"Developing partnerships to insure the world's poor"

MEDIPLUS

Health Services – Nairobi, Kenya

Notes from a visit 05-08 July 2002

(Research conducted for ***MicroSave***)

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INTRODUCTION AND BACKGROUND

MediPlus is a privately owned, for-profit health maintenance organisation (HMO). The limited company is one of the six major HMOs currently operating in Kenya, of about twenty altogether. Founded in 1996, it currently covers about 65,000 people countrywide.[1] As an HMO, MediPlus is not an insurer and is thus not regulated within Kenya.

MediPlus primarily targets medium and large corporations because it is most efficient to access many people at once. Employers pay MediPlus in lump sums or obtain members' premium payments directly through payroll deductions. However, management realises that there is an opportunity to move down-market to access a huge untapped market. To this end, they are in the process of developing a suitable product for Savings and Credit Cooperatives (SACCOs) and a large commission-based sales force is marketing the product. Clients purchasing through their SACCO access healthcare through a network of over one hundred and ten selected healthcare providers covering much of the population of the country.

MediPlus has entered the health care financing market well after the HMO pioneers in Kenya, and has benefited from their lessons learned. The company has also borrowed ideas from the insurance field, especially related to controls. Combining these lessons has helped them to create a flexible yet control-laden product.

HMOs in Kenya have not been historically subjected to regulation and supervision. However, during the July 2002 budget speech it was announced that efforts would be made to develop regulations to govern that industry. It was suggested that HMOs would be required to develop "initial" capital of Kshs 60-100 million (US$0.750 to 1.25 million). This is very likely to have a dramatic impact on the HMO industry in Kenya. MediPlus' management notes that they are preparing the institution for the effects of the new regulation. However, discussions with insurance professionals in Kenya revealed that this issue was nearly a surprise to the insurance commissioner who will need to develop the regulations and structures to implement the new policy. Thus, it is likely to be at least one to two years before implementation.

MEDIPLUS' PRODUCT

MediPlus' product is delivered through a total network of one hundred and sixteen healthcare providers spread throughout the country in the geographical areas where their clients live. Members have full choice within an extensive list of health care facilities to access healthcare for themselves and their families.

The large catchment area was designed to accommodate employees of large corporations whose families live up-country (since the plans cover the whole immediate family). While this means additional administrative costs, it is part of the institution's flexibility and plays an important role in helping MediPlus retain corporate customers. The institution hopes to use this network to expand proactively within the SACCO micro-market.

Staying competitive is an important institutional value for MediPlus.

[1] The authors would like to thank the management and staff of MediPlus for their kind assistance during our visit. They were extremely open and helpful, answered all our questions and clarified many issues for us. MediPlus is different from the other case studies in this series in that they are a large for-profit institution that does not yet focus on the low-income market. They were selected for the series by the authors who believe that there could be important lessons for microinsurance within a for-profit organisation.

An independent actuary does the pricing for MediPlus' product and MediPlus regularly compares its prices with hospital rates and international drug pricing to ensure continued competitiveness. Institutional management also continually compares its product to those offered by competitors, studies the weaknesses of competitor products and uses these in marketing its product to competitor's clients.

MediPlus prides itself on its ability to design flexible, tailor-made healthcare financing packages. Customers have a range of options to choose from and while the current clientele are mainly drawn from large corporations, the institution plans to revisit its packages in the next 3 years in order to reach lower income groups. The management is already planning to design appropriate healthcare financing packages for SACCOS.

MediPlus' core product is in-patient cover, however there are a variety of optional benefits that include outpatient coverage.

PRODUCT	
Eligibility Criteria	▪ Open to both corporate bodies and individual families that can afford to pay the premiums. ▪ Extensive medical history questionnaire is administered as part of the application. This is analysed to determine eligibility and premium levels that will be applied to the applicant. ▪ MediPlus specifically reserves the right to refuse an application or subsequent renewal.
Coverage	▪ Consists of a standard package and optional benefits. • Standard package: in-patient care, in-country ambulance and air evacuation services, post-hospitalisation treatment, personal accident coverage and funeral expense coverage. • Optional benefits: out patient, maternity, critical illness, special benefits (corporate clients might add coverage for usually excluded items such as: HIV, pre-existing conditions, excess of limits), optical, dental and international evacuation and rescue benefits.
Duration of Cover	▪ One year
Exclusions	▪ Pre-existing, chronic, or recurring conditions, congenital illness, venereal diseases, illnesses resulting from or related to HIV, maternity, abortion, medical issues related to participation in a riot, strike, or war. ▪ Any person below the age of 3 months or over the age of 65. ▪ Claims for inpatient care within 120 days of the effective date of coverage, or outpatient care within 30 days (except as a result of an accident which is effective at membership acceptance). ▪ Inpatient care when notified more that 48 hours after admission in an emergency, or admission without preauthorisation by MediPlus for normal admission. ▪ Children who are not legally recognised as the member's child ▪ Current and future care of anyone who defrauds the company including through false information on their application.

Limitations	▪ Dependent on the coverage purchased. ▪ Annual ranges from KShs1.2 –20 million (US$15,000 to 250,000) for in-patient. ▪ Annual ranges from KShs50,000 – 100,000 (US$625 to 1,250) for out-patient. ▪ Accidental death between KShs1 and 10 million (US$12,500 to 125,000) depending on the in-patient coverage selected. ▪ Post-hospitalisation care up to 90 days and KShs30,000 (US$375) ▪ Funeral expense coverage to KShs100,000 (US$1,250). ▪ Maternity to KShs100,000 (US$ 1,250) and policy must be in force twelve months before any maternity claims. ▪ Critical illness coverage: lump sum of Kshs1 million (US$12,500). ▪ Optical: KShs20,000 (US$ 250) per member per year with 20% co-payment. ▪ Dental: KShs20,000 (US$ 250) per member per year with 20% co-payment.
Mode of Delivery	▪ Through a network of 116 partner clinics and hospitals around the country. Patients have the freedom to choose from a variety of listed health service providers. ▪ Policies are sold through an array of sales people primarily to corporate entities, with some policies sold directly to individuals (especially at the high end).
PRICING	
Premium	▪ In-Patient: ranges from KShs10,580 to KShs30,850 (US$132 to US$386) per person per year for a single member. Coverage for four family members ranges from KShs33,320 to KShs97,155 (US$417 to US$1,214) per year. Additional family members covered for a fee that ranges from KShs6,665 to KShs19,430 (US$83 to US$243). ▪ Outpatient: ranges between a no co-payment premium of KShs14,870 (US$186) for unlimited services (most expensive plan), and a premium of KShs9,425 (US$118) with a co-payment of KShs100 (US$1.25) and treatment limits of KShs50,000 (US$625) (least expensive plan). ▪ Other Benefits: • Maternity (Kshs11,730, US$147); • Dental and Optical (Kshs4,315 each, US$54); • Personal accident to Kshs 2 million (US$25,000)(Kshs4,000, US$50).
Method of payment	▪ Lump sum at start of period ▪ Monthly payments with eleven post-dated checks presented at approval of application (with an additional charge of about 18%).
Other	▪ Co-payments varying from KShs50 to KShs100 (US$0.63 to 1.25) per out-patient visit depending on type of coverage purchased
PLACE	
	▪ Out-patient and non-emergency in-patient: Any MediPlus pre-approved and listed clinic/hospital. ▪ In an emergency, any medical facility.

PROCESS	
Enrolment / Renewal	▪ Sales agent contacts employers, disseminates product information, presents product to employees. ▪ Sales agent makes presentation to individuals. Customer chooses coverage from menu, completes an application (by family group) and specifies beneficiaries. ▪ Full payment made by check to MediPlus (or eleven monthly post-dated checks are submitted with the application). ▪ ID card prepared for each beneficiary.
Receipt of Treatment	▪ Client presents card at hospital/clinic registration desk for verification and is given claim form. ▪ Cllient receives consultation and doctor indicates this on claim form. ▪ If client needs to go to lab, referral form is provided on which lab indicates tests carried out and cost. ▪ Doctor prescribes needed medication/treatment. ▪ Client submits prescription plus claim form to pharmacy and receives medication.
PHYSICAL EVIDENCE	
	▪ ID card. ▪ Detailed application. ▪ Claims and referral forms.
PEOPLE	
	▪ Marketers. ▪ Registration desk personnel. ▪ Physicians and nurses in the hospitals and clinics.
PROMOTION	
	▪ During 2001 and 2000, MediPlus spent KShs9.8 million and KShs5.9 million (US$122,500 and US$73,750) respectively on direct expenses of advertising and marketing. That represents 3.2% and 3.9% respectively of total premiums for those years. Methods included: • Word of mouth. • Additional benefits offered free of charge. • Brochures. • Billboards. • Television. • Radio. • Sponsorships. ▪ Professional commissioned sales people (MediPlus paid KShs38.4 and 22.5 million (US$480,000 and US$280,000) on commissions during 2001 and 2000, respectively. That represents 12.8% and 15.0% respectively of total premiums for those years.

HEALTH PROMOTION

While MediPlus is not involved in the actual delivery of health services, clients have access to two types of health promotion: through the workplace and through the provider.

MediPlus corporate customers can provide employees with healthcare information. MediPlus provides information and education packages on the maintenance and control of specific conditions including control of hypertension, HIV prevention and maintenance, diabetes control, and nutrition. On request, MediPlus organises health education forums where consultants and

experts are invited to speak with employee groups. Additionally, MediPlus customer care nurses will sometimes accompany MediPlus sales agents to client meetings to provide free first-aid demonstrations.

Health promotion is a key to reducing costs for healthcare financing programs. MediPlus provides informational packages on:

- ✓ Control of hypertension
- ✓ HIV prevention and maintenance
- ✓ Diabetes control
- ✓ Nutrition

In addition, MediPlus maintains a monthly claim history for each company and reviews claims of individuals to identify recurrent illnesses. The purpose of these reviews is to refer individuals to specialists for proper treatment to prevent the re-occurrence of these conditions.[2]

MediPlus' customers also have access to preventive healthcare interventions though some provider partners. For instance, Purple Hearts, one of MediPlus' strategic partners, offers immunisation, weight loss counselling, and family planning services to patients.

INSTITUTIONAL STRUCTURE

MediPlus has a branch network of six offices: three in Nairobi, and one each in the east, west, and central regions of Kenya. A managing director heads the MediPlus operation.

Each branch has a Marketing and Customer Care Department. The Marketing Department sells the product and carries out some of the product servicing. The Customer Care Department is staffed primarily by nurses who visit each in-patient daily to monitor the quality of healthcare received from the provider, communicate empathy with the patient on MediPlus' behalf, and monitor medical expenses to ensure that patients do not exceed their coverage limits.

MediPlus has centralised Underwriting, Claims and Accounting Departments. The Underwriting department receives all applications, carries out initial risk assessment, moves new clients onto coverage, and processes membership cards. This department also maintains a centrally operated client database and sends weekly updates to all provider hospitals.

The Claims Department reviews all claims invoices and advises management on the pricing for renewals. Approved claims are forwarded to the Accounts Department for processing of payment.

HEALTH SCHEME OPERATIONS

Providers

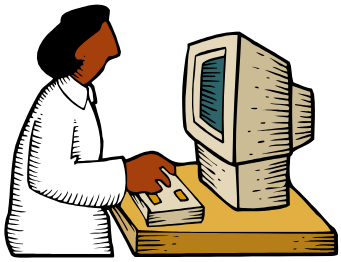
MediPlus does not own health facilities[3] but chooses to maintain contractual arrangements with independently owned health service providers in forty-one towns and cities throughout much of the country. The institution primarily works with private practitioners but also tries to work with

[2] This was explained by management, but was not tested with corporate clients to determine if these interventions are actually provided, and if so how effective they were.
[3] One health clinic is related to MediPlus by virtue of common ownership and directorship.

mission hospitals outside Nairobi because many of these have a reputation for delivering affordable and good quality medical care.

The interface between providers and MediPlus is critical to the smooth operation of the health scheme. MediPlus offers a range of packages with different limitations, exclusions, and restrictions. Members have the freedom – within the limits of the type of coverage they purchase – to visit any of the approved service providers throughout the country. A MediPlus ID is required each time a patient visits a healthcare provider, and helps protect healthcare providers from giving medical services to impostors. But, a regularly updated client database is also critically important.

MediPlus' client database, updated weekly, helps ensure that treatment received is consistent with the coverage purchased, and protects both the healthcare providers and the health scheme from fraud.



When a new client's application is accepted and the accounts department has verified receipt of payment, relevant data about the client is posted to the database by the Underwriting Department. A list of current clients is sent out to each service provider on a weekly basis, and any changes that occur within the week are independently posted to each Nairobi service provider. This effectively protects against fraud by clients who might exceed their coverage limits in one health facility and try to get additional healthcare from another health facility. It also protects MediPlus and providers from clients receiving treatment after their coverage has expired, ensures that treatment received is consistent with coverage purchased, and helps to ensure that clients do not exceed their coverage limits.

Each time a patient receives treatment, a claims form is processed. Healthcare providers process a separate claim form for each patient. This provides important and necessary controls against cost escalation and has sometimes been used to detect patients with chronic illnesses who did not initially declare their medical conditions. Claims forms and lab referral forms are used to track the nature of treatment received and the costs involved. The claims forms are also used to track patient medical histories and are useful in re-negotiating coverage.

When out-patients near their coverage limit, the appropriate Sales Agent is contacted. He/she then notifies the client of the remaining benefits. Similarly, Customer Care Nurses keep track of the daily expenses of each in-patient and inform them when they are about to reach the limits of their coverage. MediPlus usually advises patients on which health facilities to use in order to sustain their coverage throughout the year.

Claims Department

The busiest department in the institution is the Claims Department, which verifies all invoices and treatment costs. MediPlus follows a very detailed and thorough verification process as a control against fraud and cost escalation and also to identify adversely selected clients who might have been untruthful in their application. The department has a claims manager, basic data entry staff, more advanced staff who review claims details, and approval level staff who approve claims and send them to the Accounts Department for payment.

Providers present their claims to MediPlus periodically – weekly for some providers and monthly for others – depending on volume of use. MediPlus stamps all claims with date of receipt and the claims are then forwarded to the Claims Department for verification. Claims reviewers verify that the claims submitted are for covered patients, at listed facilities, with covered procedures and medications, and for the agreed price. They do not conduct a clinical review or question treatment or procedures, because they note that they could be sued for holding back payment on covered procedures that the doctor deemed necessary.

If treatment received is not covered, the system sends out an alert and the claim is taken up with the client. If claims are discovered for treatment received on an expired client account, they are returned to the provider.

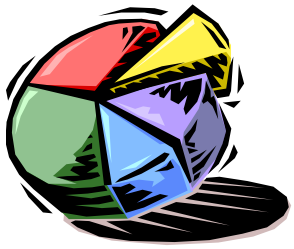
After invoices are verified by the Claims Department, they are forwarded to the Accounts Department to process payment.

Data Tracking

The Claims Department tracks frequency of usage, frequency of illness types by age groups, and histories of individual clients or groups for claims versus premiums, and conducts variance analysis for each claim. Though cases of cost escalation are rare because both provider and insurer use an agreed list of drug prices, the Claims Department nevertheless routinely carries out these analyses.

Around the time of our visit, the claims manager noted that they were processing an average of one thousand claims per day in two shifts, or about five thousand claims per week. Of those claims, she said that about two percent had some error or reason for rejection.

Health care data management is critical in tracking utilisation, claims and recurrent medical issues in need of referral. All are important in controlling costs.



MediPlus has a sophisticated healthcare management software package that is capable of running a claims experience report for each individual and group client. In addition to automatically conducting variance analyses, the package enables the institution to track, among other things:

- ✓ Level of utilisation per institution
- ✓ Number of non-payable claims per institution per period
- ✓ Individual claims experience to detect recurrent medical problems that might need referral, how much they spend on drugs and consultation per period, and any misuse of coverage (for people who switch facilities)
- ✓ Usage information to make decisions for terms to govern future renewals
- ✓ Comparison of procedures charges across doctors so they can make referrals to reasonably priced providers to enable the clients to better manage their coverage limits

MediPlus also tracks time to payment for each of these invoices. Average processing time is currently forty-five to sixty days, an increase in time since the days when the institution was smaller. Management uses this data in decision-making about staffing, pricing, underwriting, and coverage inclusions, exclusions, and limitations.

Costing and Pricing

MediPlus has agreements with each health facility regarding the costs of different medical procedures, and providers are bound to keep their pricing within these limits. Occasionally, patients will be referred to specialists. When this happens, the specialist is also bound to operate within certain price limits and must inform MediPlus immediately if the costs of the procedure come near the agreed limits.

These agreements are important because cost of treatment is one of the considerations for product pricing. Other considerations that go into product pricing include the international cost of drugs, fees for insurance / re-insurance, MediPlus operations costs, and a mark-up for MediPlus.

In setting prices for products, MediPlus considers cost of treatment, international cost of drugs, fees for re-insurance, operations costs and a mark-up.

MediPlus conducts extensive price surveys to understand health care pricing in different regions of Kenya. For clinics with no pharmacy, a support pharmacy is sought and prices from the neighbouring hospitals are compared with those of the support pharmacy.

MediPlus tailors its premium packages for different towns and hospitals. If patients prefer a certain hospital, pricing is based on costs at that facility and MediPlus receives discounts from these selected providers. Service providers in each town are classified: a, b, c and d with classes c and d catering to the more downscale markets. Product pricing therefore includes discounts for geographical regions and for the level of service provider.

Currently, pricing does not factor in differences in risk levels that apply to different geographical locations. For instance, the fact that there is higher incidence of malaria in Kisumu than in Nairobi does not affect the pricing for this area.

Accounts Department

MediPlus' has a strong accounting function that consists of three processes:

- ✓ Accounting for premiums received: This process involves receipting of premiums, ensuring that new clients who have paid-up premiums are posted onto the database, and tracking changes in premiums received from one period to the next. This process interfaces with the Marketing Department (and their system for compensating agents through commissions) and the Underwriting Department.
- ✓ Accounting for claims made against the premiums: This process involves re-verification of claims received from the Claims Department (in terms of confirming agreed upon pricing) and processing of the claims payments. This process interfaces with the Claims Department.
- ✓ Internal accounting processes: through which administrative and operational costs are tracked

Treasury management is also conducted by the Finance Manager and processed by the accounts staff.

The finance manager tracks key ratios from the accounting processes, including:

- ✓ Claims as a percentage of premiums
- ✓ Overhead ratios
- ✓ Efficiency ratios
- ✓ Marketing/advertising as percentage of premium
- ✓ Package preferences and how value can be added to other less popular packages to increase interest in them
- ✓ Growth/change in premiums received

The finance manager regularly updates the management team with regard to these and other performance indicators.

Marketing

"Finally . . . affordable, quality, healthcare"

In addition to a catchy slogan, MediPlus has a large but purely commission-based sales force. All Sales Agents receive initial training on how to carry out an initial risk assessment of potential clients, how to approach clients, and how to sell the product. MediPlus has a standard 'sales kit' and Sales Agents are trained on how to use it effectively. A corporate sale can take up to three months because of the lengthy decision-making processes involved in the client organisation. To ensure that Sales Agents remain encouraged in spite of the challenges of their job, managers hold weekly motivational talks. These meetings also serve as a forum for new or less experienced agents to learn from their more experienced colleagues.

There is a high level of team work within MediPlus, and this is evident in MediPlus' marketing approach. Unit managers earn an additional commission for the business brought in by Sales Agents under their supervision and therefore have incentive to work with the Sales Agents and ensure that the Sales Agents are productive. While unit managers also sell the product, in many cases Sales Agents make initial contact with clients. However, managers are available to provide back-up support and in almost all cases the unit manager will make the 'benefits presentation' to potential clients. This serves to standardise the marketing approach and content and clarify any misinformation with regard to the product. Sales Agents will often flag client-specific issues before this presentation to enable their managers to adapt the content to the specific audience.

Team work is essential to the MediPlus marketing strategy

On a quarterly basis, Sales Agents attend an in-house workshop through which the relevant managers communicate any changes to the product or institutional procedures. Sales Agents regularly carry out feedback surveys with clients and the quarterly workshops serve as a forum

through which they can bring client concerns to management attention. Product refinements have resulted from some of these meetings.

Customer support and follow-up is an important component of the marketing approach and ensures that customers are satisfied. MediPlus staff gives a 'customer care' presentation two to four months into the coverage period for each corporate client. These presentations offer customers the opportunity to bring to MediPlus' attention any difficulties they have experienced in their initial encounters with the product.

In addition to the fact that Sales Agents are only paid for the business that they bring in, the institution has clear minimum performance standards and Sales Agents who do not meet these standards are disqualified. Each Sales Agent is expected to bring in premiums worth at least KShs300,000 (US$3,750) per month. Sales Agents have the opportunity to win very attractive prizes. For instance, Agents can win a trip outside the country if they bring in business worth KShs5 million (US$62,500) a year. There are interim targets worth a variety of rewards. This system works well and guarantees that even without supervision, Sales Agents effectively manage their time. MediPlus continually carries out surveys of competitors' remuneration to ensure that their Sales Agents' remuneration is more attractive than competitor packages and the Agents are not tempted to divert potential business to competitors.

Overall:
It is evident that professionals manage MediPlus with experience in health care finance management. Institutional risks appear well controlled. The marketing staff appears highly motivated (and their work has resulted in doubled premiums over each of the last two years). Their capital position is, however, rather precarious.

Some ratios calculated during the visit include (calculated in Kenya shillings where appropriate):

- Insured to Staff (inclusive of commissioned marketing staff) as at June 2002: 542 (65,000/120)
- Administrative costs to Premiums[4]: 70.9% (2001), 86.5% (2000) (includes all costs other than direct client claims)
- Claims to Premiums[5]: 28.6% (2001), 21.7% (2000) Change in premiums written[6][7]: 98.9% (2000 to 2001), 163.5% (1999 to 2000)
- Reserves to claims: MediPlus does not have an insurance license and thus insures all premiums through an insurer and a re-insurer. The company also accumulates a revenue reserve which at 31 December 2001 stood at KShs -50.3 million (US$-0.630 million)
- Dropout rate: We were unable to directly assess this indicator. Dropout rates are said to be 15% on average though the reasons are varied. Some clients drop out for financial reasons while others drop out because they have switched to other providers.[8]
- Days of unpaid claims: We were unable to directly assess this indicator. MediPlus tries to settle all claims within thirty days. However, a thirty to sixty day payment duration is more common, and one doctor we spoke with noted that payment of physicians is getting more and more delayed. MediPlus says that they do have a limit of 120 days after which

[4] Source: MediPlus Services Limited, Financial Statements, 31 December 2001. (Audited by Deloitte and Touche)
[5] Ibid.
[6] Ibid.
[7] Premiums written: 1999 = 57.2 mill KShs (US$715,000), 2000 = 150.7 million KShs (US$1.9 million), 2001 = 299.7 million KShs (US$3.8 million), in constant dollar terms.
[8] The HMO market in Nairobi is highly competitive with one HMO offering discounted premiums in the first year to get business, and then increasing the rates in the second year to cover the real cost of a company to the HMO. Thus, many companies only stay with an HMO for one year.

if there are any claims still outstanding, providers receive a payment that is based on precedent, and the institution then works on settling any outstanding balances

Likelihood of Sustainability:
In Kenya, the market for HMOs is rather competitive and there are six major players in the market. However, in spite of that, MediPlus is said to be positioned as the number two or three HMO in terms of market share. The organisation has well-designed controls which minimises risk. For instance, with very few exceptions, most of the institution's packages have clear limitations and the institution closely tracks utilisation by each client, ensuring that clients stay within these limits. The institution is also well cushioned against adverse selection in that it works with corporate clients and enrols all the staff of its client institutions. In instances where claims exceed premiums, the risk is born by a reputable reinsurance company, Africa Re-insurance.

Still, two issues of concern arise in consideration of sustainability. The first is the current capital position of MediPlus. The capital position of the company is substantially negative and has been essentially stagnant over the prior two years of operation. Audited financial statements at 31 December 2001 show a capital deficit of Kshs48.8 million (US$600,000), or 16% of premiums earned in 2001. The second issue of concern is the intended move by the Government of Kenya to regulate the HMO business and the potentially high level of government-required initial capital being discussed at the time of the visit. The potentially high level of government-required initial capital would appear to be difficult for MediPlus to generate, especially when coupled with the current negative capital position of the organisation.

Exacerbating the concern about the capital is the fact that trade payables (mostly payments due on claims to clinics and hospitals) have increased by 308% while total premiums have only increased by 98%. Trade receivables grew by 123%. This suggests that there have been some difficulties getting payables paid and they are thus delaying for cash flow reasons. Although we were not able to calculate the time-to-payment of claims, one doctor at an affiliated clinic volunteered that payments had been coming later and later. MediPlus does have a line of credit secured by personal guarantees of the directors. The average interest rate for this line during 2001 was 26%.

MANAGEMENT AND GOVERNANCE
MediPlus is part of a group of companies that operate independently of each other, though with common ownership and directorship. The Board of Directors has three members,[9] though only one is actively involved in the day-to-day running of the company. The company's financial statements[10] show a very limited investment on the part of the shareholders. At both 31 December 2001 and 2000, shares authorised were 5 million at KShs5 (US$0.0625) each for a total possible investment of KShs 25 million (US$ 312,500). However, only 10,000 shares had been issued and fully paid-up, for a total investment in the company of KShs 50,000 (US$625). This is a mere 0.2% of the total authorised investment. In addition to this, net accumulated losses (the revenue "reserve") totalled KShs 48.9 million (US$0.6 million). Thus, total capital at 31 December 2001 was at a deficit of KShs 48.8 million (US$0.6 million).[11]

The company's Managing Director worked with a formal insurance provider for several years and has significant insurance knowledge. The other two Directors also have significant

[9] A Kenyan, an American, and a South African
[10] Data in this section is sourced from the MediPlus Services Limited audited financial statements for the years ended 31 December 2001 and 2000, provided by the company.
[11] Should the proposed regulatory minimum capital requirement be imposed, MediPlus would need to generate approximately US$ 1.4 million to comply.

experience in the management of health care financing operations. The scheme is therefore owned and managed by experienced and professional individuals. At the scheme's inception, a customer care expert was also involved in the design of the products. MediPlus' emphasis on capacity building and their structured approach that relies on clear targets for each staff member ensure that staff are not only competent but also productive.

PARTNERSHIPS WITH PROVIDERS

MediPlus itself does not own hospitals but works with a network of hospitals, including Aga Khan, Nairobi Hospital, and the Aga Khan network throughout the country. They have institutional relationships in almost every significant town outside Nairobi. Providers are selected partially based on client preferences and recommendations, an approach designed to enhance client comfort and satisfaction with the insurance coverage. However, physical visits are made to each facility to verify its adequacy with regard to infrastructure and staffing. Some of the selected healthcare providers lack lab or pharmaceutical facilities and where this is the case, MediPlus ensures that the selected provider has access to these facilities within the same locality.

Other activities that constitute part of the process of provider selection include: soliciting the community's opinion of the provider and verifying that a medical doctor and not just clinical officers run the facility. Providers must be willing to accept MediPlus terms that include:

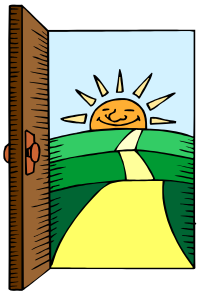
- Carrying out the membership verification process prior to providing any health care treatment
- Obtaining payment from MediPlus and not the patient. Providers agree to submit claims within 45-60 days of the end of each month and can expect payment within a month of MediPlus' receipt of their invoice. In practice, providers take up to 90 days to submit their invoices.
- All services relating to each patient must be consolidated in a single summary invoice each month.
- Where the clinic, lab, and pharmaceutical facilities operate independently of each other, bills from all three facilities must be submitted together before MediPlus processes the claims. MediPlus tries to process the claims as fast as possible because the management regards speed of processing claims as a reflection of how well the service is managed. The institution has set up an arrangement whereby if payment/settlement of claims is not made within 120 days of receipt of invoice, providers are paid a fixed amount based on precedent and MediPlus then works on offsetting any outstanding balance. In about two percent of the claims cases, payment delays result from need for clarification or correction.

During the visit, we were able to meet with managers from Purple Heart Health Clinic that is one of the health care providers for MediPlus clients.[12] About 80% of Purple Heart's business consists of MediPlus clientele. Purple Hearts has two physician employees as well as access to several other MediPlus approved physicians who sub-let space within the Purple Hearts facility. Each of these providers prepares a claim for each patient they see. The facility tries to have at least two doctors on site at all times. On average, the treatment procedure per patient (including a lab visit) takes about forty-five minutes. The clinic as well as the neighbouring lab and pharmacy – both of which are independently run – have access to the MediPlus database and all three are required to verify a patient's membership before dispensing care or medication.

The process of using the MediPlus database seems to work well. Purple Heart's accountant noted that occasionally there are instances when clients whose coverage has run out receive

[12] Although Purple Hearts is legally a separate company, and their transactions with MediPlus are said to be at arms length, they share ownership and directorship with MediPlus.

treatment but such occurrences are rare. The facility's accountant prepares a separate claim for each patient and preparation of all MediPlus claims takes about an hour each week.



MediPlus's "open door" policy fosters a positive relationship with health care providers.

The facility's management has informal/formal meetings with MediPlus at least monthly. In addition, the management has the freedom to approach MediPlus should an urgent problem arise. According to Purple Heart's management, the relationship is working out very well so far and the open door policy of MediPlus helps smooth out any potential crises. For its part, Purple Hearts offers MediPlus a discount on its consultation rates. The relationship benefits patients. Purple Hearts physicians noted that they have informally observed that the insured patients tend to come in for treatment earlier in the illness cycle than those who are uninsured, suggesting significant additional benefits to the coverage.

While on the whole MediPlus has retained most of its providers, they have dropped a few on the recommendation of medical staff in the Claims Department who regularly carry out reviews and can identify providers who over prescribe or inflate cost. Such physicians are dropped rather than having their invoices reduced to minimise MediPlus' legal liability should they seem to be dictating treatment. The table below summarises the comments of providers with regards to the relationship between them and MediPlus.

	PROVIDERS
Objectives and Expectations	▪ Significant volumes of new business through MediPlus ▪ Timely payment
Relationship	▪ MediPlus initiated relationships based on recommendations ▪ Both sides report being satisfied with the relationship ▪ MediPlus keeps an open door policy where partners are free to come in and raise issues ▪ There is a steady stream of communication, both formal and informal, between MediPlus and the selected providers
Partner Role	▪ Provision of healthcare ▪ Charging fees as agreed ▪ Timely submission of accurate invoices
MediPlus Role	▪ Recruitment of new clients ▪ Training clinic staff on customer care and the bookkeeping aspects of the relationship ▪ Timely and accurate payment of claims submitted
Capacity Demands	▪ Limited capacity issues because MediPlus simply adds new providers based on customer recommendations. ▪ MediPlus has had variable capacity issues within the claims department, but has solved this with an occasional period of operating a second shift in that department

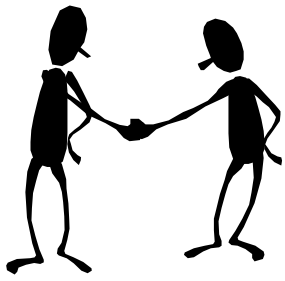
CLIENT LEVELS OF SATISFACTION WITH THE PRODUCT

Since the beginning of 2002, the Small- and Micro-Enterprise Programme (SMEP) has provided its staff with MediPlus healthcare financing coverage. In 2001, the institution had provided its staff coverage with Health Plan (a competing HMO).[13] SMEP initially chose Health Plan because of the attractive pricing of their product. However, it soon became evident that outside Nairobi, Health Plan's selected providers lacked the capacity to deliver quality health care. Many of Health Plan's upcountry healthcare providers were also employed bythe government and were only available at their clinics in the evening. In some towns, Health Plan had only one approved healthcare provider and SMEP's staff found the long waiting times very inconvenient.

At the end of 2001, SMEP reviewed the packages of a range of HMOs and health insurers and chose to purchase coverage from MediPlus. So far, after less than six months SMEP employees are happy with the quality of health care they receive through MediPlus' approved providers. Staffing at approved facilities still remains an issue but the waiting times have been significantly reduced. The staff especially like the fact that they have the freedom to select from a range of providers (including hospitals) and can switch from one provider to another if they are not satisfied.

SMEP pays for coverage of each staff member and three other people from the staff member's immediate family. Premiums per person per year are KShs6,000 (US$75) for outpatient care of up to KShs500,000 (US$6,250) per year. Initially, SMEP managed staff health care on an in-house basis. A similar amount (KShs6,000) was allocated to each person per year. However, staff found that this amount got used in two or three visits and they then had to meet family health care costs out of pocket. Also, SMEP employees were inconvenienced by the fact that they had to pay for health care out of pocket and then get reimbursed. Sometimes they did not have money available and were unable to get healthcare immediately.

Corporate clients expressed satisfaction with the convenience of providing employees with a health care plan managed by MediPlus



The in-house scheme involved a significant amount of administration and much opportunity for fraud. The staff person responsible for managing the scheme spent a significant time verifying and paying out claims and checking that each person had not exceeded their limits. Purchasing coverage from an HMO has not only relieved the institution of a huge administrative burden, it has also enabled the institution to manage employee health issues in a much more efficient and effective manner. There is general all around satisfaction. SMEP is able to get good healthcare for its staff without any additional costs to the institution, and employees are able to get quality health care all year without incurring out of pocket expenses.

[13] As in other parts of the world, it is becoming common in Kenya for HMOs and insurers to simply rotate a large pool of customers. A corporate or other group is acquired through discount premiums, and then after one year of experience the premium is increased to reflect the reality of utilisation levels, so the group moves on to another HMO or insurer who is offering them discounted premiums.

An issue that has arisen is that the covered SMEP employees are aware that doctors treat them differently because they are insured. Some SMEP employees expressed doubts about the relevance of some of the tests that the approved facilities request. They have also noticed patterns of over-prescription, or prescription of expensive (brand name) drugs simply because their payment is already assured.

Because of the success of the arrangement, SMEP management has considered negotiating with MediPlus to sell HMO services to their clients (MFIs). However, they have hesitated because of the reputational risk involved for them if the HMO fails to deliver good quality healthcare after having been introduced by SMEP staff.

RISK MANAGEMENT

A detailed review of common risk management tools and how they are addressed at MediPlus is provided in Appendix 1: Managing Insurance Risks: Strategies Used by MediPlus.

In spite of the large sums of money involved, MediPlus has chosen to re-insure its risk with a reputable company, Africa Re-insurance.[14] Re-insurance not only increases the company's credibility, but also allows the company to pursue its growth plans with minimal constraint. The re-insurance company was chosen because of its solid reputation and the ease of conducting business with them.

In addition to being re-insured, MediPlus has their underwriting overseen by an independent company, Pioneer Insurance. This, plus the re-insurance coverage, helps to minimise risk to MediPlus. As an HMO, they are not legally permitted to accept any insurance risk.

MediPlus has in place a reasonably effective system to ensure that patients do not exceed the limits of their coverage. For in-patients, MediPlus prepares all the discharges. Members who have exceeded their limit personally pay for the additional costs of the care provided to them. To guarantee that patients are well prepared for this, patients and hospital staff are kept informed of approaching limits by the MediPlus Customer Care Nursing staff.

For out-patients, claims histories are prepared for each client to track their spending and patients are informed when their coverage is about to run out. Once patients reach the limits of their coverage, the system alerts the Claims Department staff and a notice is immediately sent out to all providers. Otherwise, providers all have access to the MediPlus database that is updated on a weekly basis. Hospital staff manage the client master list within the health care facility by contractual agreement. The providers take on this responsibility because they realise income implications if they do not adequately manage their relationship with MediPlus clients. If a hospital fails to consult the database before providing uncovered treatment to a patient, the hospital absorbs the loss. Otherwise, if a loss is due to a delay in updating the master list, then MediPlus absorbs the loss

Because of the potential for fraud and inflation of medical costs as a result of patients colluding with providers or forging medical bills, all health care is provided on a non-reimbursable basis. As an additional safeguard against cost escalation, MediPlus questions any claims for medicine that are over KShs4500 (US$56). In addition, when MediPlus members are admitted, providers have instructions to contact MediPlus immediately for approval. On a daily basis, Customer Care Nurses check what each patient is being charged against the agreed price list. Where MediPlus has no Customer Care Nurse, as in some semi-urban areas, MediPlus works with nursing officers. In these areas, costs and volumes are much lower as is exposure to risk.

[14] Re-insurance costs in 2001 and 2000 were KShs72.4 million and KShs46.5 million (US$0.91 million and US$0.58 million) or 24% and 31% of premiums earned, respectively.

While MediPlus has no direct control over the health service providers, the institution maintains agreed price lists for each provider and providers are required to inform MediPlus if treatment costs seem higher than the approved price limits. Prescription drug lists contain details regarding which medications MediPlus will cover, as well as quantities and durations. MediPlus also insists on diagnosis before prescription to make sure that people receive appropriate treatment. For chronic illnesses, covered patients will only receive medication for an additional week after admission. Providers must understand the full coverage, as well as the limitations and exclusions; otherwise, mistakes could prove very costly.

Risks to Corporate and Provider Partners:
Because of the capital position of MediPlus and the practice of paying premiums for one year in advance, there is potentially some prepayment risk to the partners, as both corporate clients and providers take on some risk in this program. Providers risk not having their invoices paid, and corporate clients risk physicians stopping treatment of covered employees to limit their risk. Beyond this, risks are limited.

Healthcare providers are aware of which clients are approaching the limits of their coverage and this protects them against patients who might try to receive treatment after their coverage has run out. The photo ID system operated by MediPlus protects providers against treating impostors. In instances where patients with expired coverage or who have exceeded coverage limits receive treatment because of delays in updating the database, MediPlus takes responsibility and absorbs the losses. The only losses absorbed by partners are those that result from negligence on their part.

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

A detailed SWOT analysis is provided in Appendix 2, below.

PRODUCT

MediPlus' product is flexible and there is opportunity for the institution to design tailor-made packages to suit the budgets of different clients. The product has been developed with effective controls that protect the institution against moral hazard, adverse selection, and cost escalation.

A potential weakness with the product is the fact that when individuals purchase a MediPlus plan, they are not required to enrol the entire household. Corporate clients are similarly not required to purchase coverage for all permanent members of employee households. This could result in adverse selection. However, MediPlus seems to have foreseen this weakness and has built adequate controls into corporate packages.

OPERATIONS

MediPlus has a well-integrated MIS that allows the Accounts, Underwriting and Claims Departments to share information. This system is an effective control against fraud and has a multiplicity of strengths that include:

- Processing individual claims separately. This allows tracking of utilisation habits and levels for each individual client. The system can therefore very quickly identify high risk clients or clients who might have chronic illnesses that were not declared at the beginning of the period of coverage.
- MediPlus' system automatically carries out variance analysis of treatment costs and immediately allows the institution to identify over-pricing.

- Providers work within certain cost limitations and these strict cost limits are an effective guard against cost escalation
- The system automatically tracks how much has been consumed by each client and the institution is therefore always up to date with regard to how much more coverage each client has available.

MARKETING

MediPlus' approach to marketing constitutes an institutional strength. Sales Agents are purely commission based and are accountable for certain minimum performance targets. This certifies that the Sales Agents are always productive. However, a danger with this approach is the fact that Sales Agents are not bound to the institution and can divert sales to other HMOs with more attractive incentives. Additionally, there is a temptation to sell what MediPlus might not be able to satisfy, or to help unqualified clients obtain coverage. Strong marketing management mitigates this problem and, in response to both of these issues, the institution attempts keep in place a range of short, medium, and long-term incentives.

RISK MANAGEMENT

MediPlus' delivery systems and product have been developed with careful thought to minimising incidences of moral hazard, adverse selection, fraud, and cost escalation. The systems are already discussed in the section on risk management and are also detailed in Appendix 2.

LESSONS LEARNED

Operations:

- While a computerised and well-integrated MIS is an expensive initial investment, it could result in a significant amount of savings for an insurance service provider. MediPlus' system can track utilisation histories by client and allows the institution to adjust its pricing and packages or even to carry out midterm reviews of packages with clients, thus acting as a safeguard against abuse of health plan coverage.
- Ultimately, the clients' decision to renew coverage is based on their satisfaction with the services previously received. MediPlus tries to guarantee client satisfaction through working with their providers of choice (without compromising quality of health care). This strategy has earned MediPlus high retention rates – 85% over the last year.

Marketing:

- Health plan sales are often made not through a one time sales effort but through a sustained marketing effort that can take up significant amounts of a Sales Agent's time and resources. Therefore, while commission-based marketing approaches can be effective, the commission must be such that it is worth the trouble of continued follow up of a potential sale. MediPlus pays its Sales Agents a 17.5% commission per sale in addition to other incentives to certify that they are adequately motivated to pursue each potential customer for a sustained period of time.
- A standardised marketing approach, complete with a presentation conducted by marketing management and sales kits for use by each Sales Agent, is critical. MediPlus has found that these tools help to confirm that the proper message is getting to potential customers. They believe this minimises customer confusion and improves renewal rates.
- Frequent follow-up has been important to success.

Accounts:

- The ability of the Accounts Department to provided detailed analysis of the business activities has been an important management tool.

- Their significant negative capital and very limited owner investment puts the company at risk.

Partners:

- Corporate clients can be an efficient market, but the relationship must be continuously managed.

Appendix 1: Managing Insurance Risks: Strategies used by MediPlus

Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	Work with a network of providers in forty-one towns all over the country
	Claims limits	Depends on coverage purchased. Ranges from KShs1.2 million to KShs20 million for in-patient care
		Ranges from KSshs50,000 to 100,000 for out-patient care. More expensive out-patient plans have no limits.
	Co-Payments	Depends on cover purchased. Relevant only for out-patient. Cheaper coverage plans have co-payments that range from KShs50-100
	Loss review	Done regularly by Claims Department and coverage re-priced
	Exclusions	Pre-existing, chronic, or recurring conditions, congenital illness, venereal diseases, illnesses resulting from or related to HIV, maternity, abortion, medical issues related to participation in a riot, strike, or war
		Any person below the age of 3 months or over the age of 65
		Claims for in-patient care within 120 days of the effective date of coverage, or out-patient care within 30 days (except as a result of an accident which is effective at membership acceptance).
		In-patient care when notified more that 48 hours after admission in an emergency, or admission without preauthorisation by MediPlus for normal admission.
		Children who are not legally recognised as the member's child
		Current and future care of anyone who defrauds the company including through false information on their application
	Limitations	Limitations are dependent on the coverage purchased.
		Annual ranges from KShs1.2 –20 million (US$ 15,000 to 250,000) for in-patient
		Annual ranges from KShs50,000 – 100,000 (US$ 625 to 1,250) for out patient
		Accidental death between KShs1 and 10 million (US$12,500 to 125,000) depending on the in-patient coverage plan
		Post-hospitalisation care up to 90 days, and KShs30,000 (US$ 375)
		Funeral expense coverage to KShs100,000 (US$1,250)
		Maternity to KShs100,000 (US$ 1,250) and policy must be in force twelve months before any maternity claims.
		Critical illness coverage – lump sum of KShs 1 million (US$12,500)
		Optical – KShs20,000 (US$ 250) per member per year with 20% co-payment
		Dental – KShs20,000 (US$ 250) per member per year with 20% co-payment
	Waiting periods	Thirty days for out-patient care (except for corporates and individuals previously enjoying coverage with a different HMO)
		120 days for in-patient, except in the case of emergencies
	Proof of event	Customer Care Nurses check on in-patients every day
	Client identification	Each client must present MediPlus ID in order to receive treatment
		Client ID matches client number in database to confirm ID
	Pre-approval of treatment	Out-patient Registration nurse must check validity of patient's coverage prior to receipt of treatment
		Patient must get admission pre-approval
		In emergency, patient must get admission approval within 48 hours

Risk:	General Strategy:	Specific Strategy:
	Expense verification	MediPlus requires providers to process separate claim for each patient and expenses first verified against limits of coverage before receipt of treatment and later expenses verified against agreed price limits with provider and for drugs, against international drug prices
	Deductibles	None required
	Initial exams	None required
	Use of pre-existing groups	Institution mostly works with pre-existing groups. Some individuals, especially at higher levels, are able to purchase coverage.
	Prerequisites to care	Approval of detailed application
	Membership from existing groups only	MediPlus focuses on corporate clients, though they do take on some individuals, especially at higher levels.
Adverse Selection	Whole family membership required	Whole family membership is not required
	Required membership within groups	Most new clients must be a part of an employer group
	Defined risk pools	Detailed application analysis allows for this, but it is limited
	Waiting periods	One month except for corporates and individuals previously enjoying coverage with a different HMO
	Tying insurance to other products	HMO product is not related to any other product
	Periodic cost evaluation	Company systems automatically carry out variance analysis and send out alerts when provider has over priced a service
Cost Escalation	Preset pricing agreements with providers	Providers only treat within agreed price limits and if there is the expectation that a procedure's cost will exceed these limits, approval must be sought from MediPlus
	Preset drugs list	Adherence to approved drug list is required
	Near limit warnings	MediPlus notifies clients and health care facilities when a client is about to reach their maximum
	Co-payments	For some out-patients, cheaper coverage has co-payments which range from KShs50-100
Fraud and Abuse	Computerised ID systems	Each patient has ID card
		Continuous database updating halts use beyond expiration and maximum use
	Coverage limits	Ranges with coverage purchased for both in- and out-patient
	Full payment in advance	MediPlus requires either full payment in advance, or with some cases, they require eleven post-dated checks to cover monthly payments (in Kenya, writing a check with insufficient funds is a criminal offence)
	Physical identification	ID has photo and treatment only given to individual in photo on ID card

Appendix 2: SWOT Analysis

MediPlus: Institutional SWOT			
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
PRODUCT			
Uses a modular approach to develop packages that respond to client needs	Extensive list of exclusions	Possibility of achieving deeper outreach because of flexibility in designing packages	Very strong competition in the HMO market
Wide network of providers	No requirement that the whole Families to join. Could result in adverse selection.	Flexibility offers opportunity to enter the low-income market through MFIs or others	Threatened legislation may constrict flexibility of the product.
OPERATIONS			
Clients are fully reinsured, and underwriting oversight is by an independent insurer	Controls are more limited outside the major cities with branches, but the risk in those areas is lower, at present.	Opportunity for efficient growth since institution has created an infrastructure in forty-one towns.	
Well developed computerised system with important controls in place		Rigorous quality control over provider services	
MARKETING			
Entirely commission based marketing approach ensures that agents are productive, in a supportive environment	Commission base may incentivise marketers to push inappropriate companies to buy, though supervisory controls seem strong	There could be strong incentive for sales staff to push into the low-income market through MFIs and others since this is a largely untapped market	Danger of agents taking business to other HMOs that provide a more attractive commission
Standardised sales kits and general presentations, with extensive follow-up with client groups		Large growth potential without added cost since agents only get paid for business they generate	
ACCOUNTING			
Frequent production of financials allows management to stay informed and make decisions based on data	Claims payments to hospitals and clinics appear to be extending in duration	99.8% of authorised shares are still (in principle) available to be sold with a potential inflow of KShs24.95 million (US$312,000).	Threatened HMO regulation could require MediPlus to generate up to KShs150 million (US$1.88million) in new investment (covering the deficit and getting to a net KShs 100 million)
Regular tracking of premiums, claims and of key ratios	Capital position is seriously precarious		
RISK MANAGEMENT			
Strong controls in place against fraud, moral hazard, adverse selection, and cost escalation.	Risk management strategies are weaker outside the main cities.	Limitations to amount of treatment that can be received and close tracking of individual treatment expenses mitigate effects of adverse selection	Management is continuously researching control mechanisms in other companies through literature and other sources.
Strong underwriting oversight, and re-insurance		The same control structure could easily be used for low-income groups.	

Appendix 3: Patient process when accessing care: