

# **Reducing Vulnerability: The Supply of Health Microinsurance in East Africa**

**Michael J. McCord and Sylvia Osinde**

**A synthesis report**

**July 2003**



*“Developing partnerships  
to insure the world’s poor”*

***Microfinance  
Opportunities***  
*“Putting Clients First”*

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## Acknowledgements

This study is part of a larger work looking at both the supply and demand side of microinsurance in East Africa. The effort was made in recognition that there is generally demand for microinsurance and that there are, at the very least, semi-formal organisations in the region that are working to satisfy that demand. However, we had little understanding of the specifics of that demand, nor a clear picture of how, or even if, it was being satisfied. In a constant push towards practicality, we decided that studying both sides of this market could provide practical information in at least two areas:

1. Developing an understanding of specifically what low-income households in this region are looking for to assist them in their risk management strategies, and
2. Identifying and documenting not only what is available on the supply side, but more importantly, what lessons they had learned that can be used to improve existing programmes or develop appropriate new programmes.

This research took much coordination and the skills, knowledge, and time of many people. Monique Cohen (MicroFinance Opportunities) and Jennefer Sebstad (a freelance consultant based in Ethiopia) coordinated the demand side study (*Reducing Vulnerability: The Demand for Microinsurance*) and assisted in the supply side with information from their research. Additionally from the demand side work, the primary researchers in each country, Altemius Millinga (who also did some qualitative research for the supply side team), Grace Sebageni, Francis Simba, Jane Mbaisi and Shahnaz Ahmed were all helpful in providing a preliminary understanding of the demand-supply relationships in their respective countries, and identified some of the supply side case study targets based on information from their demand studies. The authors thank them all for their assistance.

At each one of the institutions, we were greeted with openness and an eagerness to share. Without this, such work would have been, at best, deeply frustrating and, at worst, impossible. These institutions offered access to whatever the authors needed to see. We are sincerely thankful and indebted to the managers and staff of Microcare, CIDR, and the Kitovu Patients Prepayment Scheme (Uganda), the Community Health Plan and MediPlus (Kenya); and the Community Health Fund and Poverty Africa (Tanzania). When we visited these institutions, we also visited organisations that were related to them through the product. Numerous hospital administrators and doctors, clients and non-clients, and intermediary partners also gave of their time and knowledge to make this work meaningful. We are appreciative of their help.

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Michael J. McCord  
President – The MicroInsurance Centre

Sylvia Osinde  
Consultant

## Abbreviations

|       |  |
|-------|--|
| AIMS  | Assessing the Impact of Microenterprise Services (USAID)       |
| CHeaP | Community Health Plan (Kenya)                                  |
| CHF   | Community Health Fund (Tanzania)                               |
| CIDR  | Centre International de Développement et de Recherche (Uganda) |
| Comp  | Comprehensive  |
| FP    | For-Profit   |
| HMO   | Health Maintenance Organisation                                |
| IP    | In-patient   |
| KPPS  | Kitovu Patients Prepayment Scheme (Uganda)                     |
| MBA   | Masters in Business Administration                             |
| MFI   | Microfinance Institution                                       |
| MIS   | Management Information Services                                |
| NFP   | Not-For-Profit   |
| NGO   | Non-governmental organisation                                  |
| OP    | Outpatient   |
| PoA   | Poverty Africa Health Programme (Tanzania)                     |
| PRA   | Participatory Rapid Appraisal                                  |
| SEEP  | Small Enterprise Education and Promotion Network               |
| SWOT  | Strengths, Weaknesses, Opportunities, and Threats              |

## Foreign Words and Phrases

|                     |                                     |
|---------------------|-------------------------------------|
| <i>Munno mukabi</i> | “friend in need” societies (Uganda) |
| <i>Harambee</i>     | “pulling together” (Kenya)          |

## **Reducing Vulnerability: The Supply of Health Microinsurance in East Africa Executive Summary**

Michael J. McCord and Sylvia Osinde

Microinsurance in various forms has been available in East Africa for many generations. More recently, new efforts and formal programmes have been introduced to improve people's ability to manage their risks. Some hospitals and clinics have developed prepayment schemes. Some non-governmental organisations (NGOs) that work with low-income clients have developed risk management products like emergency credit or microinsurance products. Even some commercial insurance companies have begun to identify opportunities in this market. The quality varies from programme to programme, but it is clear that people are identifying a need for risk mitigation and that many are taking advantage of these newly created opportunities.

*MicroSave*, with The MicroInsurance Centre and Microfinance Opportunities, recognised a need to understand both the demand for and supply of microinsurance in the East Africa region. The goal was to understand what people are looking for in risk management services and match that with what is being offered, to identify market opportunities, and to understand implementation lessons of institutions currently involved in provision of services.

This paper addresses the supply side of microinsurance. The authors identified seven institutions in the region as case studies to help understand supply side products and operations. These institutions were selected based on having an active health care financing product serving the low-income market (except one). The authors wanted these potential elements in the study:

- A variety of delivery mechanisms
- A variety of organisational structures
- A mix of urban and rural institutions
- Several cases from each country
- One for-profit institution that serves the middle and upper market but that also has an interest in moving towards the low-income market (to learn lessons for professionals)

These institutions ranged from the start-up Community Health Plan in Kenya with 100 clients to the Tanzanian Government's Community Health Fund with its reported 330,000 members. Most of these institutions have limited outreach, ranging from 500 to 2,000 insured people. The for-profit commercial health management organisation (HMO) we studied covers 65,000 lives.

Each organisation we studied provides services through either a single hospital or a network of health care facilities. None of them have particularly strong governance, and most have very little insurance business capacity. Some excellent computerised systems were observed, and their benefit to a health care programme was made clear. However, in neither of the institutions with good computerised systems was the data used to anywhere near its full potential. Manual systems were sufficient for very small community-based institutions where no real data analysis is expected or attempted.

The seven institutions selected include:

1. In Uganda: Microcare, CIDR, and the Kitovu Patient's Prepayment Scheme;
2. In Kenya: MediPlus and the Community Health Plan
3. In Tanzania: Poverty Africa and the Community Health Fund

The authors visited each institution and spent three to five days in discussions with management, staff, providers, and intermediary partners about the health microinsurance programmes. Qualitative participatory rapid appraisal (PRA) sessions were held with a mix of current, past, and non-clients of each of these programmes. These discussions provided the basis for individual case studies of each of these institutions (see [www.microinsurancecentre.org](http://www.microinsurancecentre.org)). Those case studies are synthesised into this paper.

All of these institutions worked with groups – employers with low-income employees, microfinance institutions (MFIs), village groups, or others – to facilitate the marketing of their product. Those working

with employers found this far superior to working with MFIs because in most cases a single person makes the decision and there is no need to convince all members of a group.

Financially, all of these institutions have weaknesses except the Tanzanian government program where local groups collected premiums for the fund but the government paid for the medications and the care, thus allowing the fund to grow. All of them have had capital problems, and only the commercial HMO has insurance to cover its claims. The others had no reserves except the CIDR program, but its reserves were quickly depleted.

Pricing has been extremely difficult for all of these institutions. Most began with premiums that were far too low to even cover the costs of claims let alone operations costs and something for a reserve. Partly this derives from a desire to charge only “what people can afford” without consideration of the likely costs to be incurred. If these programmes are to be successful, pricing will have to be outsourced to professional actuaries.

Even with all these issues, some low-income people are getting access to better health care at an affordable price, and although there are certainly some client issues, generally they are happy with the microinsurance product they purchase. Still, non-renewals for groups have been significant and this creates difficulties regarding growth, although non-renewals for employer-based groups have been relatively low. There is tremendous opportunity in the low-income markets of these countries where formal insurers cover maybe the top five to ten percent of the population leaving the rest to fend for themselves. The institutions we studied are trying to service this market and are learning important lessons along the way, and most do try to apply the lessons as they move forward. These cases show us that realising these opportunities will take much effort, and the implementation of lessons learned as well as those yet to be learned.

Some of the institutions are implementing health prevention programmes such as bednet sales (to reduce the incidence of malaria) while others are talking about other potential health prevention activities. Several of the institutions are in some way related to healthcare outreach entities, but none have contacted them to begin to coordinate the outreach with the microinsurer’s clients.

Some good examples of risk management policies and procedures were observed. Two institutions had employees stationed at covered health care facilities, and one had a networked computer system to both confirm identities and to input health care transactions for immediate analysis and invoice control. All institutions had at least some well-considered controls however, for marketing expediency (and sometimes because of poor control over staff), these have occasionally been ignored. In most cases where this has happened, the institution found itself with a problem.

Are these institutions sustainable? For all of them sustainability is somewhat questionable. When we observe the effectiveness of some of the key areas of consideration in microinsurance – capacity, pricing, controls, growth, reserves – all have at least some strengths in one or more areas. However, in the insurance business one weakness can be an Achilles’ heel. All of these institutions are significantly vulnerable. The good news is that vulnerability can be mitigated, but for some of the smaller programmes the remedies are likely beyond their capabilities. Even so, there are other mechanisms with the potential to achieve the desired result. Outsourcing may be one answer.

These institutions provide many lessons; some of them learned the hard way, for developing similar programmes. These include:

1. Management and Governance
  - ✓ To make microinsurance programs successful, management capacity in insurance is necessary.
  - ✓ Because microinsurance is a complex business and management and staff tend to have weak capacity in microinsurance company management, it is imperative that boards be strengthened.
2. Microinsurance Products
  - ✓ Emergency loans with disbursements made directly to the health care facility can be appropriate and sometimes preferred over insurance.

- ✓ Follow a product development process when developing these products. When this is done, issues are caught early and cause fewer problems to the institution.
- 3. Operations and Accounting
  - ✓ Pricing of microinsurance products must improve. If they are to be successful, microinsurers must begin working with professionally derived premiums.
  - ✓ Underwriting needs to be simple and efficient for the low-income market.
  - ✓ Microinsurers need good accounting and timely access to management data.
- 4. Marketing
  - ✓ Marketing management is a critical ingredient in creating an effective commissioned marketing team.
  - ✓ Marketing requires a strong component of market training.
  - ✓ Employers of low-income employees have proven a very good market with efficient access.
- 5. Risk Management
  - ✓ The closer your staff members are to the health care facility, the easier it is to manage controls.
  - ✓ The partner that carries the risk should be well capitalised and willing and able to lose some money while the product is growing.
- 6. Provider/Insurer/Intermediary Relations
  - ✓ MFIs have been weak partners in microinsurance. Microfinance institutions must become more committed and involved in terms of staff incentives and support products if they are interested in getting health microinsurance to their clients.
  - ✓ Construct formal agreements with partners so that everyone is clear about their role.
  - ✓ Conduct due diligence exercises on partners. These programmes can go very wrong, and a good institution should not become embroiled in problems because of issues with a partner.
  - ✓ Coordinate external health information outreach programs with microinsurance.

These institutions are blazing a trail in a new realm. Their experiences help us all to carve out a better, more efficient, and more effective trail on the way to achieving the lofty goal of providing affordable, high-quality health care to low-income families.

# Reducing Vulnerability: The Supply of Health Microinsurance in East Africa Main Report

Michael J. McCord and Sylvia Osinde

## 1. Introduction<sup>1</sup>

### 1.1. Risk Mitigation in East Africa

It is a fact: life is risky, things happen, and crises bring financial stress – no matter who one is, and no matter where one lives. When a family has a very low income, however, and is already living on a financial edge, any crisis can push the household back into deeper poverty. Microinsurance in various forms has been available in East Africa for many generations. From the informal yet ubiquitous *munno mukabi* (“friend in need”) systems of Uganda, to the *harambee* (“pulling together”) culture in Kenya and the funeral societies of Tanzania, low-income people have come together to create mechanisms that help them to manage the financial risks in their lives. We find these activities in urban and rural areas; among low, middle, and high-income groups; as well as among men and women. People have made great efforts to manage their risks in terms of health, property, funeral expenses, and others.

More recently, new efforts have been introduced to improve people’s ability to manage their risks. Some hospitals and clinics have developed prepayment schemes. Some non-governmental organisations (NGOs) that work with low-income clients have developed risk managing products like emergency credit or microinsurance products. Even some commercial insurance companies have begun to identify opportunities in this market. The quality of service varies from programme to programme, but it is clear that people are identifying a need for risk mitigation and many are taking advantage of the newly created opportunities. In all these efforts so far, the stated objective has been to help people to manage more easily from the financial crises that everyone faces.

### 1.2. The Study

Over the years, *MicroSave* has conducted a great deal of research to understand the demands of microfinance clients and the supply of products provided to meet those demands, at least in terms of savings and credit. The efforts of low-income people to mitigate risks by whatever means they had available to them, even when these mechanisms themselves were highly risky, were a clear and recurrent theme in *MicroSave* research. Further, several of the *MicroSave* action research partners were growing more interested in microinsurance, indeed some were already providing it, but it was clear that more could be done.

To begin to address the microinsurance issues in a more focused manner, *MicroSave* initiated the MicroInsurance Centre in early 2000. Then, in mid-2002 *MicroSave*, with the MicroInsurance Centre, embarked on a major study of the demand and supply of microinsurance in East Africa.

#### 1.2.1. Objectives

The study was designed in order to satisfy several objectives:

- To understand the key components of risk that low income people in East Africa face
- To understand how these risks are currently managed by these households
- To understand what is currently available to assist these people in their risk management strategies
- To identify gaps between the supply and demand of risk mitigation tools
- To provide practical lessons learned about the supply of healthcare microinsurance
- To clearly identify opportunities for additional risk management interventions

#### 1.2.2. The Demand Side

The demand side research was conducted from May through July 2002 by a team of qualitative researchers using primarily *MicroSave* and AIMS/SEEP research tools and led by Ms. Monique Cohen and Ms. Jennefer Sebstad. This team researched issues of client risk and strategies for risk management in urban and rural areas in three East African countries: Tanzania, Kenya and Uganda. The three specific

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<sup>1</sup> Please note that there is a glossary at the end of this paper to assist with insurance terminology.

country studies will be available on-line from *MicroSave* and The MicroInsurance Centre. A summary and analysis of this work is also available on the web sites of these organisations.<sup>2</sup>

The demand side researchers found that there are six cost types related to health care expenditure.<sup>3</sup> These are:

- Short-term illnesses
- Hospitalisation
- Chronic illnesses
- Transport costs
- Medications
- Others, which include both preventive as well as curative care

The case study targets for the supply side research cover various combinations of these (although none provided transport funds<sup>4</sup>). Potentially, all of these could be insurable as part of a comprehensive package, or they could be unbundled and offered as riders to a basic plan.

### *1.2.3. The Supply Side*

This paper takes a detailed look at the supply side of microinsurance in East Africa. It presents an analysis of several risk mitigation microinsurance suppliers that are offering products available in the region in an attempt to bring out some of the key issues in their provision. The research is not spread across different product areas, but rather focused specifically on healthcare financing products in order to obtain a critical mass of information on a specific product area. This allowed for in-depth consideration of practical information in relation to one of the most important risk mitigation areas: health.

This paper will first provide information about the institutions selected for the research. Section Two reviews the microinsurance supply situation in East Africa. This review includes general comments on risk management in the region, a look at institutional structures, the product development processes used, the quality of service provided, and the risks to each the different models. Operational management is discussed in this section. Section Three addresses financial issues in terms of setting viable premiums, underwriting quality, and sustainability. The fourth section includes lessons learned, categorised according to different operational and financial areas. The fifth section offers a summary and conclusions. Several appendices are included relating to controls, common strengths and weaknesses, and other issues.

## **1.3. The Study Details**

### *1.3.1. The Research Team*

The research team included Mr. Michael J. McCord and Ms. Sylvia Osinde. Mr. Altemius Millinga conducted the client research in Tanzania.

### *1.3.2. The Study Visits*

Each research visit lasted from two to five days. Each visit included meetings with:

- Management of the target institution
- Back office staff related to the product
- Front line staff related to the product
- Any partners that the institution worked with (insurers, MFIs, or others)
- A sampling of management of the provider institutions (hospitals, clinics)
- At least two participatory rapid appraisal (PRA) sessions with product clients

During the visits, the research team sought to gain a detailed understanding of the operations of the product and the institution that offered it. Where possible, the team obtained financial details of the product and the institution.

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<sup>2</sup>Cohen and Sebstad (2003)

<sup>3</sup> Ibid

<sup>4</sup> Subsequent to the visit, the members of several groups overseen by the successor to the CIDR programme have decided to include coverage of transport for their members.

### 1.3.3. The Institutions

Seven institutions were selected within the three East African countries, all of which offer a health insurance or health care financing product. Institutions representing the four different general delivery models were included,<sup>5</sup> as well as a government-based community insurance program. In Uganda, we examined the Centre International de Développement et de Recherche (CIDR), Kitovu Patients Prepayment Scheme (KPPS), and Microcare Ltd. In Kenya, looked at Community Health Plan (CHeaP) and MediPlus. In Tanzania, we investigated the Community Health Fund (CHF) and Poverty Africa Health Programme (PoA).

We selected several of the institutions based on information provided by the demand side researchers. We chose others because they had the potential to provide important additional insights that would deepen the overall lessons learned. The institutions exhibit a range of delivery mechanisms and institutional ownership structures, as well as an urban-rural mix. The intent was to visit a variety of health insurers working in different areas so that the researchers could gain a better understanding of the dynamics of these institutions, the resiliency of the key lessons, and the opportunities available for the low-income market. Papers providing expanded discussions of each of these institutions are available on The MicroInsurance Centre website.<sup>6</sup> Basic information about the institutions is provided in Table 1.1: Target Institutions Basic Information.

**Table 1.1: Target Institutions Basic Information (June 2002)**

|                            | <i>Microcare</i>             | <i>KPPS</i> | <i>CIDR</i>     | <i>CHeaP</i> | <i>MediPlus</i>              | <i>PoA</i>  | <i>CHF</i>    |
|----------------------------|------------------------------|-------------|-----------------|--------------|------------------------------|-------------|---------------|
| <b>Country</b>             | Uganda                       | Uganda      | Uganda          | Kenya        | Kenya                        | Tanzania    | Tanzania      |
| <b>Type</b>                | HMO                          | Hospital    | NGO             | MFI/NGO      | HMO                          | MFI         | Govt.         |
| <b>Model</b>               | Partnership                  | Provider    | Community based | MFI Insurer  | Insurer (with insured risks) | MFI Insurer | Provider      |
| <b>Legal form</b>          | Company limited by guarantee | Hospital    | NGO             | NGO          | Company limited by shares    | NGO         | Govt. Program |
| <b>Year Scheme started</b> | 2000                         | 1998        | 2000            | 2002         | 1996                         | 2001        | 1996          |
| <b>Covered Lives</b>       | 776                          | 1,750       | 837             | 100+         | 65,000                       | 600         | 330,000       |

The sample includes two health management organisations (HMOs). One, Microcare, is a non-profit entirely focused on the low-income market. The other, MediPlus, is the only for-profit institution in the study. Unlike all the other cases, which work strictly with lower income clientele, MediPlus' market focus has traditionally been the middle and upper income market in and around Nairobi. They have developed a product to market to the SACCOs and their management and control structures are well developed and professionally managed.

Two MFI insurers (CHeaP and PoA) are included. These institutions demonstrate the classic issues of an institution moving into a second business area without adequate capacity. Both see health microinsurance as a necessary tool to aid their markets, but neither had proper knowledge of insurance basics and one (PoA) did not follow its own policies.

One community-based organisation, developed and overseen by the international NGO CIDR, helps us to identify some of the issues surrounding self-managed programmes and provides a very interesting comparison between insurance and emergency credit.

<sup>5</sup>These include the Community-based, Provider-based, Insurer, and Partnership models. A detailed discussion of these models relative to health microinsurance is provided in McCord, 2001.

<sup>6</sup>[www.microinsurancecentre.org](http://www.microinsurancecentre.org)

Finally, two provider model institutions (KPPS and CHF) offer a different perspective of microinsurance delivery. KPPS is managed through a mission hospital, while CHF is a government run programme that works through the network of local clinics and district health offices.

Most of the institutions are rather small in terms of numbers of insured and currently serve fewer than one thousand people. This is an indication of the lack of maturity of the health microinsurance options in the region. There is a strong recognition of a need for this product, but few programmes. However, despite the low volume of clients, all of these institutions have learned important lessons that are worthy of discussion.

#### 1.3.4. Product Information

Table 2: Basic Health Care Product Information provides essential information about the products being offered by the case study institutions.

**Table 1.2: Basic Health Care Product Information**

| <i>Institution</i>                     | <i>Microcare</i>                      | <i>KPPS</i>                | <i>CIDR</i>   | <i>CHeaP</i>                    | <i>Medi Plus</i>                                  | <i>PoA</i>   | <i>CHF</i>                                    |
|--|---------------------------------------|----------------------------|---|---------------------------------|---|--|---|
| In-Patient cover                       | Yes                                   | Yes                        | Yes   | No                              | Yes options                                       | Yes options  | No  |
| Out-patient cover                      | Yes                                   | Yes                        | No  | Yes                             | Yes options                                       | Yes options  | Yes   |
| Diagnostic tests                       | Covered                               | Covered                    | In-patient  | Covered                         | Covered   | Covered, limited   | Covered, limited                              |
| Medications                            | Covered, limited                      | Covered, limited           | In-patient needs                                      | Covered                         | Covered   | Covered  | Covered                                       |
| Duration                               | 4, 6, 12 months                       | 4, 6, 12 months            | 1 year  | 1 month                         | 1 year  | 1 year   | 1 year  |
| Limitations (in US\$)                  | IP 195 per 8 months                   | IP-44<br>OP-8<br>Per visit | 44-56 per admission (varies by group)                 | 63 annual maximum               | As per selected policy                            | As per selected policy   | Not limited for OP (no IP)                    |
| Premium (per person per year, in US\$) | Adult: \$22.00<br>Child: \$11.00      | \$5.40                     | \$2.00 (might vary by group, discount for big family) | \$4.50                          | OP: \$118.00 - \$186.00<br>IP: \$132.00- \$368.00 | OP only: \$21.00,<br>OP & basic IP: \$64.00,<br>Comp: \$213.00 | Average \$1.06 (one set fee for whole family) |
| Method of Payment                      | Lump sum at start, or by MFI loan     | Lump sum at start          | Lump sum at start, collected for three months prior   | Must be paid for upcoming month | Lump sum at start                                 | Lump sum at start  | Lump sum at start                             |
| Co-Payments? (in US\$)                 | Yes (OP: \$0.56<br>OP and IP: \$1.86) | No                         | \$1.10- \$2.80 (varies by group)                      | No                              | Yes (\$0.63- \$1.25 for OP)                       | No   | No  |
| Claims                                 | Direct to provider                    | Direct to provider         | Direct to provider                                    | Direct to provider              | Direct to provider                                | Direct to provider   | Direct to provider                            |

## 2. The Supply of Microinsurance in East Africa

### 2.1. Options for Risk Management

After recognising the potential frequency and severity of risks, people have five basic options in managing the risk in their lives. These strategies, as related to low-income households, are:<sup>7</sup>

**Table 2.1: Risk Management Options**

| <b>Risk Management Strategy</b> | <b>Implementation Methods</b>  |
|---------------------------------|--|
| <b>Avoid Risk</b>               | Low-income people tend to be seriously risk-averse, leading to missed opportunities. Often they will simply not choose options that increase their level of household risk.  |
| <b>Reduce Risk</b>              | When risk is unavoidable, they do what they can to minimise it. The focus here is to reduce overall risk and this involves forethought and planning. Where a shop is flimsy, the owner might transport valuable items to her home at night. A small manufacturer might chain his machine to a post to keep thieves from taking it or at least making it more difficult for them.   |
| <b>Share Risk</b>               | Sharing risk is very common in East Africa and includes methods where small groups gather to assist a member. These include the <i>munno mukabis</i> (“friend in need” societies) of Uganda, the <i>harambees</i> (“pulling together”) in Kenya and the burial societies of Tanzania, where people come together to help someone through a risk event. They thus share their risk among the other members of their group.  |
| <b>Retain Risk</b>              | Most people retain at least some risk because it is simply not cost effective or is prohibitive for them to access other means. In using this strategy, low-income people will try to save or develop potential lending relationships in advance of the occurrence of the risk event. Once the event has occurred, they will access these relationships, reduce consumption or otherwise restrict expenses, and sometimes liquidate personal and productive assets. Financial institutions can assist people with this strategy. |
| <b>Transfer Risk</b>            | The transfer of risk to another entity is the essence of insurance. In this case, the household experiences a low periodic expenditure (premium) that covers a significant insured risk event without seriously affecting their household or their social groupings. It is facilitating this strategy that will be addressed in this paper.  |

Table 2.1 shows that people have several general options for managing their risk. Usually, a household, of any economic level, will use several of these as part of its risk management strategy. Thus, insurance becomes simply one tool that they may choose if it satisfies voids in their strategy, or enhances their risk management in a way that clearly helps them control their costs or improve quality. This is critical in microinsurance product design.

Clearly with healthcare low-income people have many options for care. They can self-treat, visit government clinics or hospitals, or even go to private facilities depending on a combination of the amount they have to spend at any one time and the cost benefit that they perceive from the different options. For low-income people, once the self-treatment has proven ineffective, their option frequently lies with the government facilities. However, even though the governments in this region are working to improve these facilities, patients report extensive corruption, poor quality care, and relatively high expenses. Further, these expenses often come at a time when the financially responsible party is not prepared. Microinsurance products, which are simply risk pooling products that are specially designed for the low income market, have the potential to help people smooth their health care expenditure – so they can get proper care when they need it, and improve the care they receive. Microinsurance products therefore become just one more option from which people will select their risk management tools.

MFI and other financial institutions can facilitate the retention of risk with specially designed products focusing on risk management. Such products are limited, however, and few institutions offer health care savings accounts or emergency credit. One example where this has been effective is CIDR in Uganda.

<sup>7</sup> For a more detailed discussion of risks faced by low-income households in East Africa and how they mitigate them, see: Cohen and Sebstad, 2003.

### **Emergency Health Care Credit with CIDR<sup>8</sup>**

CIDR Luweero members have settled on two health risk management options to offer to their groups. The first is a community-based insurance programme with risk pooling and linked to a local hospital. The other is an emergency credit facility.

The insurance program requires a recurrent annual *premium* payment at the beginning of the year while the emergency health care credit programme requires all members to contribute a set amount of *capital*. The first year capital investment of the loan programme has the same value as the annual insurance premium for the other CIDR groups, and forms the capitalisation for the loan fund. The funds are held at the partner hospital. When someone from the group requires in-patient care, they are cared for at the hospital and the charges are taken directly from the accumulated fund. At subsequent annual renewal periods, members simply pay a small fee to cover the minimal operating expenses.

The loan is repaid to the group over a three-month period with no set repayment dates except that full payment must be made within three months of hospitalisation. The groups charge no interest. With the insurance program, there is no repayment to the group.

By the third year, CIDR clients almost exclusively chose the credit option over the community-based insurance programme. They found it cheaper overall and noted that it satisfied their needs better. Several members noted that the three months repayment period allows them a chance to accumulate funds in a more effective manner (away from desperation of the moment when someone is hospitalised) and that is what they find most helpful.

CIDR provides one important lesson: in helping low-income people manage risk, insurance is not always the answer. We need to be careful to respond to what fits people's needs the best, and listen carefully to what they tell us.

This leads directly to the next lesson: when designing programmes, it is critical to understand the market. People will buy what they want, if they can. This requires an understanding of what risks people perceive, how they are currently addressing them, and who else is providing similar resources. From there, we can develop market led products that also respond to institutional issues. The sister paper to this one is Cohen and Sebstad's *Reducing Vulnerability: The Demand for Microinsurance in East Africa*, the result of a detailed examination of the demand side issues in East Africa.

## **2.2. The Models**

In East Africa, as elsewhere, several models of microinsurance delivery are being utilised. Each of these models is represented among the selected study institutions. These models include:

**Table 2.2: A Summary of Microinsurance Models**

| <b>Model</b>    | <b>Key Elements</b>  | <b>Study Example</b>   |
|-----------------|--|------------------------|
| Provider        | Health care provider offers health care risk pooling product to cover its own services, and retains all risk | KPPS                   |
| Community Based | Owned and managed by members who absorb all risk   | CIDR, CHF <sup>9</sup> |
| Insurer         | MFI as insurer, or insured HMO coming down market. MFI or other insurer retains risk                         | MediPlus, CHaP, PoA    |
| Partnership     | Insurer works through MFI or other group and retains risk  | Microcare              |

A key element for consideration regarding the different models is where the insurance risk lies. This is a critical aspect that relates to the strength of the risk bearer and their ability to absorb the risk without destabilising the insurance activities or other aspects of a multi-faceted business (such as the capital of an affiliated microfinance business).

<sup>8</sup> McCord, 2002b.

<sup>9</sup> CHF works with community-based groups but is overseen by the government

### 2.3. Institutional Structures

The institutions in the study group are diverse in the extremes on several levels, from MediPlus (shareholder owned and for-profit), to CHaP (owned and run by the Catholic Diocese), to CIDR (village owned and managed). This diversity provides a richness of trends in institutional types from which to draw. However, this same diversity limits the ability to clearly see causal relationships by type. This noted, however, there were still several lessons to glean from this data.

#### 2.3.1. Ownership

All of the institutions studied are registered non-profits except the share-held MediPlus. Private ownership and the drive for profit clearly sets this institution apart from the others, and not just in terms of its higher income market. Clearly, private ownership pushed them to start with the upper level market, but a drive to find new profitable markets in a competitive environment has led them to invest in developing a product for the low-income market.<sup>10</sup> In fact, it is the primary shareholder that promoted this concept within the institution.

**Table 2.3: Ownership Summary**

|            | <i>Microcare</i>             | <i>KPPS</i> | <i>CIDR</i> | <i>CHaP</i>      | <i>MediPlus</i>            | <i>PoA</i>             | <i>CHF</i>         |
|------------|------------------------------|-------------|-------------|------------------|----------------------------|------------------------|--------------------|
| Owner      | Non-shareholder Board        | Hospital    | Members     | Catholic Diocese | Shareholders <sup>11</sup> | Providers as investors | Members            |
| Legal Form | Company limited by Guarantee | Hospital    | NGO         | Religious entity | Company limited by shares  | NGO                    | Government project |
| Tax Status | NFP                          | NFP         | NFP         | NFP              | FP                         | NFP                    | NFP                |

(For-Profit (FP) / Not For-Profit (NFP))

One of the key differences between the share-based HMO and the NGOs is the strength of the finance area and their focus on profitability. Although MediPlus is not yet profitable, there is a trend towards profitability with aggressive yet careful pricing, as well as strong and enforced controls. Interestingly, where the other institutions have problems is precisely in this area: pricing and enforcement of controls.

In addition, as a result of being a professionally run, share-held company, MediPlus is the only institution in the group with formal reinsurance. Their policy with Africa-Re is a stop-loss policy that is activated when the HMO's premiums are depleted.

Among the NGOs, two additional ownership models were observed (besides the rather ambiguous ownership that derives from donor funding). CIDR groups are owned and managed by their members. CIDR's objective is to work with these groups over a period of time so that they will be truly independent: managing their funds, membership, and controls, as well as negotiating with the hospital and any other relevant entities. We learned that most of these groups find it difficult to manage the insurance product, and their funds were depleted before mid-year. This is related to pricing problems as well as member management issues. In the third year, all groups had migrated from the insurance option to the loan option except for one, which was trying a hybrid method. Before the visit, CIDR had determined that it would take more than ten years of expatriate technical assistance to get these groups truly independent, and so transferred the programme to local management.

#### 2.3.2. Management

Management of these programmes encompasses a range of management ability and professionalism, from the private company (MediPlus) with its MBA senior management and well-trained middle management, to the community-based programs (CIDR) where local members manage the programmes. Physicians manage two of the schemes (Microcare and

*The quality of the programme and its potential for profitability is directly related to the skills and experience of the senior managers.*

<sup>10</sup>This same response is seen in AAR Health Services, MediPlus's main competitor, among several, in Nairobi. AAR has worked to develop a partnership relationship with K-Rep in order to gain efficient access to the lower-income market.

<sup>11</sup> The owners are three local and international business people.

Poverty Africa), and development workers manage the others (Kitovu and CHEaP), while government managers cover the last programme (CHF).

Only MediPlus' management has formal insurance experience. Management personnel from the others (except CHEaP) have attended ILO trainings on community-based microinsurance and the senior manager at Poverty Africa conducted an intentional self-education in microinsurance that included several courses. Microcare is currently searching for a senior insurance professional to become its chief executive officer.

Of the non-government programs, only MediPlus has been profitable (without donor grants) and even they have barely reached profitability in the latest reported year, 2001. MediPlus' management team is clearly the strongest of the study group with extensive insurance-specific experience and education. This organisation also has the most comprehensively skilled staff.

The other institutions we visited show management strengths in specific areas: Microcare in systems and controls (with specific computer and security expertise), Poverty Africa in working with providers (their manager is a physician), CIDR and others in working with communities. What is clear is that, as with many businesses, the quality of the programme and its potential for profitability is directly related to the skills and experience of senior management.

#### **Responses to Weak Management**

An interesting case is presented by CIDR, where local village members manage the schemes. Because these leaders were unable to adequately address pricing issues (among other reasons), members all moved towards the loan product, which is potentially much easier to manage and requires far fewer skills.

At CHEaP, potential clients noted that the price of the product was so low that they knew their costs would be far greater and CHEaP would end up with the bill. This reflects a market more savvy than management.

Although management skills and experience are critical to the effective management and development of an insurance product, the bias or priority of management and the board is another key element. This comes in two main types: social development or business. In fact, both of these priorities can be fulfilled, but it seems clear from these institutions that a business approach must be followed first. Those institutions that utilise a business approach (MediPlus and Microcare) show a decided potential for profitable insurance operations while at the same time serving the low-income market. Institutions that are mostly or entirely focused on social development (CIDR, Kitovu, CHEaP) are experiencing significant problems because of a combination of pricing issues and managerial and board objectives. The two approaches require different types of managers with a different set of skills. An appropriate combination might be to have senior management from business, and field managers from social development. In this way, the two objectives could be satisfied.

### **A Business with Weak Management**

At Poverty Africa, the senior manager is a physician and the accountant is a well-trained and experienced business professional. The senior manager recognised the benefits of health microinsurance to the low-income market in Tanzania, and thus attended several courses. He worked hard to educate himself in the field of microinsurance. The skills he developed were not enough, however, to ensure a stable and growing programme.

This organisation takes an interesting business approach in requiring participating private physicians to make cash investments in the programme based on what were wildly optimistic projections. The private physicians very naturally wanted a return on their investment, and when the actual covered lives reached a mere 0.6% of the projected volume, fraud became rife to obtain their return. Management had little experience setting and managing controls and, because the controls were limited (and ignored), fraud was allowed to continue. The programme was decapitalised to a point where management now works without pay, provider payments are several months late and lengthening, and providers are starting to refuse care to “insured” patients – all of which will lead to product failure without significant and rapid adjustments, and even then, growth will be difficult.

Finally, an important institutional management consideration is that of doctor and patient confidentiality. In programs where neighbours are managing the health care expenditures of other neighbours, such confidentiality is non-existent. This may be an important reason for insurance management to be separate from the community.

#### *2.3.3. Management Information Systems*

Management information systems (whether manual or computerised) are critical to the proper management of a health insurance programme. Without the ability to track premium payments, utilisation, and other costs, it becomes virtually impossible to adequately manage a programme, set adequate premiums, and manage controls.

The most detailed MIS were at MediPlus and Microcare. Both institutions have the ability to easily analyse usage in terms of patients, providers, diagnoses, and treatment. Additionally, although both use several provider facilities, because they have good MIS systems they are able to manage and track usage, and control (at least to some extent) the level of care.

### **MIS and its Role in Fraud Reduction**

At Microcare, management identified that 30-40% of direct health care costs are related to fraud. They concluded that in order to provide efficient coverage to the low-income market this expense must be reduced. They thus set out to develop an MIS that would effectively control fraud. To this end, they have a mixed computerised and personnel based system that virtually eliminates many opportunities for fraud. Their detailed and comprehensive software system controls transactions at the source, and provides the opportunity to review care and utilisation by patient, physician, and facility.

Microcare places a check-in desk of their own in their provider facilities, and covered patients gain access approval from Microcare within the care facility. The combination of the staff and the system combine to minimise potential fraud from clients (patient substitution and collusion with physicians), physicians (over-treating and over-prescribing), and the facilities themselves (over-billing). Additionally, having nurses staffing the check-in desks allows for an efficient mechanism of quality control for in-patients.

This system is seen as so effective that the Uganda office of the world’s largest insurance broker, Aon, has purchased use of the system and pays Microcare to install and manage check-in desks in provider facilities for Aon clients.

While MediPlus works with a comprehensive MIS (encompassing both front and back office), Microcare’s MIS was limited to front office activities, leaving the back office weak. This imbalance reduces the effectiveness of the overall MIS and has clearly made management decision-making difficult

at Microcare, with financial reporting months late and no significant link between accounting systems and insurance management systems.

Clearly there is a cost to obtaining and maintaining comprehensive MIS. However there are several areas in which costs can be controlled better given a quality system. These include:

- Reducing the costs of fraud, moral hazard, and cost escalation
- Providing experience data to enhance pricing
- Offering a control on hospital invoicing

The value of these benefits is difficult to quantify, and deserves greater research, however, the value of reducing fraud alone at 30-40%, plus the ability to better understand the risk premium components, and provide a relatively easy mechanism to review extensive invoices for chronic excess charges, is certainly significant.

Other institutions used a less detailed manual or mixed manual/Excel system. Generally, this leaves significant gaps in the information required for proper management decision-making.

At CIDR, both the hospital (which also holds the cash) and the groups keep records, and this provides a back up and controls on both parties. In addition, the hospital representative and groups hold monthly meetings to sort out the claims.

#### **Hospital-Based MIS: Information Management at KPPS**

At KPPS, the hospital accounting department itself holds the premiums and pays claims from that fund. Notification of transactions was not usually made to the scheme manager, and the manager reported that he was frequently unable to obtain even the aggregated data to reconcile. This left him with no data for decision-making, and no controls on the accounts department. It was virtually impossible to make informed management decisions with this lack of information.

The manager responded, after some time, by developing an Excel based system and hiring an assistant to input the data. The manager acknowledged that even with this new method there were still significant data quality issues. Although this approach had not fully satisfied his need for information, he was hopeful that it would improve. However, duplication of the data management process further reduced the efficiency of the system not only for KPPS, but also for insured patients who were then required to inform the KPPS office of service utilisation (to accommodate the need for data gathering in an additional location). All systems should move towards improving operational efficiency for all parties.

#### *2.3.4. Capacity*

There are several areas of capacity where issues can arise. These include management (discussed above), different institutional departments, and the providers and other partners.

During the visit, the capacity of providers to take on new patients was assessed. In all cases but one (KPPS) the providers had enough capacity to manage many times the patients that were being brought by the microinsurance programmes. Provider capacity, therefore, was deemed adequate for nearly all the programmes in the study.

#### **Limited Capacity at the Outpatient Clinic**

When KPPS was started at Kitovu Hospital (KPPS), patients were already waiting in the outpatient lobby for hours. This made marketing of the health plan very difficult since the hospital was somewhat distant from the centre of town already, and potential insured were well aware of the waiting times once they arrived. To get the hospital to address this, the scheme manager conducted a formal time study to quantitatively identify the time it took for patients to be served. This was done in a reasonably scientific manner, and the results were dramatic enough that the hospital hired another physician to reduce the delay. This helped in the marketing of the health plan, but it has continued to be difficult to change people's perceptions of this aspect of quality of care.

Institutionally, all of the microinsurers have important capacity gaps with the possible exception of MediPlus, and in the areas where institutional capacity was limited, microinsurers had difficulties.

Frequently, the primary capacity issue was in marketing. For example, Microcare lost or released most of their marketing staff and when renewals came up, they were unable to go back to clients to promote renewals. This led to a dramatic level of non-renewals.

At the time of the study, Poverty Africa only had three staff (since even they were working without a salary) and some of the providers were located far from the head office. The ability to market the programme was, therefore, limited. However, because providers have a financial interest in the programme, at least one of them actively marketed the programme in his market area.

Commonly, accounting capacity was also limited and this led to problems of management information delays, inaccuracies, and thus, poor management decisions. Where data was available, the proper information was often not provided, or management did not have the capacity to interpret it adequately. Key information for an insurance business is specific and different from that of other businesses. Where management does not understand the insurance business (as was the case with almost all of these institutions), they are usually unable to utilise data appropriately in decision-making, potentially putting the institution at risk.

### 2.3.5. Marketing

*For partnerships to be successful, MFIs will need to do more than just open their doors to insurers.*

Some microinsurers expected marketing to be efficient through partnering with MFIs, and this was the initial strategy for Microcare, KPPS, and CHaP. The success of this strategy proved to be limited for Microcare and KPPS. The MFIs they tried to work with provided little more than access to clients, and in some cases, marketing during formal client meetings was nearly impossible given MFI priorities. Subsequently, one of Microcare's partners has begun to offer a special loan to cover the cost of the insurance. This has improved the incentive for the MFI and is showing initial positive results.

The challenge of marketing microinsurance through MFIs has led to both Microcare and KPPS approaching companies with low-income employees. Management note that they are still facilitating health care financing for the low-income market, but in a manner that is significantly more efficient than struggling with MFIs.

As an MFI insurer, CHaP notes that marketing is much easier for them because they are marketing to their own clients (and therefore have a greater incentive to succeed). It is still early in their programme and what they report is primarily stated rather than actual paid-up demand.

It seems apparent that there must be incentives in marketing if programmes use intermediaries, and this provides an important issue for further study. If it could be proven that the priorities of MFIs (better on-time repayment, better attendance at meetings where these are required, and better cycle-to-cycle loan growth) are actually served through microinsurance, this might provide an incentive for them to market more aggressively. However, it is also likely that direct sales staff (cashiers, loan officers, and other front line staff) will also need incentives.

One way to provide incentives for MFIs is to encourage them to offer loan or savings products in partnership with microinsurance. Savings products, where there is an adequate investment mechanism, can provide additional income to an MFI. Health care financing loans, which potentially provide income benefits to MFIs, can also be an incentive to MFIs, but these increase the cost of premiums, by easily ten to twenty percent, and further move the product out of reach of the poorer low-income market.

### 2.3.6. Efficiencies Employed

If microinsurance provision is to be successful, efficiencies must be utilised at every level, including:

- Marketing and servicing the final client
- Documentation
- Financial transactions
- Risk management
- Accounting

*Profitable microinsurance interventions will only be possible if we make use of every possible opportunity for efficient delivery channels and product management.*

- Underwriting
- Claims processing

Though efficiency is a key for potential profitability, it must be balanced against controls and marketing. Controls are critical for the protection of capital and marketing is critical not only for selling the product, but for educating clients about the product. The trick is to maintain these in an efficient manner. Some of the institutions in our study have developed appropriate efficiencies, including:

- Marketing to employers of low-income employees. Marketing to employers is a primary marketing strategy of MediPlus. Both Microcare and KPPS are using to this strategy as a result of the difficulties they have experienced marketing through MFIs. The benefit of marketing to employers is that they may purchase coverage for their entire workforce, adding tens, hundreds, even thousands of insured as a result of marketing to one person – the human resources manager. In comparison, marketing to MFI clients entails several return visits by the insurer to close a sale with a few MFI clients.
- Monthly claims submission and payments are practiced by all the organisations sampled.
- Some organisations try to use MFI staff or others to market their product.

### 2.3.7. Health Prevention

All the institutions we studied see the benefits of health prevention, methods to reduce the potential for disease and to increase a person's ability to improve and maintain their health. All were involved at least to some extent in trying to impact the health of their clients beyond the clinic. Some of the more significant methods employed are noted here.

**Table 2.4: Examples of Health Prevention Activities**

| Method   | Institution                                | Comments   |
|--|--|--|
| Sale of insecticide-treated bednets against malaria  | CIDR, KPPS, CHEaP                          | Typically, these are sourced from a subsidised vendor. Effectiveness of the nets is limited unless a large proportion of the local population use them. None have reached such a level and effectiveness is unknown for these groups.  |
| Related organisation providing health care education | KPPS, CHEaP, PoA, CHF                      | These programmes all belong to larger multi-product organisations that have an arm that provides health care education. However, none of these intra-organisation programmes are integrated with the health care financing programmes. |
| Distribution of education packages                   | MediPlus                                   | These are distributed through employers and providers and include information on control of hypertension, HIV prevention and maintenance, diabetes control, and nutrition.   |
| Free check-ups                                       | PoA  | Offered to new members but none have utilised the opportunity.   |
| Antenatal care                                       | Microcare, PoA, CHF, CHEaP, KPPS, MediPlus | As an incentive, Microcare requires three antenatal visits to obtain coverage of birth expenses.   |
| Daily preventive health presentations at clinics     | CHF  | These were started by CHF but they found very limited demand and have stopped them.  |
| Claims history review                                | MediPlus                                   | Monthly review of claims helps to identify concentrations or indicators of issues that should be reviewed by specialists. MediPlus then suggests such additional care to members.  |

The effectiveness of any of these methods as applied within these organisations is unknown. All of them are trying to identify and address the issues that cost the most, not only to the microinsurer but to the members as well. Currently some of these institutions are trying to clarify the effectiveness of their bed net programmes, since malaria is the most frequent cause of claims and any reduction would be helpful.

The primary objectives of health prevention programmes are (1) improved health of the insured which will directly lead to a reduction in claims costs, (2) attract and retain insured clients. Theoretically, at least, consistently lower claims costs should translate into reduced premiums and the ability to attract

clients from even lower economic levels. However, two issues are critical if this objective is to be met. The first is that the intervention must be efficient if it is to reduce the overall costs of the health prevention activity. The second issue is effectiveness.

In order to provide efficient health prevention, it is necessary to use available data effectively. Institutions that are actively mining their utilisation data are most likely to be able to pinpoint their interventions. MediPlus can focus on either individuals or corporate entities when they see particular utilisation patterns and create an intervention specifically for that individual or group. Of course, they may adjust premiums based on these patterns, but this should also allow for a reduced burden on others, allowing for a premium reduction over time. Using a database is another way of determining health prevention needs. Microinsurers can efficiently coordinate with other organisations that conduct health prevention activities as their primary mission. It is interesting that none of the four institutions that have access to such a programme have made significant attempts to coordinate with them.

It is important that health prevention methods are effective since these activities can be very expensive and a sustainable institution must understand the return on their investment in these activities. Prevailing understanding of the return on these methods is often vague and limited. Additionally, some institutions are concerned that even if health prevention efforts are effective, given the low renewal rates that most microinsurers currently experience, the return will not accrue to the organisation. More research is needed to better understand the return on these interventions.

#### 2.4. Governance

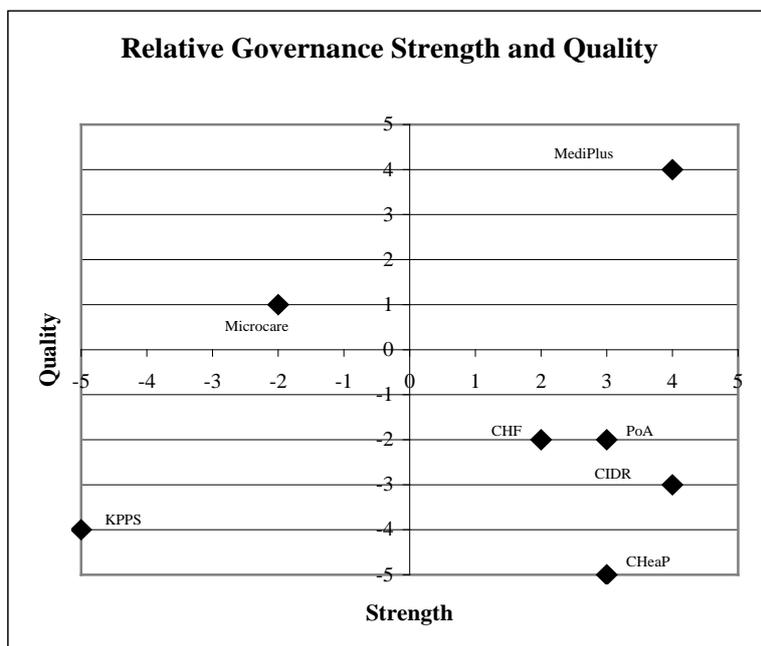
*Strength and quality of governance, with specific insurance knowledge, are keys to a strong microinsurance programme.*

As noted in Table 2.3: Ownership Summaries, the governance structures of these organisations are varied. Two key issues for consideration are the strength and the quality of these overseeing structures. Strength comes from a board's ability to actually lead the organisation, and quality comes from the ability of that board or governing body to make prudent and proper decisions based on insurance principles.

For example, CHaP has a strong board that makes all strategic decisions, but it has no significant insurance knowledge. The result is a programme that lacks even basic adherence to fundamental insurance principles. In contrast, MediPlus is the strongest and has high quality. It is governed by its three owners who all have very significant experience and education in insurance organisation management, thus resulting in a company that is managed by solid insurance principals with appropriate controls, strong underwriting and claims policies, and insurance relationships.

Microcare has provided most authority to its CEO while an insurance company executive chairs the board. KPPS is caught in a transition within the hospital with no one claiming governance over this project, and with limited oversight assistance coming from a national association. CIDR members run the groups and provide reasonable leadership, but their insurance knowledge is low. A mix of members and the government effectively governs CHF, with limited oversight from the Ministry of Health, but again, their knowledge of insurance principles is low. Poverty Africa has a reasonably strong board and the chairman has worked to learn about microinsurance, but even here, the knowledge remains very limited.

The chart below provides a general visualisation of the relative strength (the extent to which the board satisfies its role as the governing body of the institution) and quality (the level of insurance expertise available on the board) of the governance of the studied institutions:



We see most of the institutions bunched up in the quadrant of strength with limited quality. Most of these are the community-based organisations with local management that understands the people and the area, but not the insurance. KPPS is in transition and has serious governance problems. Except for MediPlus, all these institutions need to improve their level of governance in order to improve the effectiveness of their programs.

**2.5. Partnerships**

Regardless of the methodology used, each of the institutions works with at least one other organisation for treatment and/or marketing

opportunities. The most common partners are health care facilities, then MFIs, local groups, employers, and schools. Each of these relationships has demonstrated varying degrees of success.

**2.5.1. Relationships with Providers**

In entering relationships with the health care financing organisations visited, providers were consistent in their primary objectives related to:

- Increasing patient loads. Some were operating at levels as low as twenty percent of capacity, as in CHaP’s hospital partner, Saint Mary’s.
- Better manage their cash flow and minimise their collection efforts through timely consolidated insurance payments: Some, such as Microcare’s partner Kibuli Hospital, were losing nearly ten percent of their fees to “runaways” (patients who leave the hospital prior to discharge to avoid paying treatment fees).

Some providers had additional objectives specific to their situations and structures. Some of the more interesting include:

- Saint Mary’s Hospital, a CHaP partner, wants to use up a steady flow of near-expiry medications that they receive as donations
- PoA provider partners want a return on their investment to PoA

These objectives form the basis of interactions between providers and the health care financing organisations. An understanding of these objectives should not be underestimated because they drive the success of the partnership and thus of the programme itself. The more the microinsurer is able to satisfy partner objectives, the more leverage they will have in the relationship.

The impact of this is seen, for example, in discounted services. When a microinsurance programme provides a significant proportion of a provider’s business, (thus satisfying both provider objectives) these programmes have the potential to negotiate a price reduction. The table below shows the percentage of microinsurer clients to the total clients of several of the programmes.

**Table 2.5: Market Share of Microinsurer within a Health Care Facility<sup>12</sup>**

| Microinsurer | Percent of total facility patients |
|--------------|------------------------------------|
| KPPS         | 11% outpatient, 2% in-patients     |
| MediPlus     | 80% (of the Purple Hearts clinic)  |
| PoA          | 3% (on average)                    |
| CHF          | 30% (on average)                   |
| Microcare    | 10% (on average)                   |

<sup>12</sup> The percentage of the total health care facility’s patients during a period that are insured with the microinsurer.

Since utilisation by MediPlus clients is 80% of Purple Heart’s clinic, they have been able to negotiate for and receive substantial discounts on care. CHEaP also obtains discounts particularly on medications from St. Mary’s Hospital in response to the hospital’s objective to rid itself of nearly expired medications. CIDR started with a 5% discount with their only provider partner, but they have negotiated an agreement that as the insured and credit member numbers grow, this discount will increase to 12.5%. This issue is reiterated by the managing director of Microcare, who notes that as Microcare grows to the point where a

*Work with health care providers who have realistic objectives, and who see the benefits of the programme without coercion.*

significant portion of a provider’s business is represented by Microcare insured, then they will be able to negotiate as well. He suggests that this level may be fifteen to twenty percent.

The providers we spoke with echoed this sentiment. In all cases except MediPlus, providers complained that microinsurers were not insuring enough of their patients. PoA operates through a network of twenty-five providers. Of these providers, management notes that they had to push all but one into participating. Recognising the problem of low uptake, PoA management has urged providers to market the product from their offices. Management notes, however, that only provider has promoted this product in any significant manner, and he was the only one that came to PoA to participate. None of the providers that were pushed to participate have bothered to market the product, even though they all have equivalent investments in the programme.

**An Unsatisfied Objective**

At PoA, full provider partners were required to invest about US\$320 in the PoA programme. This, it was thought, would generate ownership among the providers as well as help to capitalise the programme. Providers made this investment partly based on PoA projections (which they participated in) of one hundred thousand microinsured within the first year. First year productivity actually generated six hundred microinsured, a mere 0.6% of the target.

Provider investors are now looking for a return on their investment, but there are few patients from which to earn it. Thus, these investors have responded with dramatically inflated invoices, over-prescription, and over-treatment, all to generate returns from their investment.

Certainly there are other issues in this case including weak controls, but it is obvious that a primary motivator for this level of overcharging is the lack of “promised” return to the providers. Their objective was left unmet.

**2.5.2. Relationships with Groups**

The visited programmes all work with groups in some manner in order to increase efficiency of sales and servicing. Some of these relationships are quite fruitful for all parties, especially when the partners are motivated to keep their members/students/employees healthy as a way of minimising disruptions in their broader objectives. For example, a branch manager of an institutional partner of KPPS in Uganda noted that she wants healthier clients (and client families) because she wants better attendance at group meetings, more consistent repayments, fewer disruptions to her clients’ businesses, more rapid cycle-to-cycle loan growth and, ultimately, greater profitability with fewer problems for her staff. In Kenya, employers who have chosen MediPlus admit that they have a responsibility to cover the costs of their employee’s illnesses. Working with MediPlus helps them achieve that objective easily while creating an efficient opportunity for MediPlus.

*Without seeing these products as theirs and experiencing a benefit from their sale - both in terms of direct benefits from the sale and in terms of portfolio improvement because of a healthier clientele - it is not at all surprising that front line MFI staff are not more aggressive at selling these microinsurance products.*

Microinsurers that have partnered with MFIs told us that these relationships have proven to be disappointing. Though some of this disappointment is related to issues internal to the microinsurer – lack of proper follow-up, product issues, lack of mechanisms for premium accumulation – some of the problems relate to the way the MFIs approach insurance products. The MFIs and their staff do not see these products as their own. Thus, no targets are set for policies sold or renewed and there is no direct

benefit to the front line officer who sells them. Among the busiest people in MFIs are the front line people. Without some sense of ownership and perceived benefit from their sale (both in terms of direct benefits and portfolio improvement), it is not at all surprising that front line staff do not try to sell microinsurance products more aggressively. This forces microinsurers to sell their product directly to MFI groups, losing the huge efficiency benefits that are possible with a knowledgeable and eager MFI front line staff.

To help staff understand the product better, it may be appropriate to have them insured under the same policy they are selling.

One of Microcare’s MFI partners has recently developed a loan product to help their clients finance insurance premiums. This is likely to improve the situation, but it is unlikely that these programmes will ever be truly successful and profitable as long as the microinsurance organisation’s salespeople are required to conduct the direct sales and servicing with MFI clients.

An unintended response to the difficulties of working with MFIs is that some microinsurers have begun to focus instead on the low-income employed market. Because employers are obliged to cover their employees’ medical costs, and because the usual practice of reimbursement is fraught with fraud, employers are looking for effective ways to fulfil their obligation. Thus, they comprise a ready market for microinsurance programs. By convincing one person, the personnel director for example, a microinsurer may gain hundreds of insured. This is in contrast to working with MFIs where salespersons must make the pitch to everyone, and educate and convince each member.

Microinsurance organisations have as a stated mission to provide health care financing opportunities to low-income people within their market areas. This transfer of institutional energy towards low-income employees accessed through their employers is not a fundamental shift away from this mission (since low-income employees are still, strictly speaking, low-income individuals). It does, however, represent a shift in marketing focus, a shift with broader ramifications. Although shifting the marketing focus away from MFI clients is not a complete abandonment of the working poor, it will nevertheless have the effect of shifting access from the self-employed market to the employed market, a market that is very likely a (relatively) wealthier group. If providing all working poor with access to quality medical services remains a priority, then the working self-employed cannot be left behind. MFIs still offer the best opportunity for accessing this market, and this is why it is crucial to work towards viable solutions for partnerships between microinsurers and MFIs.

The partners in these relationships each face risks including: insurance risk, risks to institutional reputation, credit risk, and others. Though schemes should place the insurance risk where it can be best managed, our research shows that credit risk and risk of institutional reputation are often not assessed through any kind of due diligence. Thus, organisations open themselves to potentially significant risks, without even working to mitigate them in most cases.<sup>13</sup>

*All partners should conduct a due diligence exercise to ensure their partner will be able to comply fully with their expectations.*

None of the group-based partners, while absorbing risk to their reputation, had made an effort to confirm the strength and capability of the microinsurer. Likewise, most health care providers, absorbing risk to their reputation and credit risk<sup>14</sup>, failed to adequately assess the ability of the microinsurer to satisfy payment agreements. The result is that many health care providers have experienced ever-increasing delays in claim payments from the microinsurers. This problem is often rooted in the issue of setting realistic premiums and exaggerated growth expectations, but the result is that providers wait a long time for their payments because less money is flowing into the microinsurer to allow them to make their payments. As an example, Poverty Africa management, with their plans of 100,000 clients have had to repeatedly visit providers to obtain more time to accumulate the funds needed to pay claims since there are no reserves and claims are paid from incoming premium payments. One provider noted that in the one year they had

<sup>13</sup> A due diligence checklist for identifying an insurance partner can be found on page 132 of Churchill, Liber, McCord, and Roth’s “Making Insurance Work for Microfinance Institutions” (ILO, 2003).

<sup>14</sup> Credit risk is related to treating microinsurer clients based on a promise of future payment from the microinsurer.

worked with PoA, they had received only two instalments on claims due to them versus twelve submitted invoices. These providers are facing increasing risk as they continue participating with the thought that maybe they will receive the claims due to them. Because they did not initially understand the abilities of Poverty Africa, they have dug themselves into a hole that is ever deepening.

As a strategy to eliminate their credit risk some health care providers, such as those that work with Microcare, require a guarantee fund. This fund, typically about US\$500, is held by the provider to guarantee claims payments from the microinsurer. The stated policy is that Microcare's accumulated client bills will not exceed the guarantee amount or services will be halted. The concept is a good one, but on further investigation, we discovered that management of the funds was weak and, in several cases, the agreement was not being followed, as there seemed to be no one in the hospital that was responsible for managing the fund/claims relationship.

### 3. Operational Results

Table 3.1 provides a summary of some of the basic indicators for a health insurance business. The results vary widely depending on the model, ownership structure, and other factors. This section will review each of these key indicators to pull out some lessons and discuss valuable issues.

Of particular interest are the administrative and claims ratios. Together, these are the key to profitability and therefore sustainability. Ideally, administrative and claims ratios combined should be below 100%, and the gap between them is available for reserves, profits or surplus, or dividends to shareholders. The only institution visited whose operations resulted in net income was MediPlus, with a combined 99.5% of premiums.

**Table 3.1: Basic Key Indicators for the Programmes Visited**

|                                  | Microcare <sup>15</sup> | MediPlus <sup>16</sup> | KPPS  | CIDR                       | CHepP <sup>17</sup> | PoA  | CHF <sup>18</sup> |
|----------------------------------|-------------------------|------------------------|-------|----------------------------|---------------------|------|-------------------|
| Total # covered lives            | 776                     | 65,000                 | 1,750 | 837                        | 100+                | 600  | 330,000           |
| # Insured / # staff:             | 38.8                    | 542                    | 878   | 209                        | 50                  | 100  | 9.5               |
| Administrative costs to Premiums | 1,073%                  | 70.9%                  | 78%   | 18%                        | 42%                 | N/A  | N/A               |
| Claims to Premiums               | 70%                     | 28.6%                  | 89%   | 133%                       | 280%                | 470% | 400%              |
| Non-renewal rate                 | 60%                     | 15%                    | 6.2%  | 100% for insurance program | N/A                 | 48%  | 64%               |
| Change in premiums written       | -5.5%                   | 98.9%                  | 11%   | 82% (2001)                 | 91%                 | N/A  | 220%              |
| Days of unpaid claims            | 89.5                    | <120                   | Nil   | Nil                        | N/A                 | N/A  | 180               |
| Reserves to claims               | Nil                     | Not Relevant           | Nil   | 12%                        | Nil                 | Nil  | Not Relevant      |

#### 3.1. Total Number of Covered Lives

Most of these organisations are in the relatively early growth stage. Microcare has intentionally limited its growth due to a lack of reserves and reinsurance. Management saw only danger in dramatic growth without such protection. The two oldest programmes (MediPlus and CHF), at six years each, both have by far the greatest number of covered individuals.

<sup>15</sup>Data at 31 May 2002

<sup>16</sup>Staff includes commissioned salespeople, annual data ending 30 June 2001

<sup>17</sup>Projections for quarters seven through ten

<sup>18</sup>Total insured number is for the whole programme, other data are from one dispensary for period ending June 2002

Geographically, these programmes are focused in urban areas but extend to more rural centres when they can find acceptable health care facilities. Some programmes are limited in their geographic coverage by linkages to a limited number of particular hospitals or other facilities (KPPS, CHaP, Microcare, PoA). Although geographic limitations also limit growth in numbers, these programmes are far from saturating their markets.

Certainly, product issues as well as marketing limitations have hindered the growth of many of these programmes. One positive example, though working in a bit higher market than the rest, is MediPlus. Even though they operate in an extremely competitive market, MediPlus has managed to garner a substantial market share. Their marketing is strong and efficient, their product is in demand, and they are reasonably flexible in adapting to specific needs.

### **3.2. Insured-to-Staff Ratios**

The ratio of insured clients to insurer staff is an important indicator of the efficiency of a microinsurance organisation. In general, the more insured clients per insurer staff member, the more efficient the organisation. Unfortunately, at this point we have no particular benchmark for this indicator for microinsurance.

KPPS, with almost 900 clients per staff member, appears at first glance to be the most efficient. Two people manage the organisation, with accounting outsourced to the hospital. However, their growth rate (change in premiums written) has been the second slowest in the study group despite the fact that premiums written had doubled during the period in which growth was measured. Although they appear efficient, they have been unable to effectively market their product and follow up the marketing to close the sales. An additional salesperson would bring the per-client ratio to 580 – still very good – while allowing for a concerted focus on sales. However, cost implications should be reviewed before such a decision is made.

MediPlus may offer the best general guide for insured-to-staff ratios at this point as it manages a large sales staff (many who receive commission only, but are included in this calculation), a strong management team, and a large claims department. These are usually the largest areas of insurance company operations (though MediPlus is not an insurer).

The other organisations have ratios that are simply too low for the long term. Fortunately, most of these have excess capacity initially built in to allow for more rapid growth, confident in the knowledge that when (if?) they get to scale, they will be able to dramatically improve their efficiency, but the initial objective is growth.

At 38.8 staff to insured, Microcare has the greatest capacity for significant additional growth but has intentionally restricted this while working hard to develop or acquire a reserve fund for their operations. Once that is done, they will be poised for rapid growth and improved efficiencies. Subsequent to the visit, Microcare acquired about six thousand clients from another programme (complete with a reserve fund) in another area of the country. The integration of this programme resulted in no net change in staffing (because of reductions in other areas) so the ratio has improved to better than three hundred clients per staff member.

### **3.3. Administrative Costs to Premiums**

Although the efficiency ratio of clients to staff is important, the real key is the cost of all those people and other administrative costs versus the premiums that are paid to cover them. Ultimately, total premiums must cover the cost of the “pure premium” (the claims), operations costs (including insurance, reinsurance and commissions), a reserve allocation, and some profit or surplus. By breaking the premium down into its component parts we can better identify where problems occur. In general, established insurers in developed countries expect administrative cost ratios (often significantly) below 15%.

This indicator is not applicable to two programmes, CHF and PoA. The CHF insurance fund simply accumulates and is intended to pay for additional medications for the scheme or fixed assets for the facility. The government pays for the operation of the health care facility and its staff directly, as well as

for government mobilisers who form and manage the groups. For the most part, therefore, the insurance fund has remained untouched.

PoA has experienced such difficult times that its senior managers have been simply volunteering their time to manage the project with the hope that the programme will grow or that a donor will step in to assist them. Thus, administrative costs are masked in this programme.

Administrative costs for all other programmes except Microcare fall well below the total value of premiums during the study period, but only one approaches 15%. CIDR keeps administrative costs to a relatively modest 18% by using a fixed allocation from premiums to fund the relatively minor administrative expenses of the local village groups (one of the benefits of this model). CHaP had not yet hired its full contingent of staff. KPPS is relatively efficient as well, though limited in their marketing effectiveness. Microcare has management and structures available for growth many times their current size, so their ratio of fixed to variable costs is heavily skewed towards the fixed, and incremental costs of growth are limited.

MediPlus, at 71%, appears to be operationally inefficient. The percentage seems high but, in fact, a significant portion of this is related to insurance premiums that are passed on to a regulated insurer.<sup>19</sup> Additional operational efficiencies could improve this ratio, but not dramatically.

### 3.4. Claims to Premiums

All of these organisations pay claims directly to the providers. This increases efficiency (improving the administrative cost ratio) and is far superior for clients than any method of reimbursement.

In general, established regulated insurers in developed countries look for claims cost ratios around 80%. Certainly, developing country ratios would be different and those for microinsurers different still. Much of the industry is so new that it is not possible at this point to determine appropriate claims cost ratios for the different models of microinsurance. That being said, however, in order to maintain any hope of profitability, microinsurers will need at the very least to fully cover their claims costs with premiums. Initially, and for a short and determined period, it may be appropriate to subsidise operations, but claims costs should be covered.

CIDR, PoA, CHaP, and CHF are not covering their claims costs through premiums. The government pays all claims costs for CHF so the ratio is largely irrelevant for them. The others all hope to become sustainable through growth. However, as long as their premium levels are not adjusted to cover claims costs, it is likely that growth will only exacerbate their problems. There is no particular efficiency achieved in terms of claims as a programme grows, except for a better negotiating position with providers in terms of claims costs or through more stringent underwriting. Thus, as the pool grows it is likely that this ratio will not be significantly altered without intervention. Institutions can grow out of operational deficits, but they are not likely to grow out of claims deficits without intentional policy adjustments.

The three organisations that are covering their claims costs (Microcare, MediPlus and KPPS) have the potential to grow into profitability. The fact that premiums cover claims and approach or fall below 85% shows that at least this aspect of their pricing may be appropriate. However, if we consider the fact that established regulated insurers in developed countries look for claims costs ratios at about 80%, MediPlus' 29% may deserve another look. Though at first glance this number appears beneficial, it may suggest several issues, all of which could be ultimately detrimental. Some possibilities include:

- The year of data collection was anomalous and subsequent periods may show a higher level of loss
- Their underwriting is too stringent, which will create market difficulties
- Their premium is too high in covering the costs of the HMO and an insurer, and this would also create marketing problems

<sup>19</sup> Because MediPlus is an HMO, it technically cannot retain risk on the health care financing it manages. Thus, they must pass on much of the premium to a regulated insurer. This insurer then takes on the risk of MediPlus' clients.

To reiterate, the key for overall profitability is that the sum of the administrative and claims ratios should be below 100%. Any gap is then available for reserves, profits or surplus, or dividends to shareholders. The only institution visited whose operations resulted in net income was MediPlus, with a combined administrative and cost ratio of 99.5% of premiums.

### 3.5. *Non-renewal Rate*

*There is little doubt that microinsurance sales and retention are easier with formally employed groups.*

As with any other business, the ability to retain clients is critical to efficient operations and potential profitability. This is especially true for a business that is selling an intangible product like microinsurance. The non-renewal rate is very high for all visited microinsurers except MediPlus and KPPS. Of the study group, MediPlus is in the most competitive market and yet is still able to retain its clients.

With retention there are positive product and service attributes, but the one commonality shared by the single provider-based KPPS and the upper market MediPlus, which is also exclusive among the group, is that these organisations primarily cover through employers. The issue for consideration is, then, how can we better facilitate retention among the self-employed?

When asked, former clients generally use one of two reasons for their non-renewal. The first is that they did not use the service, and thus they simply lost their money. This is potentially a factor of not understanding the policy or the risk-pooling concept. The second most common reason for non-renewal is that it is too expensive. This may be related to limited availability of options for accumulating the premiums, may reflect seasonality issues, or a number of other possibilities. It is important that microinsurance programmes develop an effective mechanism to monitor their non-renewals so that they can develop strategies to address the underlying causes of the non-renewal.

### 3.6. *Change in the Value of Premiums Written*

This is the best indicator of growth for an insurance organisation. Overall, we see very high levels of growth indicative of newer companies in the build-up stage. However, as expected, Microcare and KPPS both experience slow growth, Microcare due to poor marketing coupled with their reluctance to grow due to a lack of reserves, and KPPS due to operating with a small staff and no one in sales.

### 3.7. *Days of Unpaid Claims*

Tracking days of unpaid claims (claims payable/medical expenses per day) is a good way of monitoring an organisation's ability to meet its obligations and to observe trends in their liquidity. It is also an indication of the efficiency of the back office. Under reasonable conditions the average days of unpaid claims are likely to be between thirty and forty-five days from receipt of the provider's invoice.

For KPPS and CIDR there is no delay since the providers hold the funds. At KPPS, the funds are debited daily since the hospital controls the accounting for the scheme. For CIDR, the hospital holds the funds and a representative personally reviews the invoices monthly with the groups who then authorise immediate payment.

For the larger institutions, CHF bills are paid through the government bureaucracy, thus there is a delay to private providers. MediPlus was unable to provide the specific number of days of unpaid claims, but did note they are occasionally slower than their target of thirty days and then must add a second shift to their claims department (as they did during our visit). However, MediPlus has made an arrangement with their provider partners whereby if payment/settlement of claims is not made within 120 days of receipt of invoice, providers are paid a fixed amount based on historical invoice levels and MediPlus then works on offsetting any outstanding balance. In about two percent of the claims cases, payment delays result from a need for clarification or correction.

Microcare's delay to almost three months relates to cash flow problems. Many insurers will cover temporary cash flow deficiencies with growth in premiums, but because Microcare is not growing substantially, they do not have the volume and consistency of cash inflows. This problem should be addressed through growth once management is comfortable with its level of reserves.

### 3.8. *Reserves to Claims*

The insurance business is based on trust. People pay premiums over time and their expectation is that when a covered event occurs, they will actually be covered. Fundamentally, an insurer is obliged to cover those claims. Insurance companies have an array of methods that help them ensure that they can respond to these obligations. They begin with the design of the product and proceed with product controls, adequate liquidity, reserves for times when the liquidity is not sufficient and, finally, reinsurance. The only institutions in this group that are fully and adequately covered are MediPlus and CHF. MediPlus does not retain any risk through insuring all its obligations (thus requiring no reserves), and the Government of Tanzania pays all CHF's claims.

Reinsurance is generally available only to regulated insurers. Microcare, KPPS, CHaP, and PoA do not have reinsurance, nor do they have any reserves available, and their claims and administrative ratios show that the intake of premiums is insufficient to cover costs in all four institutions. Taken together, it is clear that outside support is needed to maintain them, support that is unlikely to remain indefinitely. To avoid failure, these institutions will need to improve their pricing, efficiencies, and/or product design to both generate needed reserves and safeguard the organisations.

#### **A Unique and Innovative Response to Cash Flow Problems**

Although Microcare has received some donor funding to support its operations, this organisation has experienced some seriously lean times. In order to get them through these periods and provide an additional source of capital, Microcare management began developing an IT business whereby they would provide IT services for a fee to other businesses. This included everything from data entry of large client information files, to network set-up, to the sale of use of their in-house developed microinsurance monitoring software. These activities have kept Microcare operational and have diversified their income streams so that they could begin to build at least a source of reserve cash flow, enhancing liquidity and substituting, at a basic level, for the lack of true reserves.

### 3.9. *Likelihood of Sustainability*

To consider issues of sustainability we must examine the key components of the insurance business. There are a number of critical indicators of sustainability, the most important of which is a strong and growing capital base. Our study of these institutions has helped us identify the key elements that help a microinsurer to generate a strong and growing capital base. The most significant of these are discussed in this section.

In their current state and with current trends almost all of the institutions in the study appear to have questionable long-term sustainability. There are two exceptions. One is CHF because the government currently covers the claims and operational costs while the premiums simply accumulate. By the time the government funds stop, the plan should have significant reserves that could keep them operational given good management, controls, and pricing. The other exception is MediPlus because although their capital position is extremely weak, their risks are apparently covered by insurance and their last year was profitable.

#### 3.9.1. *Insurance Capacity of Management, Staff and the Board*

Those institutions where management, staff, or board had little or no knowledge of the insurance business had several key deficiencies that together will make sustainability extremely difficult. CHaP is one example. The founding organisation had a genuine desire to help people and insurance seemed a good idea, so they introduced the product without any real understanding of its components. We found that, as a result, all the key insurance management considerations were weak and these combined make sustainability virtually impossible. After discussions with CHaP management and board, they decided to suspend their product until they could learn more about critical areas that need to be addressed in their programme.

An important component of management and board capacity is the data that they receive and review in order to make management decisions. There is a large deficit in of both data and ability to act based on that data among most of these institutions. MediPlus has strong management accounting structures and good and timely data provision. They also have a strong management team capable of reviewing the data and making decisions based upon them. The CIDR system is extremely simple and well designed for

small community-based groups. However, group management appears unable to evaluate the cumulative data and use it for decision-making. As a result, they have experienced two years in a row of depleted funds, and members have fled the insurance program. Microcare has a strong client utilisation system that is a powerful control tool, but their back office is weak and they have no accounting basis for management decisions. This limits the effectiveness of their decision-making.

### 3.9.2. Pricing

Pricing is the single most common problem that was seen in the institutions we visited. Even regulated insurers sometimes have problems with pricing – with disastrous results! Companies with weak management and insurance knowledge will not be able to adequately price a health insurance product.

The premium of an insurance product has several components, each of which must be understood by the institution. These include:

- The pure premium (the cost of claims)
- Operations expenses (including commissions)
- Different types of reserves, and
- A surplus or profit

Operations costs are calculated with relative ease in terms of projections given a reasonable assumption for growth. Reserves and surplus are often (or at least should be) matters of policy with targets set by the board.

The most difficult calculation issue comes from the pure premium. Mathematically the concept is simple enough – how many people will utilise the service and what will that service cost. Understanding these inputs however, is the realm of the actuary. But calculating an appropriate premium also requires an understanding of underwriting to determine what risks should be covered, and strong controls to ensure “legitimate” utilisation. Clearly, this activity takes specialised knowledge, and without proper pricing sustainability is impossible.

Unfortunately, only two of the institutions we reviewed had made any serious attempt at proper pricing. MediPlus contracted actuarial pricing that was further reviewed by their insurer. In addition, and subsequent to our visit, Microcare contracted a formal actuarial review to assess its risk and premium calculations, and still needs to make the required premium adjustments.

Of the remaining institutions, none had fully considered the pricing components. CHEaP, CIDR, CHF, and Poverty Africa made pricing decisions that responded more to the market’s “ability to pay” without an assessment of the related coverage and its costs. Most of the institutions priced only for their best guess at the pure premium without covering operations or building reserves and capital.

Some of the rationale used in setting premiums was that donors were willing to cover operations costs, and reserves were not even considered. In fact, all institutions studied except MediPlus and CHF had experienced very serious disruptions in cash flow due to donor expectations.

Several of the institutions in our study told us that they were attempting to grow into sustainability, but “growing” into sustainability will only work in terms of operational costs (where a small margin from many will improve profitability as the pool size gets larger). This will not work if institutions are not covering their pure premium. If the pricing on the pure premium is incorrect, growth will only continue to exacerbate financial difficulties, ultimately ruining the company.<sup>20</sup> At the time of our visit, only three of the target institutions were covering their claims costs with premiums (see Table 3.1).

### 3.9.3. Control Structures<sup>21</sup>

There are essentially two outcomes when control structures are weak: the institution will experience financial haemorrhaging until either the controls are improved or until the insurer goes bankrupt.<sup>22</sup> In

<sup>20</sup>If an institution manages to improve underwriting and controls for adverse selection, then it is possible to achieve coverage of the pure premium and thus profit from growth.

<sup>21</sup> A discussion of specific control structures used in these institutions is provided in Section 5: Risk Management.

<sup>22</sup> An example of this is Pan African Insurance in Uganda. Though a regulated insurer, they simply did not control adequately for fraud, moral hazard, and adverse selection and ended up bankrupt, leaving their paid-up customers uninsured.

microinsurance, the key controls are related to moral hazard, adverse selection, and fraud. The institutions included in this study offered a broad range of control mechanisms from strong computerised controls (as in MediPlus and Microcare), to very limited controls (as in CHaP and Poverty Africa).

The Managing Director of Microcare notes that he believes his company saves forty percent on the cost of claims due to their extensive computerised control structure. MediPlus has good computerised systems as well but may be having problems with controls on partner clinics. MediPlus clients observe that they seem to receive a different level of treatment from their non-insured friends and mentioned unnecessary diagnostic tests, over-prescription, and brand name versus generic drug provision. This could result in serious problems for MediPlus.

Poverty Africa is suffering financially due to limited controls and its inability to enforce even those. With no external funding, no reserves, claims to premiums of a reported 470%, and an all-volunteer staff (because there is no money to cover operations costs), Poverty Africa must make major changes or the institution will never be sustainable.

#### *3.9.4. Expansion of the Risk Pool*

Insurance is a business that requires large numbers of clients. In theory, as the risk pool gets larger it comes closer (in terms of service utilisation) to the average utilisation of a large population. This theory is the source of actuarial tables critical to proper pricing. Expanding the risk pool helps an institution manage its risk better and allows ultimately for even better pricing which improves its ability to market its product.

The largest institutions (MediPlus and CHF) are showing the best growth among the group. The smaller institutions, like CHaP and CIDR, are showing significant growth in percentage terms but from a very low base, so nominally these increases are actually small. Microcare has intentionally restricted growth as it searches for capital and reserves that will allow it to grow.

What is most alarming with some of these institutions is the non-renewal rate. Microcare, CIDR (from its insurance programme), PoA, and CHF all experienced substantial non-renewal rates from 48%-100%. This suggests that simply to retain the same number of insured, half to all clients must be replaced each year. When marketing is already difficult, this exacerbates the problem.

Much of the growth issue hinges on two key elements –product design, and the institution’s marketing ability. These, in turn, hinge on the level of client satisfaction, which taps the demand side of this equation. Client responses to product design are discussed in Section 4: Client Satisfaction.

#### *3.9.5. Reserves*

An insurer that hopes to be sustainable must have a mechanism to cover potential shocks to its capital. This usually includes strong controls and underwriting, a positive capital position, specific reserves, and insurance or reinsurance.

Of the study group, only CIDR and CHF had reserves, and only MediPlus had insurance relationships (but negative capital that creates significant risk). As noted, Microcare has no reserves and has responded by limiting growth. The others have operated without reserves, capital, or insurance at significant risk to themselves, the providers they work with, and their insured clients.

#### *3.9.6. Sustainability Summary*

Institutions that are strong in the above areas are more likely to achieve sustainability and profitability. The table below indicates specific strengths of the institutions we studied.

**Table 3.2: Sustainability Indicators for the Case Study Institutions**

|                | <b>Capacity</b> | <b>Pricing</b> | <b>Controls</b> | <b>Growth</b> | <b>Reserves</b> |
|----------------|-----------------|----------------|-----------------|---------------|-----------------|
| Microcare      | XX              | XX             | XXX             | X             | X               |
| MediPlus       | XXX             | XXX            | XX              | XXXX          | XX              |
| KPPS           | XX              | XX             | XXX             | XX            | X               |
| CIDR           | X               | X              | XXX             | X             | XX              |
| CHeaP          | X               | X              | X               | X             | X               |
| Poverty Africa | X               | X              | X               | X             | X               |
| CHF            | XX              | XX             | XX              | XXXX          | XX              |

(X=Poor, XX=Fair, XXX=Good, XXXX=Excellent)

Table 3.2 helps us to understand the likelihood of sustainability for these institutions. However, these institutions are ever evolving and changes can have a positive or detrimental impact on any of them. The ones that “score” lower are at greater risk, but even the more stable institutions could have difficulties. The key lesson here is that if these issues are adequately addressed, an institution has a better chance of sustainability. It is important to remember, however, that addressing the issues is not a guarantee of success, simply an indicator of potential.

*If these issues are adequately addressed, an institution has a better chance of sustainability.*

Institutions that “score” low can address the deficiencies and dramatically improve their potential. If KPPS, a relative inexpensive programme, can manage to improve its pricing and marketing, this could help with its reserves and growth. However, most of the potential for improvement is predicated on skilled management. For the lower “scoring” institutions, improved management capacity and insurance knowledge is a key to making this work. It may be, and definitely is the case with several of these institutions, that some of these management aspects must be outsourced to skilled insurers.

#### **4. Client Satisfaction**

In PRA discussions with clients and non-clients of each of the case study institutions, issues arose in three areas:

- The product
- The health care provider
- The insurer

In general, all groups noted some satisfaction with the products and the efforts of the institution to address their health care needs. All groups also had specific issues that they thought could be addressed better.

When people make a decision to purchase or, more significantly, renew their coverage, they are making a statement about their level of satisfaction with product. Their opinions develop from their understanding and benefits received from the product features, as well as the quality of service from the partners, especially the health care provider. There is certainly an “ability to pay” issue for some clients which relates to household cash flow and supersedes any demand for or satisfaction with the product. If there is no money, there simply is no money. However, it is also true that the greater the satisfaction, the greater the effort will be made to generate needed funds. Thus, retention may be an important indicator of satisfaction. People have choices about which strategies they will follow in the financing (or not) of their health care needs. When they believe they have an option that better suits their needs, they can and do shift their strategies. Microinsurers should not assume this to be a captive market.

In looking at the data, there are two distinct markets within these organisations – the MFI and community groups, and the low-income corporate market. The highest renewal rates and the greatest (generalised) level of satisfaction are with the corporate clients. These organisations see that their employees or students are receiving much better health care than before, and they have noticed that this has come with a dramatically reduced administrative burden. The two institutions in the study that have focused on the corporate market are KPPS and MediPlus, the two institutions with the lowest non-retention rate. Even Microcare, who works with some corporate clients, has noticed a dramatic difference in the level of satisfaction among those clients.

Certainly the corporate market is easier to work with than the MFI market, but this should not mean that microinsurers should abandon the self-employed market. It suggests, instead, that we still need to find better and more efficient ways of serving self-employed clients. The issues noted below from the PRA groups may help to improve servicing of this market.

*“I recall that when my son was sick two years ago, my bank account had a balance of Tshs40,000 (US\$43). I was forced to withdraw Tshs30,000 (US\$32.00); the bank requires a minimum balance of Tshs10,000 (US\$11.00). He had severe malaria and anaemia, Tshs30,000 was not sufficient, and I had to borrow money from friends and relatives. When my son recovered, I had a debt of Tshs150,000 (US\$160.00). After his recovery, I had to sell my television set to pay the debts. I think now I feel secure since I can minimise the chances of my children being admitted by reporting to the health provider as a disease strikes rather than spending a lot of time looking for money.” (Poverty Africa Client)*

#### **4.1. Product Issues**

In most institutions, clients we interviewed indicated problems with communication. From three of the institutions, clients noted a significant difference between what they thought they bought and what they did, in fact, buy. CHaP clients thought they had comprehensive coverage while they have only outpatient care, and PoA clients said the information they were given was insufficient, unclear, confusing and contradictory. CHF and Microcare clients expressed similar concerns. In contrast, CIDR works with group leadership to select the coverage that they will offer as well as determine pricing and other parameters of their group’s programme. This has a positive effect on member understanding.

If organisations expect clients to renew, they must be sure before premiums are paid that clients fully understand what they are buying. Research has shown that when clients do not understand what they are buying, they will perceive that they are not getting their money’s worth because they were unable to access the health care they expected. This is a communication and education issue. Microinsurers can improve this situation if they concentrate on client education rather than marketing.<sup>23</sup>

Exclusions and limitations, for example, create difficulties for clients when they are not adequately communicated. Several groups noted the limitation that they must use particular health care facilities because the locations were often distant (as with CIDR and KPPS). MediPlus and Microcare clients noted that the ability to choose among different facilities mitigated the limitation of having to use only certain facilities. However, Microcare clients are unsatisfied with the exclusion of chronic care treatment and medications. This has had an impact on growth and retention, yet including chronic care coverage would drive the premium cost significantly higher. One suggestion was to make an arrangement for insured clients to purchase discounted chronic medication so that they feel they are benefiting in some way.<sup>24</sup>

KPPS, CHF, PoA, and Microcare clients all noted that paying the premium in one payment in advance was difficult for them. CHF clients noted that the organisation did not even consider seasonality of income in their collection efforts. Helping clients generate funds for premium payments will help to increase the client base by minimising the “inability” to pay, and some institutions are innovating in this area. CHaP offers an advance payment option (which can also be problematic) whereby as long as the member has their premium paid up by the first of the coverage month, they can make payments in any frequency. Microcare had just begun testing a loan facility with one of its MFI partners at the time of the study.

#### **4.2. Provider Issues**

Clients expressed concern with quality of care and treatment by hospital staff. In general, people had no interest in access to poor quality providers, and some expressed doubts about the care they were receiving

<sup>23</sup>Education versus marketing is difficult to get salespeople to address since they are often simply looking for the initial sale, and do not consider the need for renewal. CIDR addresses this through separating marketing and education. Incentive structures might assist in this area, for example, there may be an initial incentive payment for acquiring the client, and a payment that is more substantial for the renewal of that client.

<sup>24</sup> Offered in a presentation to the Board of Directors of Microcare in June 2002 by Janet Schenk McCord, the team leader of the Minority International Research Training program that had investigated clients’ attitudes towards Microcare.

through their plans. KPPS and CHF clients in particular had concerns about the quality of care at their provider facilities. MediPlus clients noted that although the urban health care facilities are of acceptable quality, the rural facilities are not. Microcare management has noted that they simply will not offer coverage in an area that has poor quality or untrustworthy medical facilities and staff. In many of these areas, quality of health care is an issue that will limit the ability of microinsurance programmes to provide health-financing options in rural areas.

People noted that some of the health care facilities frequently ran out of medications. This forced insured clients to purchase drugs from non-affiliated providers with no option for reimbursement. Some of the institutions (MediPlus, Microcare, and CHF) address this by allowing clients to choose their health care facility from among several qualified providers. If they are not equipped, people simply go to a different participating clinic the next time. Microcare works with mission hospitals and to accommodate times when the hospital runs out of needed medications, they have established a relationship with a multi-branch pharmacy. In the CHF programme, affiliated clinics are allotted a certain quantity of medications by government drug stores so that core drugs will always be available to their members.

#### **Improving the Quality of Health Care**

KPPS is a provider based microinsurance programme. Early in the programme's history, management found significant difficulties in selling their health care financing product because potential clients had no confidence in the quality of care available at the hospital. After several months of marketing difficulties, the programme director conducted a detailed study of treatment and care at the hospital. He found that the wait for consultation was excessively long, the consultations were most frequently with nurses and not a doctor, and that staff treated patients poorly. This report was presented to the hospital management committee and, after some consultation, an additional treatment room was made available and another doctor was hired to work the outpatient clinic. This resulted in a dramatic improvement in the wait time, and a doctor saw most of the patients. Those who used the service noted the improvement, however, because the perception of poor quality persisted in the area, it was still difficult to convince people of these changes. This was slowly occurring based on the positive comments filtering out to the community from those who did use the service.

In more developed countries, insurers and health care facilities often agree on treatment protocols to ensure standardised care (in most cases). In PRA discussions, KPPS and CIDR noted no perceptible difference in their treatment because they are insured, but clients from PoA, Microcare, and MediPlus all perceived that they are treated differently than non-insured patients. MediPlus clients noted seemingly unnecessary diagnostic testing and prescriptions of name brand drugs. Microcare clients perceived unnecessary testing.

Clients of PoA believe that they wait in provider waiting rooms longer than other patients and possibly received reduced levels of care. They linked this treatment to complaints from providers about the delays from PoA in paying their claims. It was clear from the PoA example that the financial relationship between the insurer and the health care facility is not properly managed and that this had a detrimental effect on patient care. Without a good financial relationship, providers will stop servicing the insured or treat them poorly, and this will have a strongly negative impact on growth and marketing.

*“Now, we don't have to worry about what will happen to our families if they fall sick and we don't have any money to take care of them. I know that if my child falls sick suddenly, I can just walk to a hospital and get good quality healthcare even if I have no money on me.”* (Microcare Client)

#### **4.3. Microinsurer Issues**

PRA participants were willing to offer their views about the microinsurers themselves, and a number of important issues were identified. In two cases, clients and non-clients alike expressed concerns about the sustainability of their microinsurers and chose to either leave the programme or not to join at all. This is not, by any means, a unanimous response but it shows that there are potential clients that do consider the stability of the insurer in their decision-making.

Many PoA clients were concerned that PoA would collapse because of a lack of funds, and this concern was based on comments providers had made. They knew that they had paid their premiums, and could not understand why the bills were not being paid and many clients expressed their intention not to renew to protect themselves from loss.

At CHaP, clients and non-clients alike were convinced that everyone's care would cost more than the premiums, but participants were split in their responses to this keen perception. Some bought or planned to buy the policy because they knew that they could benefit very quickly from the scheme. When asked how the balance of medical costs (beyond what had been paid as premiums) would be paid, one client offered, with a smile from ear to ear, that CHaP would simply have to pay it. Others decided not to buy the plan because they were convinced that the programme would not last and they believed that if they paid the premium and joined, the funds would be depleted before they had a chance to use the services and their money would be lost.

Several clients expressed a belief that insuring more people would help the institutions become more sustainable and thus protect the clients' access to care. They noted that they did not understand why PoA, KPPS, CHF, and Microcare did not work harder to get more members. Several mentioned the poor level of follow-up by some of the organisations that, they presumed, must lead to significant non-renewals.

Although many of the people we work with in microinsurance do not fully understand the risk pooling concept or basic insurance fundamentals, they can see the obvious: when bills are not paid the company is in danger, and when the price is too low the company cannot survive. When they see the obvious, they respond rationally through non-renewal or not buying at all. Even potential clients recognise the importance of proper pricing and aggressive marketing. Microinsurance managers should also recognise this.

*"It is very difficult these days to get assistance for treatment. If you do not have the money, you will just be left to die. With death, people can easily assist you, but not [with] sickness. Sickness is for you and your family."* (Poverty Africa Client)

## **5. Risk Management**

Risk management in insurance is a cross cutting activity that influences most management decisions. It starts with prototype design, and continues through underwriting and claims, control structures, pricing, MIS, reserves, and insurance and reinsurance relationships. In microinsurance, controls are generally focused on mitigation tools for the common insurance risks of moral hazard, adverse selection, cost escalation, and fraud. Without controls in these areas, the door is open to abuse that can destroy the company. In many cases, this has already happened. Conversely, when these areas are properly managed, an institution has much better potential for profitability.

A summary table of the controls that are used by the case study institutions is presented in Appendix 1: Managing Insurance Risks - Strategies Used by Case Study Institutions. We found that in most of these institutions, many of these risk management tools were weak.

### **5.1. Moral Hazard**

Moral hazard is defined as the possibility that people will act differently with insurance than without. For example, there is a moral hazard that an insured person will bring her neighbour's child for care and say that he is among her insured children. Insurers control for moral hazard mostly through restrictions like claims limits, exclusions, and limitations on the product, as well as through identity control, co-payments, and deductibles.

All of the case study institutions require their clients to show an identification card when accessing treatment. Usually these cards have photos of the primary insured on them and in some organisations, each insured family member has their own card. These cards are presented upon arrival at the health care facility to confirm their insurance status.

Two institutions (Microcare and KPPS) have their own staff at the provider facilities to confirm patient identity and to assist with the logistics of receiving care. The other institutions require identification as

well but these organisations leave the confirmation of insurability to health care facility staff. At both MediPlus and PoA, there is evidence that providers sometimes “confirm” people who are actually not insured and charging the organisations under the name of an insured person, thus committing fraud. Microcare management notes that even though there is an added cost to having someone at the facility, and they use nurses in these positions, they believe that the reduction in fraudulent claims pays for this many times over.

All organisations in the study also use pre-selected health care facilities so that they can identify those that will provide quality care and (hopefully) show integrity in their dealings with the insurer. The vetting process for these relationships, however, is often weak.

Many of the insurers require small co-payments to access care in order to weed out frivolous claims. All have been careful to ensure that the co-payment is efficiently applied, and the amount of the co-payment is balanced between the need to have a minor restriction to care on the one side, and the institutional requirement that clients obtain care early in the disease cycle on the other.

Some institutions have implemented claims limits to control their maximum liability and again keep clients from frivolous access. Such a policy requires both good systems and rapid communications with providers. Most of the institutions we visited, however, do not have the capacity to manage this requirement in a timely and accurate manner. Institutions must be able to implement their controls: it does no good to have great policies with no ability to enforce them.

## 5.2. *Adverse Selection*

Adverse selection is the tendency of people with a higher-than-average chance of loss to seek insurance at standard (average) rates which, if not controlled by underwriting, results in higher-than-expected loss levels for the insurer. An example of this is the person who hides his high blood pressure and diabetes and buys a comprehensive medical policy at the common rate, knowing that his utilisation will be high.

To combat adverse selection, insurers will often require initial examinations to confirm the health of the potential client, though none of case study institutions do that. Other strategies are to source clients from groups, require a waiting period prior to care provision, create specific risk pools of people with similar levels of risk (a separate pool for the housemaids, and one for the welders, for example), and examine the costs of a specific client or group of clients. They use these strategies to make sure that people of average health pay an average premium, and ultimately so that people pay appropriate rates for their specific risk level.

Risk pools are difficult to create for microinsurance because it is difficult enough to market insurance products to this sector, and people will have difficulty understanding why their neighbour pays half as much as they do. Thus, for the case study institutions, adverse selection controls focus on waiting periods and group membership.

Waiting periods in these institutions range from none (KPPS and CHF) to one hundred and twenty days for in-patient care (MediPlus). All organisations offer immediate access in the case of an emergency, but wish to stop clients from buying insurance because they are sick now and know that the cost of their care will be more than the cost of the insurance.

The institutions in this study all work with groups in some way, both for reasons of efficiency and to limit adverse selection. Some work with corporate clients who wish to cover their employees, and in these cases they usually get all of the low-income employees covered at once. Others, like Microcare, KPPS, and CHaP, access MFI groups. With these groups, since the products are not mandatory, the microinsurer requires sub-group purchase by at least 50% or fifteen members (whichever is higher) from each group (KPPS and CHaP require 60%). The expectation is that this requirement, coupled with family member coverage, will create a mix of risks that in aggregate will be near average.

Microcare and KPPS have both, in the past, reduced these requirements for marketing purposes. The result for each was at least one group where all the insured members were sickly and required much more care than average. This became very expensive, and each has vowed to stick to their policies regarding

minimum group purchases in the future. Even following such a policy, the insurer still runs the risk of signing a larger percentage of adversely selected clients, unless the requirement is that one hundred percent of the group purchases the product.

### 5.3. *Cost Escalation*

Microinsurers set premiums and require payment in advance of treatment, and the term of coverage for these institutions ranges between six months and one year. During this period there could be upward adjustments to the price of medical care that were not accounted for in setting the premium, and this could have a serious detrimental effect on the stability of the institution. Insurers typically try to counter the risk of cost escalation through agreements with providers, but this requires the insurer to have leverage in terms of numbers of clients (MediPlus and CHF) or a special relationship with the provider (CHeaP and CIDR).

MediPlus has so many clients for the clinics it uses (80% of the market for one clinic) that they have negotiated price limits with the providers. This both controls their costs and often reduces the aggregate cost through discounting. CHeaP was able to work with the regional network of Catholic mission hospitals to obtain pricing agreements on consultations and medications. Even with relatively few clients, CIDR was able to negotiate a 10% discount at their provider hospital. PoA has at least gotten providers to continue serving clients as they work out their financial arrangements. Microcare management predicts that they will be able to negotiate with their providers once they account for 10-15% of the provider's business.

### 5.4. *Fraud and Abuse*

Fraud is intentional deceit used in order to obtain something from someone else. When fraud occurs in an insurance relationship, it is commonly due to actions by providers. Providers sometimes charge for services not provided, deliberately bill a higher price than normal, or provide generic drugs while billing for brand names. Medical insurance business fraud is often rampant and can mean the downfall of insurance companies. Thus, control of fraud is critical to the success of microinsurance organisations.

Common fraud control tools include:

- Expense verification: Ensuring that the insurer has charged the correct amount for treatment
- Identification confirmation: Making sure the person that is treated is the person that is insured (discussed in Section 5.1)
- Advance payment and the ability to terminate treatment in case of fraud
- Limitations can relate to drug type or to the amount up to which an insured person will be covered. While this might not be entirely effective, it does put a ceiling on the amount for which the insurer can be defrauded
- Agreed pricing lists to an extent ensure that the provider does not over-charge for a treatment course – KPPS has an agreed drug price list with the hospital

The institutions we studied have been somewhat weak in their ability to verify expenses. None of them have treatment protocols that must be followed by providers to control the types of expenses that may be incurred because of different treatment plans ordered by different physicians. Thus, it is difficult for insurers to know when extra, unnecessary expenses have been added. Most institutions in the study have found that their clients cannot confirm the care they have received, and if the insurer rejects certain treatment costs as unnecessary, the doctors argue that it is they (the doctors) who are skilled in medicine and not the microinsurer. All of this ambiguity makes fraud more possible.

Microcare considered fraud to be its biggest potential enemy and implemented a stringent defence plan. They place Microcare nurses in the health care facilities and approve each new charge on the spot, with the patients confirming provision of the charged items. When a client leaves the hospital, Microcare already has in its database the details of every related transaction. When the invoice from the hospital comes, Microcare can easily confirm each item. Where there are charges not in the data base, Microcare has soft and hard data to research and if the charge is still not accounted for in Microcare's system, the invoice is rejected. Microcare management notes that when they began implementing these controls, numerous additional charges were identified, saving them significant amounts of money. As hospitals have gained a better understanding of these controls, additional charges have all but disappeared.

KPPS also has immediate knowledge of health care transactions, but the system is fraught with risk for internal fraud. The invoices go directly to the hospital accounting department. The hospital accountant then pays the invoices from one pool of funds (KPPS) to another (Hospital Income), both of which she controls. KPPS has had difficulty reconciling these transactions, and separation of duties would suggest that KPPS should approve the payment of all invoices before they get to the accounting department.

CHF reviews invoices each month at a meeting with the hospital representative and community group executives. Invoices are matched with information from the group, and payment is then authorised by the groups. CHF reviews invoices with the district medical officer even though they are paid directly by the government. MediPlus requires a separate claim form for each covered patient and confirms the invoices against the agreed upon price ranges.

Interaction with provider physicians to review treatment or to interact as mutual professionals can be an important safeguard against provider fraud. Of the institutions studied, only two did not have access to physicians, but in two of the institutions the senior manager is a physician.

All the institutions require advance payment of premiums covering the period of care before access is available. This helps them to ensure that an adversely selected client does not obtain care without at least having paid the premiums. Additionally, if clients are found to have committed fraud against the insurer, their coverage is immediately terminated. This is a positive control in theory, however only MediPlus, Microcare, and KPPS had the ability to quickly inform the health care provider of service termination. These organisations all have direct and rapid access to the provider: Microcare and MediPlus with their networked computers, and KPPS and Microcare with their on-site staff. The ability to interact with the provider aids in the control processes.

### 5.5. *Risks to Partners*

In addition to the insurance risks presented and discussed above, there is a relationship risk and a risk to partner reputations involved in each of these programmes. Lack of high quality service provision on the part of any player has a negative impact on the other partners. These relationships require a level of due diligence to minimise the potential risk to any of the partners.

For example, the delinquency in payments to providers by PoA affects the cash flow of the providers and reduces the organisation's ability to market its product. The perception of poor quality service at Kitovu Hospital made it difficult for the KPPS program to obtain new clients. At least in the urban areas, MediPlus is very careful about confirming the quality of care provided by its approved clinics and hospitals. They look for respected clinics that are clean, capable, stable, and convenient, both to better serve the client and to minimise the risk to their reputation – in fact, to improve their reputation through leveraging the good reputation of the clinics.

### 5.6. *Risk Summary*

Insurance is the business of managing risks. This section has examined five types of risk that are common with microinsurance programmes and large-scale insurers alike. Among the institutions in the study that are having some success and that have the potential to gain significant outreach and profitability, we have seen that they considered risks carefully in the early stages of product development. They integrated controls into the product design and followed procedures from the beginning, and now continue to monitor their effectiveness and adapt controls as necessary. Institutions that have taken an *ad hoc* approach to controls (and to many of the other key issues identified in this research) are having serious difficulties and their sustainability is questionable.

## 6. *Common SWOT Analysis*

It was clear during our visit that these institutions have many commonalities in their strengths, weaknesses, opportunities and threats. We have consolidated these common issues in Appendix 2: Common Strengths, Weaknesses, Opportunities, and Threats. It provides an overview that can be generalised across the field of microinsurance (exemplified by these cases) of what seems positive and where more work is needed. Ideally, this analysis will help practitioners to identify areas of further study and capacity-building focus. The table addresses the SWOT issues within the specific categories of

Product, Operations, Marketing, Accounting, and Risk Management, as these were deemed critical areas for success. Some of the key issues from this appendix include:

- **Keep things simple:** Simple products are easier for people to understand. The application process should also be easy, with access in areas where people meet.
- **Price realistically:** An aim towards comprehensive coverage by some organisations shows an effort to provide complete care at a reasonable price, but that price has been erroneously calculated and not fully inclusive of all costs, thus limiting the potential for sustainability.
- **Develop capacity:** There is an attempt to develop innovative products and delivery mechanisms to provide quality care, but management lacks the capacity to make these innovations effective or successful.
- **Educate clients:** Although the marketing approach is frequently through commissioned sales, a viable structure for marketing microinsurance is lacking. Market education is needed, with marketing coordination and standardised marketing presentations to keep the message straight. Microinsurers are borrowing the aspect of commissioned sales from insurers but have not recognised that there is an underlying structure that makes it work.
- **Analyse the data:** Some organisations are assessing at least some of their accounting data, but generally these departments are weak and management is left to make decisions without the value of accounting data. This makes them vulnerable.
- **Place controls at provider sites:** Risk management is stronger when there are microinsurance representatives at the health care facility. This allows for on-site implementation of controls by the organisation that has the most to gain if controls work. Leaving controls to the health care facilities, which have an incentive to cheat, is risky, and some of the organisations in this study are experiencing the related problems. This is not a practical solution for all sites, but may be appropriate for facilities with greater volume.
- **Educate and incentivise staff:** These are the people who will operationalise the insurance business and this business is often far from the educational or experiential background of most of these busy workers. If they do not understand the microinsurance product and have an incentive to sell and service it, the product will not be well sold or serviced, and the program will have significant difficulties in efforts to grow.

There is a very large market open to microinsurers who respond to the low-income market's needs while structuring products and processes that satisfy institutional goals, but there is still much work to be done to get there.

## 7. Key Lessons Learned

Lessons from visiting these case study targets were numerous and rich. These programmes have had successes and have made mistakes, all of which have provided them with lessons for the future. Many were shared during the visits as we explored the development of their products and their operations to service them. Details of their products and operations and even most of the lessons have been presented above. In this section, the lessons are synthesised and summarised.

### 7.1. Management and Governance

- ✓ For microinsurers to be successful, management capacity in insurance<sup>25</sup> is necessary, not just a nice addition. Those institutions with insurance capacity, either within the institution or outsourced, are making better decisions about critical aspects of the microinsurance business.
- ✓ Because microinsurance is a complex business and management and staff tend to have weak capacity in microinsurance company management, it is imperative that boards be strengthened with strong and knowledgeable people who can and do actively oversee these programmes.
- ✓ The bias or priority of the board is a significant determinant of potential success. There must be a balance of business priorities, to make the institution profitable, and social priorities, to keep the

<sup>25</sup> Management capacity in insurance would include an understanding of the different major components of the insurance business such as underwriting, claims, and marketing, as well as a basic knowledge of the components of pricing insurance product and risk management. Like all company types, the insurance industry has particular elements that require a specialised knowledge. These are the insurance management skills that improve the potential for success of a microinsurance business.

focus on the low-income market. However, the board must guide institution towards profitability within the constraint of the market.

### 7.2. *Microinsurance Products*

- ✓ Emergency loans with disbursements directly to the health care facility can be more appropriate than insurance, and sometimes preferred by clients.
- ✓ In-patient-only coverage requires a mechanism to allow clients to gain hospital admission efficiently. Risks to the client, costs, and relationships should be minimised so that when they need admission, they can obtain it without significant additional costs.
- ✓ Follow a stringent product development process when developing these products. Too many of these institutions skipped the demand work and went from prototype to rollout without any proper testing. Most of the problems they encounter could have been cleaned up in a more controlled manner if it was part of a test. Fixing problems when the product is already rolled out has proven very difficult and negatively impacts growth. Typically, one of the problems is with pricing because of limited information on utilisation and uptake.

### 7.3. *Operations and Accounting*

- ✓ Pricing of microinsurance products must improve. Insurance pricing is a technical activity and NGO microinsurers are not doing it well. Clients in most of these programmes have had to suffer endless increases in premiums while the institution tries to get it right, and still none of them are close to sustainability pricing given current trends in client base growth. Professional actuarial assistance is expensive, but if they want to be successful, microinsurers must begin using them to move towards charging professionally derived premiums.
- ✓ Risk management policies, like the requirement of uptake of sixty percent of a group by KPPS and CHaP, must be followed religiously. Some institutions have adequate policies, but for marketing expediency they ignore them and almost always suffer for that lapse. A caveat: make sure from the start that the policies make sense for the market and are enforceable. This requires practical flexibility and innovation to fit strong controls within the low-income market.
- ✓ Underwriting needs to be simple and efficient for the low-income market. There must be efficient, easy-to-understand underwriting tools and policies, both in terms of assessing individual risk (which should be minimised or eliminated wherever possible), and in educating people to understand the applications. It is clear from our study that low-income clients have difficulty filling out applications if they are too detailed. Additionally, in a practical sense, review of client applications is weak or non-existent in institutions that serve the low-income market.
- ✓ Microinsurers need good accounting systems and timely access to management data. Where this is the case, management appears much better equipped to make decisions. However, capacity to know what they are seeing, and then what to do about it, is also a critical requirement, though typically lacking.
- ✓ A computerised system may be expensive, but it can be extremely helpful in tracking health care utilisation that is necessary for proper pricing, underwriting, risk management, corporate management, claims, and health prevention activities. Without this information, management decision-making is weakened, and there would be virtually no chance of obtaining reinsurance.
- ✓ Claims processed by the insurer and paid directly to the provider are far superior to reimbursement programmes. However, the insurer must fulfil payment requirements within a reasonable time, at most sixty days, otherwise this creates problems for the providers and ultimately destabilises the microinsurance programme.
- ✓ Because these cases have shown the difficulty of managing microinsurance, the institution that takes on the insurance risk should be manage it as a separate business from any other activities.

#### 7.4. **Marketing**

- ✓ Marketing management is a critical ingredient in creating an effective commissioned marketing team. These teams need coordination, oversight, and clear targets and objectives, as well as a mechanism to ensure that they are providing a consistent message. Most institutions have poor marketing management.
- ✓ Marketing requires a strong component of market education. Where market education is limited or non-existent, renewal rates are lower. In their push to make the sale, marketers do not always inform people properly about exclusions and limitations in favour of promoting the product. Perhaps someone other than the marketer could confirm that people understand the risk pooling concept and the details of the product before the sale is closed. Methodologies like the Freedom from Hunger “Credit with Education” might prove to be one effective mechanism for providing this market education.
- ✓ Employers of low-income workers have proven a very good market with efficient access, a simple, almost painless, premium collection method, and generally lower utilisation than MFI clients. These are all factors that will help microinsurers move towards profitability. This market should not serve as a replacement for the MFI market, but should be viewed as an additional market opportunity.
- ✓ Access to convenient, good quality providers with flexibility in client choice is important in marketing and retention. It also introduces competition into the programme and provides an incentive to providers to treat their covered patients well. However, the financial relationship between the provider and the insurer must also be good for both parties in order for the provider to want to satisfy the covered patient.
- ✓ MFIs still hold significant potential as a sales and service intermediary for microinsurance products. However, there is still work to be done to develop a combination of efficient inputs and incentives to help them become successful. The self-employed sector is often the largest in many of these developing countries. We need to improve access to them and find ways to do this through MFIs.

#### 7.5. **Risk Management**

- ✓ The closer staff is to the health care facility the easier it is to manage controls. Those with staff placed in a provider facility to work with clients appear to have minimised the potential for fraud, as well as improved cost management.
- ✓ The partner that carries the risk should be well capitalised and willing and able to lose some money while the product is growing. Institutions without reserves or significant capital are at serious risk and ultimately may lose the insured’s money and the institution’s capital, as well as leave providers with large unpaid invoices. Ideally, the institution that holds the insurance risk should be a regulated insurance organisation because they have potentially better controls on them to make sure that they will perform as agreed with both client and provider.
- ✓ Adverse selection must be controlled, especially in the low-income market. With people who have little disposable income and little knowledge of insurance, the first purchasers are likely to be the sick who are confident that they will benefit a great deal from their premium. Minimum absolute numbers or percentages of groups should be implemented and enforced.

#### 7.6. **Provider/Insurer/Intermediary Relations**

- ✓ MFIs have been weak partners in microinsurance. Before they will make a strong effort, MFI management must understand and appreciate the benefits to the institution that should accrue from a microinsurance product. Without active support from the MFI and its management, microinsurers are forced to market directly to MFI clients and when this occurs the benefit of the efficiencies they had hoped to gain is lost. For this reason, simply allowing an insurer access to clients has not been successful. Microfinance institutions must become more involved in terms of

staff incentives and support products. Without these, front line staff will not be interested in adding one more thing to their to-do list. The key to all this is clarifying the benefit of health microinsurance to MFI managers in terms of improvements to their bottom lines. This requires additional research.

- ✓ Construct formal agreements with partners so that everyone is clear about their role. When this is not done there is, in almost every case, needless misunderstanding between players.
- ✓ Conduct due diligence exercises on partners. These programmes can go very wrong, and a good institution should not become embroiled in problems because of issues with a partner. Problems with the provider, the intermediary, or the insurer could create problems for the others. Confirming that the organisations one works with are stable and likely to perform well in the relationship must be done in advance of entanglements.

### 7.7. *Health prevention*

- ✓ Coordination between microinsurers and related health information outreach programmes could prove an efficient and effective means of improving the volume and quality of health care information getting to the insured clients. Better knowledge of preventive care should help reduce the claims costs in some areas.

## 8. **Conclusions**

This study looked at seven very different institutions providing health care coverage. The market focus for six of these is low-income families. The institution that works with the middle and upper level market was also reviewed in the hopes that it might illuminate some issues that we did not see in the low-income market providers. In fact, all of these institutions provided important practical lessons that can help new and already active institutions in their efforts to provide health microinsurance to the low-income market.

Sustainability and, alas, profitability, has been a difficult objective to reach for each of the institutions studied. All are trying innovative ways of reaching the market in terms of specially designed products or delivery channels. Some of these are effective, while some are not.

Most of the methods for service delivery are relatively new, and the institutions that are trying them, indeed developing them, should be commended for their efforts to bring what is clearly an important addition to the risk management strategies available to low-income households. Their successes provide us lessons, as do their mistakes. Their flexibility to continue adjusting as they learn new lessons is an important lesson in itself.

The issues identified in this study, and particularly in sections six and seven, are practical issues that can be, indeed must be, addressed by any microinsurance activity to improve their potential for sustainability.<sup>26</sup>

These institutions are blazing a trail in a new realm. Their experiences help us all to blaze a better, more efficient, and more effective trail on the way to achieving the lofty goal of providing affordable, high quality health care to low-income families.

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<sup>26</sup>For those who wish to dig more deeply and learn more about the individual institutions, the individual case study reports can be found at [www.microinsurancecentre.org](http://www.microinsurancecentre.org).

**Appendix 1: Managing Insurance Risks: Strategies used by Case Study Institutions**

| <b>Risk:</b>   | <b>General Strategy:</b>  | <b>Specific Strategy:</b>  |
|--|---|--|
| Moral Hazard   | Pre-selected providers  | Work with a network of providers (all institutions)  |
|  |   | Network is from the same religious group making negotiating easier (CHeaP)                                     |
|  | Claims limits   | Depend on cover purchased (allows client choice) (MediPlus)  |
|  |   | None (PoA, CHF)  |
|  |   | Fixed with single product (Microcare, CIDR for some groups, KPPS)  |
|  |   | Limits set but no efficient means to monitor and manage them (CHeaP)   |
|  | Co-Payments   | Depend on cover purchased (MediPlus).  |
|  |   | None for inpatient (MediPlus)  |
|  |   | None (PoA, CHeaP, CHF)   |
|  |   | Always (Microcare, KPPS)   |
|  |   | Some CIDR groups require co-payments   |
|  | Loss review   | Conducted regularly (MediPlus, Microcare)  |
|  |   | Annually (PoA)   |
|  |   | Monthly (CIDR)   |
|  |   | None (KPPS, CHF)   |
|  | Exclusions and limitations  | Extensive with MediPlus  |
|  |   | Limited - excludes chronic care (Microcare)  |
|  |   | Chronic care of HIV (CHeaP)  |
|  |   | Limited (CIDR, KPPS)   |
|  | Proof of event  | Customer care nurses check on in-patients every day (MediPlus and Microcare)                                   |
|  |   | Based solely on provider invoice (PoA, CHeaP)  |
|  |   | Confirmed for both in- and out-patients at insurer check-in desk (Microcare)                                   |
|  |   | Confirmed by KPPS in-hospital clerk  |
|  |   | Confirmation by group executives (CIDR)  |
|  | Client identification   | Each client must present ID at health care facility to receive treatment. (All institutions).                  |
|  |   | Client ID matches client number and / or photo in data base so further confirmation of ID is possible.         |
|  |   | Verification is responsibility of provider (all but Microcare and KPPS)  |
|  |   | Evidence of patient substitution with some providers (MediPlus, PoA)   |
|  |   | Cards are replaced each year (CIDR)  |
|  |   | ID presented to KPPS clerk and provided with access form (KPPS)  |
|  | Pre-approval of treatment   | Out patient registration nurse must check validity of patient's cover prior to receipt of treatment (MediPlus) |
|  |   | Patient must get admission pre-approval (MediPlus, Microcare)  |
| In emergency, patient must get admission approval within 48 hours (MediPlus) |   |  |
| In facility check-in desks provide pre-approval (Microcare)                  |   |  |
| None (PoA, CHeaP, CIDR, CHF, PoA)  |   |  |
| Deductibles  | None required (all institutions – too difficult to track such a system) |  |
| Initial exams  | None required (MediPlus, Microcare, PoA, CHeaP, CIDR, CHF)              |  |
|  | Available to clients, but not used as underwriting tool (PoA)           |  |

| <b>Risk:</b>                                | <b>General Strategy:</b>          | <b>Specific Strategy:</b>  |
|---|-----------------------------------|--|
| <b>Adverse Selection</b>                    | Initial exams                     | None required (MediPlus, Microcare, PoA, CHaP, CIDR, CHF)  |
|   |                                   | Available to clients, but not used as underwriting tool (PoA)  |
|   | Whole family membership required  | Whole family membership is not required (MediPlus, PoA, CHaP, CHF)   |
|   |                                   | Require member plus at least three (Microcare, KPPS)   |
|   |                                   | Whole family (“living under one roof”) membership required (CIDR)  |
|   | Required membership within groups | Generally new clients must be a part of an employer group (MediPlus)   |
|   |                                   | Require greater of 50% or 15 members of group to join (Microcare)  |
|   |                                   | 60% of each group required though it has been completely ignored (CHaP, KPPS)  |
|   | Defined risk pools                | Detailed application analysis allows for this, but it is limited (MediPlus)  |
|   |                                   | None (PoA, CHaP, KPPS, CIDR, CHF)  |
|   |                                   | Adults and children priced differently (Microcare)   |
|   | Use of pre-existing groups        | Not required (PoA, MediPlus, CHF) though most marketing is through groups  |
|   |                                   | Required (Microcare, KPPS, CHaP)   |
|   |                                   | Form community groups for insurance purposes (CIDR)  |
|   | Waiting periods                   | None (KPPS, CHF)   |
|   |                                   | 30 days for outpatient care (except for corporates and individuals previously enjoying cover with a different health insurer) (MediPlus) |
|   |                                   | 120 days for inpatient, except in the case of emergencies (MediPlus)   |
|   |                                   | Only until ID is printed (PoA) but they will confirm membership to hospitals for people who request immediate care                       |
|   |                                   | 14 Days (Microcare)  |
|   |                                   | 90 Days (CHaP)   |
|   |                                   | 90 day payment period with cover starting at one point each year (CIDR)  |
|   | Tying insurance to other products | None (MediPlus, PoA, CIDR, CHF)  |
|   |                                   | Tied to MFI loan, employment, or some group membership (Microcare, KPPS)   |
|   |                                   | Require savings but not linked (CHaP)  |
|   | Periodic cost evaluation          | Company systems automatically carry out variance analysis and send out alerts where provider has over priced a service (MediPlus)        |
|   |                                   | Annually in aggregate (PoA)  |
|   |                                   | Aggregate monthly, not individuals but capacity is available (Microcare)   |
| Responsibility is left to communities (CHF) |                                   |  |

| <b>Risk:</b>           | <b>General Strategy:</b>                 | <b>Specific Strategy:</b>   |
|------------------------|--|---|
| <b>Cost escalation</b> | Preset pricing agreements with providers | Providers only treat within agreed price limits and if there is the expectation that a procedure's cost will exceed agreed price limits, approval must be sought (MediPlus) |
|                        |  | None (PoA) (CIDR- But they negotiated a discount, KPPS, Microcare, CHF)   |
|                        |  | Fixed price agreement for consultation and medications (CHeaP)  |
|                        | Preset drugs list                        | Adherence to approved drug list is required (MediPlus, Microcare, CHF, CHeaP)   |
|                        |  | None (CIDR, PoA, KPPS)  |
|                        | Negotiated discounts                     | 10% plus (CIDR)<br>Fixed price agreement for consultation and medications (CHeaP)   |
|                        | Near limit warnings                      | Notification of clients and health care facilities when a client is about to reach their limit (MediPlus)   |
| <b>Fraud and Abuse</b> | Computerised ID systems                  | Each patient has ID card (all institutions)   |
|                        |  | Continuous data base updating halts use beyond expiration and maximum use (MediPlus)  |
|                        |  | Manual (PoA, CIDR, KPPS-with excel data base, CHF, CHeaP)   |
|                        |  | ID card with photos of each covered person, matching digitised photos at insurer check-in desk (Microcare)  |
|                        | Expense verification                     | Providers to process separate claim for each patient (MediPlus)   |
|                        |  | Expenses first verified against limits of cover, before receipt of treatment (MediPlus)   |
|                        |  | Expenses verified against agreed price limits with provider and for drugs, against international drug prices (MediPlus)   |
|                        |  | Only in cases of "unrealistic" billing (PoA)  |
|                        |  | Monthly (Microcare, CIDR)   |
|                        |  | Based on treatment sheets, verified monthly (KPPS)  |
|                        |  | Regular review with District Medical Officer (CHF)  |
|                        | Coverage limits                          | Range with cover purchased for both in- and out patient (MediPlus)  |
|                        |  | None (PoA, CHF, CHeaP)  |
|                        |  | In-patient limited to value and time hospitalised (Microcare)   |
|                        |  | Limits (not exclusion) for chronic care (CIDR)  |
|                        |  | In- and out-patient limits (KPPS)   |
|                        | Full premium payment in advance          | In some cases, require eleven post-dated checks to cover monthly payments (MediPlus)  |
|                        |  | Full payment in advance required (all institutions)   |
|                        | Physical identification                  | ID card required for treatment access (all institutions)  |
|                        |  | Verification is responsibility of provider (CIDR, CHF, MediPlus, PoA, CHeaP) (MediPlus, PoA report abuse suspected when provider verifies ID)                               |
|                        |  | Presented to insurer staff at the facility (Microcare, KPPS)  |
|                        | Cancellation of service                  | Current and future care of anyone who defrauds the company including through false information on their application (MediPlus)  |
|                        |  | Cancelled on non-payment but formal policy is lacking as are tracking mechanisms (CHeaP)  |

**Appendix 2 –Common Strengths, Weaknesses, Opportunities, and Threats**

(These include issues that arose multiple times, but do not necessarily reflect every institution.)

| <b>STRENGTHS</b>  | <b>WEAKNESSES</b>   | <b>OPPORTUNITIES</b>  | <b>THREATS</b>   |
|---|---|---|--|
| <b>PRODUCT</b>  |   |   |  |
| <ul style="list-style-type: none"> <li>• Simple products</li> <li>• Provides access to quality providers</li> <li>• Provider networks</li> <li>• Modular approach to product differentiation</li> <li>• Comprehensive coverage options</li> </ul> | <ul style="list-style-type: none"> <li>• Weak pricing procedures</li> <li>• Controls not designed well into the product</li> <li>• Product development process is rarely followed</li> <li>• Limited effort in aiding premium generation</li> </ul> | <ul style="list-style-type: none"> <li>• Address identified market needs, requires greater focus on the demand side</li> <li>• Flexibility in product design and distribution will improve outreach</li> <li>• Linkages for loan and savings product available with MFIs</li> </ul> | <ul style="list-style-type: none"> <li>• Dependency on external funding</li> <li>• Legislation may restrict flexibility in testing new approaches</li> </ul>         |
| <b>OPERATIONS</b>   |   |   |  |
| <ul style="list-style-type: none"> <li>• Some have strong computerised tracking systems</li> <li>• Innovative approaches</li> <li>• Relatively low administrative costs</li> </ul>  | <ul style="list-style-type: none"> <li>• Weak insurance training leads to poor capacity</li> <li>• Limited structures to manage controls</li> <li>• Weak governance</li> </ul>  | <ul style="list-style-type: none"> <li>• Potential for relatively low operating costs</li> <li>• Much interest from health care facilities</li> </ul>   | <ul style="list-style-type: none"> <li>• Claims payments extending may cause problems with providers</li> <li>• Inadequate support from MFIs</li> </ul>              |
| <b>MARKETING</b>  |   |   |  |
| <ul style="list-style-type: none"> <li>• Reputable providers</li> <li>• Strong renewal for those with low income corporates</li> <li>• Commission based marketing</li> </ul>  | <ul style="list-style-type: none"> <li>• High non-renewal rates for those with MFIs</li> <li>• Weak marketing staff</li> <li>• Limited market education</li> <li>• Lack standardised marketing</li> </ul>   | <ul style="list-style-type: none"> <li>• Wide untapped market</li> <li>• Much demand for quality health care financing</li> <li>• Access to potential clients from focal point organisations</li> <li>• Support from opinion leaders</li> </ul>                                     | <ul style="list-style-type: none"> <li>• Operational missteps reduce credibility</li> <li>• Market confusion about insurance</li> </ul>                              |
| <b>ACCOUNTING</b>   |   |   |  |
| <ul style="list-style-type: none"> <li>• Effective invoicing systems</li> <li>• Where premiums, claims, and key ratios are tracked there is usually better management</li> </ul>  | <ul style="list-style-type: none"> <li>• Limited insurance accounting knowledge</li> <li>• Poor costing and pricing ability</li> <li>• Accounts have limited input in management decision making</li> </ul>   | <ul style="list-style-type: none"> <li>• Accounting systems for insurance are available</li> </ul>  | <ul style="list-style-type: none"> <li>• Limited accounting knowledge opens the door to fraud</li> <li>• Limited data for this market for actuarial study</li> </ul> |
| <b>RISK MANAGEMENT</b>  |   |   |  |
| <ul style="list-style-type: none"> <li>• Stronger when there is representation in the</li> </ul>  | <ul style="list-style-type: none"> <li>• Policies and controls not</li> </ul>   | <ul style="list-style-type: none"> <li>• There is significant information available</li> </ul>  | <ul style="list-style-type: none"> <li>• Lack of reserves</li> </ul>   |

|                      |  |  |  |
|----------------------|--|--|--|
| health care facility | documented <ul style="list-style-type: none"> <li>• Lack of reserves or reinsurance</li> <li>• Non-compliance with controls</li> <li>• Limited ability to access risk</li> <li>• Weaker strategies in rural areas</li> </ul> | on insurance controls <ul style="list-style-type: none"> <li>• Microinsurance controls are beginning to be documented</li> </ul> | <ul style="list-style-type: none"> <li>• Potential regulatory problems</li> <li>• Lack of due diligence with partners</li> </ul> |
|----------------------|--|--|--|

**Glossary**<sup>27</sup>

- Actuary:** A person who calculates insurance and annuity premiums, reserves, and dividends.
- Adverse Selection:** Tendency of persons with a higher-than-average chance of loss to seek insurance at standard (average) rates, which, if not controlled by underwriting, results in higher-than-expected loss levels
- Agent:** An insurance company representative who solicits, negotiates or effects contracts of insurance, and provides service to the policyholder for the insurer, usually for a commission on the premium payments.
- Claim:** A request for payment of a loss that may come under the terms of an insurance contract.
- Co-payment:** Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, which establishes a formula for dividing the payment of losses between the insurer and the policyholder. For example, a co-payment arrangement might require a policyholder to pay 30% of all losses while the insurer covers the remainder.
- Covariant risk:** A risk, or combination of risks, that impacts a large number of the insured items/people at the same, for example an earthquake, or a major flood.
- Coverage:** The scope of protection provided under a contract of insurance, and any of several risks covered by a policy.
- Credit Life Insurance (or "Outstanding Balance Life Insurance"):** Insurance coverage that repays the outstanding balance on loans in default due to the death of the borrower. Occasionally, partial or complete disability coverage is also included.
- Deductible(s) (or "Excess"):** Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, which establishes an amount or percentage that a policyholder agrees to pay, per claim or insured event, toward the total amount of an insured loss.
- Distribution Channel:** Type of process used to deliver insurance policies to clients. Direct marketing and agents are two examples of different distribution channels
- Exclusions (or "exceptions"):** Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.
- Experience:** The record of claims made or paid within a specified time period.
- Fraud:** Intentional perversion of truth in order to induce another to part with something of value.
- Group Insurance:** Insurance written on a number of people under a single master policy, issued to their employer or to an association or other organization with which they are affiliated.
- Health insurance:** Coverage that provides benefits as a result of sickness or injury. Policies include insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.
- Health maintenance organization (HMO):** Organization that provides a wide range of comprehensive health care services for a specified group for a fixed periodic prepayment.
- Insurance:** A risk management system under which individuals, businesses, and other organizations or entities, in exchange for payment of a sum of money (a premium), offers an opportunity to share the risk of possible financial loss through guaranteed compensation for losses resulting from certain perils under specified conditions.
- Insurer:** The party to the insurance contract who promises to pay losses or benefits.

<sup>27</sup> Glossary definitions from [www.microinsurancecentre.org](http://www.microinsurancecentre.org)

**Moral hazard:** Hazard arising from any non-physical, personal characteristic of a risk that increases the possibility of loss or may intensify the severity of loss for instance bad habits or low integrity. An example might include failing to properly care for an insured goat because it is insured, thereby increasing the chance it will die of disease.

**Policy:** The printed document issued to the policyholder by the company stating the terms and conditions of the insurance contract

**Premium:** The sum paid by a policyholder to keep an insurance policy in force.

**Reinsurance:** A form of insurance that insurance companies buy for their own protection. One or more insurance companies assumes all or part of a risk undertaken by another insurance company.

**Risk:** The chance of loss. Also used to refer to the insured or to property covered by a policy.

**Risk Management:** Systematic process for the identification and evaluation of pure loss exposures faced by an organization or individual, and for the selection and implementation of the most appropriate techniques for treating such exposures.

**Risk Pooling:** Spreading of losses incurred by a few over a larger group, so that in the process, each individual group members' losses are limited to the average loss (premium payments) rather than the potentially larger actual loss that might be sustained by an individual. Risk pooling effectively disperses losses incurred by a few over a larger group.

**Risk Premium:** The portion of the premium that is used to fund claims and is equal to the expected claims.

**Settlement:** Payment of the benefits specified in an insurance policy.

**Stop-loss policy:** An agreement from a reinsurer to cover total claims over a certain agreed upon value of an aggregate pool of policies

**Term insurance:** A plan of insurance that covers the insured for only a certain period of time (term), not for his or her entire life. The policy pays death benefits only if the insured dies during the term.

**Underwriting:** Process of selecting risks for insurance and determining in what amounts and on what terms the insurance company will accept the risk.

**Waiting period:** The length of time an insurance client must wait before their insurance becomes effective.

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