; lower claim servicing cost
  - Demonstration effect, good service, brings in new members

Benefits of ‘Cashless’-2

- For extension worker
  - Increased confidence and ability
  - Means of livelihood

Modified Cashless – Hospital Reasons - 1

Microinsurance members typically use:

- Low cost, relatively small hospitals
- Government hospitals

Hospitals did not agree to be paid directly

- So had to pay member
- Had to pay in 2-3 installments

Modified Cashless – Hospital Reasons - 2

- Some hospitals agreed for direct payment, but
  - member paid cash for services/drugs purchased outside the hospital

Modified Cashless – Member Reasons

1. Members do not inform Vimo until after discharge – claim treated as ‘normal’
2. Members leave hospital without informing extension worker – additional servicing costs
3. Documents incorrect – name, age etc. so claim transferred to ‘normal’ claims

Challenges

1. Issues around documentation
   - o Incomplete documents lead to delayed settlement or transfer to ‘normal’ claims settlement

2. Extension workers have to carry cash to pay members. Problem as sum insured increases.

Learnings - 1

1. Programme **evolves** over time, as learning occurs:
   - Payment made before 24 hrs – but later changed because:
   - o Member discharged before 24 hrs
   - o Some claims inadmissable
   - o Initially only extension worker had phones – later one central number added

Learnings - 2

2. Programme **improves** with time

- It takes time for members to transit to the new system (e.g. forget to inform extension worker, or contact extension worker as per previous system)

- Providers become more cooperative over time; increased claims volume incentive to reduce costs, preserve quality

Learnings - 3

3. Two key factors

- Confident extension workers who can communicate with doctors

- Responsive claim scrutiny system that quickly decides admissibility (good database)

Learnings - 4

4. Empanelment of hospitals helps monitor quality – constant monitoring required

5. Members can be steered towards government and trust hospitals – quality care at lower cost

Learnings - 5

- It is possible to build the capacity of barefoot insurance promoters to become cashless extension workers and negotiate the hospital system