



Receivable financing proposition for Healthcare sector

*Non-recourse financing for Hospitals / Diagnostic centers against
certified receivables from Insurance companies – a discussion paper by
Artfine Advisory LLP*



Opportunity

- Opportunity for funding various Private/Trust managed hospitals as there is significant time lag between hospitals raising claim on Insurance companies & Insurance companies paying to Hospitals.
- Hospitals may invoice the insurance company through Insurance Company's appointed agencies called (*TPA –Third Party Administrators*).
- **Working capital limits are usually with recourse. By Factoring the insured receivables, an incremental funding source can be availed.**
- Receivable period/actual claim settlement period range from 30-90 days.
- Financing hospitals against TPA /Insurance accepted invoices / Final Cashless authorization intends to help hospitals quickly realize the receivable.
- If there is a steady track record of insured receivables, a future flow financing based on a revolving three month line can be created. By linking it to Vendor payments, ie setting up vendor finance lines the Hospital's working capital cycle can be managed better.

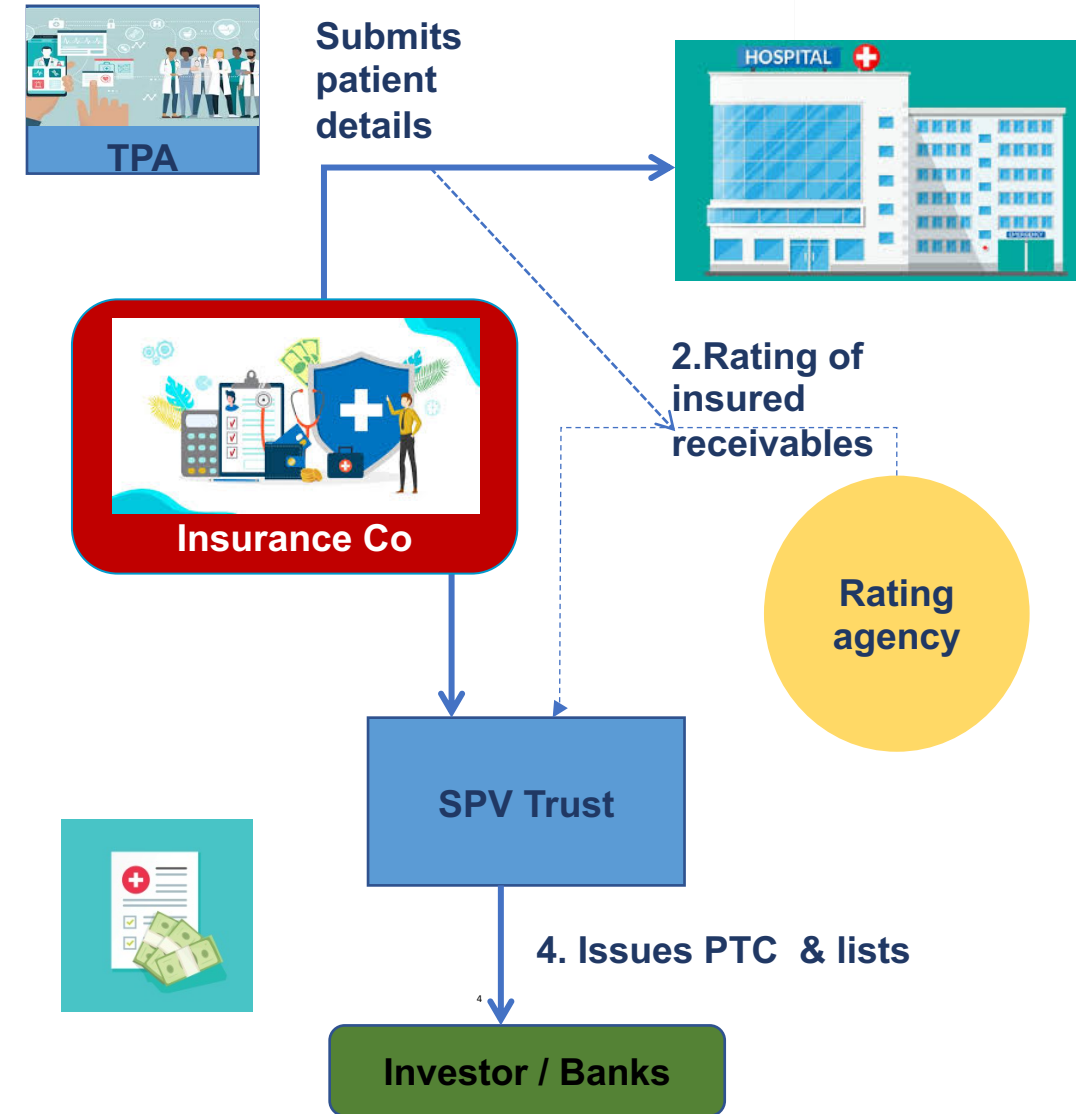
Background

- Hospital industry does not have avenues to finance patient receivables due from insurance companies.
- Hospitals show this as trade receivables from Insurance companies in their financials
- Agreement exists between the Hospitals and Insurance company for providing services to the policy holders of the Insurance companies basis the approved initial authorization and subsequently the final authorization.
- As there is time gap between pre-authorization and actual receipt of proceeds by hospital as per agreed payment days (60-120 days). Hospital remains out of funds for this period against final pre-authorized amount.
- Financing these receivables on non-recourse basis would entail marking lines/credit on Insurance companies on an unsecured but disclosed basis.

Process flow

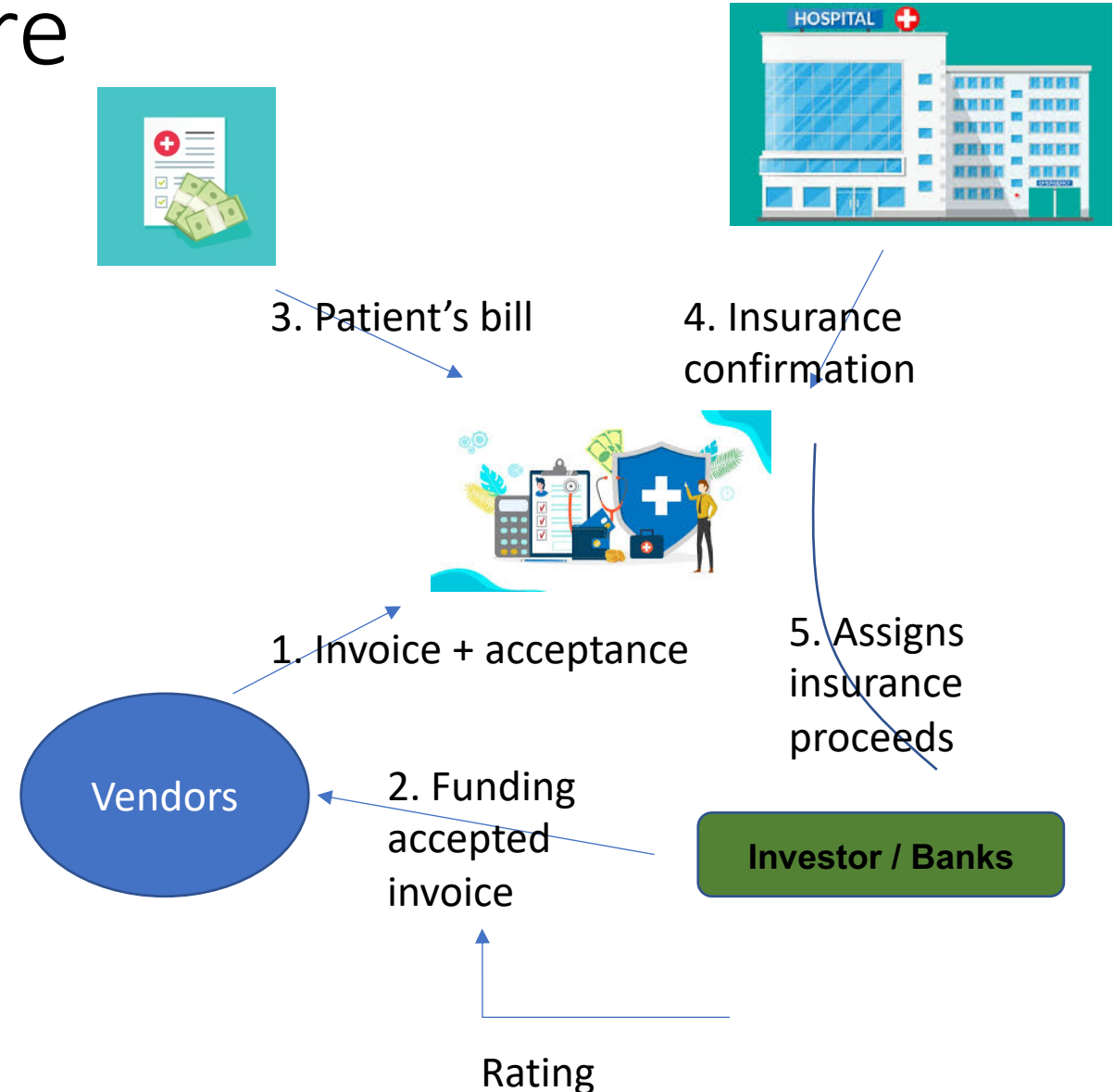
It is proposed to finance the receivable once the final authorisation from insurance co is received till payment is processed by the insurance co.

- Preauthorization – Patient fills up the form for medical procedures and hospital provides the estimated cost of medical procedures and stay. This is then sent to the TPA who approves a temporary amount basis which the hospital starts the medical procedure.
- Once medical procedure is completed the patient fills the final form for cashless hospitalization which the hospital sends to TPA for approval.
- Once final cash authorization is approved by TPA and the balance is settled by the patient, the patient is discharged and balance amount is now receivable from Insurance company.
- Hospital in mean time is out of funds and gets funds once they submit original documents to Insurance company. Insurance company clears the invoice and makes payment to the Hospital
- Cashless facility, however, is not available if treatment is sought in a hospital that is not part of Insurance companies network hospitals



Vendor Finance structure

- Set up a limit for financing MSME and other vendors.
- Limit would be supported by an assignment of insurance proceeds.
- Rating would enable a the financing to funded at good rates even if it has no hard collateral.



Information required

Transaction level data

1. Billing and payment history of the hospital for the insured patients for the last 3 years. This should cover the amount invoiced, due date, amount insured, date of payment by insurer and amount paid. This can be aggregated by insurer on a monthly basis for the last 3 years.

2. Contract with Insurers and TPA

3. Proforma patient invoice and proforma approval by insurer

Points 2 and 3 read together should establish a valid commercial claim on the insurer - which has been accepted by the insurer. [The acceptance is quite important as the obligation will otherwise remain an operational debt]

4. KYC details of the originator, insurer and TPA. Patient KYC to be available on demand.[Can be obtained prior to closure of the trade]

5. Financial details about the hospital - annual reports and projections

6. Rating / financial details of insurer.

Annexure

Medical Insurance - concepts

Health Insurance in current context of discussion may be classified into 2 categories:

- 1. Personal/Family Health Insurance Cover-** Such insurance covers are taken by individuals by buying health insurance policies by negotiating and bearing the cost of insurance *premia* on their own.
- 2. Corporate Insurance Cover-** Such insurance cover is provided by various employers to their employees and dependents of employees. In such cases employer negotiates *premia* for various eligible employees and may recover from employees as per organization's policy.
- 3. Cashless Mode:** Insurance companies have tie-up arrangements with several hospitals all over the country as part of their network. Under a health insurance policy offering cashless facility, a policyholder can take treatment in any of the network hospitals without having to pay the hospital bills as the payment is made to the hospital directly by the Third Party Administrator, on behalf of the insurance company. However, expenses beyond the limits or sub-limits allowed by the insurance policy or expenses not covered under the policy have to be settled by the policy holder directly with the hospital.

IRDA Protocol

IRDA protocol for Hospital which is essentially the clauses that need to be incorporated between the insurance company and hospitals.

13. Insurance company guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 48 hours of receiving the RAL.

17. Once the insured is to be discharged, the Provider shall make a final request for the pre-authorization for any residual amount along with the standard discharge summary and the standard billing format. Once the provider receives final pre authorization for a specific amount, the insured shall be allowed to get discharged by paying the difference between the pre-authorized amount and actual bill, if any. Insurer upon receipt of the complete bills and documents shall make payment of the guaranteed amount to the provider directly.

19. All the payments in respect of pre-authorized amount shall be made electronically by the insurer to the provider as early as possible but not later than a week, provided all the necessary electronic claim documents are received by the insurer.

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For more information please contact us at :

Artfine Advisory LLP,
111, 91Springboard, Kagalwala House, CST Road, Kalina, Mumbai
-98

saini.rajgopal@artfine.in M: +919820852293
arvindtca@artfine.in M: +919820237155
Shantanu.bairagi@artfine.in M: +918454850007