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Health Care MicroInsurance

A Synthesis of Case Studies from Four Health Care Financing Programs in Uganda, Tanzania, India, and Cambodia

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ABSTRACT:
The topic of Microinsurance is becoming very popular among Microfinance and development practitioners, donors, and interested parties. There is still little actual documentation on implementation of this line of business outside that of credit unions. ***MicroSave*** recognizes the potential of Microinsurance as a risk management tool for poor families that that brings the poor beyond self-savings into the leveraged position of risk pooling. Four health insurance programs representing the four general models of insurance provision were reviewed through case study visits during July/August 2000. Two of the four programs are still in the testing phase while the other two have more than three years experience with their products.

The microfinance related programs all chose to create an institutional barrier between the insurance program and the microfinance activities citing issues of capacity and risk. A very high dropout rate was seen in three of the programs related to premium issues as well as a universal lack of client understanding of the benefits of risk pooling. In very early testing of one program, no evidence was found to confirm the belief that access to quality health care has any impact on client performance or retention with a related MFI. An understanding of all these issues would benefit from additional study.

Much study of microinsurance programs is still needed. Topics such as the relationship between the specific product and the client's willingness to pay for it are critical to the issue of surplus generation with these programs. A very high attrition rate was evidenced and needs further study. One example from each model is not enough to gain a comprehensive understanding of the model and its application. More case studies will help to build a better foundation from which to make decisions about which model is appropriate in which circumstances.

Finally, it is clear from these cases that the provision of health insurance is a very complex business activity and great care should be taken by any institution considering entering such business.

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Microinsurance schemes are risk-pooling tools designed for the benefit and affordability of low-income persons (Brown et al, 2000). Some forms of microinsurance have been around for years, such as indigenous burial societies and credit union life savings products. Recently, however, microinsurance has become a very popular topic for donors, meetings and conferences, and this new attention has generated an interest in research into the ways in which microinsurance products can assist the very poor.

Research of this kind was recently initiated by ***MicroSave***. This organization has historically focused on savings products, which help the poor to manage relatively certain and inexpensive risk events and opportunities. Since there is a theoretical continuum from savings to insurance products as risk management tools, ***MicroSave*** recognized the important role that microinsurance products could play in mitigating unfortunate events that are comparatively uncertain and expensive for the poor. Seeking a better understanding of these tools, they conducted several case studies to review the different models of microinsurance provision currently in practice.

Four models of microinsurance provision were evaluated through case study visits to existing programs in Uganda, Tanzania, India, and Cambodia. The primary goal was to discern the strengths and weaknesses of the models, and to identify any lessons learned by these market innovators. A significant consideration was to determine who held the risk and the administrative burden, and to assess capacity to manage both. Is the risk falling on the party most able to manage it? The incentive structures in the relationships were reviewed as well. Is the client, the provider, or the insurer motivated to actually make the client well?

The visits were conducted between June and August 2000 for one to two weeks per institution and focused on the operational and financial aspects of the programs. Discussions with clients, staff, management, and partners were conducted to gather insight into the methodologies. Some of the results and preliminary conclusions are presented herein, to help stimulate further discussion of these issues.

FOUR MODELS OF INSURANCE PROVISION:[1]

The four general models of insurance provision for the poor are: the partner-agent model, the community-based model, the full-service model, and the provider model.

In the partner-agent model, insurers and MFIs are beginning to team up for reciprocal advantage. Insurers utilize the efficient delivery mechanism of the MFI agent, which provides the sales and basic servicing to the client in the field. MFIs use the relationship to get health care financing to their clients with limited administrative burden and no risk.

One example of a partner-agent model is the relationship between the Nsambya Hospital Healthcare Plan (NHHP) and FINCA Uganda, an MFI. NHHP operates as a semi-autonomous unit of Nsambya Hospital (Kampala, Uganda) with a professional management team. They have their own systems and staff, and control all premiums and claims. FINCA Uganda provides NHHP with access to its clients with the objective of improving borrower retention and portfolio quality through better health.

[1] The detailed case studies are available by internet from *MicroSave's* MicroInsurance Centre at www.microinsurancecentre.org.

In a community-based insurance model, the policyholders are the owners and managers of the scheme. Policyholders elect a group of their members to act as volunteer managers, who are responsible for all aspects of insurance operations. They design, develop, service and sell the product, and are responsible for negotiating coverage contracts with external health care providers. Volunteer management must manage the risks, maintain the books, collect the premiums, and review the claims from the provider for both accuracy and quality of care. This model requires a significant investment in training and capacity building in order to develop the volunteers' ability to manage the scheme.

One example of the community-based insurance model is the Cooperative Health Care for the Informal Sector of Dar es Salaam (UMASIDA) program in Tanzania. This program was created in response to an ILO study (1993-5) showing that poor people around Dar es Salaam wanted better health care services. UMASIDA generated specific demand among several local groups and followed the ILO community-based approach in training them to insure themselves.

The full-service model operates in many ways like any formal sector insurer. Here, a single entity is responsible for everything related to the insurance product, from product concept development through marketing, servicing, and claims assessment. The insurer assumes all of the insurance-related risk, is responsible for any financial losses, and receives any profits. To manage this risk and avoid losses, full-service insurers maintain a competent staff, build and maintain adequate reserves, and adhere to regulatory requirements.

The Self-Employed Women's Association (SEWA) of India is an example of the full-service model. SEWA saw improved health care as crucial to their strategy of improving the quality of life, ensuring that women's health needs are met, and enhancing member empowerment. They began as an agent for United India Insurance Company (UIIC) but took over the insuring of their members because of UIIC's rigidity and lack of maternity coverage. They copied the coverage and pricing of UIIC, added maternity and, subsequently, cataract, hearing aid and denture coverage. SEWA packages this product with life and property insurance for one premium.

The last model is the provider model, in which the provider and the insurer are one. These providers, usually doctors, clinics, or hospitals, offer policies to individuals or groups. The policies cover general ranges of care limited by the services available within the provider's unit. Often providers offer capitation agreements whereby the insured pays a fixed amount and coverage is provided for a certain period, making administration easy. The insured pay their fee and access services whenever needed. Financial accounting is conducted through the books of the provider who is responsible for all technical issues relating to the coverage (pricing, risk management, and care), and absorbs all the risk.

An example of the provider model is the GRET program in Cambodia. EMT, GRET's microfinance program in Cambodia, recognized that although their credit products were assisting clients to improve income levels, medical problems could rapidly negate any improvements. At the same time, EMT management realized that the risks, and expertise required to offer insurance, were formidable, and they wished to retain an organizational focus on growth and improvement of credit and savings products. Therefore, they requested that GRET create another entity to develop and test health insurance products in an overlapping client market.

THE CASE STUDIES:

Table 1 shows selected details of the four programs. None of the organizations studied are regulated insurers. Two are related closely with microfinance organizations, and all but GRET serve urban markets.

Table 1: General Information on the Insurance Programs

	NHHP/FINCA Uganda	UMASIDA	SEWA Health	GRET Health Insurance
Type	Insurer/MFI	Organization of Community based insurance programs	Non-Profit Insurer	Primary care provider and insurer for other care
Model employed	Partner (NHHP)-Agent (FINCA)	Community-Based	Full-Service	Full Service and Provider
Year scheme formally started	1999	1997	1992	1998
Target market	FINCA Clients and their families in greater Kampala	Labor groups around Dar es Salaam	SEWA members and husbands	Residents of certain communes
Total number insured as of June 30, 2000	625	?[2]	23,214	711
Majority of clients urban / rural?	Urban	Urban	Urban	Rural
Geographical coverage of program	In and around Kampala	Around Dar es Salaam	Mostly Gujarat State	2 rural communes
Reserves	None, but get underwriting and operational subsidies from DFID	None	Fixed grant amount (approximately $225,000)	None, but get underwriting and operational subsidies from GRET

The NHHP/FINCA and GRET programs are still in the early phases of product testing. Only GRET and NHHP implemented adequate testing protocols, and they are moving through their tests and collecting data in order to make educated decisions about the viability of their products. The other two, UMASIDA with three years, and SEWA with eight years of experience, are more settled with their products and procedures, although SEWA is currently reviewing its operational structure, products, and pricing.

For the past two years, UMASIDA's oversight manager has devoted less and less time to the project, providing only part-time oversight and marketing, and membership has actually declined as a result. Of all the programs, only SEWA (eight years in operation) services substantial numbers of clients at this point, but membership has declined even here in the last two years from a peak of about 32,000.

SEWA is the only one of the four that maintains significant reserves (provided by GTZ and carrying a principal-plus-inflation maintenance requirement). GRET and NHHP have donor backup to cover both operational and claims loss deficiencies, while UMASIDA, which had received initial donor funding, has no reserves and no reinsurance. These latter three are thus in a precarious position, but at least GRET and NHHP are working to rapidly improve their sustainability (see Table 4).

[2] See note 1.

Table 2 summarizes the individual products. Both NHHP and UMASIDA offer coverage that is virtually complete with few restrictions and reasonable limitations. Both require clients to seek medical care from specific providers – Nsambya Hospital for NHHP, private clinics contracted by the mutual group for primary care and a state hospital for secondary care with UMASIDA.

Table 2: The Insurance Products Offered

The Products:	NHHP/FINCA Uganda	UMASIDA	SEWA Health	GRET Health Insurance
Coverage	In- and Out-patient full coverage: • Tests • Medications • Basic dental • Basic optical	In- and Out-patient full coverage: • Tests • Medications	In-patient with related medications and tests, plus grant for: • Maternity • Cataracts • Dentures • Hearing aids (Single premium also provides death, widowhood, and property coverage)	Basic in-home: • Primary care • Preventive care • Education • Check-ups Restricted cash benefits for critical health risks of the: • Surgery in the torso, • Childbirth • Funerals
Exclusions	• Continuous medication for chronic diseases • Self inflicted issues • Addictions • Elective surgery • Hearing, sight, dental appliances	Medications outside the "essential" drugs list	Pre-existing and chronic illnesses	• Medications outside the "essential" drugs list • Illnesses not on specific list
Limitations	• Care only from Nsambya hospital (two additional dentists and one other pharmacy) • 3 weeks in-patient care per 3 month period for chronic diseases • $235 in any single	• Insured need permission from gatekeeper executives to utilize services • No amount limitation • X-rays and expensive tests provided in state	• Covers only expenses related to illness or accident that requires more than 24 hours hospitalization ($27.27 annually). • Maternity ($6.82 grant), cataracts ($27.27), dentures ($13.64), and hearing aids ($22.72) only covered for "lifetime insurees". • Certain procedures only after one year. • Ages 18-58.	• Cash benefits cover only serious matters of the "trunk of the body"(surgery $51.95) • Delivery (normal $3.90, suction/forceps $15.58, Caesarian $46.75). • In-home care only for specific limited list of illnesses (mostly intestinal, respiratory, and fever related illnesses). • Above amounts are cash benefits and require only confirmation of treatment by GRET doctor.

	period of illness	hospitals.		

SEWA reimburses clients for in-patient care only in state medical facilities, and coverage is limited to particular ailments. GRET provides limited in-home preventive care, and reimburses clients for secondary care, limited to certain illnesses.

INCENTIVES FOR CLIENT HEALTH:

Health insurance is more effective if people are cured earlier in the illness cycle, thus limiting the overall negative financial impact on the client. The optimum incentive system, satisfying the range of client's health needs, offers control over the costs and quality of medical treatment, and incorporates preventive care and education. These systems vary in the models.

In a community-based model, the clinic actually has incentive to keep people returning, so no preventive activities are offered. Additionally, UMASIDA groups restrict early access to medical treatment because members are required to get permission from a group leader prior to obtaining care. Members stated that often their request was rejected because they were deemed "not sick enough" and it would cost the group "too much."

At UMASIDA, doctors report that they see no difference between insured and uninsured clients in the stage of illness in which they first come to the clinic. One provider even suggested that UMASIDA clients seem to seek care later in the cycle than average. Furthermore, doctors have an incentive to over-prescribe drugs and/or prescribe drugs on which they make greater margins, and group leaders have the opportunity (and incentive) to steal the group's funds. Such a structure undermines rather than guarantees quality health care.

In contrast to the doctors at UMASIDA, NHHP reports that their clients seek care earlier in the illness cycle than do the uninsured. Clients corroborate this data. Partly this has to do with NHHP's corporate philosophy – that people will be healthy only when their medical care is comprehensive. Additionally, NHHP advises clients to seek care immediately upon the onset of illness because it is cheaper for the insurer to stop an illness early in its cycle, and because the overall cost to clients (including lost earnings due to illness) is lower.

In the partner-agent model, there is an entity between the insured and the provider that offers a level of control over the quality of care and cost of services. NHHP uses a full-time doctor/administrator for the plan. Staff nurses in the hospital confirm and track the insured, track care data, and provide health care education. The potentially high volume of insured clients is used as a tool for negotiating costs and care elements. Preventive care reduces the overall cost to the client and the insurer, allows a potential price reduction and thus access to a greater number of poor clients – and maintains client health. Clients report generally improved health. One client, who had "free" medical care through her husband's job, stated: "before, my family was perpetually sick, and now we are all healthy because of this scheme." This organization has the incentive and capacity to make and keep its clients healthy.

In the provider model, the doctor offers both formal and informal preventive care. After enrollment, insured are examined and recommendations made for addressing existing conditions to get clients to a basic level of healthfulness. GRET seeks to stop client illness at onset with door-to-door primary care, though there are many restrictions as to what illnesses can be treated. When GRET clients require secondary care, a set cash benefit is provided to offset the overall cost of care.

Although GRET's direct provision of primary care has provided a level of service to the rural poor that few wealthy are able to access – personalized in-home health care – in at least one commune, this service is provided in close proximity to, and in competition with, a government health center. Subsequently, they have gained better knowledge about the cost implications of home delivery of

primary care and have decided to shift their clients to utilizing the local clinic on an insured basis. GRET has incentive to keep people well so that they can minimize secondary care treatment costs, and they have the capacity to create a client-health-focused structure.

In the full service model, SEWA covers preventive issues through a separate SEWA unit, the "Barefoot Doctors." This unit, when working jointly with the insurance division, enhances the level of care clients receive in terms of preventive and primary care, and accessing the hospital. The problem is that the "Barefoot Doctors" are not covered as part of the basic insurance product, and the basic product is structured so that there is no incentive for clients to be treated early in the illness cycle. Instead, clients are forced to get sicker in order to access the insurance coverage (provided only after 24 hours of hospitalization), and then, the reimbursement (made after almost three months) covers an average of only 22% of the cost of hospitalization.

PREMIUMS VS. COVERAGE

Table 3 summarizes the basic premiums charged by each of the institutions. There is a large disparity in both the price and the level of coverage among the different programs. The basic premiums charged by these programs vary from $1.56 to $11.68 per person per year for GRET and NHHP, respectively. This range generally reflects significant differences in coverage purchased with those premiums – the higher the premium, the broader the range of coverage.

Table 3: Insurance cost to the Client

Relevant Issues	NHHP / FINCA Uganda	UMASIDA	SEWA Health	GRET Health Insurance
Basic Premium (annualized)	$46.70 (4 persons at an average $11.68 per person)	$31.30 (6 persons at an average $5.22 per person)	$1.65 for client only	$1.56 (per person)
Co-payments	$0.66 per outpatient visit, $1.33 per in patient visit	None	Balance over set coverage amount	$0.26 for adult in home care plus the cost of medications
% average medical costs coverage	90.7%	100%	22.0%	15.6% (hospitalization only)

Higher priced, broader coverage raises the question of the ability and willingness of the poor to pay the premiums. This question becomes critical if the intended market is the poor, as it is in each of these programs. The question must be set against the scenario for the uninsured poor. When the tragedy of illness strikes, the poor will typically borrow from family, neighbors, and/or moneylenders, and will sometimes sell assets, to cover medical costs. It is not just the outflow of resources to pay the medical bill that is the problem, although this is significant enough. They subsequently have fewer productive assets (equipment, land, inventory), reducing earning potential, or fewer household resources (grain stores or cash lost to interest paid for an emergency loan). This often plunges families into greater poverty, and the situation as a whole ultimately increases the vulnerability of the household.

Insurance has the potential to smooth the financial shock of medical crises and health care for the poor. In order to fulfill this role, however, three conditions must exist. First, the cost of premiums must not be so high that it pushes people to sell assets, increasing household vulnerability. Secondly, the coverage should be reasonably comprehensive. The trick, of course, is to satisfy both conditions with a financially sustainable program. Third, there should be a mechanism that allows clients to pay the premium with a minimum of financial stress.

The four cases studied demonstrate serious gaps in some of these conditions. SEWA and GRET offer low premiums – and state that their pricing decisions were based on discussions with potential clients. Their plans are, therefore, theoretically affordable for clients. But the coverage provided by these two plans is extremely limited – an average of 22.0% and 15.6% coverage of actual costs of care – and structured as reimbursement for receipts. Clients are forced to pay large amounts out of pocket for their medical needs, and only a small percentage of this is reimbursable. At both SEWA and GRET, clients reported having to sell assets to cover the cost of care. Additionally, although GRET usually provides its cash payment while the patient is still in the hospital, reimbursement from SEWA takes almost three months. Thus, with SEWA, those needing care still need to cover 100% of health care costs from their own resources. Low premiums with low coverage do not smooth the health care shocks for clients.

Contrast this with NHHP. Here, clients pay a much larger premium – about $1.00 per month compared to $1.50 per year, but coverage is comprehensive and clients are encouraged to obtain services as soon as they are ill. When they need care, they simply need the co-payment, and are covered with no additional cost to them. NHHP clients who made use of the services stated that the price of the insurance was less than what they had paid in the past when they were uninsured and suffered from an unplanned-for illness.

On the other hand, premium payments for comprehensive coverage can be easily beyond the capacity of the poor to pay. To address this, NHHP, UMASIDA, and SEWA (even with its highly restricted coverage) have developed mechanisms to help clients pay the premiums (see Table 4). SEWA has created a special fixed deposit account in the SEWA Bank, and clients direct the interest earned to pay the annual premium. This is painless for the insured as long as they continue to maintain the designated balance. UMASIDA groups decide individually on the appropriate payment mechanism to match their member's cash flow, often a daily premium collection. NHHP aligns its premium payments with FINCA's four-month loan cycles so people can save weekly with FINCA and then use those funds for the premium. FINCA also offers an option to borrow the premium. By creating a savings mechanism, which allows frequent small payments, even the poor can afford reasonably comprehensive coverage and protect themselves and their families from health care financing shocks.

The key is to provide broad coverage at a premium level that the poor are willing to pay because they see the value in the product, coupled with a mechanism to minimize the negative impact of the premium payment, and a constant effort to improve efficiencies on the part of the insurer. More research is needed to better understand the relationship between what the poor say they "can" pay versus what they actually will pay for full service insurance

SUSTAINABILITY:

Sustainability should be a priority for Microinsurance programs if the poor are to be served over the long term. As shown in Table 4, NHHP, UMASIDA, and GRET are far from overall sustainability. NHHP and UMASIDA are not yet covering their claims costs, and UMASIDA is in serious trouble with a growing deficit to clinics and dwindling premium payments from the groups. As the deficits grow the clinics are rejecting the clients and this further reduces client incentive to pay premiums. On top of this, all external funding for UMASIDA has ceased.

NHHP structured its test phase to experience maximum utilization in which to test its systems and to generate information about potential sustainability. They selected their initial groups closest to the hospital (there is a direct correlation between claims and distance from the hospital), and expected significant testing of the system by insured clients (regardless of illness or lack thereof). Costs were expected to be high initially and then settle down as people gained confidence in the system and new groups were added from areas further from the hospital. The test expansion stalled in the second cycle (due to institutional transformation issues) and they experienced a very high attrition rate (see Table 4). This has had a negative impact on sustainability, but is expected to reverse in future cycles.

Table 4: Program Cost Coverage

Relevant Issues	NHHP / FINCA Uganda	UMASIDA	SEWA Health	GRET Health Insurance
Sustainability: Premiums paid / Claims received	74% (10/99-6/00 covering first six months of operation)	Between 50% and 75% by individual group. (1-6/00)	124% (1999/2000).	178% (1/5/99-30/4/00) only includes the cost of secondary care
Sustainability: Income to Total expenses (claims, operations, reserves, and others)	38% (10/99-6/00) Strong plans for improved performance, sustainability likely.	Approximately 50% after six years	N/A	8% (1/5/99-30/4/00)
Mechanisms for Aiding client Premium Savings	Savings can be accumulated through normal weekly FINCA savings, paid in full each four months, or borrowed	Groups collect in agreed manner, often daily, from insured	Annual premium, or maintenance of a set level fixed deposit with interest allocated to premium payment.	Annual payment only, with plans for split payments (two and three installments).
Attrition	Average 42% in first 4 month test cycle	Individual groups report as high as 75% dropout after the last price adjustment.	Dropouts not tracked	69% and 42% from the first and second commune, respectively.
Pricing methods	Premiums based on projected costs with objective of sustainability. Slow on adjusting for actual costs	Premiums were originally set very low based on group self-pricing. Increased often in attempt to cover costs.	Premiums copied from United India Insurance when SEWA took over insuring their members	Premiums based on actual results and projections of costs.

GRET is also in its test phase, but has recognized, through the input of two periods of actual results to their projections model and the related adjustments, that the primary care delivery as provided is not viable. In response, they are altering their model in at least one commune to provide primary care through local clinics rather than through GRET's own doctor. This should significantly improve their overall sustainability.

GRET has more than covered their claims costs for the secondary care cash benefits, but this ratio only includes the cash benefits versus the total premium. The difference of 170% between basic and overall sustainability dramatically demonstrates the impact of the primary care delivery costs. UMASIDA and NHHP, for example, report between 25% and 40% operational costs (the difference between the two sustainability values in Table 4) versus 170% for operations and primary care for GRET.

SEWA shows coverage of their claims from premiums, but a reasonable value for the unit's operational costs was not available. Without this figure, it is difficult to assess whether or not SEWA can adjust

coverage to make it more comprehensive. The high level of claims sustainability is related to the limited nature of the coverage and the requirement of public hospital care. Another important factor in SEWA's ability to offer this program and cover its basic claims costs with a very low premium is the strong subsidy component provided by SEWA's health care program and the "barefoot doctors" service. Though not directly associated with the insurance program, these other services provide accessible primary health care, preventive care, and direct assistance to insurance clients to help them to access insured services. This creates a more comprehensive package for clients in areas of parallel operations.

ATTRITION:

Attrition was astonishingly high for three of the programs, yet each institution expected that clients would be very excited about the insurance product and that retention would require only minor effort. In fact, there are a number of reasons for the attrition, including changes in price and/or services, lack of effective marketing, local drains on cash flow due to natural disasters, conceptual misunderstanding of insurance, and reduction in pent-up demand.

Sometimes, as with UMASIDA and GRET, attrition was strongly related to pricing and service adjustments. GRET doubled the premium to enhance institutional viability. UMASIDA increased the price frequently and reduced service (due to high arrears to the clinics). In addition, members had unrealistic – and unmet – expectations of donor subsidies, which contributed to a significant dropout of both individuals and groups. Of the six groups that were part of the initial test, only one remained after two years.

SEWA has not tracked attrition, though they have experienced an overall decline in the number of insured members by 6% each in 1999/2000 and 2000/1. They offer a single entry point to the program each year during four weeks in June/July. During this period in 2000/1, Ahmedabad (where most of their clients reside) was hit by flooding that damaged member's homes and businesses significantly. Thus, there was little money available for the annual premium payments. This resulted in many fewer applications from annual payers, and those that remained in the plan are likely the wealthier clients, since generally it is the wealthy who are able to attain and maintain a fixed deposit account type membership through otherwise disastrous situations.

NHHP lost 42% of its clients in the second cycle, but the reasons for the attrition are less clear. The product was new and anecdotally popular, the demonstration effect was dramatic with several clients reporting that they "would have died" without the insurance, and there was no adjustment in the premium.

The cause may be poor client understanding of the benefits of risk pooling. Several clients expressed the concern that they had bought the policy but had not gotten value from the program. Basically, those who used the services were pleased; those who did not felt cheated. One client's husband would not let her renew since she had "wasted" the money in the previous cycle, although she knew that illness "can come anytime".

Indeed, clients in each of the four institutions made similar comments, indicating that clients misunderstand the purpose of insurance and the concept of risk pooling. Insurance programs need to market their products effectively and educate their clients. If clients do not understand the product, they are not likely to continue purchasing it.

There may be additional reasons for NHHP's attrition. NHHP has no exclusions for preexisting conditions. Anecdotally it is known that women, especially, will refrain from obtaining proper care of personal ailments. This creates a pent-up demand for care. It is possible that clients purchased policies to clear up these pent-up problems. One client reported that prior to the insurance her family was "perpetually sick, but now all my family is healthy." Others confirmed this sentiment. It is possible to speculate that some of those who have become healthy have dropped out, and are waiting to enroll again

until they build another critical mass of illness. These high attrition rates deserve additional study so that we can better understand the dynamics of the microinsurance business.

MANAGEMENT AND CONTROLS:
The insurance business requires specialized skills and management capabilities. Formal sector insurers are normally regulated and have supervisory oversight to ensure that management is adequately skilled and that they exhibit appropriate fiduciary responsibility in their insurance activities. Ultimately, the objective of supervisory boards is to protect the consumer who pays premiums and expects coverage under the agreed terms. Insurance managers are required to create a controlled environment that protects and increases the capitalization of the company and its reserves.

None of the institutions studied is a formal, regulated insurer. These institutions have, however, created a series of controls to protect their insurance business and their clients. Table 5 provides a summary of some of the more significant controls implemented by these institutions. Generally, they are protecting against adverse selection, moral hazard, fraud and abuse, and cost escalation.

The particular controls and management systems have evolved from the methodologies and institutional objectives. For example, the three programs related to Microfinance business activities (FINCA, SEWA, and GRET) recognized the specialized requirements of professional insurance management, such as the importance of separating insurance risk from their finance business, and the benefits of minimizing the insurance-related administrative burden on their rapidly evolving Microfinance business. Therefore, FINCA partnered with NHHP, and EMT convinced GRET to start a new institution. These strategies helped them to provide a potentially useful product to clients while absorbing only minimal management energy and no additional risk. GRET and NHHP also had the strongest controls. GRET stays on top of things through daily visits to the communes, and NHHP uses digital access control systems.

While SEWA created a separate insurance unit within the SEWA structure, it still required significant senior manager input. In terms of controls, SEWA covers claims directly to clients by reimbursement after claims are processed through their control mechanisms. Further management changes are being considered. Under the new insurance law in India, SEWA management is currently exploring options to convert their insurance operations into an insurance cooperative which will isolate the risk from the Bank, and maintain its own management structure

Because of institutional objectives to maximize client participation, UMASIDA chose the community-based model. They did this to empower policyholders in a model that had been successful in creating an insurance industry in developed countries many decades ago. This methodology has not been successful as implemented by UMASIDA. Group leaders are not professional managers, yet have a great deal of responsibility. In general, they seem unable to manage the systems, get frustrated with all the work involved, and find themselves tempted by the premiums. The organization has experienced serious theft by many elected leaders, they have had difficulty developing and maintaining an adequate pricing scheme, and controls are weak due to informal relationships between leaders and members. Every group visited has historically experienced a change in leadership because of fraud. Ultimately, all but one of the initial test groups left the scheme, and almost all replacement groups are receiving quit notices from their health care providers due to poor financial management by the groups and UMASIDA. This dramatically demonstrates the need for professional management of insurance products.

Table 5: Summary of Significant Controls

	NHHP / FINCA Uganda	UMASIDA	SEWA Health	GRET Health Insurance
Controls to Manage Insurance Risks (not a comprehensive list)	• Adverse selection controlled through FINCA group participation requirements (60% in a group must join). • Moral hazard controlled through client IDs and co-payments, with digital ID at the registration desk. • Fraud and abuse controlled through coverage limits, medical and cost reviews, and digital ID. . • Control over cost escalation through cost confirmation but limited.	• Adverse selection is poorly managed with premium unit size not controlled • Moral hazard controls limited with nighttime access controls stated but not evidenced, and very weak leader oversight. • Cost escalation controlled through UMASIDA doctor review of bills and care provided, and agreement between clinic and UMASIDA. • Fraud and abuse by group leaders is rampant.	• Adverse selection is controlled through access being limited to the client only and large potential risk pool. • Moral hazard controlled through reimbursement process with medical claim reviewed by a doctor, plus insurance committee reviews all claims. • SEWA reports that they control cost escalation through limiting covered care and setting minimal coverage reimbursement levels. • Fraud and abuse is controlled through coverage limits and reimbursement process.	• Adverse selection is limited through requirement of the "whole" family being insured. • Moral hazard limited by virtue of GRET staff presence in the village every day. • Cost escalation control is favorable because of staff doctor with annual salary, and the set cash benefit protects GRET from increasing hospital costs. • Fraud and abuse is controlled through coverage limits, though client transactions are conducted in cash with the insurance agent in the field.

PRELIMINARY CONCLUSIONS:

One example of each offers only a small glimpse into the broader picture of the four models and their application. However, the cases were selected because of their prominence as insurance provision test cases.

The examples demonstrate the **benefit of having a separate entity provide the insurance**. In each case where the insurance grew from a Microfinance provider, the MFIs created or found another entity to provide the insurance. When the distinction is clear, the MFI is protected from risk and the need for insurance capacity and reserves, and the insurer obtains an efficient service provision mechanism.

The **incentives to obtain and maintain client health** were skewed in the community-based model so that most incentives seemed against good health – doctors wanted frequent visits from insured, group leaders stole group premiums, and no one provided preventive care. The other models, especially as the insurer became more clearly defined, provided greater levels of action to obtain and maintain health among their insured.

Though **insured report a preference for complete coverage**, and many stated that they would pay for it, studies are needed to clarify the balance between what clients say they can pay and what they actually will pay when they see the product, confirm the benefits, and understand the concept of risk pooling.

Clients generally stated that they wanted insurance products, however, universally there was **poor understanding of the benefits of risk pooling** and this exacerbated the problem of attrition. Adding a preventive out-reach (and one is planned by NHHP) might provide a perceived continuous benefit to clients, thus improving retention as well as the overall quality of health for the client and her family. This being said, there is no clear indication that the one-on-one preventive care provided by the GRET medical assistant results in any significant improvement in retention than those programs that had no preventive out-reach system. The impact of preventive systems and their relation to insurance purchase requires additional study.

The issue of **how clients save for the premiums was important**. The community-based model was best at satisfying client needs to save for premiums in small increments, yet the method was disastrous on an institutional level because of group leader theft, poor controls, and the level of effort required for an unpaid executive to collect the funds. The partner-agent model helped clients save through the agent's existing Microfinance mechanisms. The provider model required annual premiums to minimize the administrative burden, but found that clients had difficulty generating the required cash, especially after the rates increased. Offering full service, SEWA's fixed deposit mechanism through its partner bank assisted clients in saving for the annual premiums, and also resulted in a much greater retention of clients than the other models. The issue here is getting clients to maintain the required balance in the fixed deposit, adding sufficient funds when premiums increase so that the interest will cover the additional cost.

Properly testing these products was advantageous. Both NHHP and GRET had testing plans focusing on product objectives and test expectations. These plans allowed them to gauge successes and respond to problems. GRET increased premium costs when they found results deviating unfavorably from projections. NHHP proposed an increase that was not implemented. Managing the testing process for insurance products is critically important.

Assessment of the objective by FINCA to obtain improved client responses to their credit program proved inconclusive. At this very early stage, there was no evidence to suggest that insured clients showed any change in meeting attendance, individual repayment rates, or growth in borrowing. These are early results and call for additional study.

These four programs are interesting experiments, but clearly **there is still much to learn** about microinsurance. Throughout this piece, several areas for further study have been suggested. It is hoped that over time a significant pool of case studies will be developed that will greatly assist those working in the field of Microinsurance to understand their business and their clients better.