USAID FROM THE AMERICAN PEOPLE | HEALTH SYSTEM STRENGTHENING PROJECT

HSSP Trip Report

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EXECUTIVE SUMMARY

This paper represents the findings and recommendations of an assessment of the Georgian health insurance sector, the Terms of Reference which were to:

1. Design and conduct a training needs assessment (TNA) of health insurers' ability to manage and deliver health insurance services and products to determine performance gaps of manager level staff and executives.
2. Recommend training programs, based on the results of the TNA, for the health insurance industry, that is comprised of four two-to-four day training courses.
3. Review university-based curriculum in insurance management, assess for best practices, relevancy and accuracy, and make recommendations to revise the curriculum.
4. Meet and access local providers of training to recommend potential training pool and trainer mechanisms.

The assessment was conducted by Mr. Richard Webb from 25 January 2010 to 9 February 2010.

The assessment included consideration of needs relevant to health insurers, and the broader needs of insurers generally where such needs had substantial impact on Georgian insurers offering health insurance. It also included consideration of the environment in which health insurance and health insurance financing operates in Georgia.

Comprehensive discussions were held with health insurers, training providers, associations, institutes, health service providers, and relevant government agencies and Ministries.

The Georgian government has chosen to outsource health insurance for the poor by paying the premiums for private insurance (the MAP program). It also subsidizes the premium for a specified package of health care services for the remainder of the population. The government provides health insurance for teachers, the police, the army, the very young, the aged and other targeted groups, and for dread disease (HIV, TB, cardiac). In all, 30% of the Georgian population has some form of health insurance. Those in the rural areas also have access to rural ambulatory clinics, in respect of which the government pays doctors and nurses a monthly fee.

The Georgian insurance industry consists of 14 insurers, with a total premium income from all sources of USD 115,000,000 as of 30 June 2009. Twelve of the 14 insurers write health insurance. Health insurance premiums represent 72.6% of total premium income from all sources. Premiums from government- subsidized insurance represent 78% of total health insurance premium income, with MAP representing almost half.

Disease and treatment classification and coding mechanisms are neither extensive nor consistent. Standards, licensing and certification of medical service providers are either non-existent or seriously deficient.

A health insurance mediation services exists to mediate disputes between policyholders and insurers, with binding authority up to USD 600.

Recently, the government has added a package of drug benefits to the MAP program. It also indicated its intentions to require the insurance industry to enforce standards indirectly, by preventing them from conducting business with providers who do not meet the standards. Such standards are very rudimentary.

The training needs assessment resulted in a number of conclusions, including the following:

1. The quality of health insurance operations in Georgia is generally good, although it varies from insurer to insurer.
2. Public information may not be completely reliable and sharing of information within the industry is inadequate to allow for the development of proper fraud identification.
3. In many insurers, management style is "top down", and mid-level managers are not sufficiently empowered to make decisions that are typically within their domain.
4. Insurers are too dependent on government-subsidized insurance, and appear to be becoming increasingly dependent.
5. Product pricing abilities and techniques, underwriting abilities and practices, and claims management abilities and practices are inadequately developed.
6. The level of actuarial expertise and availability is very low.
7. Distributions systems are inadequately developed, and the qualifications of agents is subject to little supervision or regulation.
8. Regulation of insurers is at a low level on the prudential side, and is virtually non-existent on the market conduct side.
9. Insurance operations are hampered by internal and external infrastructure deficiencies, including:
    - inadequacy of claims managements practices and procedures
    - inadequacy of underwriting knowledge and abilities
    - lack of necessary software
    - underdeveloped customer service standards and skills
    - deficiencies in internal communications/coordination/cooperation
    - lack of actuarial knowledge
    - low consumer knowledge of and interest in insurance
    - insufficiency or unreliability of information
    - lack of proper provider standards
    - lack of proper auditing and accounting standards

Few insurers identify staff training needs, develop staff training plans, provided in-house training, or offer support (financial or time-wise) to staff wishing to enroll in trainings.

Georgia State University (GSU) and the Caucasus School of Business (CSB) offer any substantial insurance-related training. Much of this training had been developed in cooperation with US universities.

An assessment of current training opportunities offered by GSU and the CSB resulted in the following conclusions:

1. The programs offered to students are good that is understandable because both institutions are universities.
2. The educational and training opportunities and providers are generally not well regarded by insurers.
3. Previous training efforts through universities and other providers have suffered from a lack of industry interest.
4. Seasoned insurance practitioners are not available in Georgia, resulting in substandard lecturers.
5. Few seasoned insurance practitioners with broad insurance experience and familiarity with international operations and standards speak Georgian, and few insurance-related materials are available in Georgian.
6. More training is required in technical/professional areas, such as actuarial science and underwriting, which will require longer-term training.

An assessment of GSU's and CSB's training curricula resulted in the following conclusions:

1. Training appears to have been developed from the supply side rather than from the demand side.
2. Training appears to have focused on identified needs to the exclusion of what is currently possible.
3. Training appears to have been developed without sufficient prior assessment of industry needs or wishes.
4. Training subject matter often reflects the experience and practice of particular foreign jurisdictions which is less relevant in the Georgian reality.
5. Some of the subject areas are irrelevant in the Georgian context.
6. Training does not appear to embrace the concept of education through gradual but continual increase in knowledge and exposure to subject areas..
7. Training offered was often too academic and insufficiently-focused on practical skills areas

Skill areas which would benefit from training were identified, and categorized into four areas:

1. General skills (short term)
   - General Management
   - Customer Service/Relations/Complaints Handling and Resolution
2. Insurance specific skills (short term)
   - Insurance Sales/Marketing/Consumer Education
   - Insurance Ethics
   - Insurance Risk Management
   - Insurance Pricing
   - Insurance Underwriting
   - Legal

3. Health Insurance specific skills (short term)
    - Overview of Health Insurance Operations
    - Underwriting Health Insurance
    - Actuarial Management of Health Insurance
    - Introduction to health Insurance Information Technologies
    - ICD/PCPY Coding
4. Targeted professional development training (long term)
    - Actuarial Training and Certification
    - Underwriting
    - Claims Management
    - International Financial Reporting Standards

Training needs were prioritized and training opportunities were assessed for their abilities to provide cross cutting training opportunities. As a result, the following training programmes are recommended:

1. Short-Term
    - Active Leadership and Management
    - Building Customer Relations by Enhancing customer Service
    - Strategic Product Development

If the project were to consider a long term training approach the following is recommended:

2. Long-Term
    - Actuarial Training (or, as an alternative, short-term training in *Actuarial Management of Health Insurance*)

ASSIGNMENT BACKGROUND

In October 2009, the United States Agency for Economic Development (USAID) awarded Abt Associates Inc. (Abt) a five year contract under the Health Sector Strengthening Project (HSSP).

The objectives of the HSSP Project are to:

1. Strengthen insurer capacity to provide quality health insurance services.
2. Strengthen providers' capacity to manage and deliver quality health care services.
3. Strengthen the capacity of the government of the Republic of Georgia to guide and monitor health reforms.

The HSSP project is a successor to a previous healthcare-related project—the Co-Reform Project—which was also administered by Abt.

Two other consulting companies—Banyan Global (Banyan) and MD Informatics (MDi)—have been engaged by Abt as sub-contractors on the HSSP. Banyan's primary involvement is to help build management and technical capacity of primary health care providers, hospital managers, and health insurers, while MDI will help Georgia develop information systems that ensure data

compatibility between the Ministry of Labour, Health and Social Affairs and private health insurers.

One of USAID's project goals is to develop the capacity of the Georgian insurance industry and individual insurers to provide access to health care through affordable health insurance products for the population of Georgia, with an emphasis on promoting health insurance for the uninsured and underinsured.

ACTIVITIES

Mr. Webb was contracted by Banyan Global to conduct a field trip to Georgia to:

1. Design and conduct a training needs assessment (TNA) of health insurers' ability to manage and deliver health insurance services and products to determine performance gaps of manager level staff and executives.
2. Recommend training programs, based on the results of the TNA, for the health insurance industry, that is comprised of four two-to-four day training courses.
3. Review university-based curriculum in insurance management, assess for best practices, relevancy and accuracy, and make recommendations to revise the curriculum.
4. Meet and access local providers of training to recommend potential training pool and trainer mechanisms.

The field trip was conducted in Tbilisi, Georgia from 25 January 2010 to 9 February 2010.

APPROACH TO TRAINING NEEDS ASSESSMENT

The Training Needs Assessment was conducted identify and assess both current and expected needs related to the provision of private health insurance. However, certain needs--while certainly applicable to health insurance--are equally applicable to other types of insurance. For instance, proper underwriting and pricing practices are general across the insurance industry. As a result, any training needs assessment must necessarily involve a more general assessment of the Georgian insurance industry.

Moreover, some needs may be of a general business-related nature. In this regard, one would include general management training, accounting training, and so on. In short, many of the needs related to the comprehensive and efficient provision of health insurance are not exclusive to health insurance, and may--in fact--not be exclusive only to the insurance industry.

In addition, private insurance operates in--and is affected by--the overall informational, political and business environment, which includes public insurance, overriding public policy and general infrastructure development and limitations. These external realities may have considerable impact on the type of training that is appropriate, and the effectiveness, applicability and sustainability of any training provided.

While the original Terms of Reference of the current assignment required training recommendations only in respect of four short-term courses, during the course of the assessment it became apparent that many of the identified needs could only be addressed by

longer-term training. As a result, a meeting was arranged with USAID to review the Terms of Reference. During that meeting, it was determined that it would be appropriate to consider areas for longer-term training as well. Accordingly, longer-term training needs and solutions were also explored.

Accordingly, the scope of the assessment includes the above areas.

APPROACH TO ASSESSMENT OF EXISTING HEALTH INSURANCE TRAINING PROGRAMS AND PROVIDERS

Discussions with insurers and the Georgian Insurance Association revealed a lack of confidence in both the existing health insurance training offered and the experience and qualifications of those engaged to deliver the programs.

Although some of the programs had been developed in cooperation with several US universities (University of Georgia, Florida State University, Emory University, and Scranton University), the industry felt that these programs were too academic. The industry also felt that local trainers did not have sufficient practical experience to deliver meaningful training. In short, the industry wanted practical, experience-oriented training, rather than overview programmes and academic approaches.

Nevertheless, the available current local curriculum and training materials were reviewed for comprehensiveness of approach and adequacy of materials. Without review of the backgrounds of the lecturers and actual on-site assessment of their teaching approaches and abilities, their knowledge, experience and competency cannot be assessed.

Only the University of Georgia, the Caucasus School of Business and the Tbilisi State University of Economic Relations offer significant insurance-related training. The Free University of Georgia was also contacted; however, they did not provide a great deal of insurance-specific training, either at the academic or at the technical level.

Of the three institutions offering training, materials in English were available only in respect of the University of Georgia and the Caucasus School of Business; however, discussions with the Tbilisi State University of Economic Relations led to the conclusion that its training offerings were subject to similar comments, and that the extent of its offerings were even more limited.

INSURANCE INDUSTRY PARTICIPANTS CANVASSED

In view of the time available, it was not possible to meet all Georgian insurers; however, meetings were arranged with a majority of them, and the author is satisfied that the insurers interviewed were representative of the industry at large.

In all, meetings and discussions were held with the following organisations (see Schedule “A” for specific contact details):

1. Insurers
    - Aldagi BCI
    - Alpha

- Archimedes
- GPI
- Imedi L
- Vesti

2. Training Providers
   - Caucasus School of Business
   - Free University of Georgia
   - Partners for Health
   - Tbilisi State University of Economic Relations
   - University of Georgia (School of Public Health)
3. Associations
   - Georgian Insurance Association
   - Georgian Hospital Association
4. Institutes
   - Georgia Insurance Institute
5. Clinics and Hospitals
   - Curatio FamilyClinic
   - Family Medicine Health Centre
   - Saguramo (rural ambulatory clinic)
6. Ministry of Health
7. National Bank of Georgia (Insurance Supervision Department)
8. Insurance Mediation Service
9. United States Agency for International Development

Schedule "B" is an Interview Guide used during the meetings and discussions with insurers. This Guide was prepared prior to the author's attendance in Georgia, and contains more detailed questions than were required in light of current Georgian industry development and operations. Some questions had little relevance in Georgia, while the relevance of other questions varied from insurer to insurer. Nevertheless, it served as a valuable aide memoire to guide the meeting and discussion process.

FINDINGS

HEALTH INSURANCE PROGRAMMES IN GEORGIA

To place the Georgian private health insurance industry in perspective, it is necessary to consider where it fits in the overall scheme of health services delivery in Georgia. The effect of other activities and initiatives--such as other government programs, regulatory constraints, and so on--has direct impact on both the creation of new opportunities for the private insurance sector and constraints on their growth.

The approach of the Georgian authorities is to outsource the provision of health insurance for the poor ("MAP insurance") and other targeted groups--by subsidizing the cost of its provision

by the private sector-- and to partially subsidize private health insurance for those above the poverty level (the Affordable Health Insurance Program, referred to as "cheap insurance").

In addition to the MAP programme, the government of the ROG provides medical coverage for teachers, police, the army, children under 3, seniors over 60, those suffering from dread disease (TB, HIV/Cardiac, and so on). It also pays a monthly amount to doctors and nurses at rural ambulatory clinics.

In respect of MAP insurance, the government mandates the minimum services to be provided, and fixes the premium, in consultation with the insurance industry - currently set at GEL 15, approximately USD 9, per month. Insurers are free to include additional or extended benefits, but must do so within the negotiated premium. Insurers are entitled to choose whether or not to participate in the MAP insurance program. To date, of the 14 insurers licensed, 12 have chosen to participate in the program (see Schedule "C").

Those citizens entitled to participate in the MAP plan are given a voucher, which they may take to any of the insurers participating in the plan. Competition for the vouchers is aggressive.

Until recently, the term of a MAP insurance policy was one year, resulting in yearly-focused sales campaigns, with their attendant expenses and strains on personnel. During the course of the assessment visit, the government of the ROG announced that the term was to be increased to three years and that a minimum drug package would be introduced.

In respect of the "cheap insurance", the government mandates the minimum services to be provided, and subsidizes approximately 40 GEL of a premium with a minimum of 60 GEL and a maximum of 180 GEL. As with MAP insurance, insurers are free to include additional or extended benefits, either within the basic 60 GEL premium or within the 60-to-180 GEL premium. Several insurers do offer additional benefits at increased premium rates. Despite the government's hopes, however, sales of "cheap insurance" have failed to meet the government's projections, and insurers do not generally actively promote it.

Despite the massive infusion of public capital into the health insurance sector, 70% of all Georgians are without access to medical insurance, and must depend on their own financial resources, or access to rural ambulatory clinics, where available.

THE GEORGIAN INSURANCE INDUSTRY

The Georgian insurance industry is small by international standards, having a total premium income of GEL 198,416,835 (approximately USD 115,000,000) as of 30 June 2009.

Health insurance represents 72.6% of total industry premium income from all sources. The remaining 27.6% consists of various types of property and liability insurance. Little life insurance is sold.

Recently, one insurer (Alpha, which is the most recently-incorporated insurer) introduced plans to voluntarily provide a more extensive drug plan under the MAP program, thereby rectifying a serious omission in coverage under the plan. Alpha is owned by Aversi, a pharmaceutical

company. The other insurers are alarmed at what they see to be an unfair competitive advantage, and there had been some indication that Alpha would not be allowed to be a member of the Georgian Insurance Association. For their part, the other insurers are discussing acquiring a "tied house" pharmaceutical company, to enable them to compete at the same level. For its part, Alpha might be forgiven for seeing the recent mandatory inclusion of a drug plan in the MAP program and the move to the three year term for MAP policies as being an attempt to "squeeze it out" of participation in the MAP program.

HEALTH SERVICE PROVIDERS

At present, there are few agreed standards, licensing or certification requirements for service providers. International Classification of Disease (ICD) and Physicians' Current Procedural Terminology (PCPT) standards and codings are neither widely understood nor widely used.

The government of the ROG had undertaken a program of privatisation of virtually all hospitals and local ambulatory clinics. Hospitals were to be privatised according to a tender process, while the local clinics were to be transferred to the doctors and nurses running them. The hospital privatisation process was, however, slowed by the world financial crisis, and the successful bidders were unable to honour their financial agreements within the time specified. During the period of the assessment, the government of the ROG announced a change in policy which would require insurers to ensure the upgrading or building of standards-compliant hospitals. This appears to be a means of forcing insurers to assume the usual governmental function of ensuring compliance with such standards. It is still not clear if the new requirement are to be an addition to the existing hospital privatisation process, or if it is to be in substitution for it.

RELATIONS BETWEEN HEALTH INSURERS AND HEALTH SERVICE PROVIDERS

Relations between health service providers and health insurers are generally not harmonious. Insurers claim that providers engage in unnecessary procedures, "pad" their bills, or attempt to pass on their unrelated overhead expenses. Indeed, it is for this reason that most claims managers are doctors, something which would be quite unusual in western insurance operations. Invoices are not submitted in accordance with ICD coding, resulting in difficulty in comparing procedures and the necessity of a high degree of coding or recoding at the insurer level.

Providers claim that insurers arbitrarily decide that they will pay less than billed, for no apparent or justifiable reason, knowing that they have control over the financing. One senior insurance executive stated that he used his superior financial position to extract better rates. This approach is a bit worrying, as it mirrors a similar approach often used by insurers in many developing countries --settle for less now, or spend the next five years working through a court system that may or not be counted upon to deliver impartial justice.

Irrespective of which side is at fault (and the likelihood is that the complaints are justified on both sides), a great deal of insurer activity is dedicated to scrutinizing all claims at every level. This creates a very high degree of inefficiency and redundancy, forcing managers and other senior personnel to waste managerial time by performing what are--essentially--clerical duties.

HEALTH INFORMATION IN GEORGIA

Like all financial institutions, insurers (including health insurers) depend on good information. Lack of such information is a serious problem in Georgia.

There was insufficient time during the assessment to determine the accuracy of public information in areas such as mortality, morbidity and so on; however, these are often a problem in developing countries, as governments are notoriously loathe to deliver bad news.

As mentioned, lack of widespread use of procedure (ICD) and treatment (PCPT) coding makes standardization and comparison of treatment virtually impossible, resulting in duplication, overlap, heightened possibility of provider fraud, and squandering of precious personnel resources.

Moreover lack of sharing of customer information between insurers renders impossible the detection of frauds such as double-claiming, excessive and self-generated claims, and misrepresentation of existing medical conditions and claims history.

The HSSP project is undertaking work in strengthening fraud detection and prevention in the insurance industry--a vital initiative if the industry is to develop appropriately.

The work to be performed by MDi will go a long way toward improving the accuracy, availability and sharing of health information within Georgia.

HEALTH INSURANCE MEDIATION IN GEORGIA

Neither the role and mandate of the Health Insurance Mediation Service nor the adequacy of the court system to handle insurance disputes was explored in detail. Based on experience in other post-Soviet countries, however, it is likely that the court system is incapable of resolving disputes in a timely and impartial manner.

The service has binding authority in respect of claims of GEL 1,000 (USD 600) or less, but no binding authority above that amount.

The staff consists of nine persons with medical backgrounds.

The service maintains a call centre and a webpage, through both of which consumers may register complaints.

On average, the service receives between 10 and 15 calls per day at its call centre. At the time of discussion, it had received 5,569 contacts, 71% of which were informational requests, with the remainder being complaints. All but 224 of the complaints were resolved during the mediation process.

On average, the mediation process takes approximately one month.

The service appears to have had some success in assisting policyholders, especially in respect of non-group insurance, where it has been successful in negotiating settlements for approximately 80% of claimants. The opposite is true in respect of group insurance complaints.

Most of the complaints relate to misunderstandings as to what is covered by the particular insurance contract, with many consumers still expecting the Soviet type of all-inclusive coverage. Another substantial area of complaint relates to dissatisfaction with treatment; however, the service has no authority to mediate disputes in this regard.

While the service was established to mediate insurer/policyholder complaints, it also provides some unofficial mediation services in respect of insurer/health services provider disputes. Several insurers felt that the mandate of the service should be formally broadened to address such disputes. During the assessment, information was received that the government of the ROG was considering this change. While this might help insurers and service providers resolve their disputes in a more expeditious manner, it might also lead to a weakening of focus on consumer complaints.

EFFECTS OF RECENT GOVERNMENT POLICY CHANGES

The government of the ROG recently announced that MAP policies will now be issued for a term of three years. On the positive side, this will allow insurers greater scope for planning, and will avoid the administrative burdens and expenses of yearly renewals. On the negative side it will interfere with consumers' choice of insurers and may lead to a decreased focus on customer service once the policy is written.

The government also recently announced that the MAP programme will now include certain basic drug benefits. In some quarters, this change may be seen primarily as a means to assist insurers in combating the challenge posed to their operations by Alpha insurance; irrespective, however, of motivation, the effect of this change will be a very positive one, as surveys have shown that many patients are unable to afford the drugs prescribed for them. For insurers, unless the MAP premium is increased, inclusion of the drug benefits will result in additional expenses and decreased profits. However, the industry seems to be generally of the view that the MAP product will remain profitable, even with this additional expense.

The government also recently announced that it will be the responsibility of insurers to ensure that the service providers with which they transact business meet appropriate standards. Placing on insurers the responsibility for ensuring that health service providers meet appropriate standards appears to be in line with the policy of the government of the ROG to shift responsibility in many areas toward the private sector and away from the government. This is reflected not only in the outsourcing of the provision of health care services to the private sector, but also in the decisions to revoke mandatory automobile third party liability requirements and to dismantle the Competition Agency.

At present, this requirement appears to apply only to physical standards of medical facilities. The government of the ROG has published some very basic standards to be met.

This new policy will result in insurers having to bring existing hospitals up to standards or to build new hospitals that meet the standards. The general view amongst insurers is that building new facilities is probably more cost-effective than attempting to upgrade old ones. In this regard, insurers have had some discussions amongst themselves concerning joint participation

in constructing such facilities, which would then be shared by the participants. Whether this is economically feasible--or whether insurers will be able to cooperate sufficiently to turn this idea into reality--remains to be seen.

Prescribing and enforcing standards for physical facilities without doing likewise with respect to doctors, nurses and other service providers will only address part of the problem. It is unclear what is planned or who is to be tasked with the responsibility of developing and enforcing standards in respect of other health care providers.

FINDINGS OF TRAINING NEEDS ASSESSMENT

A number of conclusions arose from the training needs assessment. These conclusions--and their possible implications--follow.

Quality of Current Insurance Operations

While the extent and quality of operations varied from insurer to insurer, overall the author was impressed by the organization and level of operating ability extant in the insurance industry, which was generally of a higher degree than had been observed in other developing markets.

Senior and middle level managers appeared to have a good grasp of basic operating principles, organizational needs, and their roles and responsibilities within the organization. In fact, this level of knowledge often resulted in senior and middle managers having a good sense of what they did not know and what further knowledge and training they required. This self-identification was also accompanied by a very real desire to improve and acquire further knowledge to enable them to do their jobs more efficiently and effectively.

Unreliability of Information

As previously indicated, current information sources are incomplete, due to lack of ICD and PCPT coding, the low level of information sharing within the insurance industry, and the possibility that public information--such as mortality, morbidity and so on--may be outdated or inaccurate. For instance, the most recent industry insurance premium data available was current only at 30 June 2009. Given the previous exponential growth in the publicly-subsidized portion of the insurance sector, this data may no longer be accurate.

In addition, information obtained during the assessment varied considerably from source to source, and was often anecdotal in nature. Wherever possible, this information was verified; however, much information had to be accepted at face value. A more detailed assessment may be required to ensure the accuracy of such information.

Empowerment of Mid-Level Managers and Other Staff

Several mid-level managers advised that they did not feel sufficiently trained to perform the functions expected of them.

They also felt that they were not sufficiently empowered to make decisions, but had to seek higher authority for routine approvals. Overall, the assessment supported the view that senior personnel of Georgian insurers are less willing to delegate responsibilities and authority than

would be the norm in developed markets. This could be the result of lack of understanding of proper management principles, lack of confidence in the abilities of staff, or--in some cases--lack of staff generally to whom functions may be delegated. These deficiencies could be addressed through education, training and internal reorganization and staffing.

By developed insurance industry standards, some senior personnel did spend an excessive amount of time on matters which would usually be delegated to lower levels of authority; however, this owed as much to the specific Georgian insurance environment as it did to failure to delegate. For instance, due to the lack of good coding and communications between insurers and health service providers, it is more necessary that billing be reviewed by more than one set of eyes. And in an environment where business is often awarded on the basis of personal contact, involvement by senior personnel in the sales process is more warranted than would be the case in developed countries.

Senior managers echoed the comments of their mid-level managers to the extent that they felt their mid-level managers were not accepting enough responsibility for making appropriate business decisions. It was difficult to gauge, however, whether this was due to inertia on the part of mid-level managers, or to a lack of a corporate environment which truly allowed and encouraged mid-level managers to make decisions. Without clear confirmation from senior personnel that mid-level personnel are authorized to make decisions, and without placing clear responsibility on mid-level personnel for the consequences of their decisions, it is unlikely that the current centralisation of authority at senior levels will change.

Existing Product Mix

Prior to the introduction of MAP insurance in 2008, Georgian health insurance consisted almost exclusively of group insurance sold to employers. Typically, employers provided this coverage as employee benefits, and bore all the premium costs. Health insurance was cross-sold, with leads being generated through the sale of other insurance products (such as property and liability insurance). Some employers offered more comprehensive plans, for which employees paid an additional premium. It has been estimated that the potential market for group sales is 900,000 persons; however, 600,000 persons are now covered, and it is likely that the larger and more easily-sold employers are now covered, leaving it open to question whether or not the remaining 300,000 employees represent a viable target for future expansion of private insurance (especially in light of current economic conditions).

Little individual health insurance is sold in the ROG, and--aside from group policies--there is little pooling of risk (and even these pools are too small to constitute a safe level of participants).

Individual insurance is not actively marketed, and is usually sold on a request basis--the opposite of the standard insurance industry maxim that "insurance is sold, not bought". Insurers fear (quite legitimately) that selling individual products on a demand basis would attract an inordinately high number of clients with significant health problems ("moral hazard" or "adverse selection").

One mechanism used in developed markets to address this concern is to require pre-policy medical examinations, to impose waiting periods for policy effectiveness or specific procedures, or to exclude certain procedures entirely. However, there is a general view that it is not in the Georgian psyche for even healthy prospective clients to submit to these procedures and limitations. Insurers also argue that the level of insurance knowledge in Georgia is too low to warrant marketing individual products. It is difficult to assess whether these views are accurate, or whether they are merely excuses or conventional wisdom which may prove inaccurate in the face of actual implementation and practice.

It would appear that the 70% of the population currently uninsured--if properly targeted--would yield a substantial and reliable pool of insureds. This population would seem to be an especially promising group, as it represents relatively higher income-earners (with the lower income-earners being already largely insured through the government-subsidized programmes).

Existing Dependence on Government-Subsidized Products

Schedule "C" indicates--on an insurer-by-insurer basis-- gross industry premiums written, gross health insurance premiums written, market share per insurer, health market share per insurer, health insurance as a percentage of total business written, and publicly-subsidized health insurance as a percentage of total business written.

Schedule "D" compares gross health insurance premiums written, by type of insurance.

Of the 13 insurers in existence on 30 June 2009, two wrote no health insurance. Of the 11 insurers writing health insurance, nine depended upon it for more than one-half of their gross premium income from all lines of insurance (that is, health, property and casualty, and life), with the average dependency rate being 72.6%. Two of these nine insurers depended upon health insurance for virtually all (98.5% and 99.1%) of their gross premium income from all lines of insurance.

Several insurers were formed solely for the purpose of writing government-subsidized health insurance. One insurer indicated that it had acquired 12,000 MAP policyholders before it even had office premises or any equipment.

Overall, publicly-funded or subsidized health insurance accounts for 78% of all health insurance premium income, leaving just 22% of health insurance premium income generated by market-driven private insurance. Even this 22% is partially subsidized by the government of the ROG under its "cheap insurance" program.

As indicated, prior to the explosive growth of MAP and other government-subsidized insurance programmes, group insurance represented almost all of the premium income. Group insurance now represents only 21.6% of all health insurance premium income, and at least one insurer has made a conscious decision to abandon further growth in this area in favour of more concentration on the government-subsidized products.

Since the introduction of MAP insurance in 2008, it has become the pre-eminent product, representing 49.2% of all health insurance premium income.

With the introduction of MAP and other publicly-subsidized insurance products, Georgian insurers have ceased to be insurers in the classical sense of pro-active selling and pooling of risk, and have largely become "voucher chasers", competitive not in respect of new products and markets, but only in respect of securing pre-sold, subsidized business. They have shifted from creating product to administering product created by the government of the ROG.

While an additional 173,000 citizens are to be included in the MAP programme during the current enrolment period, it is estimated that 150,000 citizens currently enrolled in the program will no longer be included in the programme, as they no longer fall below the needs threshold. Accordingly, it appears that--barring structural changes to eligibility requirements--the market for the MAP programme is relatively saturated, and will increase or decrease only with general economic conditions.

Almost all recent industry growth relates to the MAP and other government-subsidized programmes. This is worrisome for the health insurance industry--and, indeed, the insurance industry generally--for a number of reasons.

First, it represents a dangerous concentration of business focus on products which are entirely dependent upon continuation of existing government policy. Without a proper diversification of risk on product, economic, industry and geographic bases, insurers are at a high degree of risk of institutional failure. This would have consequences far beyond the financial health of insurers--it would lead to default on insurance contracts and would put pressure on the government of the ROG to make good on the defaults.

Second, healthy growth of an insurance industry depends upon growth of the voluntary sector, not the mandatory or subsidized sector. Again, in a healthy insurance environment, products are sold, not bought. Where the insurance sector is able to make "easy money" from the public purse, it has little motivation to pursue more complex and difficult opportunities in the open market. Where it is able to purchase business through the government voucher system rather than developing, promoting, selling and servicing products in the private sector, it has little incentive to pursue the latter course. Where it can sell its products without engaging and training a proper network of qualified and informed agents, it will do so.

Third, even if insurers wish to develop health insurance products beyond those currently subsidized by the government, it is virtually impossible to develop unsubsidized products that are able to compete--at least with respect to price--with subsidized products.

Fourth, where publicly-subsidized insurance is sold at a pre-determined (albeit negotiated) price, there is little incentive for insurers to develop the infrastructure (such as actuarial, pricing and underwriting expertise and information systems) that is essential to the future development of the industry.

Fifth, because government policy in the health insurance area is not always as fully developed as one could hope--and, as previously indicated, is subject to abrupt and significant change--

reliance on publicly-subsidized products negatively impacts the willingness of insurers to focus on long-term product and market development.

And sixth, where insurers are dependent for their existence on publicly-subsidized products, they are also held hostage to government policy, which may not always coincide with market and economic principles. For instance, in some jurisdictions, the government mandates that a stated percentage of insurance business must be conducted in specific regions. This results in market distortions such as the creation of artificial and underpriced policies to meet political requirements.

It is clear that--while insurers are legally private sector entities--their strategies are currently driven by public subsidization rather than by market mechanisms.

Product Pricing and Underwriting

In developed countries, pricing is usually actuarially determined and underwriting is based on individual risk factors, such as age, lifestyle, and so on. With respect to group insurance, the employer itself is underwritten, rather than individual employees. As a result, underwriting is less specific in respect of group plans, and depends more upon plan experience, industry experience, and so on.

In developing countries, where the necessary pricing information often does not exist, the international experience--adjusted to the extent possible to reflect country peculiarities--is often used to approximate actuarial pricing.

Where substantial amounts of insurance are reinsured outside the country, reinsurers often set--or at least greatly influence--product pricing. This provides at least some form of rationale upon which a sustainable premium may be based.

Another pricing technique--especially for new insurers in an existing market--is to copy the pricing structure of competitors. This practice is, however, fraught with danger, as there is no certainty that competitors have properly priced their products, and their client bases may possess different characteristics, leading to different risk levels.

In the absence of any appropriate benchmark, insurers tend to err on the side of caution, setting higher-than-necessary premium rates.

In the absence of appropriate pricing, several dangers exist. Firstly, if the premium is too low to be sustainable, it will result in losses, and may lead to the insolvency of the insurer. It may also lead to insurers trying to keep costs low by improper means, such as denying coverage and valid claims. Secondly, if the premium is too high, insurers will be unfairly enriched and consumers will be overcharged. Lastly, those insurers with sufficient capital may be able to squeeze competitors out of the market through predatory pricing.

The most significant health insurance product in Georgia is the publicly-subsidized MAP program. The services covered and the premium to be charged are set by the government of the ROG, after consultation with the insurance industry. Insurers indicated that they are

satisfied with the current premium of GEL 15 (UASD 9) per month, even with the recent addition of a limited drug benefit. The actuary at one insurer indicated that he felt the premium was a bit high prior to the addition of the drug benefit, but that it was now appropriate.

Because premiums for the publicly-subsidized insurance products are set by the government of the ROG, and there is no rating of risk within the insured population, the question of the manner in which insurers price their products is largely irrelevant in respect of such products. However, how pricing is determined and how products are underwritten remains relevant for the 22% of the health insurance market that is not publicly-subsidized, and is vital for the creation and expansion of future unsubsidized products.

In Georgia, it appears that non-subsidized products do not follow the usual actuarial and underwriting principles in respect of health insurance or any other form of insurance. Anecdotal evidence indicates that--while group business is often bid upon in an apparently open competition--personal contact and unofficial fees often determine the successful bidder.

There are few actuaries in Georgia, and even the most pre-eminent amongst them admitted that he was not sure he was pricing his products properly (due largely to non-exposure to the comprehensive actuarial training and information inadequacies and asymmetry).

Several underwriting managers indicated that they would benefit from additional training in underwriting.

While it is difficult to determine whether or not products are properly priced or underwritten in Georgia, in view of the high proportion of publicly-subsidized products, it is not currently as large an issue as it might be in other countries; however, if the insurance industry is to grow beyond its current focus on subsidized products, the issues of appropriate pricing and underwriting will have to be addressed.

Claims Management

In August 2009, USAID's Co-Reform Project conducted an assessment of the claims management process in Georgia, resulting in the publication of a document entitled *Health Insurance Claims Training Needs Assessment* (see Schedule "E"). This document assessed the claims management process in detail, and resulted in the following recommendations:

1. Delay the development of a comprehensive training program in claims management until the claims management process is streamlined. Under the conditions of high uncertainty about the future and the split of the responsibility for the performance of the claims management function among different staff members, a comprehensive program will be difficult to develop and will not serve its purpose successfully.
2. Identify tasks within the claims management function that share similarities at most insurers in Georgia and require skills and knowledge that is not readily available and is difficult to teach on the job. Engage as a health insurance industry in a dialogue with potential good training providers to incentivize them to develop and deliver quality trainings in these areas.

3. Conduct an assessment of the HR development needs of health insurance companies and quantify, qualify and prioritize the needs of trainings including the preparedness of companies to pay for outside trainings. Aggregate the results of the assessment across the entire industry and communicate them to all potential training providers.
4. Pursue at an industry level the streamlining of claims management processes by agreeing on criteria for determining medical necessity and a standard classification of medical interventions.
5. Once the claims management process is streamlined explore the possibility to induce the owner of a reputable Western professional training and certification program in claims management to adapt the program for Georgia.
6. While the uncertainties related to claims management training are high, training institutions in Georgia developing programs for the health insurance industry can focus on developing training programs in other areas of high priority for the industry such as the formation of cost – costing tools and methods and providers and insurers pricing strategies.

In view of the existence of the Co-Reform assessment, the Georgian claims management process was not reviewed extensively during the current assessment; however, the findings of the current assessment support the findings of the Co-Reform assessment in all major respects, and the recommendations which may be proceeded upon should be considered in the near future.

Adequacy of Distribution Systems

In developed markets, insurance is generally sold through a system of company employees or agents (either exclusive or non-exclusive), or through direct sales, such as direct mail or the internet. Agents are generally required to be licensed and to know the insurer's products in detail. They are also subject to knowledge requirements (including continuing education requirements) and are required to abide by proper market conduct practices and "know your client" rules.

In view of the fact that little individual insurance is sold beyond the publicly-subsidized insurance programmes, the assessment did not focus on agents' qualifications, training and practices. It appears, however, that there are no licensing, proficiency, education or training requirements for insurance agents in Georgia.

MAP insurance (the largest single type of health insurance) is not sold through a traditional agency system--licensed or unlicensed; rather, insurers engage doctors and others having influence in the local community (such as Abkhazian refugees) to act for them in obtaining MAP business. These surrogate agents have neither the scope of activity nor the authority to act as traditional sales agents; rather, their role is restricted to acquiring MAP vouchers for the insurers they represent.

This practice has negative implications in respect of after sales servicing of the MAP product.

Moreover, the failure to require licensing, proficiency, education or training requirements for insurance agents raises several additional concerns.

First, such agents may not have sufficient knowledge of the product or products they are selling. Anecdotal evidence confirms that insurance agents are not well versed in the attributes of the products they are selling, and are unable to respond to questions from potential clients. The ability to provide good consumer information is especially important in a country such as Georgia, where a very low level of insurance knowledge and a very great need for good information to support informed choices exists amongst the population,.

Second, the possibility of accidental misstatement is greatly increased by use of an uneducated sales force.

Third, policyholders may be sold policies that are not appropriate to their needs or financial capabilities.

And fourth, where agents have no licenses to lose, they are less constrained in using illegal practices such as deliberate misrepresentation and pressure selling.

Recent information indicates that the government of the ROG is considering prohibiting the practice of using doctors as insurance agents. While this would be a positive step in regularization of agency qualifications, it could have serious implications for distribution of the MAP product, given the underdeveloped state of insurance agency in Georgia.

Regulation of the Insurance Industry

Insurance regulation and supervision falls within the purview of the Insurance Division of the National Bank of the Republic of Georgia. To date, regulation and supervision of insurers has focused primarily on the prudential side, with virtually no oversight on the market conduct (that is, consumer protection) side. Moreover, even on the prudential side, regulation and supervision is very underdeveloped. Very little--if any--regulation is addressed specifically to health insurance activities.

As a result, consumers may be subject to practices (such as unlimited pre-existing condition exclusions, sharp sales practices, no "cooling off" period, and so on) that would not be allowed in developed countries.

International standards require that no insurer be allowed to engage in both life insurance (which generally includes health insurance) and non-life insurance. Georgian insurers are not required to abide by this standard--a license to engage in insurance activities authorizes an insurer to engage in any and all types of insurance. Moreover, the minimum capital level is substantially less than USD 1 million, which is very low by international standards.

The Insurance Supervision Division indicated that it intends to strengthen its role in both the prudential and the market conduct areas; however, it appears that any such strengthening is not likely to occur in the near future. Nevertheless, to ensure that any such regulation is not

developed in a practical vacuum, insurers will have to take a greater interest and participate fully in the development of any regulatory norms.

Infrastructure Limitations

Irrespective of identified training needs, training will be of limited use if it is thwarted by limitations in supporting infrastructure (for instance, training in actuarial techniques and calculations will be of limited value if the accurate and comprehensive information necessary for actuarial calculations is not available). In this regard, in Georgia there are several serious deficiencies in the infrastructure necessary to support the development of the health insurance industry, several of which have been alluded to previously. Foremost amongst these (not necessarily in order of importance) are:

Internal

1. Inadequacy of claims management capacity and procedures

   These inadequacies are more particularly described in the Co-Reform document entitled *Health Insurance Claims Training Needs Assessment* (see Schedule "E").

   The conclusion of that assessment was that--while some degree of training may be of value at this time--it is premature to attempt to deliver comprehensive training, pending standardization of practices and procedures.

2. Inadequacy of underwriting knowledge and abilities

   While many insurers had reasonably well-developed underwriting practices, others did not. Moreover, even those insurers with well-developed practices self-identified the need for further training in this area.

3. Lack of necessary software

   Software solutions are absolutely vital to the proper functioning of health insurers, as health insurance generates many more claims than other types of insurance, and results in greater administrative burden.

   Specialised operational, decisional, MIS and expert systems software is available

   Such software assists in the processing of standard claims and procedures, leading to fewer errors and efficiency gains.

4. Underdeveloped customer service standards and skills

   Insurers lack a consumer service focus at all levels within the organization.

Call centre operations focus primarily on general information and pre-approvals for medical procedures.

Customers often have to wait for long periods of time to access call centre facilities.

The call centre personnel observed had a low level of consumer relations and negotiation skills. Indeed, many personnel were not capable of--nor were they expected to--attempt to calm customer dissatisfaction or resolve disputes.

Many disputes are automatically redirected to the mediation facility without meaningful attempts to resolve them at the insurer level.

The use of unskilled and untrained agents (such as in respect of sale of MAP insurance) has negative implications for customer service.

5. Deficiencies in internal communication/coordination/cooperation

Discussions with some insurers revealed a "silo mentality" (that is, a lack of interdepartmental knowledge and sharing of information), and a lack of awareness of the insurer's goals and operations in other areas.

Senior managers sometimes focus on smaller details (although, as noted, this may be more warranted in Georgia than in some other countries due to lack of standardization and billing practices).

External

6. Lack of actuarial knowledge

Actuaries are essential to the operations of insurers, as they are experts at assessing risk, pricing products, confirming the adequacy of reserves, and predicting future trends.

Development of proper actuarial skill has been accorded high priority in many developing countries.

In developed countries (and pursuant to EU requirements), engagement by insurers of qualified actuaries is mandated by law. There is no such requirement in Georgia--some insurers maintain actuaries on staff, while others do not.

Some Georgian insurers use actuaries at various levels of their operations (such as pricing, product development, product review and assessment, and so on), while others restrict their use to product pricing.

At present, the Georgian Actuarial Association consists of 10 members. It has no official status and no legal authority to regulate or discipline members or to prevent others from claiming to be actuaries. The head of the association is the actuary at one of the insurers, and is seen throughout Georgia to be the best actuary in Georgia; however, even he expressed the need for further training. He also expressed the view that only two or three of the members of the Actuarial Association could be considered actuaries in a comprehensive sense, with the remaining members being highly skilled mathematicians.

7. Low consumer knowledge of and interest in insurance

   Insurance is sold, not bought; however, consumers must still understand the basics of insurance and see a need for the product.

   The responsibility for educating consumers in the need for and types of insurance should be shared between the government and the insurance industry.

8. Insufficiency or unreliability of information

   As previously indicated, current information sources are incomplete, due to lack of standards and standardized application of ICD and PCPT coding.

   In addition to knowledge gaps caused by outright lack of information, lack of standardization in diagnostic and treatment identification of coding results in insurance personnel having to interpret and double-check billings from health service providers, detracting from their abilities to devote themselves to more mainstream and profitable health insurance activities.

   The low level of information sharing within the insurance industry inhibits proper pricing and fraud prevention.

   The possibility exists that public information on mortality, morbidity and so on--the accuracy of which is essential to proper insurance operation--may be outdated or inaccurate.

9. Lack of proper provider standards

   From both a reputational and a customer loyalty perspective, insurers have a vested interest in ensuring that patients are satisfied with the services provided by health care providers.

   Without proper provider standards, insurers are unable to assume that only necessary treatment is provided, or that it is provided competently, so as to minimize future claims.

10. Lack of proper accounting and auditing standards

    Georgian accounting standards do not comply with IFRS, making comparison of operations and results difficult, and hampering proper regulation and supervision.

    As there is currently no requirement in Georgia mandating the use by insurers of only approved auditors, the scope and quality of audit oversight cannot be relied upon.

RESULTS OF ASSESSMENT OF CURRENT TRAINING OPPORTUNITES, CURRICULUM AND FACULTY

With respect to the comprehensiveness and sufficiency of current training opportunities, discussions revealed that few insurers identified staff training needs or developed targeted training programmes for their staff, and even fewer provided any in-house training. Those that did offer some support for training depended primarily upon employee self-selection and motivation in identifying appropriate training opportunities. As a rule, such support did not extend to training during business hours, with insurers restricting their assistance to paying or subsidizing the costs of the training.

A number of educational institutions and institutes were also canvassed to determine the availability and quality of relevant programmes and courses offered to the insurance industry. These discussions revealed the existence of a number of insurance-related educational and professional development courses and training in Georgia, which are summarized on Schedule "F".

During the assessment, the GIA and most insurers expressed their dissatisfaction with the quality of the insurance-specific training currently available, both with respect to the content (which they found to be too general and academic, and not sufficiently targeted on skills development), and with respect to the lecturers (who were generally seen to lack practical insurance experience and--in some cases--teaching ability).

This mindset tends to minimize the value of extensive review and comment on local training opportunities.

As a result the current assessment focused more on training *needs* and their *solutions* than it did on *local training opportunities*.

Nevertheless, training offerings currently available to Georgian insurers were reviewed to test the validity of industry perceptions and to determine possible areas for improvement in scope, content or delivery of current training offerings. It is to be noted, however, that--due to lack of translation and time limitations--only the course outlines and syllabi were reviewed. As a result, the sufficiency of the underlying course materials was not assessed, and recommendations are restricted to omission in topic areas rather than sufficiency of the course materials themselves.

As mentioned, only the University of Georgia and the Caucasus School of Business offered any substantive training programmes and courses. Such training consisted of a mix of short-term courses (see Schedule "G") and longer-term training (see Schedule "H").

The review of these trainings resulted in the following conclusions :

Current Training Opportunities

1. As previously indicated, local training opportunities and providers are not generally well regarded by insurers

   Insurers want a more practical and less academic approach to training.

   Insurers want targeted skills development courses, rather than overviews and general training.

   Insurers see the need for longer-term training to develop skills, rather than short-term training to fill gaps.

   Insurers want training that addresses Georgian realities, rather than exposure to materials that have more relevance in a developed country setting.

   Insurers want training provided by trainers who are seasoned insurance practitioners.

2. Previous training efforts through universities and other providers have suffered from a lack of industry interest

   There is a perception within the insurance industry that such training is substandard or irrelevant due to inappropriate focus, insufficiency of materials or inadequacy of trainers.

   There is a perception within the insurance industry that trainers are not sufficiently experienced in the practical aspects of insurance.

   It appears that training is often developed without proper consultation with the insurance industry, thus failing to address its real needs.

   Managers of insurers expressed difficulty in balancing the operational training needs of the insurer with the time required for training.

   Overall, the assessment confirmed the validity of industry perceptions in this regard; however, it is also possible that the management of insurers may lack commitment to training and may not see the benefits of training as warranting the costs involved.

3. Seasoned practitioners are not currently available in Georgia

Currently, local training focuses more on an academic approach and broad foundation

In this regard, the assessment indicated that the perception of the industry appears to be warranted.

4. More training is required in technical/professional areas, such as actuarial science and underwriting, which will require longer-term training.

   The assessment revealed that--while some of the deficiencies identified may benefit from relatively-short term training--many can only be addressed properly by long-term training.

   This validates the perception expressed by the GIA and the insurance industry that many training needs require long term training.

5. Few seasoned insurance practitioners with broad insurance experience and familiarity with international standards speak Georgian, and few insurance materials are available in Georgian.

   The GIA believes strongly that--to be effective--training must generally be delivered in Georgian.

   The need to provide training in Georgian would hinder the ability to provide broad and comprehensive training, and would make development of training materials and delivery of training more difficult and expensive.

   Due to the lack of local expertise and the extensive use of English in the financial community, there may be little alternative to delivering most trainings in English. This may, however, not be as much of a problem as feared, as the assessment revealed a reasonably high level of English ability at management levels in many insurers.

Current Curriculum

As indicated, due to lack of translation and time limitations, only the course outlines and syllabi have been reviewed. The underlying course materials were not available; accordingly, their sufficiency could not be assessed.

It appears that the insurance industry has a deep-seated bias against the usefulness and calibre of existing local training courses, materials and lecturers, and may not be at all receptive to local training offerings despite whatever improvements may be made. Given this antipathy, improvements to local training offerings may prove to be of less benefit than one could hope.

In developing training, it is important to keep in mind not only the training *needs*--it is at least as important to identify the training *possibilities*. That is, training must take into account other factors, such as the current level of knowledge, the ability to acquire practical experience to supplement the training, the state of infrastructure (such as access to materials in the local language, access to PCs, etc.), and the ability of insurers to part with their staff for extended periods of time.

A review of current training opportunities lead to the conclusion that they were developed--both at the short-term level and at the longer-term level-- from the supply side, rather than from the demand side.

The longer-term training (Schedule "H")--developed as it was in cooperation with US universities--is very comprehensive, and covers all the areas one would expect in an academic training in developed countries. There is little that could be added to the topics covered.

This very comprehensiveness, however, is not appropriate for the Georgian environment, which is at a much less advanced stage of insurance market development than the US. In fact, this comprehensiveness and breadth of scope may be counter-productive, leading as it does to a perception by the industry that it is too academic and too general. It may be an attempt to do "too much too soon", thereby creating an atmosphere of information overload and fear of failure.

It is essential in the training process that training be targeted at skill areas which are relevant to students.

The topics covered in the longer-term training are too comprehensive and are not targeted to any particular skill need--or even any specific area of insurance activity. In this sense, they represent an overview (albeit a very detailed one) of all aspects relevant to the insurance industry.

It is this generality in approach and coverage to which the Georgian insurers take exception. Insurers have to be able to see a clear match between the specific responsibilities and skill sets of the staff which they send to training, in order to determine the appropriate staff to send. They are not likely to enrol their employees in training programs in which only a portion of the training is applicable to their day-to-day duties. This is especially true where staff levels are relatively low and the training programme requires full time attendance for two out of every four weeks over a period of five months.

Some of the topics (such as those relating to Medicare and Medicaid, accreditation, pharmaceutical policy and economic theory) are of limited relevance and interest in the current Georgian environment. Insurers want training that can help them now, not training to inform on possible future directions. That said, there is scope in developing countries for training that educates as to alternate possibilities and that challenges students to stretch beyond current realities. This, however, requires the walking of a thin line between stretching and breaking. The current longer-term training fails this test.

It is also essential that skills first be mastered at basic levels in a limited number of important areas. The skills levels and the number of areas addressed may then be increased over time. This provides students with skills which they can quickly use during their daily activities, enforcing the utility of what they are learning. It also ensures that students feel successful--rather than overwhelmed--giving them the confidence and motivation to engage in broader and more advanced training.

Given insurers' limited and specific needs--and the current industry distaste for overview and academic training--shorter-term training (Schedule "G") offers greater opportunity for success in Georgia. Even here, however, the four courses offered suffer from a similar lack of focus. Content is often broad and theoretical. In some cases, portions of the training (such as epidemiology, pharmaceutical and hospital marketing, etc.) are only marginally--if at all--relevant to specific responsibilities within health insurers or even to health insurance generally.

Shorter-term training is warranted and would be much more effective if it consisted of many discrete-but-focused trainings, rather than a fewer number of trainings which are too broad.

In discussions with the training providers, it became apparent that much of the training--both short-term and longer-term--was developed without sufficient feedback from the industry, sometimes based on study by local faculty of materials from particular jurisdictions. This is a poor substitute for training developed by those with practical experience or training based on the best practices of a variety of jurisdictions.

RECOMMENDATIONS FOR TRAINING

As indicated, while the level of insurance operations is generally fairly good, some insurers are better organized and managed than others. Because organizational and training needs vary from insurer to insurer, identifying training that would benefit the industry generally is a bit problematic. For instance, some use considerable actuarial expertise in developing and pricing products, while others do not have this ability. Some insurers have well-defined underwriting procedures, while the underwriting process is less precise in others.

Because the main thrust of the training needs assessment is related to capacity-building across the insurance industry, the training recommendations that follow focus on trainings that have maximum applicability and impact across the insurance industry, rather than trainings which are directed towards the needs of individual insurers. The specific components of such omnibus training recommendations will be of more or less interest to particular insurers depending upon their degree of knowledge, competence and organization in such areas; however, all insurers will be able to gain some benefit from other areas of the training.

The table which follows lists the major areas in which insurers' skills and knowledge were found to be deficient, and which could be improved through training. These areas are divided into four categories:

1. *General Skills* (that is, not necessarily restricted to health insurance or even insurance generally).

2. *Insurance Specific Skills* (that is, restricted to insurance generally, but not necessarily restricted to health insurance).
3. *Health Insurance Specific Skills* (that is, restricted to health insurance).
4. *Longer Term Professional Development Training.*

The first three categories could benefit from relatively short-term training (although, as indicated, some of the specific deficiencies within the categories--such as underwriting--could also benefit from longer-term training).

The fourth category would benefit little from short-term training, and is identified as an area of possibility for longer-term training.

GENERAL SKILLS	**INSURANCE SPECIFIC SKILLS**
- **General Management** (performance management, time management, delegation, employee motivation, staff feedback, goal setting, monitoring and evaluation) - **Customer Service/Relations/Complaints Handling and Resolution** (problem areas, service excellence, communications, dealing with clients, managing customer expectations, creating customer loyalty)	- **Insurance Sales/Marketing/Consumer Education** - **Insurance Ethics** - **Insurance Risk Management** (general, across all operational areas) - **Insurance Pricing** - **Insurance Underwriting** - **Legal** (understanding and interpretation of contractual provisions, regulatory compliance, future of regulatory initiatives)
HEALTH INSURANCE SPECIFIC SKILLS	**LONGER-TERM TARGETED PROFESSIONAL DEVELOPMENT TRAINING AND EDUCATION**
- **Overview of Health Insurance Operations** - **Underwriting Health Insurance** - **Actuarial Management of Health Insurance** - **Introduction to Health Insurance Information Technologies** (software--types, uses) - **ICD/PCPT Coding**	- **Actuarial Training** - **Underwriting** - **Claims Management** - **International Financial Reporting Standards (IFRS)**

Based on USAID's project goals, the identified skills and knowledge gaps, and the identification of specific skills and knowledge areas that could benefit from training, it is recommended that one seminar and two related short-term training initiatives be developed and delivered. These courses would address several of the identified skills and knowledge gaps (as highlighted on the above table) without rendering the training unfocussed or too broad, and would ensure sustainability through training of trainers within each insurer.

Consideration should also be given to developing and delivering some or all of the long-term training and education identified in the preceding table. In particular, given the importance of proper actuarial work as an underpinning of the concept of insurance and its operations, and the current lack of any formal actuarial training in Georgia, it is recommended that thought be given to developing and delivering a program of Actuarial Training.

Recommended Seminar

Active Leadership and Management

- Senior executives must engage in active leadership of their organisations. This involves a combination of skills, including
  - Clear vision and purpose
  - Willingness to accept, embrace and profit from change
  - Well-developed strategic and communications skills
  - The ability to motivate, inspire and empower staff, through example, diplomacy, effective delegation, staff recognition and conflict resolution

- The proper role of senior management is a longer-term focus on development of the organisation 's business. This involves both external and internal measures. Active leadership is one of the principal means of ensuring that this role is not hampered by unnecessary internal focus on short-term objectives or operational matters.

- This one or two day seminar for senior executives would focus on emphasizing the importance of active leadership and staff empowerment, and its benefits to executives and their organisations.

- It would also serve to "ramp up" the commitment of senior executives to the two proposed short-term training initiatives, both of which depend upon the commitment of senior executives and their abilities to convey this commitment to the participants.

- It is vital that the seminar be seen by senior executives to be both valuable and of a high quality. Given the current attitudes by senior management to the quality of local training, it is suggested that this training be conducted by a foreign trainer with considerable executive experience in the insurance industry.

- The objectives of the seminar would be to improve long-term business results by

- Focusing on growth strategies
- Meeting the needs of team members through proven communication techniques
- Anticipating and resolving conflict situations
- Increasing dialogue and constructive feedback for optimum managerial effectiveness
- Using appropriate delegation to increase efficiency and ensure staff performance

- Suggested topic areas would include
  - Effective Strategic Leadership: Ideas for Growth
    - Building client relationships through customer service
    - Responding to customer needs
    - Developing products that work for your customers
  - Effective Organisational Leadership: Promotion of Efficiency
    - Fundamental concepts of leadership
    - Models of effective leadership
    - Enhancing productivity by
    - Championing initiatives
    - Building effective teams
    - Motivating staff
    - Increasing staff morale and job satisfaction
    - Mentoring staff and coaching for performance

Recommended Short Term Training

Building Customer Relations by Enhancing Customer Service

- Customer service in a health insurance setting has a unique set of challenges specific to providing first-rate service and customer satisfaction. Issues such as customer privacy, high volume of customer interaction, and giving and receiving accurate information must be handled with care.

- This training course would introduce participants to both the basics of customer service and building customer relations, and the specifics of providing it in a healthcare setting. Specifically, it would:
  - Differentiate healthcare customer service from other types of service interactions
  - Stress the benefits of providing good customer service to both internal and external customers and how this impacts the insurer
  - Identify barriers to providing high quality customer service
  - Apply techniques for dealing with customers
  - Highlight the importance of a positive and appropriate attitude in delivering good customer service
  - Demonstrate how to successfully request personal information
  - Describe the use of appropriate customer communications—tone, clarity, politeness
  - Develop an action plan to improve customer service skills

- Suggested topics would include:
  - Why health insurance customer service is different
  - What is service excellence (and where it starts)
  - Identification and resolution of problems in customer service in the health insurance sector
  - Standardization of customer service
  - Communicating to build relations - active listening
  - Dealing with difficult clients
  - Problem solving
  - Managing customer expectations
  - Creating customer loyalty

- The results of the training would be:
  - Staff awareness of the importance of customer relations
  - Staff capacity to build customer relations
  - More efficient management of inquiries, complaints, and claims
  - Reducing the degree of senior managerial oversight required
  - Increased customer loyalty
  - Nationwide standardization of customer service
  - Sustainability of training through the training of trainers within each insurer

Strategic Product Development

- Health insurance product development is a dynamic process that involves many functions within a health insurer to ensure that new products meet customer requirements, are manageable for the insurer, and can be sold effectively and efficiently.

- This training would strengthen the realization that an integrated approach is critical. It would also develop a foundation for the product development process, and would explain and highlight the roles different divisions and their personnel play in the process. During the course, company teams would learn how to capture information that will inform the insurer about customers needs, and how to design, price, market, sell, administer, evaluate and refine the product.

- This training would involve several participants from each insurer representing diverse operational areas such as senior management, actuarial, underwriting, marketing, sales, and claims management. Groups would work in teams to appreciate the integrated nature of product development, resulting in positive changes in efficiencies and existing and future operations.

- The outcome of the training would be to design a new product—including its pricing, marketing, sales and administration—through the following activities:

- Describing the product development process, product life cycle, and the importance of health insurance in meeting the health needs of the population
- Stressing the need for a strategic approach to designing a new health insurance product
- Highlighting the importance of using an integrated and cross cutting approach in product development
- Highlighting the importance of periodic review of products for addition of value
- Explaining the roles and responsibilities of different players in the development process
- Understanding the importance of interdisciplinary team work and how to work as a team member and team leader
- Working in company teams to design a product through the complete process from needs identification to market delivery and administration

- Suggested topic areas would include:
  - How health insurers meet the needs of their clients
  - The integrated product development process
  - Determining customer needs
  - Designing product
  - Developing product specification
  - Pricing on an actuarially-justified basis
  - Principles and practice of underwriting
  - Sales and marketing practices and techniques
  - Pilot testing and implementation
  - Product evaluation
  - Final roll out
  - Product administration
  - Ongoing evaluation and improvement

- The results of the training would be:
  - Increased ability to develop new products quickly to take advantage of niche areas and market and other changes
  - Skills strengthening in integrated product development
  - Increased team work and shared values within the organization
  - Better understanding of what functional areas do within the organization
  - Sales staff better able to sell and service products due to increased understanding
  - Efficient administration and review of the product
  - Products that better meet the needs of the customer

NEXT STEPS

To address the deficiencies revealed by the training needs assessment and the training opportunities assessment, it is necessary to:

1. Develop the course descriptions and outlines for the proposed trainings.

2. Submit the descriptions and course outlines to the GIA for its review and comment.
3. Finalize and agree with the GIA the final descriptions and course outlines.
4. Develop the proposed courses.
5. Secure training resources for the proposed courses.
6. Deliver the proposed courses.

SCHEDULE 'A': CONTACTS WITH INSURANCE INDUSTRY PARTICIPANTS

Organization	Person	Title
Imedi L	Alexandr Lordkipanidze	General Director
	Ketevan Katamashvili	Medical Claims Manager
	Maia Mazmishvili	Head, Human Resources
	David Ramishvili	Head, Finance
Alpha	Eduard Tskhovrebadze	Chief Executive Officer
Archimedes	Nika Ramisvili	General Director
	Rusudan Laguilava	Head of Operations/Claims
Aldagi BCI	Nika Gamkrelidze	General Director
	Guram Mirzashvili	Director/Chief Actuary - Department of Actuarial Research, Controlling, and Personal Lines
	Tamar Gotsadze	Deputy General Director, Medical Division
	Dea Chkhaidze	Head of Personnel Management Division
	Irakli Gogia	Deputy General Director - Finance and Operations
	Nutsa Koguashvili	Deputy General Director - Retail and Marketing
Vesti	Aleksandre Chitanava	General Director
	Avtandil Avlokhashvili	Director
GPI	Nino	Human Resources
	Sophie Gastashvili	Medical Insurance Director
Georgian Insurance Association	Devi Khechinashvili	Head of Association
National Bank of Georgia	Manana Tsitsishvili	Head of Insurance Supervisory Department
Georgian Hospital Association	Mikheil (Misha) Doliadze	Medical Deputy General Director - Acad O. Gudushauri National Medical Center
	David Pruidze	Director, Tbilisi State Medical University Children's Hospital
Health Insurance Mediation	Archil Tsertcvadze	Head of Service - Mediator

Service		
Ministry of Health	Kakha Kheladze	Head of Public Health and Health Program Division
	Eka Paatashvili	Head of Public Health and Health Program Regulatory Division
Curatio Family Clinic	Beso	Head of Clinic
Family Medicine Health Centre - Retraining Programme	Focus group for 25+ rural ambulatory doctors. being retrained as family doctors	
Saguramo	Maia Muzashvili	Physician, rural ambulatory
	Manana Japaridze	Physician, rural ambulatory
University of Georgia, School of Public Health	Tamar Lobjanidze	Director, School of Public Health
	Otar Vasadze	Head of Health Management Department
Caucasus School of Business	Akaki Kheladze	Director of Graduate Studies
	Levan Gogokadze	
Tbilisi State University of Economic Relations	Avandil Chutlashvili	The Rector
	Giorgi Gaganidze	Head of Quality Insurance
Partners for Health	Zviad Kirtava	Chairman
Free University of Georgia	Vkhtang Megrelishvili	Research Center Director
	Marina Karchava	Vice Rector
Georgia Insurance Institute	George Gigolashvili	
USAID	Anne Patterson	Director, Office of Health & Social Development
	George Khechinashvili	Program Management Specialist, Office of Health & Social Development

SCHEDULE "B": INTERVIEW GUIDE

GENERAL

Industry Information

- Please provide a list of all insurers.
- Please indicate which insurers write medical insurance.
- Did any authorized insurers decide not to write MAP and/or CI?
  - If so, why?
- Have any foreign insurers considered entering the Georgian health insurance market?
  - If so, with what results?
- Please provide general information on the industry.
  - Total number of insurers?
    - Change over last five years (consolidation, new insurers)?
  - Total premium income by insurer?
    - Change over last five years?
  - Total medical premium income by insurer?
  - Broken down by medical, disability, critical care and long term care, if possible.
    - Change over last five years?
- Are medical insurers restricted to medical insurance, or do some also write other business?
- Are all insurers which are authorized to engage in medical insurance required to participate in the basic plan?
  - If they choose or are required to participate, are they allowed to refuse applicants?
    - If so, on what grounds?
- Are insurers allowed to charge more or lower the coverage based on risk-rating (e.g. health record, smokers, etc)?
  - Do they in fact consider and rate these factors?
- Do insurers reinsure medical insurance?
  - If so:
    - With whom?
    - What percentage:
      - Risk
      - Premium
- How are claims paid:
  - Direct to provider?
  - Reimbursement to patients?
    - If so, by electronic means and/or cash?
- Do insurers generally pay claims promptly?
- What are the most common consumer complaints about insurers (sales pressure, misrepresentation, slow settlement)?

Service Providers (hospitals, doctors, paramedics, nurses)

- Are the rates allowed to be charged by service providers also regulated?

    - By whom?
    - How?
- What is the status of ICD/PCPT coding (classification/procedures)?
- What is the status of doctors/nurses/medical/hospital licensing/certification?
- I understand that most of the hospitals have been transferred to private ownership, with the new owners being expected to build or renovate new hospitals, and that there is a seven year restriction on change of use.
- Do the transferees have to build new hospitals, renovate the hospitals transferred to them, or both?
- Is the transfer one-for-one (i.e. one new hospital for each existing hospital transferred)?
- Can the transferees put both the old hospitals and the new hospitals to any use after seven years, or only the old ones?
- Do any public hospitals remain?
    - If so, how many?
    - Are they to be privatized too?
- What extensions have been given to the commitment to build/renovate in light of the war, financial crisis, etc.?

<u>State Medical Insurance</u>

- What does the government (as opposed to insurers) cover (TB, HIV, dread disease)?
    - Describe how it works (public hospital, any hospital, own doctors, reimburse hospital doctors) .

<u>MAP (Multiple Assistance Program for the Poor) and Cheap Insurance (Affordable Health Insurance Program) Insurance Plans</u>

- As I understand it, the government partially subsidizes the CI plan (with no subsidy for policies with premiums in excess of GEL 180) for all income levels, while it fully subsidizes the MAP plan for those below the poverty line.
    - Is this correct?
- It appears that the government also subsidizes health insurance for teachers, the army, the police, etc. (and their families)?
    - Is this correct?
- There also appears to be different subsidization for children and those over 60 or 65.
    - Clarify how this works.
- Are there variations in premiums for the CI product?
    - If so, why (better systems, better provider agreements, tied-house agreements with pharmaceuticals, etc.)?
        - Who enjoys the most advantages in this regard?
- How do insurers compete:
    - Fees?
    - Service?
    - Tie-ins with favoured providers?
    - Other?

- Are the MAP and CI benefits the same?
- Does the government set the premium rate for the CI plan?
    - If so, on what basis does it do so (arbitrary, consensus with industry, actuarial principles)?
- Why does the government give a larger capitation rate to large (>10,000 members) corporate plans than to smaller (<10,000 members) corporate plans?

General Infrastructure

- What is the actuarial situation in Georgia?
    - Is there a training programme?
    - Is there a certification programme?
    - Is there an actuarial society?
    - Are foreign actuaries:
        - Recognized?
        - Used?
- How effective is the complaints mediation body?
    - What powers does it have?

Insurance Association

- Is there a functional industry association?
    - If so, does it have a website?
- Must insurers belong to an industry association and follow its directives?
- Does the industry have an Ethics Code (41)?
    - If so:
        - Does it address:
            - Risk acceptance?
            - Claims handling?
            - Customer service?
            - Privacy and confidentiality?
        - Is it mandatory for all insurers?
        - Is it binding on member insurers?
- Is the association involved in training?
    - If so, in what areas?
- Does the association maintain a data base of information (client history--medical event, previous coverage, other existing coverage, legislative changes, training opportunities, complaints)?

Information Availability

- Are public health statistics:
    - Comprehensive?
    - Accurate?
    - Updated on an ongoing basis?
    - Accessible to all insurers?

- Are industry statistics:
  - Comprehensive?
  - Accurate?
  - Updated on an ongoing basis?
  - Accessible to all insurers?
- Is information about client histories (medical conditions--MIB; claims filed; double coverage):
  - Available?
  - If so:
    - Who maintains it?
    - Is it:
      - Comprehensive?
      - Accurate?
      - Updated on an ongoing basis?
      - Accessible to all insurers?
- Does any "data clearing house" of applicants exist (MIS, database showing past experience with applicants, which would prevent double claiming, fraud)?
- Are any initiatives to improve/collect/standardize information under way/planned?

Legal

- Are insurers prohibited from writing both life and property and casualty in the same insurer?
- How is medical insurance licensed (life only, P&C only, separate class)?
  - If not a separate class type of insurance, is it considered life or P&C?
- Are standardized policy terms required by law?
- Are sales practices/advertising/disclosure/privacy/settlement requirements imposed by law?
- What legal/industry requirements/restrictions apply to the claims settlement function?
- Do insurers have the right to refuse to renew a health insurance policy?
  - If so, is this right restricted by law or completely unrestricted (no refusal but increased premium)?
- What accounting standards are used in Georgia (GAAP, US GAAP, IAS, IFRS)? (390)
  - If not IFRS, is introduction planned?
- Does the law require that all insurers submit quarterly and annual financial statements?
- Are insurers subject to external audit by independent auditors?
  - If so, on what frequency?
  - Must auditors be approved by the regulator?
- Are insurers required to establish an internal audit function?
- Does the law require that insurers engage qualified actuaries (employee, consulting)?
  - If the law does not so provide, do the insurer's policies do so?
- What limitations are imposed by law on investments (type, maximum, minimum, domicile)?
- What are the reserve requirements or health insurance?
- Are insurers inspected by the regulator?
  - How frequently?
  - For solvency and/or market conduct?
- Is the concept of "insurable interest" applied?
- Does the law recognized admitted and non-admitted reinsurance?

    - If the latter, is a deposit of securities required?
- Does the law provide for non-admitted or partially-admitted assets?
- Does the regulator have authority to disallow assets?
- What financial reporting standards are imposed by law? (393)
- Are rules on Asset Valuation prescribed by law?
- Is churning (frequent policy replacement) prohibited?
- Does the law impose restrictions on the time period during which claims may be contested due to inaccurate initial information/innocent misrepresentation on application?
- Does the law impose restrictions on pre-existing conditions (maximum wait periods, non-fraud only)?
    - Are insurers allowed to refuse to pay based on undisclosed pre-existing condition even if the applicant was not aware of it at the time of the application?
- Does the law impose requirements for prompt payment of claims?
- Does the law prove an initial period during which policyholders may cancel a policy (resilation)?
- Does the law require cause/notice prior to termination of policies?
- Does the law require a restoration of benefits clause?

Health Insurance Mediation Service

- Describe the process, responsibilities and powers.
    - Does the Service have binding authority?
- What are the most common complaints?

INSURER-SPECIFIC

Senior Management

- How long has the insurer been established?
- What lines does the insurer write?
- How much other health business does the insurer write?
- Is MAP and CI profitable?
- Is CI purchased equally across income levels?
- How will recent decree (provide pharmaceuticals, renovate hospitals) affect profitability?
- Is CI a disincentive to selling more expensive policies offering increased benefits?
- Is MAP or CI used:
    - As a loss leader?
    - For cross-selling purposes?
- Describe the insurer's Strategic Planning Process.
- Does the Board have committees with specific responsibilities?
    - If so, describe.
- Does the insurer or its employees participate in any external associations (IAIS, actuarial association)? (42)

- How does the insurer view training?
  - Is a specific budget allocation made?
  - Are training plans developed for each employee?
- What does the insurer see as its immediate to medium term training needs?
- How does the insurer view the training currently available in Georgia?
  - Courses?
  - Providers?

General Business Risks (13, 15)

- Does the insurer consider general business risks, and what strategies have been adopted to address them?
  - Market Risk (securities, interest rates)?
  - Credit Risk (debtor default)?
  - Liquidity Risk?
  - Legal Risk (changes in laws)?
  - Strategic Risk (changes in business environment)?
  - Operational Risk (internal deficiencies, external events)?

Financial Management (332)

- How does the insurer:
  - Plan its financial goals (solvency, profitability)? (348)
  - Plan its financial strategy (aggressive, medium, conservative)? (349)
  - Manage capital and surplus (analyze needs, measure expected return, projected ROC with hurdle rate, assess effectiveness, obtain additional capital)? (350)
  - Manage cash flows (liquidity, asset/liability management, forecasts and simulations, cash flow testing)? (351)
  - Manage investments (see next section)?
  - Manage the reporting function?
  - Perform the budgeting function?
  - Perform the financial auditing and internal control functions?
  - Perform the financial analysis function?
- Does the insurer prepare: (401)
  - Operational budgets (revenue, expense)?
  - Cash budgets?
  - Capital budgets?
- Does the Board establish/monitor/amend as necessary an investment policy that addresses:
  - General investment objectives (portfolios to match liabilities, meet obligations to policyholders, contribute to growth of earnings and surplus, maintaining adequate spread)?
  - Types of investments?
  - Minimum standards?
  - Acceptable and unacceptable risks?
  - Diversification?
  - Authority levels?
- How frequently is it reviewed by the Board?

Human Resources (80)

Insurer Organization (81-97)

- Please provide an org chart.
- Is the insurer organized along functional lines? (12)
  - Marketing? (76, 101-)
  - Actuarial? (76)
  - Underwriting? (77)
  - Reinsurance?
  - Customer Service? (78)
  - Claims/Benefits Administration? (78)
  - Investments? (78)
  - Accounting? (79)
  - IT? (79)
  - Legal/Compliance? (79)
  - Human resources? (80)
  - Finance? (80)
  - Auditing? (80)
  - Risk Management? (81)

Human Resource Management (410)

- Is the Georgian labour supply of qualified staff sufficient?
- How does the insurer project staffing requirements? (411)
- How does the insurer recruit staff (internally, externally, referral)? (413)
- How does the insurer screen and test applicants (application, testing, interviews, background checks)? (415)
- Is there an employee appraisal process?
  - If so, describe (process, frequency).
- What is the range of employee compensation?
- What is the average employee compensation?
- Are employees entitled to any non-salary benefits (pension, insurance, holidays, bonus)?
- What does the insurer do to retain employees?
- Are all the insurer's policies and procedures:
  - In written form?
  - Provided to employees?
- What is the insurer's procedure on employee termination (voluntary or non-voluntary)?
  - Minimum notice?
  - Severance pay?
  - Departure statement by employee?
  - Career counselling?
  - Job placement assistance?

Actuarial (76)

- Does the insurer use actuarial expertise?
  - If so:
    - In house or consulting?
    - In what areas is actuarial expertise used (determination of liabilities, product development, pricing, planning, management)?

Quality Control (*22*)

- How does the insurer ensure quality control?
- Are benchmarks established and monitored on a pre-determined basis?
- Are benchmarks quantitative and/or qualitative?

Training/Education (41)

- What percentage of the insurer's budget is devoted to training?
- Does the insurer have training policies for its employees/agents/producers?
- Are new employees provided with orientation training?
- What training is provided to existing employees on an ongoing basis?
  - On the job?
  - Related only to position held?
  - General insurance training?
  - General financial services training?
  - Customer service?
  - Regulatory environment?
  - Insurer philosophy and operations?
- What qualified training providers are available in Georgia?

Strategic Alliances

- Describe the insurer's strategic alliances, if any.

Outsourcing (18)

- Does the insurer outsource any of its activities?
  - Distribution?
  - IT?
  - Actuarial?
  - Underwriting?
  - Underwriting information/sources?
  - Claims administration?
  - Claims investigation?
  - Claims processing?
  - Customer Service (call centre, billing, collection)?
  - Financial Management (tax reporting)?
  - Human Resources (e.g. payroll, employee benefits, recruiting)?
  - Legal/Compliance?

Products

- What products does the insurer currently offer?
- What medical products does the insurer currently offer?
  - Government basic only?
  - Additional benefits?
  - Individual?
  - Group?
- What new products are planned?
- How does the insurer develop products?
- How does the insurer determine customer needs?

Marketing (76, 101-)

Marketing Activities (100-)

- Does the insurer have a marketing plan?
- How does the insurer position itself within the sector?
- Does the insurer have a marketing strategy for its growth? (121)
- How does the insurer:
  - Identify its market/s (market segmentation, target marketing/differentiated/undifferentiated/concentrated)?
  - Collect and evaluate information (internal database, research, industry association)?
  - Develop/test/refine its marketing plan?

Product Distribution (172, 197)

- What product distribution method(s) does the insurer use:
  - Personal sales (174)?
    - Company employees?
    - Company agents?
    - Independent agents?
  - Financial institutions (banks, insurance brokers, dealers)? (186)
  - Direct response (mail, media, internet)? (189)
  - If using agents, are they:
    - Career agents (exclusive, agent/broker)? (178)
    - Branch or agency office system? (180)
    - Home Service (geographic)? (181)
    - Worksite marketing (industrial insurance)? (181)
    - Location marketing (kiosks)? (182)
  - If using non-agents, are they: (184)
    - Insurance brokers?
    - General agents?
    - Financial planners?
    - Financial institutions (banks, other insurers)?
  - If using direct response, are they: (189)
    - Direct mail?
    - Print/broadcast media?

    - Telemarketing?
    - Internet?
- What factors were involved in determining the method of distribution: (192)
    - Customer characteristics?
    - Product characteristics?
    - Cost?
    - Degree of control?
    - External marketing environment (availability of brokers, deregulation)?

Support to Producers (202)

- What support does the insurer provide to producers?
    - Agency Systems (202)
        - Recruiting? (205)
        - Licensing? (208)
        - Training (basic, insurer procedures, insurer goals, ethics, product, sales techniques)? (208)
        - Compensation (heaped, level, levelized)? (212)
        - Sales Support (prospecting, advertising, sales aids, advanced underwriting, enhanced services, monitoring? (215)
        - Technology Support (computers, software, telecom)? (218)
    - Non-Agency Systems (220)
        - Different than above?
    - Financial Institutions (223)
        - Different than above?

<u>Underwriting (77</u>)

General (226, 28,90)

- Does the insurer establish/monitor/amend as necessary underwriting guidelines?
    - If so, who sets the underwriting guidelines?
- How is the underwriting function organized/performed (trainee, junior, intermediate, senior, chief)? (243)
- Are authority levels defined by position?
- Are risk assessment factors considered:
    - Individual (231)
        - Medical Risk
            - Age?
            - Gender?
            - Build?
            - Medical History?
            - Personal?
            - Family History?
            - Substance Use
                - Alcohol?
                - Tobacco?
                - Drugs?

    - Personal Risk
        - Occupation?
        - Moral Hazard (suppression of information)?
        - Hobbies?
        - Aviation?
        - Place of Residence?
        - Driving History?
        - Military Status?
        - Foreign Residence?
    - Financial Risk
        - Existence of Insurable interest?
        - Need for insurance?
        - Insurance amount?
        - Affordability?
- Group (236, *200*)
    - Type of group (single employer, multi-employer, association, affinity)?
    - Reason for group's existence?
    - Duration of group's existence?
    - Nature of group's business?
    - Size of group?
    - Geographic location of group?
    - Stability of group?
    - Age and sex distribution of members?
    - Member turnover rate?
    - Level of participation?
    - Classes of employees?
    - Reasonableness of coverage?
    - Expected persistency?
    - Prior coverage and claims experience?
- Are coverage/denial/premiums based on risk-rating?
- Are risks classified, rated or both?
    - If so:
        - How are risks categorized (preferred, standard, substandard, denied)?
        - Is rating flat extra/percentage or table?
- Is field/tele underwriting performed? (244, *193*)
- What information sources are used: (*127*)
    - Application?
    - Personal or specialized medical questionnaires?
    - Producer Reports?
    - Doctors' reports?
    - Paramedical reports?
    - Inspection reports?
    - Laboratory tests?
    - Insurer database?
    - Industry database?
    - TPP database?
    - Pharmaceutical records?
    - Motor vehicle records)? (245)
    - Tax Documents?

- What criteria are established for information sources required? (251)

Individual Health (*170*)

- Does the insurer write:
  - Medical Expense?
  - Disability Income (*184*)?
    - If so:
      - Short term and/or long term?
      - What is the maximum income replacement rate?
      - Are occupations rated? (*186*)
  - Critical Illness? (*190*)
  - Long Term Care? (*191*)
- Does pre-existing condition result in:
  - Denial?
  - Rating?
  - Waiting Period?

Group Health (200)

- Does the insurer actively market group health insurance?
- Does the insurer use:
  - Manual Rating (219)?
  - Experience Rating (219)?
  - Pooling (221)?
  - Step Rating (221)?
- How does the insurer deal with late enrollees/ new employees?

Product Development/Design/Implementation/Monitoring (126-)

- Does the process involve:
  - Product Planning (sourcing, screening, concept testing)? (129)
  - Comprehensive Business Analysis (market, design objectives, feasibility study, marketing plan, sales and financial forecasts)? (130)
  - Technical Design? (135)
  - Product Implementation (implementation plan, policy filing, promotion and sales materials, information systems and operational processes, education and training, product introduction? (137)
  - Sales Monitoring and Review? (142)

Product Pricing (148)

- Is pricing determined externally?
  - By law?
  - By reinsurer?
- Does the insurer use actuarial expertise?
- If so:
  - What input does he/she have in pricing?

- Does the insurer develop pricing objectives (goals) and strategies (cost driven, competition driven, customer driven)? (149)
- How are pricing assumptions made (investment earnings, costs, loading)? (151)
- Do loading assumptions include operating expenses, policy lapses, safety margin? (161)
- Are products bundled or unbundled? (164)
- How are policy reserves established? (166)
- Are models used to test assumptions? (167)
- How are pricing results monitored (actual value, assumed value, expected value)? (168)

Premium Income

- What is the insurer's total annual premium income?
- What percentage of total premium income relates to medical?
- What is the breakdown of medical premiums on a MAP, CI, Other Individual, Group basis?
- How much has premium income increased over the past two years (since MAP)?
- How much of this is attributable to the government's basic insurance plan?
- What changes to the insurer (staffing, knowledge levels) have been required as a result of the MAP and CI programs?
    - What additional changes are required/planned?

<u>Claims/Benefits Administration (78)</u>

General (284, *318*)

- Does the insurer have/review/amend as necessary a Claims Philosophy? (286)
- Describe the insurer's Claims Evaluation and Decision process: (288, *322*)
    - Verification of policy status (in force)?
    - Verification of coverage of insured? (290)
    - Verification of loss? (291)
    - Verification of policy coverage of loss (inclusions, exclusions)? (293)
    - Contestability? (*322*)
    - Calculation of benefit?
    - Determination of beneficiary?
- Describe the Claims Investigation Process (triggers, records, desktop, external). (299)
- How are Claims Analysts:
    - Organized?
    - Trained?
    - Promoted?
    - Compensated?
- What levels of authority are given to each level of Claims Analyst?

Claims

- How many claims are filed yearly?
    - All lines
    - MAP

    - In total?
    - Per policy?
    - Is it profitable?
- CI
    - In total?
    - Per policy?
    - Is it profitable?

Medical Expense, Critical Illness, Long-Term Care (*360*)

- Medical Expense (*361*)
    - Are time limits for submitting claims imposed?
    - Are diagnostic codes receipts based on ICD (International Classification of Diseases)?
        - If so, what level (9, 10)?
    - Are treatment codes based on CPT (Physicians' Current Procedural Terminology)?
    - Is the concept of usual, customary and reasonable applied?
    - How is coordination of benefits accomplished (double claiming)?
    - Do policies contain subrogation clauses?

- Critical Illness (*374*)
    - Does the insurer impose survival and or waiting periods?

- Long-Term Care (*376*)
    - Do assisted living facilities exist in Georgia?
    - What is included (skilled or intermediate nursing care, custodial care)?
    - What exclusions are imposed (alcohol, drugs, self-inflicted, other insurance)?
    - Do policies contain a restoration of benefits clause?
    - Are benefits indexed?

Disability Income (*388*)

- Does the insurer write DI policies?
    - If it does, are they short and/or long term?
- Is there a differentiation between sickness and injury?
- Describe the process for confirming disability:
    - Eligibility?
    - Information sources?
- What maximum income replacement is offered (Ind. - 60-70; Group - ST 90-100, LT 60-75) ?
- How is partial disability dealt with?
- How is total disability defined (regular occupation, any occupation, any suited occupation, regular occupation, essential v. every duty)?
- How are recurring disabilities dealt with (waiting period, benefit period)?
- Are rehabilitation benefits offered?
- Are lump sum settlements used?

Investments (78, 358)

- Do insurers retain separate (segregated) accounts?
- What is the insurer's current mix (%) of investments in:
  - Equities?
  - Bonds?
  - Mortgages?
  - Real Estate?
  - Other (specify nature if substantial)?

Accounting (79, 382)

- What accounting standards are used in Georgia (GAAP, US GAAP, IAS, IFRS)? (390)
  - If not IFRS, is introduction planned?
- Are all insurers required to submit to an independent, external audit on a yearly basis?
  - Is the choice of auditor subject to regulatory approval?
- How are assets valued?

Information Technology/Management (79, 309, *12*)

- Does the insurer maintain a call centre?
- Does the insurer maintain a webpage?
  - Is it interactive?
  - Does it allow existing and/or potential clients to transact business (apply for new products/increased coverage, change beneficiaries, file claims)?
  - Can clients receive replies to requests (email, real time)?
- What communications technology is in place (EDI, LAN, WAN, internet, intranet, extranet)?
- What types of IT systems does the insurer have: (318)
  - Transaction Processing?
  - Decision Support?
    - MIS (scheduled, exception, Ad Hoc reports?
  - Expert Systems (AI)?
  - Operations Support (database management, document management, automated workflow)?
- What IT equipment does the insurer have:
  - Hardware?
  - Software (313)
    - Accounting?
    - Actuarial?
    - Benefit Administration?
    - Claims Administration?
    - Investment Management?
    - Human Resources?
    - General Administration (underwriting, policy issue, commission, billing, collection, reinsurance, statement preparation)?
    - Marketing Research?
    - Producer Administration?
    - Production Reporting?
  - Database
    - Customer?

    - MIS?
- Is the insurer planning to replace/upgrade its equipment or software?
- Is some degree of claims processing fully automated (i.e. no individual input required--Straight Through Processing, Business Rules Engines)?
- To what extent does the insurer use modelling and scenario-testing in its operations?
- To what extent is working documentation digitized?

Legal /Compliance (79)

- Are the legal and compliance functions combined? (430)
- If not:
    - What are the relative responsibilities of the two functions (regulatory matters, customer litigation)?

Finance (80)

- Dealt with elsewhere

Auditing (80)

- Dealt with elsewhere

Risk Management (81)

- Dealt with elsewhere

Reinsurance (228)

- Does the insurer cede any business to other insurers/reinsurers?
- Does the insurer assume any business from other insurers?
    - If so, does it retrocede to other reinsurers?
- Does the insurer reinsure health business?
    - With whom?
- Does any reinsurer provide support/training to the insurer?
    - If so, in what areas?
- What is the insurer's retention limit on health insurance?
- Is the insurer party to any reciprocal agreements (mutual reinsurance)? (*231*)
- Is the insurer party to any reinsurance pools (quota share)? (*233*)
- Is the insurer party to any co-insurance (premiums, obligations, expenses shared)?
    - Modified co-insurance (direct reserves held by insco, lending of reserves)?
- Does the insurer use assumption (portfolio transfer) reinsurance? (*234*)
- Does the insurer use indemnity reinsurance (reimburse paid claims)? (*234*)
    - Automatic (as written)?
    - Facultative(offer/acceptance)?
    - Facultative/obligatory (conditional on financial capacity)?
- Does the insurer use proportional (fixed sharing) reinsurance (*260*)?

    - Excess of retention (amount beyond retention, per case, maximum limit)?
    - Quota share (amount beyond retention--fixed or %, per case, no limit)?
        - Excess (retention limit, remainder ceded)?
        - First dollar (retention percentage to retention limit, remainder reinsured)
- Does the insurer use non-proportional reinsurance (*257*)?
    - Excess of loss (single loss, range beyond specified amount)?
    - Stop loss (block of business, range beyond specified amount)?
    - Catastrophe (single event, annual total, maximum)?
    - Spread loss (stop loss with loan by reinsurer)?
    - Excess of time (reinsurer pays after period of time)?
- Is reinsurance claims administration separated from insurance claims administration?
- Does the insurer maintain staff dedicated to the reinsurance function (marketing, actuarial, underwriting, legal/compliance, accounting, auditing, claim administration)?
- Does the insurer maintain a stand-alone/integrated reinsurance information system?

Customer Service (15, 258, *418*)

- Has a Customer Relationship Management programme been developed?
    - Is it implemented, monitored and amended as necessary?
- Has the insurer established written customer service standards?
    - Qualitative and/or quantitative? (*440*)
    - How and how frequently is customer service evaluated (timeliness, accuracy, friendliness and professionalism)?
- Describe the insurer's customer (external/internal/agents/brokers) services approach and procedures.
    - Organization:
        - Product?
        - Territory?
        - Distribution system?
        - Customer?
        - Method of communication?
            - Face to face?
            - Via agents/producers?
            - Telephone?
            - Email?
            - Website?
    - Staffing?
    - Authority levels?
    - Administering policy changes?
- What information is given to customers during the currency of their policies?
- Does the insurer maintain a website that allows customers and potential customers:
    - To obtain information about:
        - The insurer/products/pricing?
        - Their policies?
        - Their rights?

    - To transact business on the web (quotes, coverage, applications, designation/change of beneficiaries, policy ownership changes, beneficiary changes, replacements, reinstatements)?
- Describe the complaints handling process.
    - Is each step fully documented?
    - How many complaints are received yearly?
    - What are the major areas of complaint?
- Does the insurer elicit customer feedback (satisfaction surveys, direct contact, mystery shoppers, focus groups, complaints review)?
    - Is customer feedback received, evaluated and acted upon?
- Is the Health Insurance Mediation Service useful?

SCHEDULE "C": HEALTH INSURANCE PREMIUMS BY INSURER (30 June 2009)

(source – National Bank of the Republic of Georgia)

2009 Year, I and II Quarter

	Name of the Insurer	Written Premium		Total Market Share (All Lines)	Health Insurance Market Share	Health Insurance as Percentage of Total Portfolio	State-Funded Health Insurance as Percentage of Total Portfolio (Average – 78.4%)
		All Lines	Health Insurance				
1	Aldagi BCI	40,564,435	21,339,412	20.4%	14.8%	52.6%	41.2%
2	Imedi L	42,091,926	37,440,864	21.2%	26.0%	89.0%	69.8%
3	GPI Holding	29,333,475	20,125,364	14.8%	14.0%	68.6%	53.8%
4	Cartu	8,992,902	8,853,793	4.5%	6.1%	98.5%	77.2%
5	Peoples Insurance	17,176,734	17,028,490	8.7%	11.8%	99.1%	77.7%
6	Vesti	9,230,364	3,570,002	4.7%	2.5%	38.7%	30.3%
7	Irao	25,752,976	15,896,167	13.0%	11.0%	61.7%	48.4%
8	AIG - Europe SA	278,034	0	0.1%	0.0%	0.0%	0.0%
9	IC Group	6,729,422	4,690,537	3.4%	3.3%	69.7%	54.6%
10	Tao	8,956,249	7,876,683	4.5%	5.5%	87.9%	68.9%
11	Partner	1,994,239	897,802	1.0%	0.6%	45.0%	35.3%
12	Standard Insurance	164,050	0	0.1%	0.0%	0.0%	0.0%
13	Archimedes Global Georgia	7,152,029	6,246,531	3.6%	4.3%	87.3%	68.4%
	Total	**198,416,835**	**143,965,644**	**100.0%**	**100.0%**	**72.6%**	**56.9%**

These figures do not include the premiums of Alpha Insurance, as it was not in existence on 30 June 2009.

SCHEDULE "D": HEALTH INSURANCE PREMIUMS BY TYPE OF INSURANCE (30 June 2009)

(source – Georgian Insurance Association)

Accounting period: 01/01/2009 - 30/06/2009

	Type of insurance scheme	Insurance Policies/vouchers			Premiums Generated (Gross)	Percentage of Total Insurance by Premium Income	Total Population Covered by Insurance
		Number			Amount		
		Insurance policies signed starting from and during the accounting year	Valid policies as of reporting date (30/06/2009)	Insured individuals as of reporting date (30/06/2009)	Premium generated during and from the start of the accounting year (gross)		
		01	02	03	04	05	06
	Health insurance						
1	Medical assistance program for the population under the poverty line (MAP)	427,911	791,116	793,289	70,817,045	49.2%	
2	State medical insurance program for Teachers	81,567	81,543	81,543	14,490,923	10.1%	
3	Other State subsidized health insurance programs *	99,967	78,283	78,283	15,365,762	10.7%	
4	Insurance programs for State/Public Entities **	82,394	153,164	157,214	11,513,561	8.0%	
5	Corporate health insurance schemes	140,521	197,058	199,048	30,982,976	21.5%	
6	Contracts signed with physical persons *(so called voluntary/individual insurance scheme)* ("Cheap Insurance" plus private, individual policies)	5,494	10,946	11,494	795,377	0.6%	
	Total	**837,854**	**1,312,110**	**1,320,871**	**143,965,644**	**100%**	**30%**

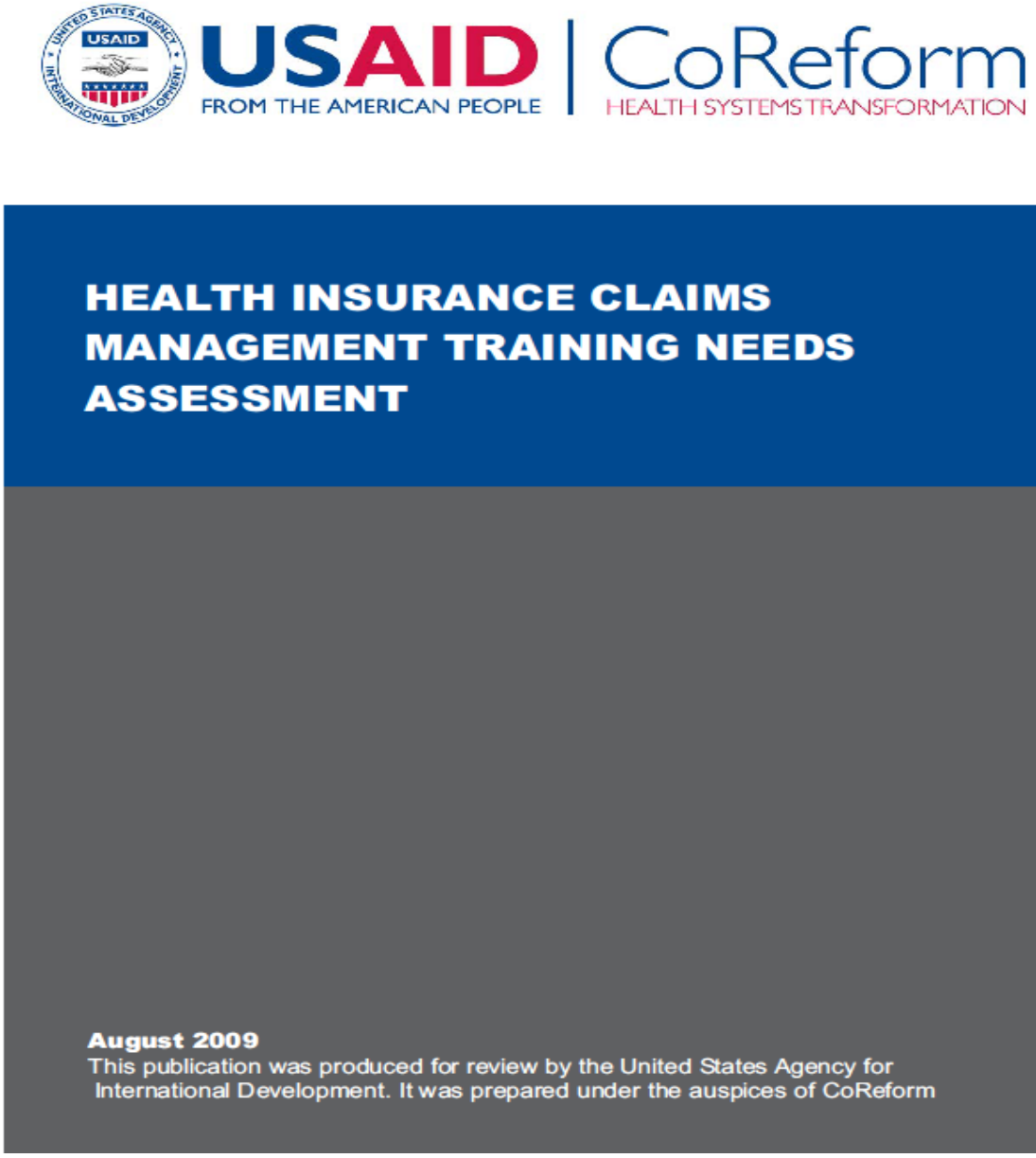
	Public health coverage		
1	Children under 3	Numbers Unknown	N/A
2	Citizens over 60	Numbers Unknown	N/A
3	Dread disease (TB, HIV, cardiac, etc.)	Numbers Unknown	N/A
4	Rural doctors and nurses	Entire Rural Population Covered	N/A

*** programs for the orphan children, refugees and State artists**

**** Ministries, Police**

Approximately 176,000 more individuals will be added during the current eligibility period under the MAP program; however, another 150,000 individuals will be removed from the program due to non-eligibility

SCHEDULE "E": HEALTH INSURANCE CLAIMS TRAINING NEEDS ASSESSMENT



SCHEDULE "F": INSURANCE RELATED EDUCATIONAL AND PROFESSIONAL DEVELOPMENT OPPORTUNITIES IN GEORGIA

Educational Programs with an Insurance Track

University of Georgia

- Masters degree program with focus on Healthcare Administration and Insurance
    - In cooperation with Scranton University and University of Florida
- Broad educational curriculum
- Educated approximately
    - 125 students in Administration and Insurance
    - 60 students in Healthcare Administration and Health Insurance

Caucasus School of Business

- Masters degree program with focus on Healthcare Administration and Insurance
- Broad educational curriculum
- 12 -15 students will graduate this year

Tbilisi State University of Economic Relations

- Masters degree program in insurance
- PhD degree program in insurance
- Broad curriculum
- 10 students pursuing this degree

Non-degree or certificate programs in Insurance related topics

University of Georgia

- 3 short courses for insurance industry
    - In cooperation with Oxford Policy Management
    - Attended by 60 students from insurance industry and HESPA
- Developed a 2 year professional Diploma course in Health Administration but do not offer due to lack of interest
- Health Care Administration and Insurance - Professionals' Competence Raising Program
    - 60 hours
    - Range of topics including: management, leadership, strategic and operational planning, presentation skills, health care services, medical statistics and reporting, health care economy, financing health care system, health insurance and marketing, social and voluntary health insurance, insurance marketin in Georgia, health care legal regulations and quality of service
- Marketing Health Care Products
    - 60 hours
    - General marketing, 4 Ps (product, price, place, promotion), marketing trends in health, promotion of medical care, innovative marketing in pharmaceutical industry, pharmacy development, insurance marketing, merging insurance market and health market brands, hospital product marketing, brands and brand development

- Management of Insurance Systems and Managed Care Systems - Certification Program in Health Insurance
    - 60 hours
    - Main topic areas include principles and basis of insurance, managed medical care/health care, risks and insurance system management

Caucasus School of Business

- Developed one short program integrating 3 areas:
    - Epidemiology
    - Finance
    - Information Systems
    - In cooperation with Georgia State University and Emory State University
- Have not delivered the program due to lack of interest

Georgian Insurance Institute

- No significant programs or courses
- No infrastructure to develop and deliver courses

Individual Insurance-Related Courses

Free University of Georgia

- One insurance-related elective in general MBA course

SCHEDULE "G": SHORT TERM TRAINING OPPORTUNITIES IN GEORGIA

Institution	Course	Time	Content
University of Georgia	Certificate Program in Health Insurance	Contact hours - 60 (12 days)	Three training modules - Main Principles and Basis of Insurance - Managed Medical Care/Healthcare - Risks and Insurance System Management
	Health Product Marketing	Contact hours - 40 (8 days)	Includes a range of topics geared to health marketing in general, including pharmaceutical marketing, insurance marketing and hospital marketing
	Healthcare Administration and Insurance	Contact hours - 60 (12 days)	Goals of the course are to develop a theoretical knowledge, evaluate needs of health care, and practical skills Content is broad and includes management functions of organisations, leadership and team work, presentation skills, and managerial epidemiology Medical Statistics and Reporting Health Care Economy
Caucasus School of Business	Healthcare Financial Management and Decision Making Technologies	Contact hours - 60 (12 days)	Three training modules - Epidemiology - Finance - Information Systems