Transparency International Georgia

The Georgian Health Insurance Industry

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This report is the third of the three reports that examine the state of health care and insurance in Georgia. The goal of this project is to examine and raise awareness of ongoing reforms and developments in the health care sector. The project's focus is on the pharmaceutical, insurance and hospital sectors. The content and opinions expressed in this report are those of Transparency International Georgia and do not necessarily reflect the views of the Embassy of the Kingdom of the Netherlands in Tbilisi, Georgia.

Contents

1. Executive Summary

This report **examines** government-run health insurance schemes as well as the current state of the wider Georgian health insurance industry. It also analyzes vertical growth and horizontal integration in the insurance market and accessibility of adequate healthcare in order to: **1. assess** effectiveness, efficiency and sustainability of the current and past public insurance schemes **2.propose** policy and regulatory intervention and corrective action recommendations to the government of Georgia (the GoG), the National Bank, the insurance regulator, and insurers to **a.** address inconsistencies and shortcomings in the GoG's insurance policy as well as the country's health insurance sector in general **b.** gear public insurance to improving the country's health care through the interventions **c.** encourage voluntary insurance schemes.

2. Introduction

In 2008-2012 the Georgian insurance market saw an upsurge in activity that had never been seen before. In 2006 there were an estimated 100,000 health insurance beneficiaries, primarily concentrated in the capital. The upsurge in activity was largely due to the GoG starting its public insurance scheme (PIS) for the neediest 196,000 beneficiaries[1] in Tbilisi and Imereti in September 2007. In April 2008 the scheme expanded to include about 740,000 people. The scheme also targets beneficiary categories other than the neediest, viz., teachers, members of community organizations, IDP-s living in areas of resettlement and people living in the proximity of the occupied territories, actors, artists, and Rustaveli Prize winners.[2]

Starting September 2012 the Expanded Public Insurance Scheme (EPIS) and the current Public Insurance Scheme (PIS) together will gradually cover approximately 2.1 million people, an almost threefold increase over the number of the current beneficiaries of public insurance.

3. Research Methodology:

Our findings **draw on**:

1. close examination of developments in the insurance sector over 2008-2012;
2. in-depth and structured interviews and extensive correspondence with the marketing and product development managers and the financial directors of Irao and IC Group, two Georgian insurance companies participating in the Public Insurance Scheme (PIS), National Bank of Georgia, which is the national insurance regulator, the Georgian Insurance Association, the Ministry of Labour, Heath Care and Social Protection, Social Service Agency, and health care professionals;
3. an insurance sector survey that we conducted in April-May 2012[3]. With more than 700 carefully designed questions, the survey targeted 252 public insurance beneficiaries, 100 corporate and individual insurance beneficiaries, and 350 uninsured respondents, as a control group. The survey provided a glimpse into the respondents' perceptions of developments in insurance and health care sectors, their attitudes, utility and satisfaction, what issues they have while seeking the medical attention they need, how accessible is the health care that is adequate for a given medical condition, etc. More importantly, however, the survey assisted our understanding of **a.** what needs to be done to

[1] This category includes beneficiaries that score at or below 70,000, which means they have next to no means to support themselves.
[2] The share of these other categories in the total number of the public insurance beneficiaries is 9.4%.
[3] The survey was conducted by the Institute for Polling and Marketing (IPM)

improve the current Public Insurance Scheme (PIS) and the Expanded Public Insurance Scheme (EPIS), which will begin in September 2012 **b.** what the GoG should do to improve the quality of health care.

Our research methodology is centered around generalizing from the samples in our insurance survey to the population and explaining how we arrived at our findings and how the findings informed our recommendations. Based on one of the major questions in our report below we detail our reasoning behind the generalization.

In 2010 the insurers participating in the PIS started building hospitals. It is not very unlikely that they were pressured into the commitment. The question that we set out to answer was what was the price of this externally imposed obligation, which has been a major financial stress that the insurers faced, in terms of unjustly rejected insurance claims (*See Ch 7 for greater detail as to the externally imposed obligations).*

The insurance usage rate, which is the number of beneficiaries served, increased by 10.8% between 2009-2010 and was matched by a 12.1% increase in the number of beneficiaries over the same period. This means that the insurers over the period were paid by the GoG for 12.1% more beneficiaries, which must have offset the effect of the increase in the usage rate. According to the Audit Report by the State Audit Office on Public insurance Programmes of the Ministry of Labour, Health Care and Social Affairs, disallowed claims increased from 1198 in 2009 to 1364 in 2010, which means the rejection rate increased by 13.8%. The 2010 number of disallowed claims, however, does not include the data by three major players in the market (Imedi L, Aldagi BCI, IC Group) while the 2009 number of disallowed claims does not include the data by just one major player in the market (Aldagi BCI). This means that the margin of error of the 2010 number of rejection rate, which is the change in the number between 2009 and 2010, is too high for the results to be realistic.

The insurance usage rate and rejection rate are positively correlated only when the overall number of beneficiaries does NOT increase. The correlation between the two is nonlinear, which means as one variable increases by one unit, the other increases by more/less than one unit. However, when the increase in the usage rate is matched by an offsetting increase in the number of beneficiaries, insurance usage rate and rejection rate are no longer positively correlated, i.e. the rejection rate does not necessarily increase in the wake of an increase in the usage rate. This was the case over the period: an increase of 10.8% in the usage rate from 2009-2010 was matched up by a 12.1% increase in the number of beneficiaries. However, to be able to say that 12.1% increase in the number of beneficiaries made up for 10.8% increase in the usage rate, we have to know what the usage rate in the 12.1% beneficiaries was. We estimated an average usage rate in 2009-2010 based on the State Audit Office's number of insurance claims and beneficiaries at 24%[4]. 24% usage rate in 2009-2010 means the 12.1% increase in beneficiaries offset the effect of the 10.8% increase in the usage rate.

Therefore, we may safely say that it was not increase in the usage rate that caused the rejection rate to increase. But is it enough to conclude that it is increase in the insurers' externally imposed obligations that pushed the rejection rate up? Clearly, it is not enough. The increase in the number of disallowed claims might have been caused by an increase in the number of ineligible claims or those exceeding the insurance limits, not necessarily by the stress that externally imposed obligations put on the insurers' profit. The number of ineligible claims that GPI Holding, one of the largest health insurers,

[4] 205031/(794994+891363)/2), where 205031 is the number of insurance claims and 794994 and 891363 are the number of PIS holders in 2009 and 2010 respectively.

provided to us is 381 in 2010 and 686 in 2011[5]. Having assumed normal distribution of ineligible claims across health insurers, we estimated the number of ineligible claims in the PIS in 2011 to be around 56,150[6].

To arrive at a realistic number of rejected (disallowed) claims in the public insurance scheme in 2011, after we estimated the number of ineligible claims, we:

1. identified the number of our insurance survey respondents whose claims were rejected, which was 28.
2. estimated an applicable multiplier of the number of our insurance survey respondents whose claims were denied to be 3611 to identify the number of PIS beneficiaries whose claims were rejected
3. estimated the number of public insurance beneficiaries whose claims were rejected to be 101,108[7]
4. estimated the multiplier of the number of rejected claims based on the average number of rejected claims per respondent in our insurance survey, which was 1.
5. estimated the number of rejected claims to be 101,108.[8]
6. calculated the margin of error (3.9%).[9]
7. Revised the margin of error of ineligible claims downwards to 2.16%.
8. estimated the number of unjustly rejected claims to be 44,950 by subtracting 56,150, which is the number of ineligible claims, from 101,100, the rounded total of rejected claims[10].
9. Revised the margin of error of unjustly rejected claims downwards to 1.71%.

Thus it was not the increase in the usage rate, nor was it the increase in the number of ineligible claims that caused the rejection rate to increase. As there is no other factor that could have caused the rejection rate to increase, we believe it was the insurers' externally imposed obligations that caused the rejection rate to increase. Therefore, we conclude that there is a positive correlation between the insurers' externally imposed obligations (building the hospitals) and the rejection rate, which means as insurers' externally imposed obligations increase, so does the rejection rate. Thus the cost of PIS insurers building the hospitals was 44,950±1.71%[11] unjustly rejected claims.

Our findings and recommendations are grounded in the evidence that our insurance sector survey gave us. We carefully examined the underlying distribution of the population, designed the sampling

[5] We asked the insurance companies participating in the public insurance scheme to give us a breakdown of ineligible claims, but it was only GPIH that provided the data (Letter #225 III of June 13, 2012)

[6] For greater detail see Sampling Design at http://transparency.ge/sites/default/files/attachment/sampling-design.pdf

[7] 28 X 3611

[8] If a claim of an insurance beneficiary is rejected, this may happen more/less than once. This means that the number of disallowed claims may be higher/lower than the number of beneficiaries whose claims were rejected. However, in our case the multiplier is 1, which means the number of rejected claims equals the number of public insurance beneficiaries whose claims were rejected (101,108 X1) .

[9] For calculations see Sampling Design at http://transparency.ge/sites/default/files/attachment/sampling-design.pdf

[10] See Sampling Design at http://transparency.ge/sites/default/files/attachment/sampling-design.pdf

[11] The margin of error of unjustly rejected claims (1.71%) is calculated as a percentage of the number of all PIS and Tbilisi Municipal Insurance beneficiaries (909,903) rather than 44,950. Therefore, the margin of error expressed in PIS beneficiaries is 44,950±15,560 (The number of rejected claims equals the number of public insurance beneficiaries whose claims were rejected. See Footnote 8 above).

procedure and identified the sample sizes[12] and weights to be able to generalize our survey results as reliably as possible.

We describe some of the simpler research methodology outside this Chapter when we are unable to extract it from the rest of the reasoning.

4. Recommendations & Major Findings

We propose that:

1. The Government of Georgia (the GoG) implement the corrective action, address the inconsistencies in the design of both Public Insurance Scheme (PIS) and the Expanded Public Insurance Scheme (EPIS) and put in place the right incentives described throughout the report;

2. The GoG put in place health care quality assurance system. See Ch 10 for detail;

3. The GoG should approximate its PIS to the new EPIS. As from April 2013 the current public insurance scheme[13] allows most of its public insurance beneficiaries to choose their insurer, while the new scheme to start in September 2012 does not[14].

Apart from this, starting in September 2012, the Expanded Public Insurance Scheme (EPIS) will **a.** target people with higher incomes than the current public insurance scheme and **b.** provide a more varied and a more generous package of services than the current public insurance scheme, e.g. preventive care[15], mammography, ultrasonography, tomography, palliative care for incurable patients, etc. [16]

The public insurance scheme to start in September 2012 and the current scheme have different target groups and, therefore, their divergent terms and conditions do not indicate a conflict between the GoG's two acts[17] regulating the two public insurance schemes, but the fact does signal a serious inconsistency in the GoG's insurance policy.

Two crucial policy questions here are: **a.** Why should beneficiaries of one public insurance scheme be allowed a free choice of insurer while beneficiaries of the other are not? **b.** Why should the EPIS target people who are better-off than the PIS beneficiaries with a broader and more generous package of health services?

[12] For the sampling procedure, sample selection, weighting, confidence intervals, margins of error, etc see http://transparency.ge/sites/default/files/attachment/sampling-design.pdf

[13] See Para 13 of Article 5 of the GoG Decree #218 of December 9 2009

[14] See Para 6 of Article 2 & Para 1 of Article 5 of the GoG Decree #165 of May 12, 2012

[15] Our insurance survey showed that about 50% of the 74 PIS respondents would contribute GEL 5 towards their insurance if preventive care is added to their insurance package. The corporate and individual insurance components of our insurance survey showed that individual insurance package holders, who are paying 100% of their insurance premia, act more responsibly when it comes to prevention. We found that about 30% more individual insurance package holders that we targeted were more likely to take preventive measures than the corporate insurance beneficiaries who are either not contributing or are contributing less than 30% towards their insurance. Failure to take preventive measures, as pointed out above, is a serious drain on the fiscal resource, which can be anticipated through voluntary insurance schemes, which are partially funded by beneficiary contributions.

[16] See Article 3 of the GoG Decree #165 of May 12, 2012

[17] GoG Decree #218 of December 9 2009 and GoG Decree #165 of May 12, 2012

We believe the GoG should either justify its differential approach or remove this[18] as well as other inconsistencies described in the report.

4. The GoG break down its public insurance spending by check-ups, lab tests, other diagnostic tests, remuneration of medical professionals, overhead expenses, etc. Unless the government knows how much of an insurance premia goes to what, it will not be able to identify policy interventions. Needless to say, public insurance appropriation cannot be broken down ex ante, as it is impossible to predict how much its line items will be, but it can be broken down ex post in the state budget execution reports to inform policy/corrective action, etc. Therefore, spending of public insurance appropriation should be detailed in the state budget execution reports;

GEL 174.1 million, the current total PIS and EPIS funding in 2012[19], can help improve the quality of health care to a degree that no other insurance (corporate, individual) can[20]. See Ch 10 for how the scale of the public insurance schemes is related to the quality of health care;

5. The National Bank request health insurers to break down corporate/individual health insurance premia ex-post by check-ups, lab tests, other diagnostic tests, remuneration of medical professionals, overhead expenses, etc;

6. The National Bank help enable early predictability by insurance companies with a platform that helps insurers put their stocks and flows to as many tests as necessary. Parallel financial accounting, as opposed to non-financial accounting, for instance, would recognize acquisition costs[21] as an expense in proportion with the profit—rather than insurance premia—from the type of insurance/insurance policies that these costs were incurred to attract[22]. See Ch.9 for greater detail on what difference early predictability can make.

7. Hospitals be run by independent management companies rather than insurers' subsidiaries. However, even if the hospitals are managed by independent management companies, the hospitals will still need to be detached from the insurers that built them, which, needless to say, does not mean taking them from the insurers. Detaching, as used here, denotes either a genuinely independent management, while the insurers enjoy the rights of an investor, or buying the hospitals from the insurers by the government to later sell to other appropriate investors;

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[18] See Ch 8 for the health services to be provided within the EPIS but not provided within the PIS.

[19] 2012 state budget at http://mof.ge/4623

[20] According to Giorgi Gigolashvili, Director of Insurance Institute (interview with TIG, May 15, 2012) GEL 174.1 million is estimated to be 40-45% of the total health insurance turnover, which means the Georgian health insurance industry is worth about GEL 400 million.

[21] Costs of an insurance company to acquire new customers, as well as introduce them to the company's products and services, including marketing costs and incentives. Total acquisition costs divided by total new customers over a given period is the ratio that has to inform an insurance company's investment decisions

[22]There is nothing wrong with parallel analytic financial accounting as long as the company's books are clean. Parallel analytic financial accounting as opposed to regular accounting, for instance, would recognize acquisition costs as expense in proportion with the profit—rather than insurance premia —from the type of insurance/insurance policies that these costs were incurred to attract. What is the point/value of analytic accounting for acquisition costs? The kind of recognition that we suggest here can help an insurer calculate the rate of commissions its sales agents are paid. In April 2011, for instance, the rate of commissions would make different business sense as opposed to April 2010 based on the flow of profit from the type of insurance/insurance policies that the acquisition costs were incurred to attract. It may be worth to pay the sales agents more, less, or the same depending on the circumstances of the costs and the risks

8. The GoG resume a voluntary insurance scheme to put the untapped potential in the industry to use, which, as argued in the report, can help ensure sustainability of the insurance as well as improve the quality of health care in the country;

9. The GoG open up competition by switching from regional assignment to free circulation of its PIS and EPIS insurance vouchers. The two major criteria assessing an insurance scheme are: whether its beneficiaries can choose their insurer and their medical institutions. The first choice is unequivocally limited, while the second remains largely unrealized. The public insurance schemes will clearly improve if the two obstacles are removed.

10. GoG Decree #218 of December 9, 2009, GoG Decree #165 of May 12, 2012 and the insurance contracts/policies detail the rights of the public insurance beneficiaries to a degree that will enable them to take full advantage of their insurance. As demonstrated in the report, PIS contracts do not provide for referral of public insurance beneficiaries to the institution of their choice. However, PIS beneficiaries can ask their insurer to be referred to a medical institution other than the provider when the latter has no or inadequate expertise treating a given medical condition.

As pointed out in Ch 8, the insurance companies we interviewed confirmed that public insurance beneficiaries may request references to a medical institution other than the providers when the latter have no expertise or inadequate expertise treating a given medical condition. The insurance survey showed that fewer than 2% of the public insurance beneficiaries are aware of this possibility.

11. The Ministry of Labor, Health Care and Social Affairs (MoLHSA) complement its list of drugs: GoG Decree #218 of December 9, 2009 entitles its public insurance beneficiaries to 50% off the medicines of GEL 50 as listed in a Decree of the Minister of Labour, Health Care and Social Affairs[23], which means the benefit is worth GEL 25. The problem with the list is that it contains just a few medicines of five different types of drugs[24]. The five types on the list are medicines for cardio-vascular, gastro-enteric, respiratory diseases, inflammations, allergies, etc. While the medicines under the types are, arguably, the most widely used drugs, around 20% of the social beneficiaries targeted within our insurance survey were unable to find the medicines they needed on the list. We suggest that the MoLHSA conduct a survey to figure out which drugs should be added to the list.

12. The Ministry of Labor, Health Care and Social Affairs (MoLHSA) ensure that Para 2 of Article 8 of the GoG Decree #218 of December 9, 2009, which prohibits insurers from offering PIS beneficiaries terms and conditions worse than those guaranteed by the decree, is not violated by PIS health insurers. Having compared health insurance packages by PIS insurance carriers, we found that Alpha, as pointed out in Ch 6, is in a serious breach of the GoG Decree #218 of December 9, 2009, which is the main public insurance regulating act. Since 2010 the GoG Decree #218 of December 9, 2009 entitles social insurance beneficiaries to 50% off the outpatient prescription drugs of GEL 50 from the MoLHSA list of essential drugs, which means the benefit is worth GEL 25. Although the GoG Decree #218 of December 9, 2009 does not limit the PIS beneficiaries right to buy their medicines only at particular pharmacies , Insurance Company Alpha, a daughter company of Aversi, limits the right unlawfully since it tells its beneficiaries that they can buy medicines only at Aversi's pharmacies[25]. First, as noted in Ch 6, there are quite a number of medicines not stocked by Aversi pharmacies, which means the GoG's

[23] #53 of February 26, 2012
[24] Types of drugs are groups of drugs that are used to treat related diseases.
[25] We have a conclusive proof of the violation, which will be provided upon request.

public insurance beneficiaries covered by Alpha will never be able to get the medicines. Second, this means that the government insurance package holders are not able to buy the medicines within the guaranteed limit when they get a better deal elsewhere.

13. The GoG make sure that failures and shortcomings in the PIS, similar to those found by the State Audit Office (Chamber of Control at the time), do not impede the implementation of the EPIS, which starts in September 2012. In 2010 the State Audit Office (Chamber of Control at the time), for instance, found that in 2008-2010 about 75 % of contracts with public insurance beneficiaries were concluded later than they should have been, while the government paid the insurance premia for the whole duration of the contract. Apart from this, the SAO found ghost beneficiaries (double entries, ineligible beneficiaries[26], and dead beneficiaries), etc. These violations were estimated at millions of laris by the SAO and subsequently recovered from the insurers[27].

14. The GoG put a better screening mechanism in place to reduce the number of ineligible PIS holders to a minimum. Ineligible beneficiaries are a drain on the GoG's public insurance appropriation, which is inadequate as it is. As demonstrated in Ch 8 below, out of 252 PIS beneficiaries that we targeted, 40 said their monthly income ranged from GEL 401 to GEL 3000, while 20 of them said their income was GEL 300-400, which means they were able to enter the scheme fraudulently. Considering that respondents are normally devious about their income, fearing that truthful answers will disqualify them from the insurance scheme, the number of the respondents whose income is higher than what is required to qualify must be higher. To estimate the number of ineligible PIS beneficiaries, we identified a multiplier of the respondents whose income is higher than what is required to qualify for the scheme (3611) allowing for a margin of error (4.6%), which then helped us estimate the number of ineligible PIS beneficiaries to be 144,440[28]±4.6%[29].

15. The GoG address fragmentation of the insurance pool. If the country's public insurance schemes are to be efficient, sustainable and anticipate overlap, the public insurance pool cannot be fragmented. Tbilisi government, for instance, offered insurance to 120,000 beneficiaries scoring between 70,000-100,000 vulnerability threshold points, secondary school staff as well as employees of pre-school institutions and other educational institutions, museums, libraries, kindergartens, employees of emergency services, members of writer, composer, architect, journalist and actor professional organizations.[30] The scheme's beneficiaries are not the same as the PIS or EPIS beneficiaries. Why should we care about different public insurance schemes running parallel as long as they target different categories of beneficiaries, i.e. if there is no overlap between them? At the heart of both efficiency and effectiveness of insurance schemes, whether public, corporate or individual, is risk pooling. Risk pooling is one form of risk management. It suggests that demand variability is reduced if an insurer aggregates demand across different groups of beneficiaries, because, as demand is aggregated across different groups of beneficiaries, it becomes more likely that high demand from one customer will be offset by low demand from another;

[26] Employees of the Agency for Social Services, Ministry of Labour, Health Care and Social Affairs

[27] Audit Report of the Health Care Programmes as of December 31, 2010 by State Audit Office of Georgia, p.35-44

[28] 3611X40

[29] The margin of error of ineligible PIS beneficiaries (4.6%) is calculated as a percentage of the number of all PIS and Tbilisi Municipal Insurance beneficiaries (909,903) rather than 144,440. Therefore, the margin of error expressed in PIS beneficiaries is 144,440±41,855.

[30] Out of the 120,000 beneficiaries 85,000 are those scoring between 70,000-100,000, 30,000 are recipients of non-old age pensions, while the remaining 5,000 are other categories. The municipal insurance appropriation is GEL 16 million, while monthly premium paid to the insurers is GEL 9.

16. The GoG minimize the risk of overconsumption in the expanded public insurance scheme. The GoG's diminishing contributions towards the EPIS ambulance services is a step in the right direction. In Warsaw, which has a population of 4 million, 600 ambulance calls are reported every day, whereas in Tbilisi, which has a population of 1.1 million, 1500 ambulance calls are reported every day. [31]

Our insurance survey helped us estimate the incidence of hoarding: 7 out of 252 PIS respondents said they had bought medicines that they did not need in the past 12 months to use up the GEL 50 limit of 50% off the outpatient prescription drugs. Multiplier across PIS sample being 3611 and allowing for the margin of error (2.1%), the number of PIS beneficiaries in the habit of hoarding medicines is 25,277[32]±2.1%[33]. The hoarding whether caused by overconsumption or any other factor is a waste of money that the GoG should try to reduce to a minimum;

17. The Agency for Social Services of MoLHSA put in place an independent screening mechanism to break down disallowed claims by types of medical conditions not covered by the PIS/EPIS.

Insurance companies do not normally keep track of insurance claims that are not covered by their insurance contracts. Arguably, it is not easy for insurers to keep track of ineligible claims as beneficiaries either call their insurance company or go there to tell the operators in person what their claims are rather than file complaints with them in writing. Without data on ineligible claims, it is impossible to estimate the rejection rate. Ineligible are claims that request treatment for medical conditions not covered by an insurance policy. Without the breakdown, it is impossible to measure whether a given public insurance scheme achieves its purpose of providing affordable health care to its beneficiaries.

Unless the data on ineligible claims[34] is collected by the Agency, the satisfaction data will be skewed.[35] To ensure impartial data collection, however, an independent screening mechanism is indispensable;

18. The Agency for Social Services of MoLHSA monitor the satisfaction as well as the utility of the PIS and the EPIS beneficiaries to see how the schemes are working (the two concepts have to be clearly demarcated). Monitoring the satisfaction, however, has to be a regular pre-defined procedure and draw from examination of the data collected all the year round. Monitoring the satisfaction, for instance, will not give a credible picture of the context unless it is properly filtered. There are beneficiaries who ask for treatments of medical conditions not covered by the PIS. Their lack of satisfaction should certainly be disregarded.

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[31] Mamuka Katsarava, Head of Tbilisi Government's Division for Social Services and Culture http://www.versia.ge/index.php/2009-03-16-12-31-57/1236-2012-01-30-11-10-38.html

[32] 3611X7

[33] The margin of error of PIS beneficiaries in the habit of hoarding medicines (2.1%) is calculated as a percentage of the number of all PIS and Tbilisi Municipal Insurance beneficiaries (909,903) rather than 25,277. Therefore, the margin of error expressed in PIS beneficiaries is 25,277±19107.

[34] We requested the breakdown from almost all insurers participating in the PIS. The information, however, was provided by GPIH alone.

[35] In response to our request for the breakdown five large insurance companies (Aldagi BCI, Imedi L, GPIH, Archimedes Global Georgia, Irao) said they did not keep track of the information. Later we found that the insurance companies, except Aldagi BCI, had provided the same information to the Ministry of Labour, Health Care and Social Protection and the State Audit Office earlier. The deviousness by the insurance companies has been a major impediment to our examination of the insurance market.

Our insurance survey showed that although more than 50% of PIS respondents were well aware of their rights as well as the services they were entitled to, about 40% were not. The Agency for Social Services, therefore, has to help PIS beneficiaries move from uninformed dissatisfaction with their insurance company to informed satisfaction. The uninformed dissatisfaction, which builds around beneficiaries' unreasonable expectations of their insurance, is heightened by the privations that PIS beneficiaries are reduced to.

5. Voucher System vs Regional Assignment of Insurers

In 2008 the GoG issued vouchers[36], which the majority of insurance holders[37] could exchange for insurance contracts with any of the nine[38] insurers participating in the PIS. The free circulation of vouchers meant the GoG opened up competition in the insurance market. Opening up competition can lead to insurers trying to offer better service, even though they are paid the same insurance premium by the government, or to offer extra services on top of what they are paid to provide. However, the insurers participating in the scheme did not know what to expect of the scheme. They did not know what the beneficiaries' rate of activity would be, and, therefore, higher risks within the beneficiary pool made them wary. Since the scheme was for the neediest, insurers knew that the poorer the beneficiaries, the likelier they are to suffer from unattended health problems which are costlier to treat. The beneficiaries, most of whom had never been insured before, also did not know what to expect of the scheme. It is not easy to get cautious insurers to offer services on top of what they are paid to provide. Skeptical and inexperienced beneficiaries are not selective, even when they are offered extra or more varied services.

Therefore, the question is whether opening up competition in 2008 made any difference to the industry. The insurance survey and the interviews with the insurers we conducted as well as the desk research demonstrated that opening up competition did not make any real difference. However, this voucher system had a promise, which did not materialize since the GoG switched to a regional assignment system in 2010.

The insurers' caution and the beneficiaries' skepticism were the two major impediments to the development of the Georgian public insurance market. The skepticism was exacerbated by the opposition parties decrying the public insurance scheme as a sham in 2008-2009, which was a foregone conclusion, to say the least. Therefore, given the skepticism, we do not contend that the government could have urged the insurers to vie with each other for beneficiaries with better terms.

In April 2010 the Georgian government decided to end the free circulation of vouchers for all public insurance holders until April 2013, meaning no beneficiaries can choose an insurer from April 2010 to April 2013, while before April 2010 the majority of them could. The country was divided into 26

[36] A voucher is a promise given by the government to a public insurance beneficiary that the latter can exchange for an insurance contract with an insurer participating in the PIS.

[37] According to Para 3^2 of Article 2 of the GoG Decree #218 the beneficiaries who were entered in the database as scoring at or below 70,000 of vulnerability threshold before December 1, 2009 and have insurance contracts made before April 1 2010 can choose their insurance company.

[38] As of the time of writing of this report there are six health insurers in the country.

regions, for the purposes of public insurance distribution, and nine insurance companies[39] were selected via competitive bidding to operate in the designated 26 regions. The annual insurance premium to be paid by the GoG to the insurers was not to exceed GEL 144. The highest bid received by the GoG was GEL 132 in the 23 medical regions, and the lowest bid was GEL 116.4 in Tbilisi and the two other medical regions[40]. The insurers offered a medical insurance package guaranteed by the government to 888,392 beneficiaries scoring at or below the vulnerability threshold of 70,000 points[41]. Each of the 26 regions had a certain number of people scoring at or below the 70,000, and the insurers automatically won all the beneficiaries in a given region. Having thus segmented the market, the GoG formally ended competition in the public insurance market for three years (April 2010-April 2013). Now that the free circulation of vouchers ended for all public insurance holders until April 2013, the insurers do not have any incentive whatsoever to offer public insurance beneficiaries any broader spectrum of services. Alpha, established in 2009, was the only health insurer that offered its public insurance beneficiaries an extra package, viz., 14-50% discount on a number of services and products by Aversi, Alpha's parent company, along with Aversi medicines worth up to GEL 100, which Alpha's public insurance beneficiaries were to receive free of charge[42]. These additional benefits, however, were soon discontinued. Our insurance survey showed that fewer than 5% of the 252 PIS beneficiaries took advantage of Alphas's additional benefits, which means PIS beneficiaries' are skeptical of the benefits. The problem with the skepticism is that it does not help build the demand for additional insurance offers.

A drawback of beneficiaries having the freedom to choose any insurer, rather than those selected by the GoG, is that the government will not be able to secure the lowest possible price through bidding[43]. However, when the market is not segmented, certain insurers might offer better terms for the standard insurance premium, which increases the value for money. Therefore, divergent terms and conditions of public insurance are a sign of sound competition, as long as all the social health insurance services guaranteed by the government[44] are provided by the insurers.

During the four years of the public insurance scheme's existence, the beneficiaries have developed a taste for insurance, as demonstrated by our insurance sector survey, and although the insurers have seen their profit margins decrease over the period due to the increased demand by the beneficiaries and investment in building hospitals, they know that the profit margins still make it possible for them to offer extra or more varied services on top of what they are paid by the government to provide. Therefore, the time has come for the regional assignment to give way to competition, i.e. where beneficiaries have unlimited freedom of choice of insurer. Our insurance survey showed that 30% of the 252 PIS beneficiaries we targeted have enquired at least once about how they could switch insurance carriers. Marina Gelashvili, a beneficiary of the GOG's public insurance scheme in Akhaltsikhe, for instance, was denied a blood test for her daughter by Imedi-L. She says "the poor in the area were just given insurance policies and told the other insurance companies were not covering the area."

[39] Alpha, Aldagi BCI, IC Group, Irao, Imedi L, GPI Holding, Kartu, and Vesti, which later merged with Archimedes Global Georgia.

[40] Seven of the nine insurers bid GEL 116 for the contract.

[41] The number of public insurance beneficiaries as of May 1, 2012 is 791,582.

[42] Standard GoG limit is GEL 50

[43] Our finding was corroborated by Curatio International research into the Health Insurance for the Poor: "as a result of the competitive tender, the premium rate for the years 2011-2013 has been reduced by 27%." Health Insurance for the Poor: Georgia's Path to Universal Coverage? Curatio International Foundation, 2012, p.18

[44] The GoG Decree #218 on the Public insurance Scheme of December 9, 2009.

The expanded public insurance scheme (EPIS), which will start in September 2012, will necessarily limit competition because in the absence of the EPIS, some of the scheme's beneficiaries would instead have opted for an a voluntary insurance scheme if it had not been discontinued or an individual insurance package. Needless to say, this does not mean that the GoG should not have initiated the EPIS. What it means is that the government could have decreased the number of EPIS beneficiaries if it had not discontinued its contribution to the 5 GEL voluntary insurance scheme, which we examine in detail Ch.11.

6. Unlawful Restrictions Imposed on the Public Insurance Beneficiaries

Having compared health insurance packages of PIS insurance carriers, we have found that Alpha is in a serious breach of the GoG Decree #218 of December 9, 2009, the main public insurance regulating act. Since 2010 the GoG Decree #218 of December 9, 2009 entitles social insurance beneficiaries to 50% off outpatient prescription drugs of GEL 50 from the MoLHSA list of essential drugs, which means the benefit is worth GEL 25. However, Insurance Company Alpha, a daughter company of Aversi, limits the right unlawfully by telling beneficiaries that they can buy the medicines only at Aversi's pharmacies. First, there are quite a number of medicines not sold by Aversi pharmacies, which means the GoG's public insurance beneficiaries covered by Alpha will never be able to get the medicines not stocked by Aversi pharmacies. Second, this means that the government insurance package holders are not able to buy medicines within the guaranteed limit when they get a better deal elsewhere. The GoG Decree #218 of December 9, 2009 does not limit the right of public insurance beneficiaries to buy their medicines only at particular pharmacies. Therefore, this restriction imposed by Alpha on its public insurance beneficiaries is a patent violation of Para 2 of Article 8 of the GoG Decree #218 of December 9, 2009, which prohibits offering public insurance beneficiaries terms and conditions that are worse than those guaranteed by the decree. We urge the government to enquire into the violation to hold Alpha accountable for this violation.

We asked Alpha to let us have a copy of its public insurance policy template. As the request was declined, we had to question insurance beneficiaries and Alpha's hotline operators, who confirmed that beneficiaries can buy the medicines within the limit only at Aversi's pharmacies.

Alpha often violating the rights of its public insurance beneficiaries is corroborated by the State Audit Office of Georgia, which found that out of the fifteen so-called complex complaints filed with the Insurance Mediation Service in July-September 2010, fourteen were against Alpha[45], while its number of public insurance beneficiaries in 2010 was the fourth highest after Imedi L, IC Group and GPI. The higher the number of beneficiaries, logically, the number of complaints would also be higher. However, 93% of complaints were filed against Alpha while the three other insurers had higher numbers of beneficiaries and fewer complaints.

One of our informants, an employee of one of the insurance companies, who chose to stay anonymous, said that they are told to decline as many claims as possible. Some corporate/individual insurance packages, for instance, do not include the treatment of tumors. He said they reject claims for treatment of any growth, dismissing them as tumorous, while a growth does not necessarily mean it is tumorous. The informant also noted that pregnancies with complications, even when covered by an insurance policy, are declined for different made-up reasons. The other informant told us that not only

[45] Audit Report of the Health Care Programmes as of December 31, 2010 by State Audit Office of Georgia, p.34

are PIS beneficiaries forced to wait for surgeries for months[46], but also for tests like ultrasonography, which is an unambiguous sign of the PIS insurers' deviousness, making thousands of insurance beneficiaries give up on their claims.

The deviousness of health insurers is not confined to public insurance schemes. We were told by an anonymous corporate insurance package holder of the academic staff of the Georgian Technical University that, while their limit for one of the outpatient treatments covered by the package is GEL 600, the actual limit is set at GEL 400.

One of our informants[47] said that health insurers not only constantly haggle with medical institutions over prices, but also question the prices of the provided medical care, which was confirmed by Curatio International[48]. Curatio researchers found that referrals to specialists and diagnostic services, particularly more expensive ones, such as computer tomography, are refused even when these referrals are backed up by a second opinion and approved by the administration of the health facility, which has often caused patient's health to deteriorate. The researchers also found that managers of the insurance companies often interfere with clinical decision making, even when they are not physicians. Moreover, the researchers found that sometimes the managers even attend surgeries to make sure that the diagnosis supplied is accurate. One of the focus group discussions with private insurance companies[49], which Curatio conducted within the frame of its insurance research, showed that one of the Public Insurance Carriers negotiated a 35% decrease in price with a health care provider for a cardiac bypass surgery for MAP beneficiaries[50], which in turn led to reduced price for other (non-MAP) users and obliged competing health providers to reduce their prices at the same scale for the same procedure. Health services in Georgia are not overpriced, and insurance companies forcing the prices further down will certainly not help improve the quality of health care.

7. Why are the PIS Health Insurers Devious

As noted above, the GoG started its first public insurance scheme in September 2007. On December 9 2009 the government elaborated on its terms of public insurance in a new decree on public insurance. The decree certainly did not make it compulsory for the insurers participating in the PIS to build hospitals, but it is not very unlikely that they were pressured into the commitment. March 30 2010 amendments to the decree[51], however, introduced the GoG's intention to build hospitals, while April 10 2010 amendments introduced a forfeiture of GEL 1 million for a breach of this commitment. Although none of the insurance companies we met said they were pressured into building the hospitals, they did not unequivocally say it was either in their short term or medium term business interests to build and run the hospitals, except IC Group. IC Group said it was in the company's business interests to both build and run hospitals. However, when asked whether they would have built the hospitals if the government had not taken the initiative, IC Group said they would not have completed the project. The question is why a business would do something that is neither in its short term nor medium term business interests unless it were pressured into doing it.

[46] Georgia is not the only country where beneficiaries of public insurance have to wait for months for surgeries, but it is rare to wait for tests like ultrasonography.
[47] The interview was conducted on July 1, 2012.
[48] Health Insurance for the Poor: Georgia's Path to Universal Coverage? Curatio International Foundation, 2012, pp.24,32.
[49] Interview of 15 November 2011 by Curatio International Foundation, Health Insurance for the Poor: Georgia's Path to Universal Coverage? Curatio International Foundation, 2012, p.29
[50] MAP stands for Medical Assistance to the Poor (MAP), which in this report is referred to as Public Insurance Scheme (PIS)
[51] See Appendix 3 to the decree.

Why did the government decide that insurance companies had to build hospitals? Based on the State Audit Office insurance audit[52] report, which looks at a number of financial performance indicators of the insurers participating in the public insurance scheme, we estimated the insurers' average profit margin over 2008-2010 to be at 51%, which, being an unprecedented profit margin for comparable schemes, is beyond any comparison. Apart from this, the State Audit office found that 45.1% of paid insurance claims did not exceed GEL 20, which signals Georgian health insurers' devious tactics.

According to Curatio International's recent research[53] the State Audit Office used inappropriate measures of the public insurance scheme's efficiency, as it did not take into account the significant acquisition, administrative and investment costs (including capital investments in hospital infrastructure). According to the research, when all the costs are taken into account, the combined loss ratio will be approximately 93 % on average for all public insurance carriers, leaving only 7% of the average net profit margin, which is within the range observed internationally.

This assessment by Curatio was affirmed by Devi Khechinashvili, President of the Georgian Insurance Association (GIA). In an interview with us, he said that the insurers' costs of acquiring customers were so high that in 2010 the GoG decided to switch to the regional assignment instead of the free circulation of insurance vouchers[54].

We also asked the companies whether the government consulted with them before changing the terms of their contract. The GoG decree #218 of December 9 2009 is, in effect, the GoG's contract with the insurers. In the interviews, the insurers said they had not been consulted. Even when a non-binding clause is added to the terms and conditions, major parties to the contract need to be consulted, and even more so, when they are pushed into complying with the formally non-binding clause of their contract. The insurance companies had an option to withdraw from the public insurance scheme. However, none of them did, even though the withdrawal would have made much more business sense to some of them than staying in the scheme and building the hospitals. Thus, the insurers staying in the public insurance scheme may be explained by:

1. the government putting pressure on them to stay in the scheme;

2. the insurers' failure to assess risks[55].

3. high PIS profit margin; having examined financial performance of the insurers participating in the public insurance scheme, State Audit Office found that the insurers' profit margin over 2008-2010 averaged 51%[56]. In all likelihood, the profit margin would have been lower had the companies not disallowed as many claims as they did. The government decided to tax the insurers' high profit margin

[52] Georgia's Supreme Audit Institution, Former Chamber of Control

[53] Health Insurance for the Poor: Georgia's Path to Universal Coverage? Curatio International Foundation, 2012, p.18

[54] According to Curatio International's research, GoG mandated the PICs to organize this process through the SSA employed social agents and pay a fixed amount of 3 GEL per contract distributed to the SSA. The CCG audit report was one of the main reasons for changing MAP content in 2010. It was assumed that shifting to longer term three year contracts would remove the need for substantial expenses related to beneficiary acquisition, motivate the PICs to invest more money in keeping insured healthier through expanded prevention services and free up some funds for investments in infrastructure to improve the quality of services. As noted above, the latter has been made a key condition of the extended contract. Health Insurance for the Poor: Georgia's Path to Universal Coverage? Curatio International Foundation, 2012, p.19

[55] See Ch 9 of this report for detail.

[56] Audit Report of the Health Care Programmes as of December 31, 2010, State Audit Office of Georgia.

by urging the companies to build the hospitals. "The taxation" was not without the cost to the insurance beneficiaries.

Our research showed that all the three factors contributed, albeit to a varying degree, to the participating companies' decisions to stay in the scheme.

We examined what implications insurers' externally imposed obligations have for the insurance beneficiaries as well as the insurers themselves. Our research showed that the number of artificial barriers public insurance beneficiaries encounter increase as the insurers' externally imposed obligations increase. One obvious artificial barrier is the increase in the number of disallowed claims. The question that we set out to answer is how externally imposed obligations (building the hospitals) contributed to the rejection rate. We found that the cost of PIS insurers building the hospitals was 44,950±1.71% unjustly rejected claims. *See Research Methodology above for the reasoning that led us to the estimate.*

8. Inconsistencies in the Design and Implementation of the GoG's Insurance Policy

Throughout the report we examine inconsistencies in the implementation of the GoG's public insurance policy. However, there are serious inconsistencies in the design of the public insurance policy that we brought to the attention of the Ministry of Labour, Health Care and Social Protection[57]. In September 2012 the GoG will start another public insurance scheme to target all old-age pensioners, pre-school children (i.e. children aged 0-5)[58], disabled children and severely disabled people[59].

Our insurance survey, interviews and desk research revealed six major inconsistencies in the design and implementation of the GoG's public insurance policy:

1. As from April 2013 the current public insurance scheme[60] allows most of its public insurance beneficiaries to choose their insurer, while the new scheme to start in September 2012 does not[61]. A free choice of insurer, i.e. a free circulation of the government's insurance vouchers, means an insurance holder can go to any of the insurers participating in the public insurance scheme, which, on their part, will be vying for beneficiaries. This is competition that can motivate the insurers to offer better terms on top of what is guaranteed by the government.[62] Therefore, the question here is why are beneficiaries of one public insurance scheme allowed a free choice of insurer while beneficiaries of the other are not.

2. The expanded public insurance scheme (EPIS) will **a.** target people with higher income than the current public insurance scheme **b.** provide a more varied and a more generous package of services than the current scheme. As of May 2012 the destitute (those scoring at or below 70,000 of vulnerability threshold points) were at least 89% of the entire pool of the current public insurance

[57] TI Letter # 03-1283 of July 1, 2012 to the Minister of Labour, Health Care and Social Protection
[58] Instead of the current arrangement which covers children under 3.
[59] Formerly called first group of disability.
[60] See Para 13 of Article 5 of the GoG Decree #218 of December 9 2009
[61] See Para 6 of Article 2 & Para 1 of Article 5 of the GoG Decree #165 of May 12, 2012
[62] Ch 4 discusses why insurers might want to provide better terms and conditions on top of what is guaranteed by the government's public insurance scheme.

scheme's beneficiaries[63]. The question is why should the expanded public insurance scheme target people who are better-off than the current scheme's beneficiaries with a broader as well as more generous package of medical services, e.g. the EPIS will provide for preventive care. This, we believe, is one of a few inconsistencies detailed in the report that need to be removed.

3. The expanded public insurance scheme will be run parallel with the current scheme, since the two schemes have different beneficiaries[64]. Thus the EPIS will offer a broader spectrum of medical services. The medical services to be provided within the EPIS but not provided within the PIS are as follows:

Service	**Annual Insurance Limit**	**Beneficiary Contribution**
Planned surgeries and related medical examination/tests	GEL 15,0000	20%, 10% for old-age pensioners
Heart and oncosurgeries for children aged 0-5 and related medical examination/tests	GEL 15,0000	0%
Oncological treatment and diagnostic and related medical examination/tests	GEL 15,0000	20%, 10% for old-age pensioners
Ambulance and medical transportation and accommodating those in need of hospitalization in appropriate hospitals	Unlimited	0%
Assessment of health status and related risks, preventive measures, palliative care, medical care to be provided at home	Unlimited	0%
Vaccinations	Unlimited	0%
Different types of X ray, mammography, ultrasonography, tomography prescribed by a specialist.	Unlimited	20%
Emergency in-patient service to cover infectious diseases and hospitalization for palliative care for incurable patients	GEL 15, 000	20%, 10% for old-age pensioners, 0% for children aged 0-5 and disabled children
50% off outpatient prescription drugs of GEL 100 from the MoLHSA list of essential drugs[65], which means the benefit is worth GEL 50, instead of the current PIS limit of GEL 25, i.e.50% off the medicines worth GEL 50	GEL 100	50%

[63] Considering that quite a number of beneficiaries of the other categories (abandoned children, IDP-s, etc) in the current scheme are equally destitute, the percentage of the destitute in the scheme is even higher than 89%.

[64] The expanded public insurance scheme will target all old-age pensioners, pre-school children (i.e. children aged 0-5), disabled children and severely disabled people.

[65] Medicines listed in the Decree of the Minister of Labour, Health Care and Social Affairs # 53 of February 26, 2012. We chose to simplify the wording in the GoG Decree #165 of May 12, 2012, which, literally, is "the annual limit of medicines of GEL 100 with beneficiary contribution of 50% of the list of MoLHSA approved list of medicines".

It is true the public insurance scheme that will begin in September 2012 and the current scheme have different target groups and, therefore, divergent terms and conditions do not indicate a conflict between the GoG's two acts[66], but it does signal a serious inconsistency in the GoG's insurance policy. We believe the GoG should either justify its differential approach or make its public insurance policy consistent.

As noted in the President's 2012 report to Parliament, the expanded public insurance scheme (EPIS) was designed to **a.** increase the medicine limit for old age pensioners to GEL 100 (50% off the medicines worth GEL 200) instead of the current PIS limit of GEL 25 (50% off the medicines worth GEL 50) **b.** cover all children under 18 that have four or more siblings starting in January 2013.

However, the GoG Decree #165 of May 12, 2012 set the medicine limit for old age pensioners at GEL 50 (50% off the medicines worth GEL 100)[67] and excluded children under 18 that have four or more siblings from the categories of beneficiaries to be covered by the new scheme. It is only old age pensioners of families with vulnerability score not exceeding 70,000 who had their contracts made before a certain date that have their medicines limit set at GEL 100 (50% off the medicines worth GEL 200)[68].

Needless to say, the government has a right to change its decision, but it has to explain the reasons for the changes such as what prompted the inclusion or the exclusion of certain groups of beneficiaries at a later stage. Our concern is with the government's consistency as well as its accountability. Unless the government explains its motives for changes in tactics, its decisions will not be informed by public debate of the health care system.

4.Rights of the public insurance beneficiaries are not detailed enough to enable them to take a maximum advantage of the health care scheme. The insurance contracts do not provide for the reference of public insurance beneficiaries to the institution of their choice. However, the beneficiaries can ask their insurer to be referred to a medical institution other than the provider when the latter has no or inadequate expertise treating a given medical condition. This needs to be clearly stated in the GoG Decree #218 of December 9, 2009 as well as in the insurance contracts/policies.

The insurance companies we interviewed confirmed that public insurance beneficiaries may request a reference to a medical institution other than the providers when the latter has no expertise or inadequate expertise in treating a given medical condition. The insurance survey showed that fewer than 2% of the public insurance respondents are aware of the possibility.

5.Out of 252 PIS beneficiaries that we targeted, 40 said their monthly income ranged from GEL 401 to GEL 3000[69], while 20 of them said their income was GEL 300-400, which means they entered the scheme fraudulently. Considering that respondents are normally devious about their income, fearing truthful answers will disqualify them from the insurance scheme, the number of the respondents whose income is higher than what is required to qualify must be higher. However, it is impossible to estimate how much higher. To estimate the number of ineligible PIS beneficiaries we identified the multiplier of the respondents whose income is higher than what is required to qualify for the scheme

[66] GoG Decree #218 of December 9 2009 and GoG Decree #165 of May 12, 2012
[67] See Para 1(d.b.) of Article 3 of the GoG Decree #165 of May 12, 2012
[68] GoG Decree #218 of December 9 2009, Article 3(1)
[69] Eleven of the respondents who are supposed to be below the poverty threshold earned GEL 901-1000.

(3611) allowing for a margin of error (4.6%). This then helped us estimate the number of ineligible PIS beneficiaries to be 144,440±4.6%[70].

In 2010 the State Audit Office of Georgia, the country's supreme audit institution, argued that "despite generous budget appropriations, quality of health services does not improve, medical professionals continue to be underpaid."[71]In February 2010 the State Audit Office said that an "absence of strict state regulation" combined with "dishonest actions of the insurance companies restricted access to healthcare services" and the lack of a public awareness campaign for insurance holders resulted in "alarming" shortcomings of the government-subsidized healthcare program.[72]

In 2010 the State Audit Office found that public funds were misused, beneficiaries' entries in the database were duplicated, and PIS insurers were behind schedule in concluding 75% of their PIS contracts. The SAO was unable to trace 13 400 beneficiaries in the insurance database. The audit found that 91 employees of social services and their family members (a total of 430 people) were insured under the scheme in 2008-2010, and total of insurance premia paid for them was GEL 109,924, while GEL 3.703 million was paid out for 17,690 beneficiaries who were dead at the time they were entered into the database. Apart from this, the SAO found that 1842 beneficiaries had been entered twice in the insurance database, and insurance premia paid out on them was GEL 145,171[73].

The SAO also found that GoG decree #218 enabled double insurance, a waste of public funds. 3,255 servicemen and their family members (a total of 15,359 people) were insured both by the Ministry of Defence and under the PIS, insurance premia of GEL 224,446 paid out on them from July 2010 to January 2011. Apart from this, 3,183 staff members of secondary schools were insured under both the Ministry of Education and Science Insurance and PIS schemes, the double insurance worth GEL 904,567[74].

9. Horizontal Integration in the Insurance Industry

Horizontal integration in the insurance industry started in late 2010 when Archimedes Global Georgia took over Vesti. In May 2012 Imedi L, one of the largest and most trustworthy players in the insurance market, was taken over by Aldagi BCI, which bought Meta's 51% and EBRD's 34% shares. Imedi L would not have been able to meet most of its financial commitments had it not been taken over. After the takeover Aldagi BCI now owns more than a third of the Georgian insurance market.[75] This recent wave of horizontal integration left the Georgian insurance market a poorer choice and less diversified.

The interviews and correspondence with the targeted insurance companies showed that their financial reporting is not geared towards informing their investment and business decisions in general. Suffice it to note that none of the Georgian insurance companies that committed themselves, or were urged to commit themselves to building hospitals, produced net present value[76] calculations, which would have

[70] 3611 X 40
[71] http://control.ge/files/upload-file/pdf/10-priority2011.pdf
[72] Civil.ge: State Audit Agency Slams 'Dishonest' Insurance Companies http://www.control.ge/eng/news/id/128
[73] Audit Report of the Health Care Programmes as of December 31, 2010 by State Audit Office of Georgia, p 40-42
[74] Audit Report of the Health Care Programmes as of December 31, 2010 by State Audit Office of Georgia, p 43
[75] Aldagi BCI's market share as of Q3 2011 was 16.9%, while that of Imedi L was 16.2%. This as well as other insurers' market shares include all insurance, including health/life insurance. We arrived at this as well as other insurers' market shares by adding up the earned and reinsurance premia and dividing these by the total of the earned and reinsurance premia of all the insurers.
[76] NPV compares the present value of money today to the present value of money in future, taking inflation and returns into account.

informed their risk assessment of the operation[77]. The risk assessment, in turn, would have prompted them to remain in or withdraw from the hospital scheme. The insurers might have stayed in the scheme, despite the high risks, when they weighed the risk of displeasing the government against withdrawing from the scheme. The risk assessment might not have convinced the government to let some of the insurance companies opt out of the scheme, but the companies should have at least tried since this was such a risky investment and business venture.

In the past two years we have witnessed these failures cause two waves of horizontal integration in the health insurance market. A failure to keep track of the investment to capital ratio, for instance, led Imedi L to its downfall. Put simply, if Imedi L had committed itself to building fewer than eleven hospitals,[78] it would not have incapacitated itself. The company only managed to build six out of the eleven hospitals. The end of Imedi L had been heaving in sight since September 2011; however, both the company and the National Bank failed to notice the encroaching problems. This failure prompted our questioning of the financial performance of other Georgian insurance companies.

This report is intended for the general public, the Georgian government, the National Bank as well as the insurers. We urge the National Bank and the insurers to act on our findings. The technical explanation in Footnote 75 is intended for the National Bank, the national insurance regulator[79].

Unless an insurer knows what its risks or costs of acquiring new customers (acquisition costs) are, it is in danger of going out of business. It was the failure to assess the risks of investing in building hospitals that forced *Imedi L*, one of the strongest players in the market with the most diversified portfolio, to merge with Aldagi BCI. This means that the Georgian insurance market is a poorer choice and that it is less diversified, i.e. consumers have fewer insurance products to choose from. A failure to assess risks contributed to *Vesti* going out of business in 2010.

Giorgi Kadagidze, President of the National Bank of Georgia, says that the consolidation of insurers will continue, causing the number of insurers to decrease. Giorgi Kadagidze says most of the insurers

[77] Insurers building the hospitals is an example of vertical growth rather than horizontal integration, but we examine the problem in this chapter because this led to the mergers, i.e. horizontal integration.

[78] Needless to say, we cannot estimate the number of hospitals that Imedi L could have built without forcing itself out of business.

[79] We have found that the insurers' failure to assess risks has been exacerbated by the National Bank, the insurance regulator, since it does not request insurers to examine their financial position on a regular basis on a platform that could help make their operations more predictable. Having interviewed two Georgian health insurers and been in correspondence with most of them for the past seven months, we found that the Georgian insurance companies not only fail to assess their financial risks, but also fail to properly amortize their acquisition costs, or produce rather inaccurate estimates by combining these costs with administrative expenses. Acquisition cost is the cost of acquiring new customers. This is an upfront cost incurred by issuing commissions to sales agents, underwriting, bonus interest and other acquisition expenses.

Failure to amortize acquisition costs means a failure to synchronize income and expenses. An incurred cost is capitalized and does not become an expense (called Deferred Acquisition Costs) until it is recognized in the income statement of the company. For purposes of accounting, it is the amortization of that cost, and not the original cost itself, that becomes the expense, which is how Georgian insurance companies account for acquisition costs. The insurers amortize their acquisition costs over the lifetime of the insurance contracts which were acquired with those acquisition costs. This is exactly how acquisition costs should be accounted for.

However, we believe insurance companies must have parallel financial accounting in place, whereby they will examine their financial position on a regular basis. Parallel financial accounting is a tool that allows early predictability by scrutinizing company's stocks and flows and putting these to as many tests as necessary.

comply with the NBG's new stricter requirements and that 10-20 staff insurers will go out of business as they are unable to comply with the new standards[80].

Some health experts[81] think that six[82] health insurers are too many for a small country like Georgia, referring to developed economies such as Israel, which only has 3-4 insurers. Admittedly, with six health insurers in a country of 4.5 million it is difficult to explore the benefits of economies of scale. Needless to say, horizontal integration in the insurance market is not, by definition, a negative development as it helps explore the benefits of risk pooling[83].

Why should we care about Imedi L exiting the market?

a. Imedi L with its client base, insurance products and very good service, created diversity in the insurance market and helped enhance competition, two indispensable pre-requisites for market devlopment. Imedi L's exit, needless to say, leaves the Georgian insurance market an inferior choice and diminishes competition. We believe that competition in the insurance market is not necessarily quantitatively driven. Quality and diversity of insurance products are very important in the expansion of competition. While it is true that quality and diversity of insurance products are functions of a number of players in[84] the market, the level of the insurers' business activity, the reliability as perceived by beneficiaries and the resulting trust are very important factors. Imedi L had all these as well as other requisites of a successful company. Therefore, the impact of Imedi L's exit was stronger than that of a less diversified and innovative player would have been.

b. Imedi L's exit signals shortcomings in the financial management of insurance companies that need to be addressed sooner rather than later by the National Bank, the insurance regulator.

Thus horizontal integration in the Georgian insurance market did not aim at monopolizing the market. Much of the horizontal integration, as shown above, was unintended and due to the insurance companies' failure to assess costs and benefits and risks of their investments. Better financial management, therefore, can help anticipate comparable developments in the future.

We believe the National Bank, the insurance regulator, has to do much more to help insurance companies perform better, by putting a framework for performance indicators in place, which are non-existent at the moment. If the frame draws from the needs of insurance companies, which should be studied carefully, the frame could help prudential financial management, e.g. how insurers go about calculating capital/investment ratios, acquisition expenses, etc. The insurers may or may not use the frame in their financial reporting, but they will have a performance measuring framework that will let them have a (much) better idea of their financial position.

As has already been pointed out, the introduction of a framework for performance indicators is about helping insurers perform better by sensitizing them to the shortcomings in their own financial management rather than improving their financial reporting. This means the framework is not about more regulation. The frame for financial reporting, while being a regulatory move, is about prudent financial management rather than regulation per se.

[80] http://www.resonancedaily.com/index.php?id_rub=5&id_artc=7896

[81] Amiran Gamkrelidze, for instance, WHO Country Programme Coordinator, MD, PhD, Professor, TIG's May 21, 2012 interview

[82] As of the time of writing of this report there are six health insurers in the country.

[83] See Recommendation 15 in Ch 4 for greater detail on the importance of risk pooling.

[84] http://www.icgroup.ge/index.php?a=main&pid=57&lang=eng

The Law on Insurance (Article 21) stipulates that the national regulator within its competence should ensure insurers' compliance with both normative and methodological requirements, examine insurers' accounting, financial reporting, etc; identify requirements for internal accounting, set marginal ratios of assets and liabilities as well as ratios of equity and liabilities, and develop methodological guidance as well financial and statistical reporting for insurers. Pursuant to Article 21[1] of the Law on Insurance the NBG can even impose restrictions on insurers retaining earnings, providing financial incentives or taking on new liabilities. The NBG can even suspend insurers' transactions or force them into administration when the insurers' and beneficiaries' interests are at risk. There is no other regulator that can do the job.[85] Therefore, we believe that the NBG could have put its regulation to a more effective use to prevent Imedi L or Vesti going out of business.

10. How Can Public Insurance Schemes Improve Quality of Health Care?

Quality and sustainability of health services to be provided within the two public insurance schemes is a pervasive concern in this report. Therefore, we will examine the problems from a number of different angles.

Starting September 2012 the Expanded Public Insurance Scheme (EPIS) and the existing Public Insurance Scheme (PIS) will together cover about 2.1 million people, almost a threefold increase over the current number of public insurance beneficiaries. The number of the PIS and EPIS beneficiaries will be about five times the corporate and individual insurance contracts combined[86].

Although the threefold increase in the number of the public insurance beneficiaries does not mean a threefold increase in the demand for health services, it does mean a dramatic increase in the demand. Insurance helps improve the quality of health care by making it more affordable to more people: increased affordability means a wider medical practice, i.e. more patients. A wider medical practice means a more diverse clinical experience. It is this increase in the demand for health services that makes it possible for thousands of the country's medical professionals to have a larger practice and gain experience they would not have otherwise. It is a medical professionals' practice that shapes their clinical expertise. The more operations a surgeon performs the better professional he/she is, as holds true for any medical professional. Apart from this, the more people use health care services, the higher the expectations of medical/insurance service quality rise. More experience helps raise the quality of health care. This is how affordability can be geared towards improving health care quality.

Although the demand for health services on this scale can help raise the quality of health care to a standard that corporate and individual insurance contracts cannot, the scale alone will not do the job.

[85] According to Article 12 of the GoG Decree #218 an Interagency Commission is set up to recommend termination of participation of an insurer in the public insurance scheme when the insurer's financial position deteriorates to an extent when it is unable to meet its commitments and has to be put in administration. Thus the Commission intervenes when an insurer goes under. It is not mandated to intervene before.

[86] The number of corporate medical insurance holders is increasing, and so is the number of Individual medical insurance holders, even though the number was decreasing in 2008-2010.

	2008	**2009**	**2010**	**2011**
Number of Corporate Medical Insurance Holders	242,689	168,267	229,317	357,366
Number of Individual Medical Insurance Holders	35,317	29,791	27,632	45,451

Provided by the National Bank of Georgia, in response to our enquiry on May 1, 2012

There is an opportunity that has yet to be taken advantage of. Our insurance survey, desk research and interviews led us to the understanding that to seize the opportunity the MoLHSA needs to develop as many guidelines and protocols as possible.

The insurance sector cannot move forward without proper clinical guidelines and protocols[87]. As of now, the country has guidelines and protocols for 105 nosologies[88]. Medical service providers have guidelines for other nosologies, but there are hundreds of medical conditions that are not detailed in any of the guidelines. It is this lack of guidelines and protocols that causes continual haggling between insurers and service providers over the scope and intensity of treatment, its costs and whether the treatment is needed in the first place. The haggling results in underpayment of medical service providers by insurance companies or delays in payment. The lack of clinical guidelines and protocols and the resulting underpayment and delays in payment are problems that need to be addressed by the GoG without delay. The problem with payments prevents thousands of public and other insurance beneficiaries from receiving the service that they are entitled to. On May 14, 2012 the GoG adopted decree #177 on Delivery of Insurance within the Public Insurance Scheme, which, admittedly, is a step forward, but without clinical guidelines and protocols these rules will be of little help.

Clinical protocols should give price lists as well. The Minister of Labour, Health Care and Social Affairs[89] said that in 60-70 out of 100 cases insurers and hospitals have disputes over payments, adding that when there are protocols for all/most of the medical conditions course of treatment/prices will not normally be questioned.

Based on our research, including the insurance survey findings, we identified the following four requirements of quality health services that the two public insurance schemes have to help achieve[90]:

1. comply with the respective guidelines and protocols
2. collect and analyse data on a patient's condition:
a. before treatment to identify the right intervention
b. after treatment to measure progress that has been made (diminished pain, functional improvement, etc). Positive post treatment indicators can then be used to reliably measure improvements in the quality of life, increased life expectancy, etc. Negative post treatment indicators can be used to examine what led to the outcome, where the diagnostic assessments /treatment went wrong
3. solicit second/third opinion of specialists in reviewing the clinical findings and lab processes and results to verify diagnosis
4. ensure proper follow-up treatment

What the government has to do is put in place a system of certification for medical professionals. Without a certification, the qualification of medical professionals will continue to be one of the most serious risks in the country's health care.

If the government decides to simply remain with average health care services, it will not need to put these changes in place, but for a better system, these changes are necessary.

[87] Clinical guidelines detail treatment of a group of diseases or separate medical conditions, while protocols give details of how much of a medication to administer, the sequence, etc.
[88] A collection or combination of diseases
[89] 24 Saati, a daily newspaper, 209 April, 2012.
[90] The new insurance scheme will not replace the existing one, as they have different beneficiaries.

10.1 PIS Beneficiaries' Judgment

Our insurance survey showed that individual and corporate and public insurance holders are not only well aware of their rights and the services they are entitled to, but, surprisingly, showed good judgment about what the terms of their insurance implied. Earlier surveys[91] show that the awareness of public insurance beneficiaries was quite low.[92]

More importantly, this discernment indicates that public insurance beneficiaries have begun to develop a taste for health insurance, which, as our research shows, was largely absent in 2008-2009. However, the survey also showed that the customer discernment, which we examined through a variety of questions across the three target groups, is not as high as would urge medical service providers to improve quality. Most importantly, customers do not have much choice if they are dissatisfied with a medical service. This means that even if they are knowledgeable enough, it does not help improve the medical service quality, because when a discerning customer cannot go elsewhere, the provider of the poor medical service is not pressured into maintaining a higher standard. Unless demand for poor quality health service decreases, the quality of medical services will not improve. If the demand for your services decreases you either have to improve the quality or leave the market. If public insurance beneficiaries ask to be referred to a medical institution other than the provider when the latter has inadequate expertise treating a given medical condition the demand for poor health services will decrease. Needless to say, a more reliable way of quality assurance is certification, rather than customer judgment. Customers cannot normally be expected to have the expertise to judge the quality of their health care. A treatment that a customer thinks is right may well turn out to be misguided. Therefore, customer knowledge can never make up for a lack of quality assurance procedures (external control of laboratories, periodic national certification of medical institutions and medical professionals, etc). However, it is not disputed that medical institutions and professionals elude the scrutiny of institutional quality assurance procedures, which is why customer judgment and the resulting discernment are very important quality assurance factors.

We found that although insurance contracts do not provide for such referrals, if PIS beneficiaries ask the insurer for a referral to a non-provider medical institution, they are in fact referred to the institution of their choice[93]. The problem is lack of requests for referrals by the beneficiaries. We believe such referrals can help increase the quality of medical service either by: **a.** forcing medical institutions whose services are not in demand to improve the quality of their medical services to an extent where they are in demand again **b.** forcing medical institutions who do not respond to the market pressure[94] out of business.

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[91] Zurab Putkaradze, Project Director of Healthy World, for instance, said in an interview with us that their preliminary research for a MATRA funded project showed that only 8% of the population insured under the public scheme was well informed about the public health insurance program and their benefits, while 40-50 % had very vague understanding and the rest did not have any idea. Low awareness was documented by the Georgian Insurance Association Research: Georgian Insurance Guide, September –December, 2010 at http://goo.gl/Tfdfh

[92] We do not know how similar the samples of (groups of respondents) that we targeted within our survey are to the samples targeted within other surveys, but as all the respondents are beneficiaries of some kind of insurance they must be more or less comparable.

[93] Our insurance survey showed there are very few PIS beneficiaries that ask to be referred to a non-provider medical institution.

[94] The medical institutions whose services are not in demand.

11. Vertical Growth in the Insurance Industry[95]

Georgian health insurers building hospitals, an example of vertical growth, is directly related to the quality of health services. Both vertical growth and vertical integration make it possible to explore economies of scale, which, needless to say, is the major advantage of vertical growth/integration. However, being a hospital operator and health insurer might also mean that the holding company will try to minimize its costs by providing the cheapest possible service to its insurance holders, which is very likely to compromise quality. Although we examined the problem at length in Ch 6, the implications of the insurance companies facing the financial stress of building and running the hospitals (how the number of disallowed claims is related to the financial stress, etc) are examined throughout the report.

As was pointed out in the previous chapter, the overarching question that we try to answer is how insurance, as well as what kind of insurance, can help improve health care. Considering that insurers were not particularly excited about building the hospitals, they are unlikely to be running the hospitals or assuring the medical service quality in those hospitals in the same manner they would have if it had actually been in their business interests to run the hospitals. Therefore, medical service quality assurance is where the government should intervene. This is where the insurance industry needs more regulation. Ideally, the government puts a quality assurance frame in place, and then the invisible hand of the market takes care of service quality. However, for the invisible hand of the market to take care of service quality, the market needs to be perfectly competitive, which is not the case in Georgia. Also, customers must have a higher degree of health care knowledge than they do at the moment.

The insurance sector survey that we conducted showed that customer knowledge, examined through a variety of questions across the three target groups, is not as high as would urge medical service providers to improve on the quality, e.g. only 5% of our PIS beneficiaries that we targeted said that they had felt they needed to double-check their diagnosis on at least one occasion, while the others said they had never felt they needed to double-check. In contrast, 13% of corporate and individual insurance holders that we targeted said they had felt they needed to double-check their diagnosis on at least one occasion, while the others said they had never felt they needed to double-check. Neither 5% nor 13% are encouraging numbers[96]. What is more important, however, is that customers do not have much choice if they are dissatisfied with a medical service, which means that even if they are knowledgeable enough, it does not help improve the medical service quality, because when a discerning customer cannot go elsewhere, the provider of the poor medical service is not pressured into maintaining a high standard.

Therefore, with none of these quality assurance factors at work in Georgia, the government has to intervene to not only put a quality assurance frame in place, but also to ensure that the hospital

[95] We use vertical growth rather than vertical integration as the latter denotes two or more existing companies in a supply chain coming together to produce different components of a product/service, which has not been the case in the Georgian insurance market. Thus merger of an existing hospital with an existing insurer would be a typical vertical integration. In Georgia, however, existing insurance companies started building hospitals to create their supply chain, which is a vertical growth rather than vertical integration. However, because the insurers are expanding into hospital sector, even though without making acquisitions, the effect of the expansion on the market will be equal to that of vertical integration.

[96] Public insurance beneficiaries cannot afford to have their diagnosis double-checked, while corporate and individual insurance contract holders can.

operators[97] spend as many resources as needed to run the hospitals and comply with the effectiveness and efficiency requirements.

The medical service quality assurance, which is effectiveness, and efficiency are absolutely crucial to running the insurers' hospitals. Crucial questions of efficiency that insurers are not asking themselves are:

a. who is managing the hospitals: whether each of the hospitals has a director or a certain number of them are sharing the management of the hospital;
b. do insurers contract independent management companies to run the hospitals or do they have their subsidiaries do the job. The insurers we interviewed managed their hospitals through their subsidiaries, a clear conflict of interest. The government should ensure that hospitals built by insurers are managed by independent management companies rather than by the insurers. We should note here that hospital operators other than insurers do not need hospital management companies to run hospitals[98].
c. how the operator is going to make sure that a qualified surgeon/therapeutist stays in the hospital.
d. how to determine which specialist has which qualifications in the absence of a nation-wide reference system to keep track of the number of operations a surgeon performs, successful treatments by a specialist, etc. In the absence of the nation-wide system, it is hospital management companies that have to keep track of medical professionals' qualifications.
e. considering the costs and benefits of having a qualified surgeon in a hospital, is it better to fly the patient to Kutaisi/Tbilisi or pay a good surgeon in a remote hospital? Is high pay the only factor that constitutes a good surgeon's satisfaction? Is pay the only factor that would make a good surgeon stay with a certain clinic given that their expertise might fall into decline?

We understand that investor interest in the Georgian hospital sector was not high at all, which means the GoG did not have many options when it came to implementing its hospital sector plan. In 2011 the State Audit Office's audit of the hospital sector found that state health care programmes were improperly managed. The improper management involved procurement as well as other fraud, which prompted the SAO's recommendation of immediate privatization of state-run hospitals.[99] Ideally, the hospitals should not have been built by insurers in the first place because of the conflict of interest that we describe throughout this report. About 60% of the 151 new hospitals were rehabilitated/built or are being rehabilitated/built by investors other than insurance companies or the government itself, an achievement that cannot be denied to the GoG. However, about 40% of the 151 hospitals were rehabilitated/built by insurance companies, which is a troublesome fact.

What the government can do now to resolve the conflict of interest is: **1. decouple** the hospitals from the insurance companies by buying out the hospitals from the insurance companies to sell them later. Now that the hospitals are up and running investors are more likely to be interested in making the investment than they might have been before the rehabilitation/construction **2. distance** the hospitals

[97] 37% of the total of 151 hospitals were either built or are being built by insurance companies. The construction of the remaining 63% of the hospitals is the responsibility of economic agents other than the insurance companies.
[98] There is nothing wrong with operators other than insurers running the hospitals. However, there are a number of investors in the Georgian hospital sector, such as the GoG, USAID, etc that should not be running the hospitals for a variety of obvious reasons: very rarely are state run hospitals either efficient or effective, while donors cannot be hospital operators. The government has to privatize the hospitals that it is building and the USAID will have to transfer its hospitals to the government so that the latter should then privatize them.
[99] Civil.ge: State Audit Agency Slams 'Dishonest' Insurance Companies http://www.control.ge/eng/news/id/128

from their parent insurance companies by putting in place a regulatory framework that will reduce the conflict of interest. The regulation has to ensure that the hospitals rehabilitated/built by the insurance companies are run by genuinely independent management companies. We believe compliance of the hospitals with MoLHSA licencing and accreditation[100] requirements is not enough: hospitals providing medical services in line with quality assurance procedures does not mean their insurance beneficiaries will be provided with the same quality services at the hospitals as evidenced by the accreditation procedure. Apart from this, the hospitals under insurance companies are very likely to offer their insurance beneficiaries as limited services as possible **3. require** that contracts between insurers and medical institutions follow a pre-defined template identifying responsibilities of and sanctions against the parties to the agreement, making reference to the applicable protocols[101].

Thus this conflict of interest has serious repercussions for the beneficiaries who are directed to the hospitals by their insurance companies. Resolving the conflict of interest, whether through decoupling or distancing, will increase the price of services at the hospitals, which will then drive insurers' costs up, but, we believe, the implications of the conflict of interest for service quality at 40% of the country's hospitals are too serious to be disregarded. Therefore, we believe quality assurance rather than how to distance hospitals and health insurers has to be the preponderant consideration.

Our interviews with insurers and experts in the field prompted us to the understanding that although insurance companies would not have built the hospitals had they been free to decide, now that they have built the hospitals they can see the advantage of providing health services to their insurance package holders in their hospitals.

Vertical growth that goes beyond the insurance capturing pharmaceutical production and retail, however, is a cause for alarm. Alpha, one of the largest players in the public insurance market, is a daughter company of Aversi,which is a pharmaceutical retailer, manufacturer, health insurer and hospital operator. Firstly, the problem with being a pharmaceutical manufacturer and retailer at the same time is that the holding company might try to clear way for the drugs it produces by not importing comparable drugs/drugs of the same group, which limits the choices available in the market. Secondly, as already pointed out, being a hospital operator and insurer means the holding company will try to minimize its costs by providing the cheapest possible service to its insurance beneficiaries, which very likely compromises quality. Thus pharmaceutical retail, production, health insurance and hospital operation create a vicious circle that needs to be broken if the country's health care and insurance industry are to move forward.

Vertical growth in the Georgian insurance industry, therefore, is a cause for concern that the GoG should address without delay.

12. Voluntary Health Insurance Scheme

In February 2009 in parallel with the public insurance scheme for the neediest, the GoG introduced a voluntary health insurance scheme, which was to make insurance accessible to more people aged 3-60. The voluntary scheme excluded the beneficiaries of the fully funded public insurance scheme and those who held an insurance package worth more than GEL 180 per annum. The voluntary insurance

[100] Accreditation is a set of service quality assurance procedures.
[101] The protocols should give prices for health services.

scheme covered primary, out-patient and in-patient health care and accidents within the limit of GEL 8000. The basic annual health insurance package was GEL 60, the government's contribution to the scheme being 67% (annual GEL 40.2), while the beneficiary contribution was 33% (annual GEL 19.8).

However, the government's premium was to be revised from GEL 40.2 to GEL 96[102] if an insurer attracted more than 10,000 beneficiaries to the scheme, which sent the insurers vying with each other for customers. If beneficiaries happened to want more varied/better services, they had to contribute to the scheme on top of the GEL 19.80, but, as pointed out by the IC Group and Irao in the interviews with us, there were very few beneficiaries willing to pay more than GEL 19.80 to receive the extra package. Thus there were no other strings attached to the higher premium that the insurers were paid by the GoG, clearly a perverse incentive[103].

The insurers targeted potential beneficiaries everywhere they could reach and took them to their offices and signed contracts with them. This is what competition is about -- making insurers compete on terms and conditions of their insurance packages. However, competition is a means to an end, not an end in itself. The scheme set a precedent of competition in the Georgian insurance market. However, the competition did not help diversify the insurance market, which, in turn, could help improve the quality of health care, because the GoG offered a higher premium to the insurers without requiring them to provide extra services to the beneficiaries. The competition did not help achieve either of these two goals. Discontinuation of the government's contribution to the scheme in July 2010 nipped the scheme in the bud and with it the difference it could have made.

The GoG planned to attract 300,000-500,000 people above the poverty line[104], including those who were self-employed and therefore not covered by corporate insurance schemes, to this voluntary insurance scheme. However, the GoG eventually succeeded in selling the package to 124,343 people. The insurance scheme did not attract the predicted numbers of beneficiaries even though **a.** it was the first of its kind to cover primary, out-patient and in-patient health care and accidents for a fairly wide range of beneficiaries **b.** it was affordable (annual premium of GEL 19.8), considering that its recipients were not among the poorest **c.** it was quite easy to buy (a beneficiary needed to produce just their ID card).

In July 2010 the GoG discontinued its contribution to the voluntary insurance scheme, which meant the beneficiaries now had to pay the annual insurance premium of GEL 60. The GoG has never come up with a more sound or fiscally sustainable scheme or one that had a promise to improve health care in a way that no other scheme could. The promise, however, did not materialize since the scheme was discontinued prematurely. Apart from this, the scheme created competition, which was not based on the right kind of incentives. The insurance survey that we commissioned, our desk research, the interviews with the product developers at the targeted insurance companies helped us see the strengths of the voluntary insurance scheme as well as the weaknesses in its design and implementation.

The insurance premium[105] of as little as GEL 60 covered the spectrum of services that it did because the calculations of the insurance premia and risks were based on three times as many beneficiaries as

[102] The GoG Decree #33 on the Voluntary Insurance Scheme, February 26, 2009

[103] A perverse incentive is an incentive that has an unintended and undesirable result which is contrary to the intentions of an undertaking

[104] Shorena Jadugishvili, Insurance Association of Georgia, Health Care Financing in Georgia 1990-2010, p 10, http://goo.gl/tKa0Y

[105] The GoG's annual contribution of GEL 40.2 and beneficiary contribution of GEL 19.8

were attracted to the scheme. Thus the scheme was based on faulty underwriting[106] and an exaggerated demand estimate, which were the major weaknesses in the design of the scheme[107]. If more beneficiaries participated in the program, the insurance premia would have been lower. A higher number of insurance beneficiaries can offset or mitigate some of the insurance risks that a scheme such as this may involve. The number of beneficiaries that the GoG planned to attract to the scheme (500,000) is about 400% higher than the actual number that the scheme attracted, which defies any reasonable margin of error. A more realistic demand estimate might have prompted the government to contribute more than 67% to the scheme to get it going and then gradually decrease its contribution as the scheme gained momentum, which must have been the GoG's plan even though it had never been articulated. Not only was the design of the scheme faulty, but also those who were responsible failed to see that with the dwindling numbers of beneficiaries, the end of the scheme was in sight. As of October 2009 the number insured under the voluntary scheme was 124,343, and it began to steadily decline in March 2010, plummeting to 63,868 by July 2010[108]. Having asked the insurance companies participating in the voluntary insurance scheme about their current number of the voluntary scheme beneficiaries, we found that very few of the remaining 63,868 beneficiaries remained in the scheme after July 2010 when the government's contribution was discontinued. Thus the scheme could not explore the benefits of scale, which was another of its major weaknesses. Most importantly, however, after the GoG's contribution was discontinued the government did not pause to examine what went wrong to anticipate a comparable insurance scheme failing in the future.

Careful examination of the responses in the public insurance survey, the interviews with the insurers and their financial data over 2008-2011 led us to the understanding that the GoG, having discontinued its participation in the voluntary insurance scheme, left the potential in the voluntary insurance untapped.

Our insurance survey results of the public insurance beneficiaries were completely counter-intuitive. The survey showed there is a sizable untapped potential in the country. The survey showed that 74[109] of the 252 PIS beneficiaries (30%) who are supposed to be below the poverty threshold are willing to pay GEL 5 a month to get services not included in the public insurance package, about 50% of them opting for preventive care in exchange for their contribution. Beneficiary contributions to the voluntary insurance scheme in 2009-2010, which targeted people with higher incomes, was GEL 1.65.

We estimated a multiplier across PIS component to be 3611. Therefore, the number of PIS respondents who are ready to contribute GEL 5 a month towards their insurance is 267,214[110]. With a 5.7% margin of error this means about 267,214±5.7%[111] of PIS beneficiaries alone could potentially migrate from PIS to a voluntary insurance scheme if the GoG were to resume the scheme and offer better terms to its potential beneficiaries. Considering that about 267,214 PIS beneficiaries are willing to contribute towards their insurance, attracting 500,000 beneficiaries to a voluntary scheme is a realistic task if the government gives it a try.

[106] Underwriting involves measuring risk exposure and determining the premium that needs to be charged to insure that risk.

[107] Exaggerated demand estimate means the GoG planned to attract a higher number of beneficiaries than the scheme was able to attract.

[108] The Agency for Social Services, Letter of May 30, 2012 to TI Georgia

[109] The survey showed that 144 respondents were willing to contribute towards their insurance. However, 70 responses were eventually were found invalid.

[110] 74X3611

[111] The margin of error of PIS beneficiaries (5.7%) who could potentially migrate from PIS to a voluntary insurance scheme is calculated as a percentage of the number of all PIS and Tbilisi Municipal Insurance beneficiaries (909,903) rather than 267,214. Therefore, the margin of error expressed in PIS beneficiaries is 267,214±51,864.

Georgia trails behind quite a number of countries with its per capita government expenditure on health at an average US exchange rate of $56[112] in 2009 and out-of-pocket health expenditure[113] in 2009 67%, and public health expenditures just 1.4 % of the country's GDP. It seems logical that the government should be advised to increase its health care expenditure rather than seek ways of exploring whatever untapped potential the country's insurance market has. The answer is that it has to go both ways: exploring the untapped potential does not preclude the government increasing its per capita health expenditure. The question that the Georgian Government has to answer is **a.** what percentage of the 67% of out of pocket expenses can be channeled to insurance and **b.** how this can be accomplished.

Our insurance survey provided another assurance that a voluntary insurance scheme supplementing the GoG's two public insurance schemes is the only correct way forward. The corporate and individual insurance components of the survey showed that individual insurance package holders, who are paying 100% of their insurance premia, act more responsibly when it comes to prevention. We found that about 30% more individual insurance package holders were likelier to take preventive measures than the corporate insurance beneficiaries who are either not contributing at all or are only contributing less than 30% towards their insurance. As PIS beneficiaries are not entitled to preventive care, we were unable to make comparisons across the three groups. Needless to say, failure to take preventive measures is a serious drain on the fiscal resources, which can be anticipated and prevented through voluntary insurance scheme partially funded by beneficiary contributions.

Last but not least, based on our desk research, insurance survey and interviews, we believe the voluntary insurance scheme, if properly administered, can pave the way for compulsory insurance in 10-15 years' time. Compulsory insurance is an even better option since it encourages responsibility for one's health. More importantly, however, the insurance schemes towards which you must personally contribute assure quality in a way that no other insurance scheme can. Our insurance survey showed that individual insurance holders who pay for their insurance themselves are more demanding about health service quality by at least 7 criteria than public or non-contributing corporate insurance holders. We believe the government can ill-afford to ignore this very valuable finding. We urge the government to conduct larger surveys to gain better insight into how beneficiaries, when they pay for their insurance themselves, advance a country's health care system. We do not contend that the GoG should introduce a compulsory insurance scheme in the immediate future (our estimate is 10-15 years). What we are saying is that the government should resume a voluntary insurance scheme to pave the way for compulsory insurance.

We believe the Georgian government should act on the findings presented in this report. Therefore, we urge the government to engage with us in a constructive, technocratic discussion of the findings and recommendations presented in the report, which, we believe, can help move the insurance system as well as the wider health care reform forward.

[112] World Health Statistics 2012, World Health Organization, p.137 at http://www.who.int/healthinfo/EN_WHS2012_Full.pdf

[113] As a proportion of total health expenditure