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# 3 Microinsurance operations

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## 3.1 Product design and insurance risk management

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Product design for microinsurance follows the same basic rules as conventional insurance: the insurer needs to establish demand from the market for insurance, determine the risks that can be insured, and devise insurance risk-management processes for ensuring the product's viability.

The design of microinsurance products, however, has some unique complications. Particular challenges are the small premiums and benefits driven by the market's limited resources and extreme cash-flow constraints, which restrict the scope of underwriting, claims management and product complexity. These challenges require scale, innovation, efficiency, simplicity and intelligent risk management.

Moreover, some microinsurers have a more complex mandate than insurance companies. The financial and economic drivers of sound insurance business may be supplemented by a development agenda, for example to expand access as widely as possible or to ensure inclusion of certain risks that might be commercially excluded. Not all microinsurers are subject to these influences, but where they are, it is critical that sound risk-management principles are not sacrificed. Where "non-commercial" risk is taken, it must be understood and managed.

As explained in Chapter 1.2, there is no "one size fits all" solution. Customer needs, preferences, appropriate delivery mechanisms and regulatory requirements vary tremendously from one territory to the next. Deep knowledge of local conditions is a prerequisite for designing successful microinsurance products.

This overview of product design answers the following questions:

- What are the needs and demands of the target market?
- Who is eligible for microinsurance?

<sup>1</sup> References in this chapter to RIMANSI and market research in the Philippines, Dong Trieu (Viet Nam), African Life (South Africa) and Constanta Foundation (Georgia) are drawn from the authors' experiences, not from the case studies.

- What are the terms of cover and the premium payment options?
- What are the benefits?
- How does product design provide for control of insurance risks?

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## I Market research

### I.1 Initial market research

The product design process begins with market research, which involves four basic steps.

#### *a) Define the target market*

Some organizations, like microfinance institutions, may determine that the insurance market is the same as their existing savings and credit markets. Others may introduce insurance to gain access to new markets – for example, persons who are not interested in borrowing, but do want insurance. A key decision is whether the microinsurer will just target the most vulnerable or whether it wants to service the broader low-income community with a range of product options. For example, the health insurance schemes of BRAC and Grameen Kaylan in Bangladesh do not just serve the members of their corresponding MFIs, but the community in general, charging higher premiums to non-members as part of the organizations' sustainability strategy.

#### *b) Identify what risks they face and need to insure (and which risks are insurable)*

Demand research will help identify the most appropriate insurable events to cover: What risks are target groups most worried about, or least able to cope with through informal mechanisms? As illustrated in Chapter 1.2, low-income persons typically worry about the premature death of breadwinners and their own sickness and that of their family members. Often the poor have some coping mechanisms at the community and/or household level through savings, borrowing and reciprocation. Insurance should complement these existing mechanisms.

#### *c) Determine which product features are important to the target market*

The third step is to assess the needs and demands of the target market, and to get information on product-specific details, such as the levels of coverage (e.g. sums insured) and types of benefits (e.g. inpatient, outpatient and pharmaceuticals) which are most important to them. For example, for life insurance, would they want pure insurance cover (e.g. term life) or insurance with a savings component (e.g. endowment)? Are they interested in covering just

themselves, or would they prefer to include their spouses, or their whole families? How quickly would they need, want or expect to receive claims payments? Where can policyholders make premium payments or submit claims?

*d) Establish how much potential policyholders are willing and able to pay*

Lastly, it is necessary to determine what the target market is willing to pay for these services. Demand can vary tremendously, even within the same country. Two surveys of microfinance clients in the Philippines came up with very different results. The borrowers from an MFI in central Luzon wanted at least Php120,000 (US\$2,160) life insurance coverage for themselves and Php 60,000 (US\$1,080) for their spouses and children, and they were willing to pay for it, having been conditioned to paying premiums to the MFI's previous insurance programme. A sample of similar clients of an MFI in northern Mindanao indicated that they could at most afford premiums providing Php 30,000 (US\$540) of coverage for themselves, Php 10,000 (US\$180) for their spouse, and Php 5,000 (US\$90) for death of a child.<sup>2</sup>

It is useful to investigate affordability and product design preferences in concert with each other. Everyone might like to have claims paid immediately, or to cover their whole family, but how much are they willing to pay for those features? Given the cost constraints facing the target market, an explicit link between product design and financial consequences helps clients make appropriate value-driven decisions, while securing their buy-in to the scheme. An example of this type of process has been developed under the Social Re programme to enable sensible decisions to be made around benefit package design (Dror and Prekker, 2002).

When assessing willingness to pay, through focus groups or individual interviews, prospective customers may overestimate their capacity to pay, which could lead to subsequent dropouts. Information about the level of income is another, perhaps more reliable, means of assessing the payment capacity of the target population. For example, when comparing the annual income with the actual contribution paid to micro health insurance schemes, CIDR found out that poor households in western Africa do not allocate more than 2 per cent of their income (Galland, 2005a). In addition, when designing a product for the poor, it has also to be taken into account that income may change from one year to another. A product that is affordable one year may not be affordable the following year.

<sup>2</sup> Research conducted by RIMANSI (Risk Management Solutions, Inc.), a microinsurance resource centre based in the Philippines.

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**1.2 Ongoing market research**

Market research must not fall by the wayside once a product is launched. Insurers should maintain contact with their clients periodically to ensure that the services are still relevant and valued by customers.

The very high lapse rates experienced by some microinsurers may be a consequence of failing to keep an ear to the ground: problematic elements of product design should be identified and, where possible, rectified to ensure ongoing viability. Policy renewals or persistency and new business rates jointly provide feedback about the value perceived by clients, and should be carefully monitored. Qualitative research such as focus group discussions may also provide further insight into the mechanics of the market and customers' preferences and dissatisfactions.

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**1.3 Consumer education**

The target market's exposure to or familiarity with insurance must be assessed. As discussed in Chapter 3.2, if the market does not understand insurance, or does not trust it, then client education needs to be built into the marketing and product delivery. Insight into the preferences and concerns of existing policyholders will also help the insurer design appropriate financial education to manage policyholder expectations.

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**1.4 The competition**

To date, many microinsurance initiatives have been the first movers in the local market, trailblazers entering virgin territory without competition. As time goes by, this is likely to change, as competitors enter the market with better products. Consequently, it is important to gather market intelligence on what competitors offer and the perceptions of their value in the market when considering a new product.

There can be an advantage in being a "smart follower", learning from the mistakes of those who have gone before. The Ugandan MFIs that collaborated with AIG in 2000–2002 rode on the coat tails of FINCA Uganda, which was the trailblazer in learning about insurance and the low-income market. The costs of introducing insurance in those organizations were significantly lower than in FINCA.

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## 2 Eligibility

Who should be eligible for coverage? This difficult question must be considered in the context of the microinsurer's objectives and the membership's preferences, but with an acute awareness of the risk-pooling principles that apply. For microinsurance, the goal is to strike a balance between broad inclusion, sufficient benefits, low premium rates and sustainability. Eligibility considerations may be driven purely by economic circumstances since large volumes of clients with small premium amounts require minimal underwriting work, permitting broad inclusion. There may also be social objectives that require broader inclusion.

When determining eligibility, it is necessary to consider whether the product is designed for groups or individuals, whether it should be mandatory or voluntary and what approach the insurer wishes to adopt to covering higher-risk persons.

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### 2.1 Group insurance

The primary feature distinguishing commercial group insurance from individual insurance is that many people are insured under one master policy. The group policyholder decides what type of coverage to buy for the members of the group. The policyholder is responsible for enrolling members, collecting premiums, disseminating certificates of insurance and product information, and helping members file claims. The policy describes and defines the eligible members of the group.

Underwriting guidelines for group insurance generally begin by specifying the fundamental requirements that define a group. The main criterion is that the group must have been formed for reasons other than to obtain insurance. For example, if a utility company required the household to be insured as a condition of being connected to the power grid, then the group is clearly defined and insurance coverage is required by virtue of being connected to the grid. It is quite unlikely that a family would seek to acquire an electricity connection to gain access to insurance. This mechanism limits the scope for adverse selection and allows more relaxed underwriting and risk management. Examples of groups targeted by insurers include employees in a company, labour union members, and affinity groups such as professional associations.

Mandatory group insurance is probably the most common type of microinsurance. For example, the microinsurance programmes spawned by many MFIs are similar to the membership of the CARD MBA in the Philippines, which is composed entirely of CARD's borrowers. The membership

of CARD MBA is a very low-risk group. There is minimal adverse selection due to mandatory participation; the participants are all women aged 16 to 64 and are actively engaged in their respective livelihoods (for which they are borrowing from the MFI); the group is thus relatively homogenous and in good average health. To minimize risk, even the 30,000 savers of CARD Bank cannot participate in the MBA because elective coverage would raise claims costs, while mandatory coverage would be difficult to sell to savers.

To be demand-driven and client-focused, one would expect that voluntary coverage would be the most appropriate. Yet in the field of insurance – and microinsurance in particular, where affordability is so important – a strong case can be made for compulsory coverage. Mandatory insurance:

- reduces costs due to higher volumes and lower collection and underwriting costs;
- lowers risk because of the broader base and limited adverse selection;
- improves claims ratios because it brings in the lower risk individuals (positive selection) who would otherwise opt out or wait to get coverage when they are older;
- reduces vulnerability to staff fraud since it reduces the chance that agents could sell policies and pocket the premiums.

One of the biggest disadvantages of mandatory coverage, besides the fact that people are required to buy something that they may not want, is that the distribution system tends to overlook the consumers' need for information. This comes through very clearly from the research in Uganda where many clients have a significant misunderstanding of what the coverage entails, which has led to profound dissatisfaction (McCord et al., 2005a). As discussed in the next chapter, when offering mandatory coverage, microinsurers (or their agents) need to constantly promote the good value of the programme. Clients need to be constantly educated about the benefits of buying an intangible service, i.e. security and peace of mind.

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## 2.2 Voluntary group insurance

Group insurance can be offered on a voluntary basis in two different ways. Either members of the group are covered unless they specifically decline coverage or each member of the group must choose to enrol in the scheme. The costs and risks associated with the first option are often closer to mandatory coverage, whereas the second option is more akin to individual insurance, with greater concern for adverse selection. Sometimes there are grey areas between group and individual coverage. For example, both VimoSEWA

(India) and ServiPerú have group policies from insurance companies, but they are marketed and sold individually.

If potential insureds are not already in groups, then one strategy employed by some microinsurers is to create groups. This is the approach taken by the *mutuelles de santé*, such as UMSGF (Guinea), whereby rural communities are organized into groups, and the groups formed into mutuals, and the mutuals affiliated into federations. To overcome the adverse selection risk that comes with groups created for insurance purposes, UMSGF encourages all members of the community to enrol and membership is often on a family basis.

Microinsurance providers can combine the advantages of mandatory and voluntary group coverage in several ways. One way is to make insurance mandatory for all members of an existing group (which minimizes adverse selection), but to give them two or three options to choose from. This allows members to opt for the coverage level that they would prefer and increases the likelihood that they will receive sufficient information to make informed decisions. Care must be taken not to give too many options or to make the options too diverse because higher-risk individuals tend to maximize coverage, thus reducing the gains of compulsory participation.

Another approach, sometimes found among MFIs, is to make coverage all-or-nothing at the borrower group level, such as a village bank. For example, in the initial FINCA-AIG arrangement in Uganda, all members of the village bank had to agree to the coverage or none got it – this simplified the administration and created an adverse selection control since individuals could not opt in or out.

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### 2.3 Individual insurance

At the other end of the spectrum are the aforementioned memberships of BRAC's MHIB and Grameen Kaylan in Bangladesh. Although many of the members come from the associated MFIs, the schemes also recruit the general public at slightly higher premium and co-payment rates. These are examples of individual microinsurance (since there is optional participation), as are the endowment policies offered by Tata-AIG (India) and Delta Life (Bangladesh). Individual microinsurance is possible, but it requires a high participation rate among the potential target market to attain desirable financial results.

Individual insurance can cost more than twice as much as group coverage because of higher sales, underwriting, administration and claims costs. Individual insurance claims costs can be reduced through more rigorous underwriting, such as medical screening (since the bad risks are identified and fil-



tered out or are limited to lower coverage). For microinsurance, however, this screening may not make economic sense because coverage amounts are very low, and it may also contradict the social agenda.

Therein lies the crux of making microinsurance work. It is relatively easy if the targeted population is a well-organized group that can accommodate group insurance arrangements, but is quite challenging if it is not because of the higher delivery and claims costs. Under what circumstances would individual microinsurance make sense? It makes sense when a group is covered by a compulsory life product already and then some members of the group would like to have additional, elective coverage. Individual coverage may also be justifiable, but expensive, when the target population is unorganized.

A key advantage of individual insurance is that the individual can continue to be covered once group membership ceases, for example MFI clients who no longer require loans. Group covers can be converted into individual policies using continuation options. To the extent that the group cover relies on infrastructure supporting the group (e.g. using the MFI's mechanisms for premium collection), continuation policies may produce additional charges and administration.

As discussed below, individual insurance can be made more viable with product design features that limit scope for adverse selection, including health declarations, waiting periods and incremental benefits. For the low-income market, individual covers may also be possible if technology can be employed to minimize the operating costs, although such examples were not identified in the case studies.

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## 2.4

### To include or not to include

A unique aspect of microinsurance is the willingness to be broadly inclusive. Generally, commercial insurers limit their exposure by excluding high risks, such as older persons or those with pre-existing conditions. The microinsurance challenge is to find ways of serving vulnerable households at affordable rates over the long term. There are several issues to consider:

- Broader inclusion has marketing and social appeal. In some contexts, the target market prefers to subsidize high-risk individuals (e.g. as the members of Dong Trieu Mutual Aid Fund in Viet Nam indicated in a recent survey; also seen in Indonesia (McCord et al., 2005b) and Cambodia (McCord, 2001)), whereas in other contexts there is a greater preference for exclusion to reduce premium costs.

- Broader inclusion produces lower operating costs by reducing the costs of screening, while accepting higher-risk persons and their accompanying claims costs. Significant volumes of policyholders are required to justify this approach.
- High-risk individuals can be included if the benefits are limited or, alternatively, if premiums are correspondingly higher for risky members than for the rest of the group. Both of these approaches reduce the cross-subsidization of the higher-risk individuals by the remaining members and support broader inclusion on a sustainable basis.
- There is a solid economic rationale in play as well: the costs of monitoring and enforcing complex exclusions must be weighed against the claims avoided; the small sums insured and premiums of microinsurance products cannot support complex screening and claims validation.

While schemes are often willing to accept high-risk members, they might not be so inclined to keep older policyholders. Most schemes have age ceilings – 60 years old at VimoSEWA and 67 years old for ServiPerú's hospitalization benefit – although some, like UMSFG, have no age limitations. To soften the blow of asking members to leave the scheme (just when they are about to really need the benefits), some microinsurers such as CARD MBA and Yasiru (Sri Lanka) provide a withdrawal payout.

Funding older members may or may not be feasible. The tradeoff is between lower premiums in order to market the programme more effectively to all, or higher premiums in order to be more inclusive. If the intention is to be inclusive, should everyone pay higher premiums, or should older members pay higher premiums or receive lower benefits in order to minimize the subsidization by younger members? The best solution, as with other tradeoffs, is to explain the differences between the cost of lifelong membership versus having an exit age, and then let the prospective policyholders decide.

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### 3 Terms and payment options

#### 3.1 Term of the coverage

Many microinsurance products are for 12 months or less. These short-term policies are generally preferred by insurers because long-term insurance involves more permanent commitments and higher risk – it is easier to predict the likelihood of an insured event in the next year than the next 10 years. An insurer needs to be conservative when giving medium- to long-term guarantees, and must ensure that significant margins in the rates are included to compensate for error (*see Chapter 3.5*). From a regulator's perspective, long-term coverage is more closely supervised because of the devastating com-

pounding effects that erroneous interest rate and mortality assumptions can have on the insurer.

For the insured, the advantage of long-term coverage is that he/she will have protection even if a condition develops. On the other hand, it is generally more expensive in the younger years than renewable term coverage.

If insurance is offered together with a loan, it is generally recommended that the loan and insurance terms end at the same time so that the client has an opportunity to renew them together. In Zambia, CETZAM and NICO Insurance had an interesting arrangement whereby the insurance coverage continued for two weeks after the loan term so that borrowers could retain insurance cover between loans, since there is often a short gap between the end of one loan and the beginning of another.

Where the insurance term is significantly longer than the loan term, however, organizations have a problem with lapses. For example, Tata-AIG initially sold its five and 15-year life insurance policies through microfinance institutions. However, of the nearly 10,000 policies sold in 2002–3, only 14 per cent were still active in 2005. The high lapse rate is largely attributed to clients who stop borrowing, and if they are not borrowing, the MFI does not have an administration system to continue collecting premiums.

Short-term covers can have a renewable-term arrangement whereby the policyholder can continue to have coverage up to a maximum age without additional underwriting or applications, as long as premium payments are made. Renewable terms combine the advantages of both short- and long-term coverage. The insured are guaranteed continued coverage, yet the insurer can adjust the pricing, up or down, depending on its experience. The renewal option may be subject to adverse selection in that policyholders more likely to claim are more likely to renew their cover, and this may need to be factored into pricing.

Local preferences are important in determining the term. Microcare in Uganda has migrated from four-month term products (matching loan cycles) to annual cover in response to client demand. Conversely, VimoSEWA had the opposite experience. Historically it only offered twelve-month insurance cycles, but it is now experimenting with three-month terms as clients wanted more regular premium intervals and coverage renewal. In general, short terms have high operational costs, as well as the significant cost of non-renewals because the shorter the term the more frequently the client has to make the purchase decision and the less time there is for the demonstration effect to make itself felt.

### 3.2 Premium payment frequency

The microinsurance target market often has irregular and unpredictable cash flows. To minimize lapses (and maximize renewals), the premium payment mechanism has to find ways of timing payments so that they correspond with periods when the households have some surplus income.

When Delta Life began offering microinsurance, it assumed that the poor needed to pay premiums on a weekly basis, because that is what they did at Grameen, BRAC and the other Bangladeshi MFIs. To make this possible, Delta employed field staff to go door-to-door to collect premiums from all the policyholders at their homes or workplaces each week. Not only was this method extremely expensive for Delta, but as it turned out, it did not quite meet the needs of its clients either. When Delta introduced monthly, quarterly, semi-annual and annual payment options, it found that different segments of the market had different preferences.

When determining premium payment schedules, another factor to consider is the time value of money. As described in Chapter 3.5, when insurers receive premiums in advance, they can invest them; the returns on that investment are used at least in part to keep the cost of the insurance down. So generally, insurers prefer up-front premium payments instead of instalments.

From the insurer's perspective, up-front payments also eliminate or reduce problems with lapsed policies. Lapses occur when a policyholder neglects to make a premium payment within a certain period of time, similar to a borrower missing a loan repayment.<sup>3</sup> The big difference with a loan repayment is that the lender still wants to get its money back; whereas a lapsed policy could work out to the financial advantage of the insurer that has taken money from the policyholder but is no longer obliged to provide insurance benefits, as illustrated in Box 26.<sup>4</sup>

*Box 26*

#### **Lapses at Delta Life**

From the start, Delta's microinsurance products have been voluntary. The fact that the insurer has sold nearly 2 million policies over the years suggests that there must be some level of customer satisfaction. Yet less than half of those policies are still in force, which possibly reflects the lack of a connection between product design and customer needs. A reasonable measure of customer satisfaction might be continued payment of premiums. When peo-

<sup>3</sup> Lapses are a problem with long-term policies with premium instalments. For short-term insurance, the corresponding concept is a non-renewal.

<sup>4</sup> Typically, a lapsed policy can be brought back into force by payment of outstanding premiums and through additional underwriting.

ple become dissatisfied, they may stop contributing. Certainly other factors also cause lapses, but it is still a reasonable indicator of dissatisfaction.

Of the 1.9 million policies sold by Delta Life up to September 2004, 57 per cent are inactive. In some cases, this is due to maturities and settlements. Inactive policies could result from changes in the customers' financial situation, or differences between what they thought they were buying and what they did buy. Alternatively, the cause may simply be dissatisfaction with the product. Customers have complained about delays in claims processing and claims being paid by crossed cheque, which means that they have to open a bank account. Some policyholders also compare Delta Life's returns unfavourably with those of banks.

Management recognizes that it has a problem with lapses. In the past, lapses have not been a priority, perhaps because the organization benefits financially when policies lapse. Field staff were not monitored or rewarded on the basis of the number of policies that remain in force, and they have not received training on how to encourage timely payments. Delta anticipates, however, that reengineering and better management information will improve the situation.

*Source: Adapted from McCord and Churchill, 2005.*

As described in Chapter 2.2, with endowment policies, one way to prevent lapses is through a non-forfeiture clause. Similarly, the primary product for a mutual benefit association in the Philippines, as required by law, is life insurance with compulsory participation of all MBA members. According to the regulations, 50 per cent of the gross premiums must be set aside as member equity. If a policy lapses, however, then the equity can be used by the MBA as a premium loan so that coverage is continuous, at least until the equity is consumed. If the member then wants to reinstate, he/she is required to first replenish the borrowed equity. Clearly, this cannibalism of policy value undermines the usefulness of insurance as a long-term savings vehicle, but at least the cover remains in force.

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### 3.3 Premium payment mechanisms

As discussed in Chapter 3.3, besides minimizing lapses and non-renewals, the other critical factor to consider when designing premium payment methods is to keep the administrative costs (and the transaction costs to the customer) as low as possible. As a general rule of thumb, the best time to collect premiums is when policyholders have cash, for example at harvest time, or when they receive a loan or a government cash transfer. Even better, collect

the premium at the source so that premiums can be bundled for multiple clients. For example, Yeshasvini in India collects premiums from producers' cooperatives who deduct the amount from the members' incomes.

Group cover has the advantage of streamlining the premium collection process: there may be only one central policyholder, who pays a premium on behalf of many persons. The collection of premiums is effectively outsourced to this policyholder.

To streamline premium payments, another common strategy is to “piggyback” the premium on top of another financial transaction. For example, one of the easiest ways to achieve the high renewals and minimal administrative costs is to link the premium payment to a loan, since clients have cash when they receive the loan and can easily pay the premium. The downside of relying on this approach is that only clients who receive a loan can get insurance coverage.

Another approach is to deduct the premium from a savings account, which is done by La Equidad in Colombia and others. This approach is strongly recommended in Chapter 2.3, as long as customers know that the money is being deducted. Another more innovative link between savings and insurance is to establish a fixed deposit account and allow the interest to pay the insurance premium, a strategy that VimoSEWA uses successfully. One challenge with this method is for the poorest clients to save up enough money to deposit in the account.

What does an insurer do when its clients do not have a regular place to live and work, let alone a bank account? There are other ways of piggybacking besides financial transactions to reach a clientele in the informal economy. For example, African Life found that many clients for one of its low-end products in South Africa had a common regular practice: going to church every Sunday. So it issued “pass books” to customers which they have stamped at the church when they pay their weekly premiums.

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### 3.4 Premium amounts

It is standard practice for insurers to apply different premium rates depending on the policyholder's age and sex, especially with individual insurance. For microinsurance, this adds a layer of complexity that can be difficult for staff and clients to understand. Within the context of the partner-agent model, several MFIs, including TSKI (Philippines) and Shepherd (India), have negotiated with insurers to provide a single rate for all ages (*see Box 27*).

Such an arrangement is possible when the sum insured is small, if there is a continuous influx of younger members, if there is a maximum coverage and/or entry age, and with annual actuarial pricing review. For higher-value

policies or with elective participation, the MFI will probably have to implement age-structured rates prepared by the insurance company or actuary.<sup>5</sup>

Whatever the premium terms, it is difficult to overstate the importance of managing premium delinquency. Many insurance schemes have failed because they provided cover without actually collecting premiums.

Box 27

### Flat-rate pricing for Shepherd

When Shepherd was developing its hospitalization product with United India Insurance Company (UIIC), one of the sticking points in the negotiations was the age brackets that the insurer proposed. Initially, UIIC wanted to offer a lower premium for members between 18 and 45, and charge those in the 46 to 60 age bracket a higher price. As is its custom, Shepherd took this proposal to its members and they voiced significant concerns, preferring instead a uniform price. Given the complications that arise from trying to determine a person's age in rural India, and the administrative costs and challenges of segregating policyholders into two categories, this was probably a fortunate choice.

*Source: Adapted from Roth et al., 2005.*

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## Benefits

The benefits provided by the insurance product should be largely determined through demand research: what is it that people need coverage for? The general lesson is that microinsurance benefits should be kept as simple as possible for several reasons. First, to keep the premiums low, the administrative costs have to be kept low; and it is easier to accomplish that objective if the benefits are straightforward. More complicated products could be managed cost-effectively if the organization had an excellent management information system, although this is not an area in which microinsurers have as yet excelled.

Second, the target market for microinsurance is often illiterate or uneducated and lacks exposure to insurance. Complicated benefit packages are difficult and time-consuming to explain to clients. Indeed, one of the reasons why the new products introduced by ALMAO in Sri Lanka have not been popular is that they are harder to explain to customers than the old basic funeral insurance product.<sup>6</sup> If a product cannot be easily explained in a few sentences, then low-income clients will not understand it and the product

<sup>5</sup> Although flat-rate pricing may be preferred from an operational perspective, Chapter 3.6 describes why it is not the ideal approach for financial risk management.

<sup>6</sup> Another reason for the limited demand is because the new products are more expensive since they include an accumulating value component.

will not be well received. In fact, where the benefit package is complicated, salespersons tend to omit to mention certain benefits.

Another reason for keeping the product simple is that many of the bells and whistles in complicated products are really just there as window-dressing, used for marketing purposes to make the product appear more impressive. In practice, however, there are hardly any claims for certain benefits, and therefore people are paying for things that they do not really need or want. For example, ASA was offering insurance in partnership with Life Insurance Corporation (LIC) of India that provided multiple benefits (*see Table 17*) for an annual premium of just Rs.100 (US\$2.22). The problem from ASA's perspective was that the insurer would hardly ever pay accidental death claims, as elaborate documentation was required to prove that death had been due to an accident, and hardly any clients made disability claims. Therefore, when ASA switched insurance partners, the MFI simplified the benefits, requesting only death cover, regardless of the cause, and no disability benefits.

Table 17

**Benefits of LIC's Janashree Bima Yojana**

<i>Insured event</i>	<i>Sum insured</i>
Natural death	Rs. 20 000 (US\$444)
Accidental death	Rs. 50 000 (US\$1 111)
Partial disabilities	Rs. 25 000 (US\$556)
Total disability	Rs. 50 000 (US\$1 111)

*Source: Roth et al., 2005.*

When determining insurance benefits, it is important to ask whether it will be easy for policyholders to make a claim. If the client cannot make a claim, or at least not easily, then the proposed benefit will not be particularly beneficial. This logic has led others to follow ASA's lead in staying away from accidental death coverage and disability benefits. Leftley (2005) agrees that disability benefits should not be included in microinsurance: "Many clients cannot claim for disability because they are unable to demonstrate that it was not a pre-existing condition as they lack formal medical records. Plus, trying to explain that they get 50 per cent of the sum insured for one arm, and 25 per cent for an eye, and so on, is also complicated and off-putting for a newcomer to insurance."

In contrast, CARD MBA does offer additional accidental death benefits (*see Table 21 below*). Since it is a member-owned scheme, it is easier for peers to assess if indeed the death was accidental even without a police or coroner's report, which are difficult to come by on remote Filipino islands. CARD MBA also follows a simple rule regarding claims settlement: "When in doubt, pay." Such an approach helps build member confidence in the scheme.



Although the benefits should be simple and “claimable”, microinsurers should also consider offering a couple of different benefit levels so that the low-income market can experiment with a very basic and inexpensive product. If they come to believe that insurance provides good value for their money, they might be enticed into higher benefit levels. This graduation from entry-level products to more substantive benefits would be a strong indicator of customer satisfaction and loyalty (and possibly an adverse selection risk!).

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**4.1****Basket coverage?**

In India, which is perhaps the world’s most sophisticated microinsurance market, there is a trend toward basket coverage, whereby a number of benefits are all thrown into one integrated insurance policy. For example, VimoSEWA’s product covers death, hospitalization and asset loss – benefits that come from two different insurance companies – all bundled together into one comprehensive product (*see Table 16 in Chapter 2.4*).

Table 18 summarizes the benefits of an insurance policy provided by UIIC to Shepherd. The core benefit from this product is the hospitalization cover. Although this is a relatively new product without a lot of claims experience, it is unlikely that there will be many claims for most of the other benefits. If that is indeed the case, then clients are paying 20 to 25 per cent more than they should for the hospitalization benefit. Indeed, one problem with basket coverage is that policyholders may be buying benefits that they do not want (although this does have the advantage of reducing adverse selection).

The rationale behind a bundled product is that it delivers a more comprehensive risk protection package while reducing expenses (i.e. it would be more expensive to sell three separate products). The marginal cost of adding additional benefits is minimal. Plus, when selling the product, the salesperson can offer a cost-effective solution to the diverse risk-management needs of the target market.

One major issue with this basket cover approach is the lack of transparency. Clients would never be told the contribution of each individual benefit to the total price, nor would they be allowed to choose the specific benefits they want. Another potential problem is that the inadequate servicing of one component of the product may taint the perception of the entire product, since the life and non-life risks are usually ceded to different companies. So if health claims are not paid on time, for example, the whole package will be affected. The converse is also possible: good servicing and good value of one component could increase the appeal of the entire package, so that an inferior component is propped up, at least for a time.

To summarize, this is an unresolved issue, as the attraction of providing more comprehensive coverage is in conflict with the compelling rationale for keeping the product simple.

Table 18

### Benefits from UIIC's UniMicro insurance scheme

<i>Product feature</i>	<i>Comment</i>
Group or individual	Group
Term	1 year
Eligibility requirements	Age 18 to 60 Declaration of good health
Delivery model	Partner-agent with UIIC
Voluntary or compulsory	Voluntary
Product coverage (benefits)	Rs. 15 000 (US\$333) accidental death Rs. 15 000 (US\$333) permanent disability Rs. 250 (US\$5.55)/month up to max Rs. 750 for temporary disability Rs. 5 000 (US\$111) hospitalization expenses Rs. 5 000 (US\$111) for house fire and allied perils
Key exclusions	30 days waiting period (except for accidents); exclusions for the hospitalization cover include childbirth, pre-existing conditions, and HIV/AIDS; during the first year of the cover, treatment for cataracts, hysterectomy, hernia, congenital internal diseases are not payable, but these are covered from the second year
Pricing	Member pays Rs. 100 (US\$2.22); Rs. 84 (US\$1.87) goes to the insurance partner; Rs. 16 is kept as commission (an additional Rs. 20 (US\$0.44) is charged for thatched-roof houses)

Source: Roth et al., 2005.

## 4.2 Family benefits

While it may be appropriate to have fewer benefits, it is also (generally) better to have more people covered by one product. A family benefit approach, which may include spouses, dependants and even parents, creates a number of important advantages for microinsurers:

- A family is a group of sorts, and consequently family coverage carries many of the same advantages as group coverage: larger numbers, lower adverse selection risk, etc. The price for a family unit is generally lower than the sum of individual premiums.
- Family coverage can have a positive selection effect by purposefully enrolling very low-risk persons. For example, African Life entered the HIV/AIDS-ridden low-end market by developing a product where the family, rather than an individual, was the insured unit.
- Family coverage often has a better marketing effect because claims are more frequent and thus there are many more examples to demonstrate the value of microinsurance.
- Microfinance institutions concerned about protecting their loan portfolio realize that borrowers have repayment problems when death or illness strikes family members.
- If the whole idea behind microinsurance is to reduce the vulnerability of low-income households, then coverage should be extended to include all household members.

The disadvantage of family benefits is that not everyone has a family, or that some people have larger families than others. To deal with the size of the family, microinsurers either ask the policyholder to identify the specific dependents who are covered by the policy or they offer different prices for different-sized households. To ensure that women and children are not left out, it is preferable to require family coverage where possible.

ALMAO's funeral policy covers up to nine people, including parents and in-laws. CARD MBA covers the spouse and up to three children under 21. Those without children can include their parents. For those who are not legally married, CARD assists by organizing weddings (*see Box 28*). Another disadvantage is that family benefits are more expensive in absolute terms (though possibly not in per capita terms), which may make coverage unaffordable for some market segments.

*Box 28*

### **Mass weddings**

CARD MBA requires that for coverage of other family members there must be legal documentation to prove the relationship. Many MBA members have not yet formalized their relationship with their spouse, often because of the costs involved. Thus, as a member benefit, the MBA occasionally organizes mass weddings for its members. This event helps members comply with MBA requirements, puts women in a better legal position, and saves them money.

*Source: Adapted from McCord and Buczkowski, 2004.*

One cannot assume that households have nuclear families of mother, father and two children. Depending on the country, many households contain extended families including grandparents, nieces, nephews, aunts, the children of friends, etc., particularly in HIV/AIDS-ravaged areas where grandmothers are taking care of orphans. Consequently, microinsurers have to be very clear who they consider to be a dependant, relying on local definitions where possible (*see Box 29*).

*Box 29*

### **UHC definition of family in Uganda**

When it agreed to sponsor the development of the Uganda Health Cooperative, management at Health Partners, a United States-based HMO, expected that many of its North American assumptions and ways of doing things would have to be adapted to the Ugandan context. One adaptation that was quickly deemed necessary was the definition of who was included under “family” coverage. The North American definition of family did not accurately reflect the reality of the lives of potential Ugandan policyholders. Instead, UHC developed a more “local” definition: “everyone who eats from the same pot”.

*Source: Adapted from Brown and Churchill, 2000.*

For example, TSKI and its insurance partner Cocolife agreed that children born outside wedlock can be included in the policy as long as they share the same family name as the TSKI client. Illegitimate children with a different family name cannot be included. However, children from previous marriages who have different names can be included under the microinsurance as long as there is documentation to prove that they are the client’s biological children. This example is not necessarily a good or bad practice, but it illustrates the types of issues that will need to be clarified under a family coverage.

Even more important than defining which dependants are eligible, is to identify them in advance. To minimize claims fraud, each person covered by the policy must be individually identified using official documents (where possible) and/or with photographs. It is not sufficient to specify which persons are covered without combining this with explicit identification of the additional persons. It is also important to control movements of dependants on or off the policy. For example, clients may have the option of adding newborn children to the policy at birth (or within a short timeframe thereafter) but not subsequently. This controls adverse selection.

When extending life coverage to spouses, it is important to recognize that men often have higher claims ratios. For example, in AIG Uganda's experience, the claims ratio of men to women is 4:1, while at CARD MBA it is 3.2:1. Spandana has had similar experiences. There are various factors involved, for example men tend to be older than their wives, while having a lower life expectancy. However, there also appears to be a screening problem. In each of these cases, the women are borrowers who have to meet specific criteria, e.g. less than 55 years old, economically active and accepted by their borrower group. However, no screening or age restrictions are applied to spouses, which leads to an adverse selection scenario in which women with sick husbands can join the scheme.

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### 4.3 Cash or in kind? Now or later?

With health insurance, benefits are either conveyed in kind, in which case the benefit is the healthcare service, or in cash. Cash healthcare benefits are usually paid on a reimbursement basis; the policyholder has to pay the bills and then submit the receipts for reimbursement. Such an arrangement is generally less appropriate for poor clients who do not have the money to pay the bills in the first place (*see Chapter 2.1*).

The benefit of having health insurance is that people do not have to delay care because they have to find the money. Most community-based health insurance schemes use a third-party or cashless payment system whereby the microinsurer pays the healthcare provider directly, so the insured does not experience any out-of-pocket expenses, except perhaps for a co-payment or transportation (which is sometimes also reimbursed by the insurer). Health insurance on a reimbursement basis is a distant second-best option.

In Georgia, where Aldagi Insurance is in partnership with Constanta Foundation, policyholders are given cash in the hospital so that they can pay the bribes required for care (which are unreceipted and thus not payable to the hospital or reimbursable to the beneficiary). While this approach may not be recommended in other contexts, it illustrates the inventiveness required to serve the low-income market.

For life insurance, benefits are almost always paid in cash, although there are some interesting exceptions. ServiPerú's coverage is paid through funeral services, which includes a coffin, flowers and a hearse. In fact, ServiPerú has found the low-income market more receptive to service provision because it is easier for it to understand than risk pooling. One advantage of the in-kind approach is that the insurer can arrange a discount by essentially buying the funeral services in bulk, so low-income households can get better value for

their money. The disadvantage is that, when a death occurs, the family often has to pay for other expenses besides the funeral, and therefore needs a cash payment as well.

Another factor to consider with life insurance benefits is when they are paid out. Typically, after a claim has been processed, the beneficiary gets a lump-sum benefit and that is it. If a breadwinner has died, the household will have to find ways of replacing the lost income. Under such circumstances, a lump-sum benefit could quickly disappear. To address this issue, La Equidad provides households with several benefits. Besides a payout if the policyholder dies or is permanently disabled, its *Amparar* (Spanish for “to protect”) product – offered to the low-income market through the MFI Women’s World Foundation – also provides financial support to help beneficiaries pay for groceries and utilities (see Table 19). For an additional premium, policyholders can purchase a children’s education rider that would make additional monthly payments for two years to assist with education expenses.

Table 19

#### Benefits of La Equidad’s *Amparar* microinsurance product

Coverage (US\$)	Plan 1 Smallest	Plan 6 Largest
Death (any cause)	1 244	8 292
Total and permanent disability	1 244	8 292
Food/groceries for 12 months	25	104
Utilities for 12 months	12	62
Funeral support (lump sum)	62	332
<i>Optional:</i>		
Children’s education expenses 24 months	15	75

Note: there are six plans. Only the smallest and largest are included.

Source: *Almeyda and Jaramillo, 2005.*

The provision of benefits over a period of time after the insured event is likely to have a greater development impact than a lump-sum payment, which may be spent on an elaborate funeral but not help the household cope with the loss of income. The staggered benefits approach is also adopted by ALMAO’s “Senehasa” product (see Chapter 2.4) and CARD MBA’s total and permanent disability (TPD) cover, which pays out over an 18-month period. The main disadvantage of staggered benefits is the transaction costs involved, especially if they are provided by cheque which might be difficult for beneficiaries to cash. This disadvantage can be overcome if benefits can be paid directly to a savings account, or to a service provider such as a grocery store or utility company.

## 4.4

**Cash-back benefits**

As mentioned above, one of the difficulties in marketing microinsurance is to convince clients that they are getting value for money, even if they do not claim. Policyholders are often left with the perception of poor value if they pay premiums for some time without receiving any benefits in return, not recognizing the importance of having enjoyed the security and protection. This may be especially true if the insured becomes too old and is forced to drop out.

To help address this problem, some benefit features may be added to longer-term products, such as those described in Chapter 2.2, although these may introduce pricing risks typically inherent in most long-term guarantees (see *Chapters 3.5 and 3.6*):

**1. Premium-back features** generally refund all or part of the premiums paid after several years of enrolment, as is required under the MBA regulations in the Philippines. If the term is long enough, a modest interest payment may even be included. Yasiru (Sri Lanka) does this as well, distributing 40 per cent of its profits to clients with at least five years of membership, which serves as a loyalty incentive.

**2. Paid-up insurance** means that after several years of premium payments, the coverage may continue for a lifetime without additional premiums. The amount of insurance may also be determined by the entry and exit age of each client. For example, with ALMAO's "Pilisarana" product, premiums are paid until the policyholder turns 60. The benefit after that age depends on how old they were when they started paying into the scheme.

**3. Savings features** may be bundled with the product and contributions returned with interest dependent on the net earnings of the portfolio. It may be difficult to market a non-guaranteed interest rate, but this can be done with hypothetical projections.

**4. Endowments** pay a guaranteed cash benefit, perhaps equivalent to the life coverage amount for a certain period of time or when the policyholder reaches a certain age.

These features tend to be relatively expensive and potentially risky for the insurer if not designed properly, especially if interest rates are low or in decline. Although "no claim" or persistency-linked cash-back awards may seem attractive to clients, like any other benefit, they must be charged for, and effectively reduce the risk spreading of insurance, which is to redistrib-

ute resources from those unaffected by the risk to those affected by the risk. In addition, care must be taken to keep the product simple when introducing such features to preserve its appeal.

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## 5 Risk management and claims controls

For both health and life insurance, it is essential to design products with the claims controls and adverse selection features to sustain the scheme and keep premiums low. In general, elective participation, diverse target populations, broader inclusions and numerous product choices all tend to increase adverse selection and thus need more controls, especially in smaller schemes.

The principle of simplicity that applies to benefit design and marketing is also applicable to risk management and claims controls. Insurers seem to have an inherent tendency to make things complicated, a tendency that microinsurance must curtail. For risk-management purposes, product options should not be choices at all, but rather pre-defined and linked to circumstances outside the applicant's immediate control. For example, if applicants have a family, then they should be required to take the family package.

Other key controls to consider include health declarations, co-payments and deductibles, and microinsurance-friendly alternatives to exclusions.

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### 5.1 Health declarations

If the potential for adverse selection is significant, then the applicant should be required to sign a declaration of good health, an approach used by many of the organizations that offer life insurance. It is even useful with credit life to discourage older or sick borrowers from attempting to maximize their loan amounts once they become aware of a terminal disease such as cancer.

The basic idea of a health declaration is that the applicants state that they are in good health to the best of their knowledge at the time of application. If policyholders then die and the microinsurer can determine that they knew about the terminal health condition at the time of the declaration but lied about it, then the microinsurer has the right to deny the claim based on the false declaration. So instead of expensive screening of all applicants, the insurer concentrates its resources on verifying a few claims.

The health declaration is useful not only as a tool for the microinsurer to reject claims, but also as a deterrent to adverse selection. For example, if a terminally ill loan applicant knows that the credit life claim is likely to be declined because of the declaration, then he/she may be discouraged from proceeding with the loan application because of the burden that will be put on the surviving family.



For credit life, health declarations may either be required for all loans or only for larger loan amounts. For efficiency purposes, microinsurance schemes minimize controls for the smallest policies, but introduce them for larger sums insured. If only required for larger loans, the microinsurer will still have some exposure to adverse selection, but will put up with it to save the administration costs involved in processing a declaration for every single loan. In such cases, the trigger for a declaration should be based on the total amount of all outstanding loans granted to the borrower rather than each individual loan.

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## 5.2 Co-payments and benefit ceilings

For health microinsurance, deductibles and coinsurance (which are different types of co-payments) and benefit ceilings are important claims control mechanisms. The most effective design combines all three. That is, all claims below a certain amount, the deductible, are paid by the insured. Then, the insured pays a coinsurance of  $x$  per cent of the claim (or a fixed amount) in excess of the deductible. The insurer pays the difference up to a certain maximum amount. These control mechanisms can be applicable to each claim or on an annual policy-year basis.

The point of such payments is two-fold: 1) to reduce the actual claims amount paid by the insurer, and perhaps more importantly 2) to help reduce the claims incidence. For example, insureds will be more reluctant to admit themselves to hospital for minor ailments if they have to pay a deductible, and would also be discouraged from remaining hospitalized beyond the necessary period if a coinsurance were payable in excess of the deductible.

An additional objective of a deductible is to reduce the administrative burden for the insurer of processing many small claims. So if a deductible were in place, the insurer would only process claims that were in excess of the deductible. Interestingly, although coinsurance is common in microinsurance (see Table 20), none of the case study organizations included deductibles. The UMSGF *mutuelles* did use deductibles initially, but when the network introduced a third-party payment system where the insurer reimbursed the healthcare providers directly, deductibles were no longer considered necessary because the administrative processes were sufficiently simplified. From a pricing perspective however, all claims should be coded in an MIS, whether or not the deductible is exceeded, whether or not a claims payment is made. This is necessary to determine true morbidity rates and medical costs (see Chapter 3.5).

Healthcare schemes that only provide inpatient benefits may find co-payments unnecessary as well. For example, Yeshasvini, which only covers sur-

gery, does not require either since it assumes that people will not have surgery unless they really need it (and elective surgery is excluded). Similarly, neither VimoSEWA nor Shepherd has a co-payment for their hospitalization covers.

Table 20

### Coinsurance and payment ceiling of health microinsurers

<i>Health insurer</i>	<i>Coinsurance</i>	<i>Benefit ceilings</i>
UMSGF	<ul style="list-style-type: none"> <li>· US\$0.38 for outpatient</li> <li>· none for inpatient</li> <li>· 30% for primary care</li> </ul>	none
AssEF	30% of expenses for specified in- and out-patient services	none
BRAC MHIB	<ul style="list-style-type: none"> <li>· US\$0.03 for MFI clients</li> <li>· US\$0.08 for other insured persons</li> <li>· none for the ultra poor</li> </ul>	between US\$8.52 and US\$17.04 for each incident when referred outside the BRAC clinics
Grameen Kalyan	<ul style="list-style-type: none"> <li>· US\$0.09 for MFI clients</li> <li>· US\$0.17 for non-clients</li> <li>· US\$0.85 for uninsured persons</li> </ul>	US\$34.08 for hospitalization due to maternity complications, and to US\$17.04 for hospitalization due to other complications
Yeshasvini	None	US\$4,545 per year which is sufficient for two of the most expensive operations and some smaller ones
ServiPerú	<ul style="list-style-type: none"> <li>· US\$1.43 per consultation (except for X-rays the policyholder pays 50% of the cost)</li> <li>· US\$11.43 per emergency service.</li> <li>· 10% of expenses for medical care in the event of accident and hospital care as a result of illness or accident.</li> </ul>	none

The co-payments amount must be carefully determined. If it is too high, then the tendency may be for the insured to wait too long to seek treatment, or not to seek treatment at all, thus possibly causing the condition to deteriorate to a more severe illness, eventually resulting in a much larger claim or perhaps even death. When considering co-payments (or deductibles), microinsurers should bear in mind “implicit” co-payments – for example the costs of travel to access healthcare services or losses of income from time away from business, which may already act as disincentives to unnecessary claims.

Another consideration for co-payments in particular is whether the infrastructure is in place to accept cash payments. For example, three of the four

government schemes analysed in Latin America also avoid co-payments because financial transactions open up vulnerability to fraud (Holst, 2005a).

For health insurance, several organizations control claims by instituting a maximum claim per annum or per hospitalization, or by limiting the number of hospitalizations per annum. BRAC and Grameen Kalyan apply these limits when cardholders have to be referred to other healthcare providers, but do not limit the amount of care from their own clinics. Yeshasvini Trust has a maximum amount that can be claimed in a calendar year (US\$4,545). These controls protect the viability of the scheme – especially since the schemes do not have reinsurance – but limits cannot be set so low as to undermine the usefulness of the insurance cover.

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### 5.3 Alternatives to exclusions

Insurers may use exclusions for a number of reasons:

- Controlling adverse selection, e.g. pre-existing condition exclusions
- Reducing moral hazard, e.g. suicide exclusions
- Reducing the cost of insurance by removing high-frequency or common claims and targeting only specific causes of claims, e.g. accident-only cover which excludes death due to illness
- Controlling covariant or catastrophe risk, e.g. war and riot or weather catastrophe exclusions
- Reducing the extent of initial underwriting, e.g. one-year HIV/AIDS exclusions applied to life cover to eliminate the need for testing

As discussed above, microinsurers may adopt a different approach to exclusions from that of traditional insurers. While the moral-hazard exclusion is justifiable regardless of the type of insurance, a microinsurer may allow typically excluded conditions for covariant risk and certain adverse selection risks in the spirit of social protection.

Where covariant risks are taken on, it is essential that appropriate risk-mitigation strategies exist, such as reinsurance or donor support in the form of guarantees. Otherwise, the only consequence of dropping the catastrophe exclusion will be the insolvency of the scheme in the event of a catastrophe, which benefits no one.

The argument against exclusions for pre-existing conditions is not quite as clear. If a microinsurer offers voluntary individual insurance, then high-risk people are most likely to sign up; if only high-risk people join, the insurer cannot effectively pool the risk. However, if it is group coverage, especially if it is mandatory, or the microinsurer recruits large volumes of policyholders,

then it can be more inclusive with regard to pre-existing conditions. This additional risk is highest at product launch. If renewal/persistency rates can be kept high, as the scheme matures, the risk associated with pre-existing conditions becomes more manageable because new insureds become a smaller proportion of the entire portfolio. It may be appropriate to fund this start up risk with donor support, which can be relaxed subsequently as the scheme moves towards sustainability.

A microinsurance-friendly alternative to exclusions is the waiting period, whereby policyholders cannot access certain benefits for some time after they enrol. For example, in South Africa, HIV/AIDS-related adverse selection is managed using six-month to one-year accident-only waiting periods for life policies backing up low-income housing loans. A waiting period has essentially the same effect as excluding pre-existing conditions except that the insurer does not have to incur the claims verification costs. If the insured event occurs during the waiting period, the claim is rejected; the insurer does not have to check with doctors and review medical records to determine if the policyholder already had the problem, as it relates to exclusions for pre-existing conditions.

Another alternative to exclusions which is more in-line with the spirit of microinsurance is to offer **benefit schedules** with gradually increasing benefits. For example, if the insured event occurs in the first year, the benefit is small, but if it occurs after the first year, the benefit is much larger. Such an approach is an effective way to control adverse selection while creating an equitable microinsurance scheme that encourages long-term participation and renewal. CARD MBA has adopted this incremental benefits approach, as illustrated in Table 21.

Table 21

**Benefit amounts at CARD MBA**

<i>Duration of membership</i>	<i>Cause of death</i>	<i>Member (US\$)</i>	<i>Legal spouse and dependants (US\$)</i>
Under 1 year	Pre-existing condition or event during contestability period	18	–
Under 1 year	Non-accidental	55	55
Under 1 year	Accident	182	55
1-2 years	Non-accidental	55	55
1-2 years	Accident	236	55
2-3 years	Non-accidental	302	110
2-3 years	Accident	575	110
Over 3 years	Non-accidental	302	110
Over 3 years	Accident	665	110

Source: McCord and Buczkowski, 2004.

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## 5.4 Fraud control

A final, critical component of microinsurance product design and risk management is a system to prevent fraudulent claims. Products must be designed in such a manner as to support coverage and claims validation with clear objective criteria. One way to implement cost-effective fraud controls in microinsurance schemes is to make use of their relationship with community structures.

In addition, cost-effectiveness needs to be considered from both the insurer and the policyholder perspective. If having sight of the death certificate involves two or three 10-kilometre trips, unofficial fees and a month's wait, is it really necessary if the agent attends the policyholder's funeral?

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## 6 Conclusions

The main messages from this chapter are:

- Microinsurance product design must strike a balance between broad inclusion, appropriate benefits, low premium rates and sustainability (or targeted profitability).
- Products have to be customized to clients' needs and preferences.
- Affordability and product design features have to be considered together.
- Microinsurance is relatively easy if the target market is a well-organized group; significant challenges are faced when trying to serve unorganized individuals.
- Group coverage is generally more appropriate for microinsurance because it minimizes administrative costs, which should lead to lower premiums.
- Mandatory coverage has significant advantages, while its disadvantages can be curbed through marketing and education efforts, and some choice in benefit packages.
- Short-term insurance is generally more appropriate for the low-income market.
- The heterogeneous low-income market prefers a variety of premium payment frequencies and mechanisms.
- It is advisable to limit benefits to the most important insurable risks.
- The spreading of life insurance benefits over a period of time might be advantageous to both parties as long as transaction costs can be minimized.
- If policyholders cannot easily claim for a benefit, then the policy is not very beneficial.
- Deductibles, co-payments and benefit limits are important claims controls for health insurance schemes.
- Product design features like waiting periods and benefit schedules allow microinsurance schemes to include high-risk persons without incurring additional screening costs.

## 3.2

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# Marketing microinsurance

Craig Churchill and Monique Cohen

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When designed properly, microinsurance can be a valuable financial tool for low-income clients. Yet even with a strong product, a microinsurance scheme will fail without an effective marketing campaign. When asked about insurance, low-income persons often express ignorance or indicate that they think it is only for rich people. A major hurdle for marketing insurance to the poor is the lack of differentiation between microinsurance and conventional insurance products. The mentality that insurance is only for the rich will persist until microinsurers can adequately differentiate their product in the market place.

Marketing insurance to the poor presents some other challenges as well. If they have had access to conventional insurance (or know of other people who have had insurance), the experience has often been negative, tainted by claims-processing delays, rejected claims and lapsed policies – all of the characteristics that microinsurance product design must avoid. Low levels of literacy among potential clients make marketing the product even more difficult.

Most people, rich or poor, do not enjoy buying insurance because they do not want to think about risks or the pending occurrence of perils. Many do not like the idea of buying peace of mind and then feeling the expense was wasted if the insured event does not occur. However, that idea is even harder to swallow when one is poor, living from day to day, not planning for the future, and without surplus cash to waste.

This chapter is organized into four sections. The first section summarizes the main marketing messages commonly conveyed by microinsurers. The second section reviews the techniques used for conveying those messages. Section 3 considers the important marketing role of after-sales service, and the final section looks at the marketing implications of mandatory insurance.

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## I Main marketing messages

The first step in designing a marketing strategy is to determine whom the microinsurer is trying to reach, including their literacy and income levels. One important lesson emerging from ICMIF (2005) is that microinsurers should avoid trying to serve too many different market segments since that can require many products and corresponding marketing channels, which can significantly drive up operating costs.

After identifying the target market, the next step is to determine the main messages that microinsurers want to convey. This is accomplished by considering the anti-insurance arguments that the target market might have, and then designing messages to counter those arguments. From the available case studies, four main marketing messages emerge: protection, solidarity, optimism and trust. Unfortunately, given the data available, it is not possible to assess their relative effectiveness, so this section merely describes the most common marketing messages.

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### I.1 Protection

A main marketing message conveyed by microinsurers is to remind low-income households that they are vulnerable, that people like them incur risks all the time, and if they do not have a way of effectively managing those risks, they will be worse off. This emotional approach often relies heavily on **testimonials** of persons who did benefit and were able to survive a crisis (as well as negative testimonials of those who did not have protection and suffered).

Delta Life (Bangladesh) uses this approach with its new marriage endowment product, which is supposed to benefit the policyholder's daughter when she turns eighteen, either from the savings or, if the policyholder dies during the term, from the insurance benefit. In the brochure for the product (see *Figure 10*), the bride is crying – even though she is getting an appropriate wedding – because her parent is not there to share her joy.

Figure 10 Daughters' wedding insurance plan: Delta Life

কন্যা বিবাহ বীমা পরিকল্পনা  
পরিকল্পনা নং-৪৪২

ডেল্টা লাইফ ইনসিওরেন্স কোম্পানী লিমিটেড  
গণ-গ্রামীণ বীমা

কেন্দ্রীয় কার্যালয় : বায়তুল আবেদ ভবন, ৫৩ পুরানা পল্টন, ঢাকা-১০০০  
ফোন : ৯৫৬৪০৮৯, ৯৫৫৬৫৩৪, ৯৫৭০৩২৪

Source: Delta Life Insurance Company Limited, Bangladesh

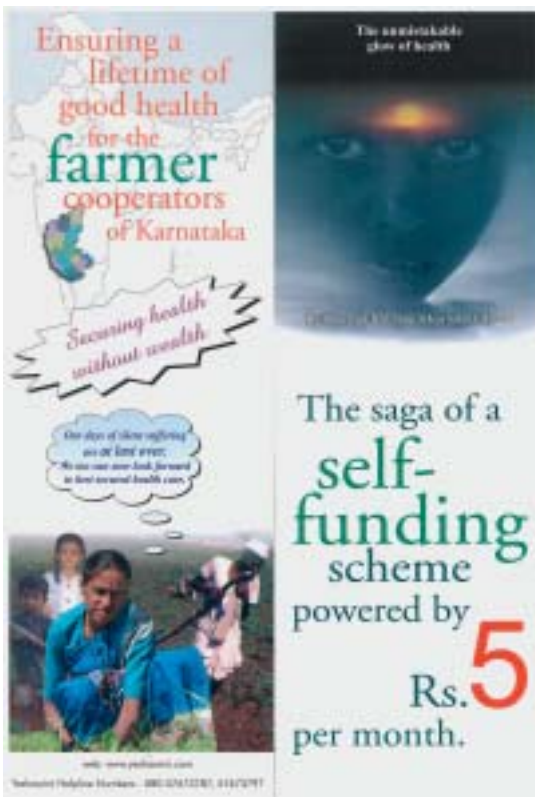


## 1.2 Solidarity

While the protection message is essentially the same for insurance and microinsurance, some microinsurers also emphasize solidarity as a key marketing message. This message builds on informal self-help mechanisms, with which people are familiar, to make insurance and risk-pooling more comprehensible to an uneducated market. For example:

- **VimoSEWA (India):** “All contribute to a common pot; those who have faced the prescribed risks can take from the pot as per the rules and regulations decided by all.”
- **AssEF (Benin):** “Mutual health organization! Huge membership + regular payment of premiums = good health for all. Risk management and solidarity for better health.”
- **Yeshasvini (India):** “Each for all and all for each” (see Figure 11).

Figure 11 Marketing brochure: Yeshasvini



**YESHASVINI**

a simple Scheme  
founded on the Principle of Co-operation  
"Each for all and all for each".

**Special Features**

- A member who has been a member of a co-operative society for at least 10 years can avail the benefits of the scheme by paying a nominal sum of Rs. 100/- per year. The wife and children can also avail the benefits by paying Rs. 100/- each year.
- Savings from any kind of insurance is not fact to avail the benefits of the scheme.
- Member age limit to avail the benefits of the scheme is 75 years.
- Member can avail free medical check-up for Rs. 100/- only, and Rs. 500/- only for medical expenses.
- Life spans of members have been included in the **Healthcare Scheme**, details of which are available at the website.
- Only females who are married with the permission of the husband, but are recognized as **Widows**, **Widely Dependent** or **Orphan** (in absence of the husband, father or mother) are eligible for the scheme. Details of the scheme are available at the website.

**Progress achieved**

- In the 100 weeks of the project 100% compliance was achieved in the scheme. In the second phase, over 100% compliance has been achieved.
- The first trial version of the scheme has been launched and is being implemented in 100% compliance. The scheme is being implemented in 100% compliance to give a sum of Rs. 100/- to the members from every Rs. 100/-.
- Over 100% compliance of members have been successfully transferred to the scheme. Compliance is 100% as on 10/10/2014.
- Many special cases have been handled and over 100% compliance has been achieved as on 10/10/2014.
- The scheme has been fully implemented in over 100% compliance.

**Programme for 2014-15**

- To identify eligible and needy cases in continuation and also build up to provide insurance in the second 100 weeks.
- To take an effective insurance and social awareness among better co-operatives about the scheme.
- Availability of all documents (brochure and booklet) in computer. Family identity cards in beneficiary co-operatives offices.

The solidarity message is more common, and perhaps more effective, when policyholders are also involved in shaping the benefits and the procedures. This message is particularly important to avoid the confusion that often happens when the policy term comes to an end, and clients who did not suffer the insured event want something back. The challenge is to help low-income households understand from the outset that insurance requires solidarity and that even though they might not benefit this year, they might in the future, and they have made it possible for many others to do so.

### 1.3 Optimism

Several microinsurers recognize that they need to put a positive spin on their marketing messages since the “doom and gloom” approach can reinforce the negative perspective that poor consumers have of insurance. This positive approach can best be seen by contrasting a smiling girl in TUW SKOK’s brochure (*Figure 12*) with the crying bride from Delta Life.

**GWARANTOWANE  
OSZCZĘDZANIE**

OFERTA WAŻNA  
OD 01.02.2002r.

**ubezpieczony rachunek  
systematycznego oszczędzania**

wysokie oprocentowanie  
nie tylko dla zamożnych  
poczucie bezpieczeństwa  
gwarantowana przyszłość

**TUW SKOK**  
TOWARZYSTWO UBEZPIECZEŃ WSKAZANYCH  
SPÓŁDZIELCZYNI KAS Oszczędnościowo-Kredytowych

Figure 12 Guaranteed savings brochure: TUW SKOK

*Translation:*

- An insured systematic savings account
- High interest
- Not only for the rich
- Feeling of security
- Guaranteed future

This optimistic approach is probably easiest with endowment or accumulating value life insurance policies. The message can focus on the amount of savings that one might have at the end of the term, or on the purposes for which that money could be used – such as building a house, sending children to school or paying for a wedding – instead of on the sum insured that the beneficiary would get if the policyholder died.

The positive spin on health insurance focuses on people being and staying healthy, rather than on illnesses and medical treatments. It is even possible to present term life from a positive angle, by linking the cover, which is relatively inexpensive, to a common superfluous expense. The same idea underlines the slogan for a health insurance scheme in India – “For just a rupee per day” – since it costs Rs. 365 per person annually.<sup>1</sup>

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#### 1.4 Trust

One of the problems with selling insurance is that policyholders do not know whether the insurer will pay out the benefits in the event of a claim. The market often perceives insurers as quick to take their money, but slow to pay it out. Low-income persons are particularly susceptible to fraudulent schemes, which in some locations have undermined the credibility of legitimate insurers. Even with respectable insurance companies, the low-income market tends to experience a disproportionate amount of claims delays and rejections. This is, in part, because the poor are not a powerful or influential customer base, so insurers do not have significant incentives to keep them happy.

Microinsurers need to find ways of convincing the target market that they are indeed trustworthy. Conventional insurers often try to create large, visible headquarters as a way to convey the impression that they are a large and stable company. Located in the centres of towns and cities, the headquarters are often far from the areas where the poor live and work, which is not so useful for the low-income market. For microinsurance, perhaps the most effective way of conveying this message is through branding – associating the insurer with something that is trusted by the poor. For example:

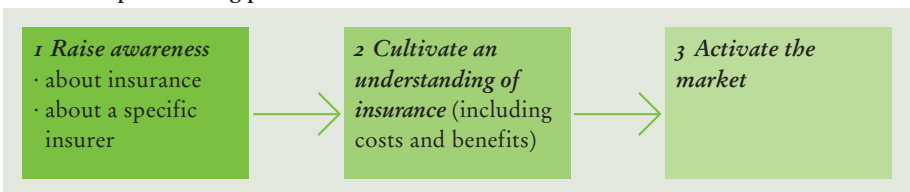
<sup>1</sup> This public sector scheme, Universal Health Insurance, has not reached as many people as expected, but it is not possible to determine if the problem was the marketing campaign, the product design or the delivery mechanism, or a combination of the three. The product is even cheaper for families living below the poverty line, who receive an annual subsidy from the central government of Rs. 200 (US\$4.60) for an individual, up to Rs. 400 (US\$9.10) for a family of seven. At the end of March 2004, 417,000 families were covered (Radermacher et al., 2005b).

- The logo of TUW SKOK (Poland) resembles the logos of the credit unions with which it works, to draw a connection between the trust that the members have in their credit unions and the credit unions' insurance company.
- SEWA has a powerful and trusted image among women in the informal economy that has significantly helped VimoSEWA. Even after difficult periods, such as the Gujarat earthquake when there was a surge of claims that exceeded the microinsurer's capacity and claims payments took three months or more, members gave VimoSEWA a degree of leeway that would not have been extended to most organizations.
- When AIG entered the Indian market, it was fortunate to start a joint venture with the Tata group of companies, one of the most respected and trusted Indian industrial conglomerates. When Tata-AIG entered the low-income market, it exploited the Tata brand: agents selling microinsurance assured potential clients that such a large company would have little interest in stealing their miniscule (in relative terms) premiums. In addition, it collaborated with local NGOs that helped strengthen its local credibility.

## 2 Marketing techniques

To convey these messages, microinsurers use a variety of marketing techniques. To get customers to the point of signing their contracts and paying their premiums, marketing managers have to go through three phases (*Figure 13*). First, they have to raise awareness about microinsurance and microinsurance providers. Second, they have to help the market understand the products, including the costs and benefits. Lastly, they have to activate the market by turning the increased awareness and understanding into a sale.

*Figure 13* Three-step marketing process



## 2.1 Raise awareness

Raising the customer's awareness of insurance has two aspects: a) a general knowledge of insurance and b) specific familiarity with an insurance provider. From the experiences of microinsurers, the general receives far less attention than the specific. Few microinsurers use social marketing techniques to:

- educate their clients more broadly about insurance,
- describe how it fits into a broader array of risk-management mechanisms and
- illustrate the advantages and disadvantages of insurance relative to other ways of managing risk (e.g. savings or credit).

The only example of creating general awareness that emerged from the case studies was Tata-AIG, which produced brochures explaining insurance without actually mentioning the insurer or its product. The literature was disseminated by its NGO partners, and their credibility in the low-income market helped raised the standing of insurance as a viable intervention for the poor. (Obviously, the success of this approach may be constrained by the literacy levels of potential policyholders.)

There are two reasons why creating general awareness is not more common in microinsurance. First, for mainstream insurance providers, it is in their interest for clients to understand their products, but to have little knowledge about the industry in general. Second, general insurance awareness campaigns could equally benefit other insurance providers, so individual insurers will be less likely to undertake such an initiative. Indeed, since general awareness is a public good, the government or an industry association might be better positioned to engage in education campaigns, which is the case in South Africa (*see Box 30*). This is an area where donors might also be able to make useful contributions.

*Box 30*

### **Creating awareness: The experience of the South African Insurance Association**

Under an industry charter, South African insurers have agreed to allocate resources to delivering insurance products to low-income households. In addition, they contribute 0.2 per cent of net profits for use in financial education. Members of the South African Insurance Association (SAIA), providers of non-life and short-term insurance products, decided to collectively deliver a consumer education programme, which covers seven themes: money management, budgeting, debt, saving, banking, life and short-term insurance and consumer rights and responsibilities. To raise awareness, SAIA has initiated three activities:

1. Development of a teacher resource kit targeted at secondary-school students;
2. A one-day financial literacy workshop in rural areas. To date, 10,000 people have received the training;
3. Commuter Net: with 17.5 million people commuting daily, this population has been identified as a priority target group. Several initiatives have been introduced:
  - Television screens have been installed in taxi parks and feature TV spots on the seven themes;
  - Radio stations provide interactive education;
  - 25,000 cassettes featuring music and financial education messages have been distributed at taxi parks; and
  - Comic books on financial education have been distributed.

*Source: Adapted from the SAIA website.*

Raising awareness about specific microinsurance providers is more prevalent than the promotion of general insurance literacy. The three most common approaches are through branding, public relations and prevention campaigns:

- **Branding** is an effective way of acquainting a market with an organization. To promote their brand, microinsurers tend to use signboards, in front of their offices or on billboards, with recognizable colours and perhaps a symbol. Another component of the brand is the tagline used in marketing materials to convey a general message about the organization to clients and potential clients; for example, Delta's materials say, "Delta Life, Prosperous Life", and similarly Tata-AIG's tagline is "A New Look at Life". Simple branding that uses illustrations or pictures is an effective way to convey a marketing message to both literate and illiterate market segments.
- Most microinsurers are engaged in **public relations** in one way or another. The most common public relations activity for life insurers is to hold claims award ceremonies, where a beneficiary receives an insurance payout at a public event. Larger microinsurers are also engaged in corporate sponsorship. For example, TUW SKOK supports a youth football team and an annual children's painting and drawing competition, low-key events intended to promote TUW SKOK's image as a community-based institution. Spandana (India) uses some of the surplus generated from its insurance scheme to finance education bursaries. These types of programmes demonstrate the organizations' commitment to the community in a tangible way without the need for glossy brochures and handouts.
- As described in Chapter 3.9, **prevention campaigns** can also raise awareness about a microinsurer. Shepherd (India) runs cattle care camps, partly funded



through a surcharge on each insurance policy, to promote the proper maintenance of animals and to provide free immunization and deworming. These camps are for the general public, not just members. Besides preventing claims, the camps also serve as a marketing vehicle. Similarly, ServiPerú has mobile medical units that visit cooperatives and other affinity groups to provide free medical consultations. Alongside these mobile facilities, a kiosk promotes its insurance services. BRAC MHIB and Grameen Kalyan (GK), both in Bangladesh, participate in the government's immunization campaign. Health authorities provide vaccines free of charge and a small contribution to cover the cost of promoting the campaign. Such participation strengthens the microinsurers' own prevention programme and enhances their image.

Creating awareness in the community-based model (*Chapter 4.3*) is a bit different because the microinsurer is not just asking prospective clients to buy insurance, it is also asking them to participate in the design and management of the insurance scheme (*see Box 31*).

*Box 31*

### UMSGF's three-tiered marketing strategy

With a community-based model, marketing involves more than just trying to persuade someone to sign a contract and pay a premium. It is necessary to work with the community to help them reach the conclusion that by working together they will be able to collectively solve individual problems. In the case of Guinea's USMGF, which promotes *mutuelles de santé*, the problem that they are trying to solve is the affordability of access to health care.

UMSGF uses a three-tiered marketing strategy to activate and engage the community in creating *mutuelles de santé* or MHOs:

The **first tier** is at the community level, where promoters give presentations about the problem and possible solutions, and try to stimulate interest in insurance. This level is akin to general awareness raising.

The **second tier** involves two group-level approaches, both of which aim to explain how health insurance works in a little more detail. With the first approach, the promoters meet existing groups – ROSCAs or tontines, religious associations, women's groups, business associations and so on – to see if they wish to form an MHO. With the second approach, promoters encourage individuals who want health insurance to create their own mutual group with others they trust. Where possible, the objective is to work with the community's social groups, whether pre-existing or organized around the *mutuelles de santé* activities. In this way, they build on an existing infrastructure and leadership.

The **third tier** is the individual households, beginning with those persons whom organizers have identified as opinion leaders. Some people are not



comfortable asking personal questions, for example about their particular health needs, in front of others. Therefore, organizers have to follow up the group meetings with household-level discussions. Once they have been able to acquire a few influential converts, the promoters can then also involve these community leaders in persuading their neighbours to participate in the scheme.

*Source: Adapted from Galland, 2005a.*

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## 2.2 Increase understanding

When the market has a general awareness of insurance and is familiar with the insurance provider, the next step in the marketing process is to increase its understanding of the specific products available, including product features and the costs and benefits of insurance relative to other risk-management strategies. This requires insurance education, which is particularly challenging in markets with low literacy levels.

Ultimately, one would hope that education would lead to shifts in knowledge, skills and attitudes, and in turn the adoption of microinsurance by the target market. Unfortunately, microinsurance providers tend to limit themselves primarily to information provision rather than education. There are, however, some notable exceptions. BRAC has pioneered the use of **street theatre** to educate target groups on the benefits of health microinsurance. Since 1998, BRAC's Social Development Programme has produced plays to highlight unjust, illicit and exploitative practices in society while preserving Bangladesh's rich tradition of local drama and folk songs. Participants are selected from among the MFI's clients and are provided with 10 days of intensive training in rural theatre. During the last three days of training, participants visit different villages to collect real-life stories reflecting critical social issues. Such methods promote the health insurance scheme by portraying the benefits if struck by a health problem.

A modern version of the popular theatre is the **video**, used by organizations like Tata-AIG to help potential customers understand how insurance works and why they should buy it. Unlike the street theatre, the video approach does not have the advantage of involving participants in the process of delivering the message, but in India Bollywood-style films can have a powerful impact on the target audience. Tata-AIG shows the videos from branded vans, and then once the film is over, the micro-agents can answer questions and sign up policyholders.

Low-tech education strategies can also be effective if they take into account the target market's education level. Perhaps one of the more com-

mon marketing techniques is the use of **pictorial presentations** – used by BRAC MHIB, AssEF and others – to illustrate how insurance works. An illustrated flipchart is a visual aid that helps to standardize the delivery of the main messages and increases the likelihood that audience will understand those messages. Yet the approach is still interactive and allows prospective policyholders to ask questions.

Literacy levels in a given community should influence the design of an educational campaign. In defining the depth and breadth of its market, a microinsurer must consider whether or not prospective clients are illiterate. If this is the case, microinsurers must provide the necessary information, about microinsurance in general and about the particular products being offered, without relying heavily on written communication.

One of the challenges when using any of these education techniques is to ensure that people actually understand and remember the main messages being conveyed. To address this challenge in Viet Nam, the Ninh Phuoc scheme has turned the exercise into a game. Key questions are written inside paper flowers, which are then placed in a tree or bush. Clients take turns picking the flowers and trying to answer the questions. If they get them right, the clients get a sweet or some other reward.<sup>2</sup>

When designing an education campaign, it is important to consider the market's heterogeneity. Different communication methods and messages may be required for each prospective market segment – a lesson learned by CETZAM (*see Box 32*). It is also important to define terms and avoid jargon. For example, in Uganda, the word “beneficiary” is associated with one who benefits from a social programme. Thus, clients frequently consider themselves as beneficiaries of their MFIs. Since there has not been adequate training, neither clients nor loan officers understand what this word means in the context of insurance.

*Box 32*

### **Regional differences in Zambia**

In September 2002, CETZAM conducted market research to gauge its clients' reaction to the new life microinsurance product, *Ntula*. The research demonstrated that 81 per cent of clients thought that *Ntula* helped protect them and their business at a time of stress. The research also highlighted the reason for the demand for insurance: 41 per cent of clients reported a death in their family during the previous year. Interestingly, 15 per cent of CETZAM's clients were opposed to the introduction of *Ntula* and nearly all of these were located in Livingstone, a town in southern Zambia.

<sup>2</sup> This information about Ninh Phuoc was provided by Nguyen Thi Bich Van of the ILO office in Hanoi.

CETZAM's head office and the majority of its clients are based in the northern towns of the Copperbelt. It is common for clients to travel between these towns. As a common language is spoken, clients in other northern towns heard about the insurance pilot that was being conducted in Kitwe via the community radio stations. By the time *Ntula* was rolled out to the other Copperbelt towns, clients were already asking their loan officers for the product and as a result, its introduction was enthusiastically received.

By contrast, Livingstone in the south is a day's drive from Kitwe with a different local dialect and culture. "*Ntula*", which means "lifting up the burden" in Bemba, does not mean anything to the people in Livingstone. The clients and staff in Livingstone had not been informed about *Ntula* and so its introduction was met with resistance and suspicion.

It was later revealed that at the time of *Ntula*'s introduction, two other factors conspired to discourage Livingstone clients. First, loan disbursements had been recently delayed, which led clients to become concerned about CETZAM's financial health. The introduction of the insurance product, which was compulsory and involved a deduction from the loan, struck clients as a desperate measure to ensure the survival of the organization. They did not consider that *Ntula* would ever pay claims, and rather saw it as a levy on the loan to keep CETZAM running. Secondly, at the time of its introduction, a local newspaper was exposing incidents of "black magic" in the town. Clients linked *Ntula*, a product covering the death of the client plus five family members (six people in all), as being somehow demonic. It took several weeks of street theatre by a local organization to change public perception of insurance in Livingstone.

*Source: Adapted from Leftley, 2005.*

When developing insurance education tools, it is also useful to consider the diverse **array of potential communicators**. Many microinsurers team up with other organizations (or other parts of their own organization), including healthcare workers, social workers and government officials, to communicate with many prospective policyholders. For example, GK in Bangladesh uses the maternal and child health services provided to poor households by the roving health assistants of a sister organization as a promotional tool. Similarly, BRAC's non-formal education teachers promote the health insurance scheme to parents of their students. Mutual and cooperative insurers use their affinity groups, which often have education committees, as a key means of promoting insurance education. In general, for these "insurance educators" to be effective, they need sufficient tools and training to deliver the messages.

One of the strongest lessons that emerged from the case studies is that it is much easier to communicate with clients if the product is kept simple. La Equidad in Colombia has two microinsurance products and has had greater success with the simpler of the two. As described in Chapter 3.1, it is easier for clients to understand the product if there are no exclusions, if the benefits are uniform or at least straightforward, and if the pricing is transparent. Ideally, it should be possible to explain the details of the product in five minutes or less.

Where products are complex, field staff often explain just a fraction of the benefits, exclusions and procedures. If staff do not mention certain benefits, then clients will not claim those benefits if the insured event occurs. If staff do not explain the procedures, then the process of making claims is also likely to be extremely inefficient for all involved.

A major obstacle to increasing the market's understanding of the insurance product is the fact that many people in the distribution system do not understand it. This staff problem, common among microinsurers, emerges for several reasons, including a lack of good staff training, insufficient monitoring and incentives for staff and high salesperson turnover. This challenge, which few organizations have succeeded in overcoming, is discussed in Chapter 3.7.

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### 2.3 Activate the customer

Once the market is aware of insurance and the insurer, and it has an understanding of the product, the third phase in the marketing process is to arrange for the customers to sign their contracts and pay their premiums.

One approach to activating the customer is through annual subscription periods or **enrolment campaigns**, such as those used by VimoSEWA and UMSGF. As summarized in Table 22, there are advantages to both annual campaigns and rolling admissions. Annual campaigns can motivate staff for one big push to sign up customers. It activates some lukewarm or undecided persons to buy insurance because they do not want to wait another whole year before receiving cover. In addition, once-a-year enrolment provides some underwriting control, since policyholders could not choose to enrol only when they became ill; they can only sign up during the campaign. A key disadvantage is that it creates a peak workload period for staff. Furthermore, members missing the campaign have to wait a year to get insurance. The campaign also has to be timed so that policyholders have a year's worth of premiums available during the enrolment period – as Karuna Trust learned (*see Chapter 3.3*).

Table 22

**Rolling admission versus annual campaign**

<i>Advantages of rolling admissions</i>	<i>Advantages of an annual campaign</i>
Workload is more evenly distributed throughout the year	Helps to control adverse selection because members cannot choose when to join
The scheme can always add new clients	Focuses marketing attention in a concentrated period
Different market segments may need to pay at different times during the year	May activate some clients

Other promotional activities include raffles or lotteries. For example, Columna periodically organizes raffles in which policyholders can win household appliances. Such an approach can be designed to benefit the policyholders, the sales agents, or both.

One activation strategy that microinsurers should avoid was tried by Delta Life. In the 1990s, it introduced a complementary product whereby policyholders could get a microenterprise loan. Indeed, a key reason for Delta's exponential growth during this period was that agents used the prospect of getting a loan as an enticement to start an insurance policy. This offer was quite attractive because one could get a Tk. 5,000 (US\$83) loan after paying a few hundred *takas* in premiums. However, many of these policies lapsed, and many loans were not repaid (*see Box 37 in Chapter 3.3*).

Regardless of whether marketing is stimulated by an annual campaign, raffles or other sales gimmicks, ultimately the most important factor in selling voluntary insurance is the agent's technique, the persuasiveness of the personal sales pitch and word of mouth from their peers who have had a good experience by having a microinsurance policy. Unfortunately, microinsurers are generally lacking in this area. Since they tend to rely on low-cost or even volunteer promoters, or on salespersons who distribute insurance in addition to their main activity (e.g. savings and loans), there is significant room for improvement, as illustrated in Box 33.

Box 33

**Sales challenges at TUV SKOK**

TUV SKOK's sole *raison d'être* is to serve the credit unions and their members. Yet the nature of that relationship creates a dynamic tension that must be carefully balanced. The success of the insurer depends entirely on the success of its distribution system, the credit unions – their ability to grow, the ability of their staff to sell insurance products and the willingness of CU managers to promote insurance sales. This arrangement creates challenges relating to the quality of the sales force, their commitment and motivation to sell and their availability for training.

The insurer recognizes that it is easier for CUs and their part-time insurance agents to sell insurance that is linked with savings or credit products than stand-alone insurance policies. If someone wants a contractual savings product, for example, then it is quite natural to ask them if they would like the inexpensive savings completion insurance in the event of accidental death or disability. It is much harder to sell a tenant's insurance product that has no link to either savings or credit.

For the member-pay products, the credit union and the insurer could be competing for the member's finite financial resources.<sup>3</sup> The only way they can both succeed is if they can increase the amount of money that the consumer is willing (and able) to spend on both.

To overcome some of these challenges, TUW SKOK invests time and money in cultivating a good relationship with the CUs, with a strong emphasis on communication and information-sharing. Twice a year, the insurer holds a retreat with the managers of the major credit unions, and uses that opportunity to inform the CUs of upcoming plans, to solicit feedback on product design and customer service, and to cultivate sales competition between credit unions.

*Source: Adapted from Churchill and Pepler, 2004.*

Early on in its relationship with AIG, FINCA Uganda recognized that its staff had limited sales skills, so it organized marketing training by a professor from Makerere University. These new sales skills led to significant improvements in growth, from a 5 per cent participation rate to over 40 per cent the year after the training. Later, however, the insurance product became mandatory for borrowers, after which all selling ceased and even information dissemination was neglected (McCord et al., 2000).

Microinsurance requires a different sales culture from conventional insurance. Instead of telling people about the product and its benefits, agents need to guide prospective clients towards the conclusion that emergencies are expensive and that they are vulnerable to emergencies by asking about their experiences or the experiences of their neighbours. They act as advisors instead of salespersons, helping low-income households to recognize what risks it would be appropriate to manage through insurance. In general, because of the target market's lower literacy levels and lack of confidence in formal insurance, microinsurance agents are required to be hands-on and personally involved.

<sup>3</sup> As discussed in Chapter 4.1, in the cooperative-network model, it is important to distinguish between insurance purchased by the credit union or SACCO as a member benefit, like loan protection and life savings, and those insurance products for which the members pay, like life insurance.

To activate the customer, microinsurance marketing has to activate the seller, and this is where things get a little sensitive. Microinsurers want to reward and encourage sales without pushing insurance onto people who do not really want it. Finding this balance is difficult and can represent a slippery slope. Microinsurers who claim to operate in the best interests of the client must actually do so. For example, although the insurance provided by ASA (India) is nominally voluntary, in practice, the scheme has the same number of borrowers as policyholders. Members feel obliged to buy insurance, as they think they may otherwise not receive the loan (which is what they really want). Some strategies to find this balance include:

- **Setting moderate sales targets** that can be achieved without aggressive measures. If microinsurers try to push agents to achieve large volumes, they might have to resort to sales techniques that are not in keeping with the spirit of microinsurance.
- **Balancing sales commissions with re-enrolment incentives** to ensure that service gets the same attention as sales.
- In commercial insurance companies, **setting up a separate operational department** for microinsurance so that it can develop a unique sales culture.
- **Encouraging the sales people to buy insurance** as well, so they can speak from experience.

Delta Life has learned a few things about which sales incentives are worth avoiding. Initially, it front-loaded commissions for new policies, which encouraged some agents to use part of their commission as an unofficial first year discount. Agents were paying a portion of the first year's premiums out of their own pockets, and when policyholders had to pay the full premium themselves, many policies lapsed. Another misplaced incentive scheme provided a crockery set to agents who sold a certain number of new policies, only to find that agents teamed up and submitted contracts under one agent's name, and then shared the dishes.

Of course, all of these marketing strategies come at a cost. Some microinsurers see marketing as an expense rather than an investment, and are therefore reluctant to commit enough money to promoting their schemes. There is also a problem at the other extreme, particularly with commercial insurers that pay overly generous commissions.<sup>4</sup> However, how much is enough, and how much is too much? The amount varies by product line, the maturity of the scheme and the institutional model, from a low of 2 per cent to as much

<sup>4</sup> For example, McCord et al. (2005a) estimates that one of AIG Uganda's sales agents earned US\$158,000 in commission in 2004 (i.e. 20 per cent of the premiums paid by the MFIs to the insurer).

as 40 per cent of premiums. Individual products require greater marketing investments, especially when taking into consideration the field agents' commissions. For group business, marketing expenses should be much lower. As a general rule, marketing expenses for group microinsurance products (including commission) should be in the range of 5 to 15 per cent of premiums.

Overall, however, marketing is not one of the strengths of most microinsurers. Yet given the reluctance of the market to accept insurance, greater attention, creativity and resources are required.

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### 3 After-sales service

One way that microinsurance demonstrates its uniqueness in relation to conventional insurance is by de-emphasizing sales and emphasizing service. Service in insurance parlance is largely linked to claims: making sure clients know how to make claims, assisting them in meeting the documentation requirements, and ensuring that claims are paid quickly with a bare minimum of rejections. In addition, continuous reminders about the product may be necessary to ensure that an illiterate market does not lose sight of its insurance coverage.

This emphasis on after-sales service is necessary. It can be seen as an extension of an on-going process of building trust between the insurer and the policyholder. Furthermore, for schemes that have already invested so much in its customers, through awareness-raising, education and so on, it is extremely inefficient to then lose those customers due to poor service. Excellent service creates a **demonstration effect** whereby the non-insured begin to see that the insurer means business, that it is fulfilling its obligations, that it is trustworthy. Excellent service can be a marketing strategy as well, since it stimulates positive word-of-mouth advertising, which is often one of the most powerful marketing channels.

Given the importance of after-sales service, one of the shocking deficiencies of many microinsurance schemes is that the client often does not receive a **policy document** that explains the benefits, exclusions and claims procedures.<sup>5</sup> Such information, and an accompanying explanation, is necessary to reduce rejected claims. When policyholders understand what is and is not covered, they are less likely to submit claims for losses that are not covered.

<sup>5</sup> One explanation for the lack of written material is the fact that the target market is often illiterate. However, in most markets, illiterate adults usually know someone who can read, often someone in their own household. Another explanation is that in some cultures, like parts of India, people do not trust written information. More realistically, however, the main reasons are: 1) not wanting to invest in printing costs and 2) not wanting to be tied down to specific terms and conditions, neither of which seems particularly justifiable.



VimoSEWA had the opposite problem. After several years of surprisingly low claims rates, it realized that many policyholders were eligible to make claims but did not submit them. Consequently, in 2003, VimoSEWA initiated a strong after-sales service campaign. Now *Vimo Aagewans* establish contact with members between enrolment periods to re-explain coverage, ask if they have been hospitalized and assist in claims submission. Policyholders receive a poster to hang on the wall as a reminder of their membership, which contains the name of their sales agent and the office's address and phone number to make it easy for the member to ask for assistance. In addition, all members are given a pre-stamped and pre-addressed postcard, which they can mail to the office if they need an *Aagewan* to visit them. VimoSEWA expects that these measures will make it easier for members, particularly poorer ones, to submit claims. Because of these interventions, current renewal rates are now at an all time high.

Despite efforts to educate clients and ensure that they understand the benefits and the claims process, there will invariably be some claims that have to be rejected. The microinsurer (or its distribution agent) has another important after-sales responsibility to convey to the insured – and perhaps to other community members as well – why the claim was rejected in such a way as to lessen the negative impact of the rejection and to turn a potential public relations nightmare into an education opportunity. For example, to lessen the impact of a rejected claim, VimoSEWA has improved its communication to members and the community through visits from the *Vimo Aagewan* accompanied by head office staff members.

Furthermore, a **claims appeal process** is needed to ensure that policyholders receive appropriate treatment, although in practice few microinsurers have such an arrangement. TUW SKOK is an exception. In its clearly defined claims appeal process, a member who is dissatisfied with the adjudicator's determination may appeal the claim in writing. All appeals are reported to TUW SKOK's board for consideration. Reversals or modifications to benefits usually occur with disability claims, for example if the policyholder submits supplementary medical information leading to an increase in benefit.

The final aspect of after-sales service is **measuring customer satisfaction** and monitoring retention. Microinsurers generally make a better job of the latter than the former, although measuring retention is tricky with mandatory insurance since the organization does not know how insurance is (or is not) contributing to desertion. In general, there is a greater need to understand why policyholders are not renewing their cover.

## 4 Marketing and mandatory insurance

An interesting marketing challenge emerges in organizations where insurance is compulsory. As described in Chapter 3.1, there are many advantages to mandatory insurance for insurer and policyholder alike, but to fully appreciate those advantages, microinsurance schemes need to compensate for the equally glaring disadvantages, especially the marketing problem.

When insurance is mandatory, there are essentially no sales activities involved. Someone gets insurance cover automatically because she or he has obtained something else, perhaps a loan, or opened a savings account. Consequently, the distribution agents tend to overlook the clients' need for information. From research among MFI clients with compulsory cover in Uganda (McCord et al., 2005a) and Zambia (Manje, 2005), a number of common problems emerge:

- Clients do not know they have insurance
- If they do know, they may not be aware of all of the benefits
- They may not know how to make a claim
- They consider compulsory insurance as a cost of getting a loan
- They do not know how much they pay for insurance because premiums may be deducted from the loan or combined with other fees – most think they pay more than they really do
- Some feel that they deserve a premium refund if they do not make a claim

To overcome these perception problems, the distribution agents have to treat insurance as a *complementary* service and persuade clients of its usefulness. Marketing for mandatory insurance essentially focuses on increasing the membership or consumption for whatever is the driver to which insurance is linked, such as a loan, credit union membership or employment. In this context, insurance needs to be presented as a valuable, additional benefit, not a cost.

Product information provided to clients should be standardized and simplified to avoid claim rejections resulting from misinformation. As a minimum, organizations should provide a simple brochure for each client showing the breakdown of fees and benefits, and describing the claim settlement process. According to Manje (2005), even though the products are mandatory, there are several opportunities for insurance marketing, such as:

1. Including some voluntary components in the insurance policies, such as additional lives for funeral insurance, to increase the likelihood that staff will explain the options to clients.

2. Highlighting the menu of financial services with prices to market mandatory insurance in a full package of services, not as a condition for getting a loan.
3. Showing clients how much they would have to pay for the same cover if they bought it on their own. Since individual insurance products are often several times more expensive than group policies, this is an important selling feature to persuade people that they are getting a great deal from the mandatory group policy.
4. Making the product real. Use testimonials from beneficiaries who have received settlements to communicate the importance of receiving that settlement when the family needs it most.
5. Promoting the solidarity nature of insurance so that people do not feel that they have wasted their money if they do not make claims.

With a mandatory product, it is rather difficult to gain a firm understanding of the true demand for microinsurance. CARD has made an effort to understand this demand and how it affects its business. In a qualitative survey conducted by Freedom from Hunger, many clients identified insurance as the most valuable aspect of the entire CARD product portfolio. Such a finding should inspire other microinsurers to market their mandatory insurance products in such a way that clients will actually appreciate it.

## 5

## Conclusion

By way of conclusion, this chapter provides a checklist of questions (*see Table 23*) that may help microinsurers to assess and improve their marketing strategies.

Table 23

### Marketing checklist for microinsurance managers

- Who are you trying to communicate with? What are effective ways of reaching that audience?
- What is the education and literacy level of your target audience? How will you incorporate this into your marketing plan?
- What is the clients' need for risk coverage? How is this being addressed? What is the benefit of the product?
- What are the anti-insurance arguments of the target market? What main messages would counter those arguments?
- What can you do to strengthen the market's trust in your organization?
- How can you convey the risk-pooling or solidarity message so that policyholders who do not experience an insured event do not expect their money back?

- How can the product be depicted in a positive light?
- What type of prevention campaigns and other public relations activities would have the greatest impact in raising awareness of your organization?
- How can your organization move beyond information and communication to include education about insurance?
- Do you have methods to assess whether your customers or the market really understand the main messages that you are trying to convey?
- What possible partners can be involved to assist in the education and promotion activities? What tools and training will they require to fulfil that function?
- Is the product and claims process sufficiently simple for salespersons to explain it to potential clients?
- What marketing techniques are likely to be most successful in attracting clients (e.g. enrolment campaigns, raffles)?
- What incentives will effectively motivate salespersons while cultivating an appropriate microinsurance sales culture?
- How can you encourage or solicit word-of-mouth marketing?
- How can you ensure that clients perceive that you are providing outstanding customer service?
- Are you monitoring customer satisfaction and retention?
- How can you persuade customers to appreciate the benefits of mandatory insurance?

### 3.3

## Premium collection: Minimizing transaction costs and maximizing customer service

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*The authors would like to acknowledge the contributions to this chapter from Aristotle Alip (CARD) and Ellis Wohlner (consultant to SIDA).*

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When extending insurance to the low-income market, the process of collecting premiums is a major challenge. The target market is largely self-employed or works in the informal economy, and is unlikely to have a savings account with a bank. Consequently, the primary premium-collection mechanisms used by mainstream insurers – salary deductions from employers and standing orders or direct debits from savings accounts – will not work for many poor households. To compound the matter, by definition the target market has low, often irregular and unpredictable incomes, so another challenge is to schedule the premium payment for a time when the policyholder has funds available.

For microinsurance to succeed, the premium payment mechanism needs to find a balance between being efficient and being sensitive to the needs and capacities of clients. Simply collecting a large number of small premium payments may make the products more accessible to the poor, but can also result in higher transaction costs that drive up premium rates.

Based on a review of the case studies, this chapter proposes possible solutions to these problems, organized around the following four topics:

1. Modes of premium collection
2. Collection frequency and timing
3. Client considerations
4. Premium collection controls

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#### I Modes of premium collection

The way in which premiums are collected has a direct bearing on per unit transaction costs. Indeed, to make microinsurance viable, it is necessary to minimize transaction costs. Undoubtedly, however, the key factor in decid-

<sup>1</sup> References to Microcare (Uganda) in this chapter are drawn from the authors' experiences.

ing on the mode of premium collection is still the clients' circumstances and access to other financial services. This section describes four modes of premium collection.

### 1.1 Premiums linked to loans

Many types of microinsurance products are linked to other financial products, especially credit. Premium collection at the point of loan disbursement or repayment is attractive since the transaction is “piggybacked” on top of another financial transaction. Consequently, the marginal cost of premium collection is kept to a minimum.

This can be demonstrated by comparing the premium collection costs of stand-alone insurance with cover combined with another financial service, such as loans. For its stand-alone tenant's cover, for example, TUW SKOK (Poland) pays the handling agent market rate commissions of, on average, 15 per cent. For integrated products such as its loan-linked AD&D coverage, the insurer incurs a total cost of less than 1 per cent of premium. TUW SKOK's systems have been developed to manage monthly premium collection from loan add-on products for over 200,000 insureds, and from more than 60 credit unions nationwide, handled by three staff members at the insurer's headquarters.

Linking insurance to loans is the mode of collection employed by many MFIs. Some clients, like those of Pulse in Zambia, are content with this method because they “don't feel the pinch”. In addition, as described in the previous chapter, the insurance cover can be marketed as a benefit of getting a loan. For other clients, this linkage can be a major cause of dissatisfaction. With CETZAM's funeral insurance product in Zambia, for example, clients complained that the deduction of the premium from the loan reduced the amount of cash that they received. The actual premium payment mechanisms vary, as described in Box 34.

Box 34

#### Linking insurance premiums to loans

Many MFIs offer insurance by linking it to their loan products. There are, however, several different ways in which the premium can actually be paid, all of which have advantages and disadvantages. The five general alternatives are:

##### *1. Deducting the premium from the loan amount*

This is perhaps the most common approach, but borrowers generally do not appreciate the fact that, for example, they apply for a US\$400 loan and only get US\$390 after the US\$10 premium has been deducted. In addition,

borrowers pay interest on the premium amount, which increases the gross cost of the insurance.

### *2. Adding the premium to the loan amount*

Another approach is to grant a loan of, for example, US\$400, but to oblige the client to repay a total amount of US\$410 plus interest. In this way, the client at least receives the expected sum, but still pays interest on the premium amount.

### *3. Building the premium into the loan interest rate*

Some organizations increase their interest rate slightly, and use the additional revenue to pay the premium on behalf of the clients. Of the five options, this is probably the least advantageous because: a) it makes the interest rate appear less competitive and b) it disguises the premium so that borrowers may not realize that they have insurance coverage. However, this method is by far the simplest of the loan-linked premium payment methods since it is just an internal accounting transaction.

### *4. Paying the premium with each loan instalment*

To make the premium more affordable, the amount can also be divided up and paid in instalments with each repayment. However, this approach shares some of the disadvantages of combining interest and premium rates: clients may not know they have insurance and the MFI probably has to pay the insurer in advance. Additionally, will the coverage be cancelled if the client falls behind with loan repayments?

### *5. Paying in cash up front*

If borrowers pay the premium up front, either when they apply for the loan or when they receive it, there is a greater likelihood that they will be aware that they have insurance. However, compared with options 1 and 2, this creates an additional transaction and increases vulnerability to fraud as cash changes hands.

The most notable disadvantages in using this mode of collection are:

#### *1. Lack of transparency*

The same reasons that make Pulse's clients "not feel the pinch" may also mean that clients are not aware of the actual price they are paying for the benefits. Interestingly, in Zambia, many clients assumed that they were paying more for insurance coverage than they actually were (Manje, 2005).

### 2. *Unaware of cover*

Even worse, clients (or beneficiaries) may not know that they have insurance, so they may not receive the benefits that are due. This situation undermines one of the important development objectives of microinsurance that is to create an insurance culture in which the low-income market develops an understanding of and appreciation for the risk-management role of insurance.

### 3. *Protection limited to loan term*

This payment mechanism means that the target market can only receive insurance protection when they have a loan. While they might require continuing cover, most people, rich or poor, prefer not to be perpetually in debt.

In response to this last problem, members of the credit unions associated with Columna (Guatemala) can renew their insurance policy without borrowing again. However, because the initial distribution system is linked to credit, it is difficult to get the credit union staff to renew the policy because it is no longer related to their core activities. Indeed, in the Philippines, CARD MBA and CARD Bank have been in dispute because the insurer wishes to continue coverage when borrowers are no longer borrowing from the bank. The bank argues that this eliminates an incentive for people to continue borrowing.

Finally, loan-linked insurance premiums are certainly appropriate for coverage that directly enhances the security of the loan for both the borrower and the lender. Credit life and property insurance for collateral are products which lend themselves to being linked. Other products may not be as appropriate, such as family life cover or health covers. Such products cannot generally be part of mandatory loan-linked cover since they are relatively expensive and do not have a direct connection to the loan.

## 1.2

### **Automation: Deducting premiums from savings accounts**

Where possible, automatic premium collection is advantageous in reducing transaction costs. For TUW SKOK, since all its low-income policyholders have savings accounts, the credit union can easily deduct the premiums from the members' accounts and forward them to the insurer, with hundreds of small premiums batched into one electronic transfer. Standing orders/direct debits lower transaction costs and minimize vulnerability to fraud.

The main disadvantage of automatic payments is that the target market may not have a savings account, or even the possibility of opening one. Indeed, to expand the availability of microinsurance to more low-income households, a key strategy is to increase their access to savings services.



However, some microinsurers have this option available to them and they are not taking advantage of it. For example, ALMAO in Sri Lanka was started by the savings and credit societies of the Sanasa movement. Yet, despite the 2 million Sanasa members, ALMAO only has a few thousand policies, in part because it is relying on door-to-door collection rather than standing orders.<sup>2</sup>

This premium collection mode is vulnerable to public relations problems if not properly implemented. VimoSEWA (India) experienced significant difficulties when it used automatic payments for its then mandatory insurance scheme because it had not adequately informed savers that the payment would be deducted from their accounts. Consequently, the organization experienced a significant backlash from policyholders and ultimately had to change to voluntary coverage.

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### 1.3 Premiums paid from savings account interest

Perhaps the simplest mode of collection is to allow premiums to be paid from the interest on a savings account. The most common example of this approach is the life savings product offered by many credit union insurers, as described in Chapter 2.3.

Similarly, policyholders at VimoSEWA – which has tested many different premium payment mechanisms – can make a deposit into a special SEWA bank account, and instead of earning interest, they receive “semi-permanent” insurance coverage until they reach the age of 60 without any additional transactions. Consequently, the depositor never pays any premiums and still has access to and ownership of the money in the savings account. In a sense, this is like pre-funding a whole life policy. Yet, since the money is still theirs, it helps overcome one of the complaints about insurance from the poor, which is, if they do not make any claims, they feel they have wasted their money paying premiums.

This fixed deposit payment approach undoubtedly minimizes transaction costs. However, it may also be limited in its penetration if the amounts required from clients are too high. At ASA in India, which also experimented with this payment method, not enough of its members could come up with the funds to justify continuing this mechanism. In VimoSEWA’s case, if a member is just insuring herself, she needs to make a fixed deposit of Rs. 2,100 (US\$46) or she could pay an annual premium of Rs. 100 (US\$2.20). Even though a quarter of its members use the fixed deposit approach, the propor-

<sup>2</sup> At its peak, ALMAO’s unregulated predecessor provided funeral insurance to nearly 50,000 persons, but its new endowment products have not been particularly popular.

tion has declined over the years (down from 33 per cent in the case study (Garand, 2005)).

This fixed deposit approach works better in a high-interest environment, and is vulnerable to interest rate decreases which may lead to a situation where interest is not sufficient to cover the cost of insurance. In such a situation, as well as when premium rates are adjusted upwards, VimoSEWA has found that it is difficult to get depositors to top up the savings account. When it is topped up, the cost to the depositor is dramatically greater than the amount of the premium increase. For example, if the interest rate is 10 per cent and the increase in premium is Rs. 10 (US\$0.22), the top-up amount must be at least Rs. 100 (US\$2.20) to cover the increase.

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#### 1.4 Physical premium collection

The fourth approach is to physically collect the premiums, either by going door-to-door to collect individual payments, or through group mechanisms where many premiums can be collected at once, or by requesting policyholders to come to a central location to pay their premiums. A key distinction between this method and those discussed above is that it is an insurance-only transaction, whereas the other modes are all linked to either a savings or a credit product. Consequently, physical premium collection is most appropriate for: a) organizations without other financial transactions such as community-based health insurance schemes (*see Chapter 4.3*) and b) accumulating-value policies that are difficult to combine with other financial services (*see Chapter 2.2*).

This physical collection method has the advantage of being accessible to clients while providing opportunities for personal interaction between the insurer and its customers. For example, in Bangladesh, Delta Life's door-to-door collection gives clients a physical link with the company, while potentially reducing lapses (although they are still a significant problem) and strengthening the relationship between field staff and the customer. In addition, women in some households are discouraged or prevented from travelling, so door-to-door collection also provides them with access to a valuable service.

The most apparent deficiency of physical premium collection is the insurer's transaction costs – door-to-door premium collection is expensive. Compensation for employees must be aligned with their perceptions of the effort involved. If staff are not motivated to collect premiums, schemes will undoubtedly fail. For example, La Equidad experienced collection problems when it experimented with door-to-door collection because the small commissions were insufficient to motivate its sales force.

Requesting individual low-income policyholders to come to a central location to make premium payments is not a practical solution unless they are already coming to perform another transaction. People are naturally averse to spending time and money to make such a payment, especially within a dictated period.

The possibility of fraud also increases dramatically through this mode of collection because of the number of people handling the premiums. A dangerous aspect of door-to-door collection is that in many legal systems, once the premium is collected by an agent or representative of the insurer, it is legally considered collected by the insurer, entitling the insured to coverage even if the agent does not transfer the premium to the insurer. If not detected early, this may lead to significant financial losses, as claims would have to be paid even though the insurer had never received premiums. In many jurisdictions, it is very difficult and expensive to recover premiums from those guilty of fraud, even if they are identified and caught.

Fraud in premium collection will not only cause financial deficits, but will also make clients wary of insurance, perhaps reinforcing the market's negative preconceptions. In one of the mutual health organizations linked to UMSGF in Guinea, group leaders misappropriated premiums collected from households. The members have lost confidence in the MHO, which is having difficulty overcoming the crisis. Mitigating such fraud requires strong controls that in turn lead to more expense.

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## 1.5

### Conclusion

A comparison of these four approaches, summarized in Table 24, has to consider the cost-effectiveness of the mechanism in relation to the value that is provided to policyholders (e.g. ease of access, understanding of the product, premium rate).

The difference in costs between maintaining a team of agents for door-to-door collection and using an intermediary entity can be substantial. Consider a comparison between Delta Life and AIG Uganda, which both serve a million or more customers. Delta employs its own agents to service policyholders on an individual basis, whereas AIG Uganda offers mostly mandatory group policies sold through 26 MFIs. The difference in operating costs between these two methods as a percentage of premiums is about 10 per cent, with the MFI agencies being significantly less expensive than an army of agents.

Door-to-door premium collection offers an opportunity to maintain a close relationship with the insured, which, if managed and exploited properly, may offer valuable information to the insurer, as well as help maintain

loyalty and keep lapse rates low. However, physical collection results in high costs because of the need to pay sales commissions out of very small premiums and the strong controls required to prevent fraud. The dangers of fraud must also not be underestimated, as they can destroy the crucial bonds of trust between the parties, and result in financial losses for the insurer. In general, it is best to stay away from physical collection if any alternative method is available, and to identify ways of collecting premiums from groups of policyholders.

Table 2.4 Comparison of premium collection modes

<i>Mode of collection</i>	<i>Enhancing value to clients</i>	<i>Minimizing transaction costs</i>
a) Linked to loan product	<ul style="list-style-type: none"> <li>+ Enhances affordability since borrowers can pay the premium when they get the loan (or spread payments over the term of the loan)</li> <li>– Can increase the cost of insurance through loan interest costs</li> <li>– Insurance coverage only available when a loan is outstanding (no access without a loan)</li> </ul>	<ul style="list-style-type: none"> <li>+ Minimal additional costs by piggybacking on existing transactions</li> <li>+ Especially when mandatory cover allows for simple group coverage</li> </ul>
b) Deducted from savings account	<ul style="list-style-type: none"> <li>– Only available to persons with savings accounts</li> <li>+ Eliminates indirect transaction costs to the policyholders</li> </ul>	<ul style="list-style-type: none"> <li>+ Only electronic transactions</li> </ul>
c) Paid by savings interest	<ul style="list-style-type: none"> <li>– Policyholder has to have enough money to fund fixed deposit account</li> <li>+ Clients do not feel that premium payments are wasted</li> <li>+ Provides semi-permanent coverage</li> </ul>	<ul style="list-style-type: none"> <li>+ As easy as savings account deduction</li> <li>– Notification and prompting required for increases</li> <li>– Not appropriate for low-interest environments</li> </ul>
d) Physical collection	<ul style="list-style-type: none"> <li>+ Door-to-door collection means no opportunity costs for policyholders (do not need to miss work to pay the premium)</li> <li>+ May enhance access for women who cannot travel</li> <li>– Large percentage of premiums goes to pay commissions and insurer's overheads</li> </ul>	<ul style="list-style-type: none"> <li>– Very high transaction costs offsetting benefits of access</li> <li>– Cost of controls to limit fraud risk can be high</li> </ul>

## 2 Collection frequency and timing

Besides the mode of collection, microinsurers also have to consider the frequency and timing of collection. As discussed in Chapter 3.5, insurers generally prefer to be paid in advance of policy activation so that they can generate additional income by investing the money, which in turn should lead to lower premium rates. For the low-income market, however, it may not be possible to pay premiums up front; it may be necessary to pay in smaller instalments over time. Similarly, it may be useful to allow for variability in clients' means by offering a flexible time frame in which premium payments can be made.

Periodic payments – monthly, quarterly or annually – are a popular mode of premium collection because they are inherently more attuned to the limited purchasing power and liquidity of the target market. The main disadvantages are the additional transaction costs (especially with more frequent payments) and the increased likelihood that the policyholder will choose to cancel the coverage – every possibility that clients have to renew their affiliation to a scheme is also an opportunity for clients to temporarily or permanently cease their membership.

One of the key lessons about collection frequency is that assumptions by microinsurance providers about clients' preferences and abilities to pay are not always valid. Delta Life started off with weekly payments in the 1980s, but experience over time led to a better appreciation of client preferences; today most policies are paid through monthly and quarterly payments. BRAC MHIB serves a particularly poor and financially vulnerable target market. As a result, it may seem obvious that payments should be as small as possible and thus collected frequently. However, BRAC MHIB's clients were unhappy with weekly premium collection because it was too burdensome to make savings contributions and loan repayments, and pay insurance premiums all at the same time.

The timing of premium collection is another critical factor. For example, BRAC MHIB learned that clients engaged in activities such as agriculture, fisheries and poultry, which generate income quarterly or semi-annually, preferred premium payments to coincide with their cash flow. Indeed, trying to collect premiums at an inconvenient time for clients can be futile. At the end of Karuna Trust's pilot phase, premiums were collected in June and July when there was unfortunately little employment for most daily labourers. Obviously, it was not appropriate to collect premiums at a time when many households barely had enough money for food. After further discussions with clients, Karuna realized that September to November would be a

better time for premium collection since they expected to have sufficient work then.

To probe the issue of timing a bit further, it is necessary to consider not just when the target market will have money, but where are they getting the money from. If many people receive money from the same source, it may be possible for that source to pay the premiums en masse for many policyholders and therefore enhance efficiency. This is the essence behind the loan-linked mechanism described above – people (usually) have money when they receive a loan. Are there other common providers of money that would allow the insurer to collect premiums at the source?

Another approach allows policyholders to make premium payments within a defined period, as opposed to a specific point in time, and is quite popular among informal funeral insurance providers in South Africa (*see Box 35*). Indeed, this approach tries to accommodate the variability in poor people's incomes and purchasing abilities. However, more administrative capacity is needed to monitor flexible payment systems, and transaction costs are higher if clients are allowed to modify their payment plans.

*Box 35*

### **Flexible premium payments for funeral insurance in South Africa**

Funerals are a major life-cycle expense for low-income South Africans. In the Grahamstown township, low-income households spend approximately 15 times their average monthly household income on a funeral. A common means of funding them is through funeral insurance. A myriad of formal and informal insurers compete to sell coverage to the low-income market, including funeral parlours that provide a benefit in kind. Some of these informal funeral schemes have adopted an interesting flexible premium payment mechanism.

Households pursue multiple livelihood strategies, with incomes from a variety of sources at different times. They need to pay the premiums whenever they have money, not at a specific time during a month. As one informal insurer put it, “people here live a hand-to-mouth existence; you cannot expect them to pay at the same time each month”.

Therefore many informal insurers allow clients to pay premiums – including partial payments – by bringing whatever cash they have on hand to the funeral parlour, perhaps making multiple visits during the course of the month. When a premium is received, the client's booklet is stamped and dated. As long as they are up to date with their payments by the end of the month, then the policy remains in force (some schemes keep policies active as long as clients are not more than three months in arrears).

The use of booklets or coupons is attractive to both insurers and their clients. With this system, clients feel they have a secure document with which

they can prove premium payment. Such a system is comparatively cheap and easy for insurers to operate. In addition, payment flexibility is also beneficial since it helps adapt insurance products to poor clients' cash flows.

*Source: Adapted from Roth, 2002.*

Flexibility in the timing of premium payments is an important component of access to microinsurance; however, there are significant costs, including losses associated with greater exposure to staff fraud, involved in providing that flexibility. The ability to manage such flexibility requires information systems that can accommodate it without a major increase in costs. Otherwise, microinsurers cannot offer this level of access without significant pricing implications.

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### 3 Client considerations

#### 3.1 Financing insurance premiums

To expand the outreach of microinsurance and make existing schemes more viable, providers need to explore ways of assisting policyholders to finance their premiums. Indeed, for most low-income households, the problems encountered in affording premiums are not an absolute barrier to purchasing insurance. Rather, the problems arise because they do not have enough money at the right time – many poor households could afford premiums if they had access to suitable financing mechanisms. These mechanisms may enable microinsurance providers to expand their markets, and gain larger and more reliable client bases. Appropriate financing mechanisms also champion the social nature of microinsurance, as clients for whom insurance was previously unaffordable will be able to benefit from formal risk coverage.

One of the simplest ways of providing financing options is to work with self-help groups or rotating savings and credit associations. Insurers that are linked to SHGs or ROSCAs can encourage members to make small increases in their regular savings deposits so that when an annual premium comes due, the members already have the money. Through financing partnerships with ROSCAs, insurers benefit from existing informal savings mechanisms, while their members can amass the insurance premiums without additional transaction costs.

Working with cooperatives may provide similar benefits. Customized options for financing premiums could be developed because of cooperatives' financial relationship with their members, as illustrated in Box 36, while providing the insurer with a group of premium payments from an income

source. In addition, cooperatives are more formal entities than ROSCAs, and therefore may make safer partners from a legal perspective. It should also be mentioned that because of the “pseudo-employer” nature of cooperatives, members might have an additional incentive to remain current with their premium payments.

*Box 36*

### **Paying premiums in milk at Yeshasvini**

Mangsandra is a small village in India with about 1,000 inhabitants. About 200 families are members of the Mangsandra Cooperative Milk Society, which is one of Yeshasvini Trust’s partners. Mr. Krishnamoti, the society’s secretary, is responsible for providing information about Yeshasvini’s health insurance, enrolling members and collecting their premiums. In the first year, 96 persons joined the scheme. In the second year, 230 members and dependants enrolled.

Mr. Krishnamoti reports that it is difficult to pay the premium for a full family at one point in time. However, the milk union developed a solution for this problem. Every morning the members of the cooperative bring in their milk and Mr. Krishnamoti records each member’s contribution in his books. Every day a lorry collects the milk and transports it to the union for processing and distribution. On a monthly basis, the union pays the society for the milk received, and then the society pays the members for the quantity of milk they have delivered in the month.

When members subscribe to Yeshasvini or renew their policy, they can have their premium deducted from the income the cooperative pays them. When Mr. Krishnamoti hands over the list of enrollees to his union, he informs the Extension Officer how many have opted for the premium deduction. The milk union advances the premium payment to Yeshasvini. The advance is then deducted from the union’s monthly payment to the co-op, which in turn deducts it from the share of the respective member. If members decide to enrol their dependants in the scheme, the society only deducts the amount for one person each month and so enables the member to pay in instalments – of milk.

*Source: Adapted from Radermacher et al., 2005b.*

A less preferable approach to making premiums more “affordable” for clients is to provide separate loans for insurance coverage. For example, some of Microcare’s MFI agents offer loans specifically to pay premiums. By issuing a separate loan for premiums, rather than integrating the premiums into a microenterprise or housing loan, the cost of insurance becomes much more apparent to clients. However, the premium for members becomes more



expensive in absolute terms because of the interest on the loan. An annual premium of US\$50, for example, becomes US\$60 if financed by an annual loan with an effective rate of 20 per cent. This results in an even lower return to policyholders in terms of claims to premiums. Similarly, the lender also takes on the additional risk of loan repayment, and therefore requires full repayment well in advance of expiry of the cover.

TUW SKOK has designed a more appropriate financing mechanism to encourage clients to purchase its more expensive insurance policies. The insurer encourages its partner credit unions to offer interest-free loans to their members, thus making the higher premium amount affordable to low-income members. To compensate the credit unions for the income that they forgo on the loan, TUW SKOK pays them a higher commission. In this way, TUK SKOK has managed to limit its liabilities, while making more expensive products more affordable.

In summary, several lessons emerge about microinsurance financing mechanisms. First, where possible, encourage policyholders to save on a regular basis so they can pay an annual premium. Collaboration with cooperatives allows microinsurers to deduct premiums at an income source. When offering a loan to finance a premium, it is more transparent if the loan is specifically for the premium. However, the increased cost of cover makes interest-bearing loans a sub-optimal choice.

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### 3.2 Balancing efficiency and affordability

The balance between efficiency for the organizations and affordability for clients is a classic trade-off. There are no one-size-fits-all answers and the balance has to be appropriate for the business environment. However, Leftley (2005) provides a useful rule of thumb to address affordability:

*Make sure that the premiums are affordable for the poorest clients. The easiest way to define affordable is to work out what cash a client will have spare on an average day. Clients are unlikely to always save for a premium payment, so a monthly premium needs to equate to the cost of a non-essential item (such as a bottle of beer).*

When considering the costs to the clients, it is also important to recognize that the premium is not the only expense. If policyholders have to travel to pay their premium, the transportation and opportunity costs of being away from work can be even higher than the premium costs. Consequently, efficiency needs to be monitored and assessed on the basis of transaction costs for the insurer and the policyholder relative to the amount of coverage provided.

To create a balance between efficiency and affordability, some organizations add a fee to the premium for convenience of collection. For example, premiums are reduced for people who pay by standing order or in fewer instalments. This arrangement increases efficiency while making the product more affordable.

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### 3.3 Preventing lapses and non-renewals

Lapses and non-renewals are an important indicator of the appropriateness of premium collection mechanisms. The ideal of completely eliminating non-renewals, however, needs to be balanced with the realities of serving poor people.

Nevertheless, microinsurance schemes should aim to protect themselves from the problems of lapses and non-renewals. Rather than relying solely on penalties, such as terminating cover for late payers, innovations are needed to help people who need leniency. For example, with Tata-AIG's endowment policy, if clients miss premiums, the insurer deducts the missed amount from the accumulated value of the policy to keep the cover in force.

Incentives can also play a role in encouraging payment discipline. For example, policyholders who regularly pay on time could be eligible to pay a lower premium. The key lesson is that rules pertaining to missed premium payments should reflect poor people's realities while being well enough designed not to be abused.

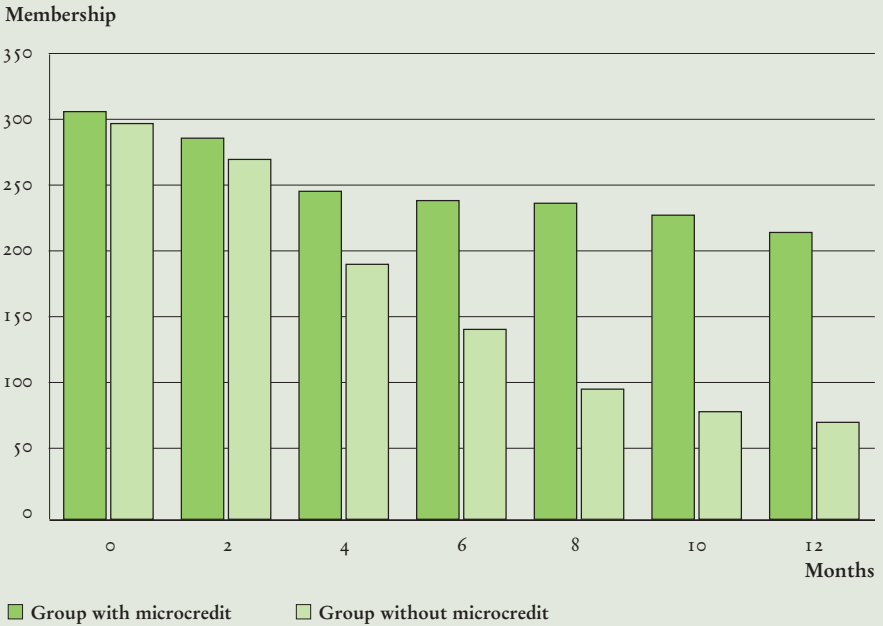
Every time clients have to pay a premium, they are forced to make a purchase decision. This may lead clients to actually choose not to pay for insurance premiums due. Therefore, the more frequent the premium collection, the more chances clients have to relinquish their insurance policies. This is illustrated quite well in the experience of AssEF (Benin), which collects premiums monthly. By December 2003, AssEF had only received premiums from 71 per cent of the people who had enrolled at the beginning of the year and realized that in schemes with frequent premium collection, more promotional and marketing work was needed to encourage clients to keep their policy in force. Following awareness campaigns in 2004, retention rates increased to between 84 and 86 per cent.

Another strategy to reduce lapses is to help policyholders to boost their incomes. Indeed, one of the major reasons why the poor fail to pay their premiums is a lack of money. However, if they had access to a microenterprise loan that enabled them to increase household income, then it would be easier to pay the premium as well. This was certainly the experience of a community-based health insurance provider in Tanzania, which learned this lesson accidentally. UMASIDA began working with two otherwise identical

MHOs – the only difference was that one had access to a separate microfinance institution and the other did not. As Figure 14 shows, the drop-out rate in the group without access to microfinance was much higher than the group with access (Kiwara and Fungu, 2005).

Figure 14

#### Microinsurance drop-outs and access to microcredit



Source: Kiwara and Fungu, 2005

This finding suggests that the link between microinsurance and microfinance is even more important than just the efficiencies that can be generated through integrated financial services. Access to microfinance may also make it possible for poor policyholders to afford their premium payments more easily. Early on, Delta Life recognized this link between premium affordability and microenterprise loans, and attempted to address this issue on its own. However, as illustrated in Box 37, it is quite risky for insurers to get involved in microenterprise lending directly.

Box 37

#### Delta Life – combining microcredit and microinsurance

Motivated by the amazing success of microcredit in Bangladesh, Delta also got into the act by offering loans of its own. Besides offering **policy loans** against the surrender value of the policy, as it is required to do by law, Delta also began offering **project loans** for microenterprise activities that were intended to help policyholders increase their incomes and therefore be able to pay their premiums with greater regularity.

Although repayments were in an acceptable range in the mid-1990s, the recovery rate plummeted at about the same time as the insurance portfolio skyrocketed. In fact, one of the explanations for the growth is that organizers (agents) were using the project loans as a marketing tool, promising to provide loans once people bought a policy.

The poor credit quality of the policy loans was not a major cause for concern. They were fully secured and organizers actively encouraged policyholders to pay their premiums rather than their loans, if they had to choose between the two, to keep the insurance contract in force. However, repayment problems with the project loans were a serious concern because the amounts were larger and were only backed by the commitments of other group members. The main problems with the lending activities included:

- Staff were not trained in using a group lending methodology or in managing borrower groups, and therefore the group guarantee was not particularly effective.
- The primary indicators used to measure the performance of organizers were the number of new policies and the amount of premiums collected; their loan repayments were not carefully monitored and chased up.
- The culture associated with collecting timely repayments is quite different from collecting premiums. With a premium payment for an endowment policy, the organization is essentially asking the client to let it hold his or her money, so it is inappropriate to press too aggressively if the client is not able to pay right away. With a loan, however, the client has the organization's money, and the organization has a responsibility to get it back.

Furthermore, as a regulated insurance company, there is some question as to whether Delta is legally able to provide project loans. There are restrictions on the investment practices of insurers and it is probably inappropriate for Delta to be investing premiums in its own loan portfolio.

*Source: Adapted from McCord and Churchill, 2005.*

## 4

**Premium collection controls**

Fraud and mistakes in premium collection are significant concerns for microinsurers as their small margins do not allow for much financial mismanagement. Therefore, effective controls for premium collection need to be in place. There should be a combination of both hierarchical and horizontal controls.

Hierarchical controls require that the insurer set up at least a rudimentary structure within the organization to monitor the quality of the premium collection process. These controls generally work better for insurers that use their own structures to manage the process, than for those that outsource the process to other organizations. Should the latter solution be selected, it might be advisable for the insurer to create horizontal controls, for example, by demanding some sort of collective security from the organization or structure to which the process is outsourced. One solution, which was widely used in Poland until compulsory liability insurance for agents was introduced, was to demand a blank promissory note from the agent, co-signed by one or more agents from the same organization or group. The note could only be used to collect on claims resulting from an agent's fraudulent actions against the insurer, but it created an additional level of security for the insurer through a collective responsibility arrangement between agents.

The significance of fraud should also not be underestimated. Indeed, the structure of entire schemes has had to be modified to deal with it. For example, at AIG Uganda, one reason why the product originally moved from voluntary to obligatory was to reduce the incidence of fraud by the MFI's field officers who took premiums from clients and pocketed the money. By making the product mandatory, the fraud risk was reduced by having premiums paid through cashless transactions in the back office.

ServiPerú has implemented an audit of collected amounts to try to avoid fraud as well as mistakes. The fee collection procedure begins with invoices that are distributed by the collectors in their designated geographic zones. Collectors visit clients mainly at their place of work, up to three times if necessary, to collect the fees. At the end of the day (or more frequently if the volumes are high), collectors deposit the money in ServiPerú's offices or bank accounts together with a record of the payments collected. Once the fee collection period for the month is over, collectors must present a report of uncollected premiums, indicating the reasons for non-collection. Internal auditors follow up with a sample of the non-renewals to ensure that they really did not pay their premium.

## 5

## Conclusion

Premium collection is a daunting aspect of efficient microinsurance provision. Some insurers (or their delivery channels) have found ways to minimize premium collection costs and maximize efficiency. Efficient arrangements mean prompt and full payment without affecting the safety of the premium transfer mechanism or sacrificing customer service advantages. To achieve their financial stability, insurers must make every effort to ensure that premiums are paid on time.

The common premium collection methods respond to client needs to varying degrees. Among the least expensive methods for the insurer is for community groups to collect the premiums from their members and make consolidated payments to the insurer. Collection by insurers of aggregated premiums from MFIs and other groups, which link the premiums to another product or electronically transfer the premiums, can be equally inexpensive. The door-to-door method of collecting premiums from individual policyholders is typically very expensive.

Premium payment lessons include:

- A balance must be maintained between the efficiency of the insurer, and the cash flow and transaction costs of the policyholder. Without an acceptable balance between the two, microinsurance may not succeed. It does not help retention or new client generation if the insurer reduces its collection costs to near zero, while simply transferring the costs to policyholders who may then be expected, for example, to travel to make payments.
- Electronic transfers reduce the costs of all parties involved. Greater availability of savings services for the poor can dramatically improve affordable premium payment mechanisms.
- Where possible, collect premiums from a specific source of funds at a time when those funds are available, such as a loan disbursement, the monthly payment from a milk cooperative, or an employer's salary payment.
- Fraud is an important problem for premium collection. Having individuals handling premiums requires strong controls. Fortunately, some of the more efficient transaction methods, such as electronic transfers, can be among the easiest to control.
- Collection frequency and timing require an understanding of policyholder cash flows and preferences. The assumption that policyholders prefer frequent small premium payments does not necessarily hold true. Market research is required.

- Clients must understand the collection mechanism, and that must lead to an understanding of the policy they are purchasing to move towards developing an insurance culture among the poor. It is not sufficient simply to pay premiums through interest rates where the policyholders do not know they are insured.
- Strategies to minimize non-renewals should take account of poor people's realities. The objective is to keep the policyholder active in paying premiums. It is important that late payment penalties control adverse selection and fraud, but still allow for client retention.

Clearly, efficiency cannot be the only criterion in selecting the best mode of premium collection. The insurer must keep in mind its strategic position and its strong points, as well as the long-term goals it wishes to attain. If the insurer stresses product price as its greatest strength – i.e. attempts to offer lowest possible premium for competitive coverage – it should focus on the least expensive methods, such as electronic transfer from add-on products. If, however, the insurer's strengths lie in a close relationship with the market and high mutual loyalty, the increased cost of door-to-door collection may be offset by lower lapses and lower fraudulent claims from customers who feel they have a closer relationship with the insurer, at the expense of higher premiums. In short, no single aspect can be used to find a solution to a multi-faceted problem of the insurer-insured relationship, the ultimate success of which depends on the long-term survival of the insurer, in turn resulting in secure protection for the insured.

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## Claims processing

Michael J. McCord and Richard Leftley<sup>1</sup>

*The authors appreciate the editing and suggestions of the following readers: Aris Alip (CARD), Dobby Mahalanobis (formerly Microcare) and Ralf Radermacher (University of Cologne).*

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Claims processing, from notification to settlement, is often a costly and time-consuming activity fraught with difficulties. The balance between operational costs – including controls to minimize improper claims – and the cost of fraud, leads to an expensive process, especially for health insurance. Yet for microinsurance to be successful, the costs of operations and controls must remain low to maintain premiums that are affordable to the market.

The claims process for microinsurance differs from that of traditional insurance in its recognition of the realities of low-income life, for example:

- Claims need to be settled rapidly because low-income people have insufficient access to funds to manage the financial costs of risks.
- Health claims should be paid directly to the provider since low-income people frequently do not have the available funds to obtain treatment and wait for reimbursement.
- Conventional documentation requirements must often be replaced by alternative evidence because of the difficulties low-income people have in obtaining some documents.
- The claims process often replaces underwriting because it is cheaper to look closely at a few claims than to require extensive underwriting for large volumes of small policies.
- With small premiums and very limited benefits, the options for different claims documentation requirements must be assessed on the basis of their costs and benefits
- To be efficient, insurers should streamline their controls for the smallest policies, since effort involved in enforcing the controls may be more costly than the actual benefit.
- In general, the process must be as simple as possible.

<sup>1</sup> References in this chapter to Microcare (Uganda), Compartamos (Mexico), Aldagi (Georgia), Kashf Foundation (Pakistan) and Gemini Life (Ghana) are drawn from the authors' experiences, not from the case studies.



This chapter discusses these differences in detail, using examples to illustrate why there is a need to manage microinsurance claims differently from in conventional insurance. It also summarizes the lessons learned in trying to make microinsurance claims processes efficient, effective and controlled. The chapter first looks at the process in general, and then looks specifically at claims notification, settlement, controls and management.

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## I Introduction

Arguably the most important aspect of insurance for the policyholder is claims. Without efficient and effective claims processing, it will become difficult for the insurer to sell policies as customer dissatisfaction mounts. The right to efficient claims under certain circumstances is what policyholders buy with their premiums.

The cost of processing claims is a critical factor in determining success for insurance companies. They must be efficient with effective controls to ensure that only legitimate claims are settled and for the correct amounts. Yet the controls and processes that work for a wealthier market can be ineffective in the low-income market. Indeed, where claims processing becomes too demanding or too expensive, the related products simply cannot be offered to the low-income market. Such is the critical nature of claims processing.

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### I.1 The claims settlement process

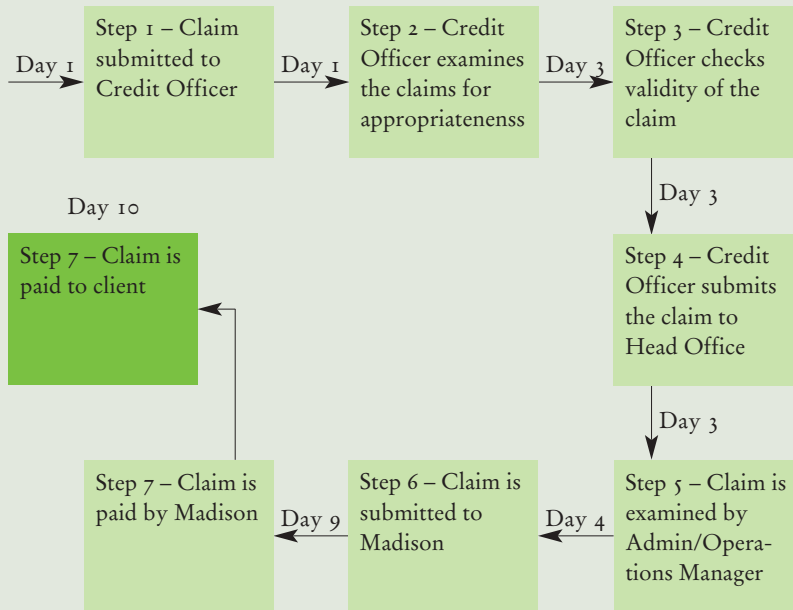
The claims process generally includes the following components:

- An insured event leading to notification of loss
- Collection of required documents
- Presentation of the claims application to an intermediary or the insurer
- Claims adjustment
- Claims settlement

For microinsurance to succeed, it must balance the amount of information required to actually confirm that the event has occurred with the policyholder's ability to obtain that information in a timely and cost-effective manner. Indeed, the claims process must be kept simple to gain the trust of the clients. As illustrated in Figure 15, the process at Madison Insurance in Zambia for example is clear and somewhat timely (compared to other cases).

Figure 15

### Typical claims settlement process for Madison's microinsurance product



Note: In a case where documents are not properly filled in (Step 1 or Step 5) the claim will be returned to Credit Officer/client and the process will require additional days – around 2–3 more days.

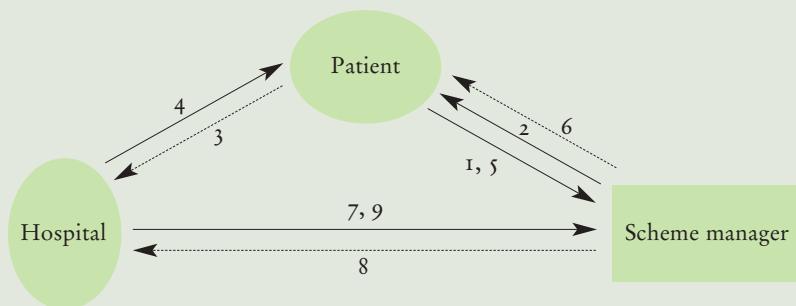
Source: Manje, 2005.

The process at Madison Insurance takes up to 10 days, as long as the documentation is correct and the claim is legitimate. At Delta Life in Bangladesh, the process can take up to 60 days or more. Even though much of Delta's process has been decentralized to the Zone Operations Centres (ZOCs), a number of activities remain at the head office and some claims approvals even require the signature of the Managing Director. Yes, there is a need for strong controls, but every step takes time and costs money, and thus increases operating costs.

Health insurance claims are more complicated than life insurance because a new party is involved – the healthcare provider – and the claim assessment is subjective, requiring medical expertise. Plus, a single policyholder might make several claims during the policy period. At UMSGF, a mutual health insurance programme in Guinea, the process begins with confirmation that the person seeking medical care is actually covered by the policy. The nine major steps in accessing care with UMSGF are indicated in Figure 16.

Figure 16

The claims process at UMSGF



- 1° The patient requests a treatment authorization.
- 2° The scheme manager controls that the patient is eligible for care and issues the authorization.
- 3° The patient goes to the hospital and pays for the consultation.
- 4° The hospital controls the validity of the patient's member card, provides care and issues a treatment voucher.
- 5° The patient hands the treatment voucher over to the scheme manager, once out of the hospital.
- 6° The manager reimburses the patient's transport costs.
- 7° The hospital sends the summary invoice.
- 8° The manager verifies and pays the invoice.
- 9° The hospital issues a receipt.

—> Information flow  
 .....> Financial flow

Source: Gautier et al., 2005.

As described in Chapter 2.1, a health microinsurance scheme that requires the policyholder to pay for treatment and then apply for reimbursement, such as the health benefits from VimoSEWA and Shepherd (both in India), does not provide the core advantage of insurance – being able to seek care without having to accumulate funds to pay for it.<sup>2</sup> In contrast, UMSGF, Yeshasvini (India) and Microcare (Uganda) reimburse the healthcare provider directly.

### 1.2 Upfront screening versus back-end controls

In many microinsurance schemes, the effort to reduce costs has shifted the normal policy underwriting from the underwriting department to the claims department. Prospective policyholders do not undergo a medical examination, for example. They do not have to present birth or marriage certificates, or health records upon initial policy application. In many cases, screening of

<sup>2</sup> VimoSEWA is in the process of testing a cashless payment system to overcome this problem.

potential policyholders is eliminated, or to some extent covered by the underwriting of partners. For instance, a woman belonging to an MFI may require microinsurance. She would be accepted automatically for insurance as long as she met the MFI's loan criteria. The cover may even include family members, as with AIG Uganda, Spandana (India) and CARD MBA (Philippines), without any additional underwriting requirements.

Even with individual sales, such as with Delta Life, prospective policyholders simply have to sign a declaration of good health. If anyone suffers an insured event, then the insurer requires confirmation of the declaration, for example, that there were actually no pre-existing conditions. In this manner, microinsurers minimize the workload associated with assessing the mass of applications for cover, and concentrate their efforts on the few claimants.

In general, there must be enough checks and balances to ensure that fraudulent claims are not paid, but the process also must be user-friendly and cost-effective for all parties. However, the whole insurance process must be considered. Where controls are minimized for the mass of insurance purchasers, there is a heavier burden on the claimants. Another strategy for improving efficiency is to have tiered claims requirements, with a limited number of documents and a simple process for the smallest claims, but more stringent controls for larger claims.

The next sections analyse how the key claims sub-processes serve the policyholders, and how microinsurers have made these processes work in an efficient and effective manner.

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## 2 Claims notification

Claims notification occurs on two levels. First, the approach may be either by the policyholder, the beneficiary or the insurer's representative. Then, the application is completed and submitted to formally launch the claims settlement process.

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### 2.1 Approach

Most microinsurers leave the responsibility of initiating claims to the beneficiary. Although several institutions, such as Delta Life, AIG Uganda and La Equidad (Colombia), require beneficiaries to approach the insurer or its agent, insurers can improve their customer service by approaching the beneficiaries, which enhances the credibility of the insurer and strengthens a burgeoning insurance culture.

For MUSCCO in Malawi, beneficiaries generally advise the SACCO that a member has died, although there are instances when beneficiaries are not aware of their designation or the insurance coverage. Under such circumstances, the SACCOs inform the beneficiaries and encourage them to initiate the paperwork. The SACCO has a particular motivation to do so if the member dies with an outstanding loan balance.

Similarly at CARD MBA, the field officer and the group members are motivated to find the beneficiaries to be able to clear the deceased's loan balances. If there is no beneficiary named or that person predeceased the insured, it is the policy of CARD MBA that "in the event of the death of a member without designation of her beneficiary, all benefits due will be paid to her legal heirs according to law" (McCord and Buczkowski, 2004).

Even if there is not a loan to be repaid, with life insurance it is important for microinsurers or their intermediaries to make sure that claims are initiated even if they have to seek out the beneficiary. Trust is still being built with many of these programmes, and claims payments show policyholders that they can trust the insurer to pay.

With healthcare, either the policyholder approaches the insurers for reimbursement, or the insurer keeps the policyholder out of the process by paying the healthcare provider directly. The latter approach is simpler for policyholders and more efficient for the insurers. Grameen Kalyan (Bangladesh) uses a third approach that eliminates the claims process altogether. At GK, members are provided with cards to present at the time of treatment. The treatment cost is then simply discounted and no claim need be made. However, the policyholder still requires cash to access care at the discounted rate, and the cost of medical care that is beyond the capacity of the health centre is covered on a reimbursement basis.

As a means of assistance with the claim process, TUW SKOK (Poland) and Aldagi (Georgia) have implemented 24-hour toll-free help lines to assist in claims queries (among other things). For TUW SKOK, it is interesting to note that only 10 per cent of claims are started through the call centre, while the rest are initiated through their credit union partners – a clear indication of the preference for physical human contact in this process.

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## 2.2

### Claims application

Claims applications for insurance products are complicated and can be problematic for low-income policyholders, especially those with limited education. For example, Delta Life's claim form requires significant information including details from local authorities and the deceased's employer, as well as specific information on the cause of death. Completing this form with all

the required signatures and information creates frustration and delays for the beneficiary. Additionally, the claims rejection rate at Delta is about 15 per cent, and this is partly due to incomplete claims applications.

At some microinsurers like Delta, claims documentation has not evolved sufficiently to accommodate the low-income market. For example, while documentation from an employer may not be difficult for a middle-class widow in a city to obtain, it may be a serious challenge for a rural, low-income beneficiary. Claims rejections are often a direct result of the complexity of the forms and the insensitivity to this market's ability to acquire the formal documentation, which can undermine the intention of microinsurance as illustrated in Box 38.

Box 38

### **Claim rejection: A case of insufficient documentation in Zambia**

Philip Zulu's wife died and he began the claims process after her burial. Upon submission of the claim form with burial and death certificates, Philip was advised that he also needed to produce the official Cause of Death Certificate. He went back to the hospital only to be told that it was not possible to produce the certificate because too much time had elapsed since his wife's death. After spending three weeks going back and forth between his MFI's office and the hospital, he eventually gave up on the insurance claim.

*Source: Adapted from Manje, 2005.*

Some microinsurers, however, have adjusted their claims requirements for their target market, for example:

- VimoSEWA requires a receipt for the wood used in building the funeral pyre
- A burial permit can be used for AIG Uganda and Madison in place of a death certificate

Part of the complexity of claims requirements relates to negative experiences insurers encounter with policyholders taking advantage of the combination of simple initial applications (and thus limited or no underwriting) coupled with relatively simple claims processes. As the controls were weak at both ends of the transaction, CARD MBA encountered a serious and recurring problem with adverse selection, especially for clients' family members. This prompted CARD MBA to initiate a contestability clause for deaths or disabilities that occur during the first year of coverage (*see Chapter 3.1*).

The complexity of the claims form will be partially driven by the extent to which the insurer relies on underwriting through the claims process, as well as the complexity of the product itself. Simple products with few exclusions require less information to make a claim since the insurer does not have

to verify that cause of the claim is covered since (almost) everything is. A simpler claims process not only reduces costs for the beneficiary, the agent, and the insurer; but also leads to a higher level of policyholder satisfaction.

For example, Microcare and Opportunity International use a form for their credit life and funeral policy package that is straightforward (see *Figure 17*), although even this form requires a death certificate, which may be difficult to obtain in rural Uganda. Consequently, Microcare recently started accepting a letter from the clergy or imam who performed the burial if a death certificate or police report is not available. Without such adjustments, beneficiaries can become frustrated, as was the friend of the policyholder in *Box 39*.

*Box 39*

### **Beneficiary frustration**

One policyholder in Uganda noted: “I know of someone who lost her husband and she didn’t have any money to process the documents, yet her husband had died of an accident and was thus due a significant claim. As a result, she gave up.”

*Source: Adapted from McCord et al., 2005a.*

The objective is to find a balance between confidence that the insured event has occurred and accepting less than complete documentation. TUW SKOK, for example, requires the death certificate of the policyholder and acceptable means of identification to confirm the identity of the beneficiary. Madison requires the death certificate, a post mortem report, the burial permit, police report, and identification. Often obtaining the required forms is expensive and time-consuming. However, in rural areas, Madison will accept instead three written confirmations of death from the District Secretary, the local chief, the deceased’s employer, or the local police.

Yeshasvini has adopted a very different approach by requiring that claims be pre-approved by its third-party administrator before the insured receives treatment. This approach provides an up-front control to ensure that only authorized services are provided, which has consequently minimized the likelihood of rejecting claims.

In general, claims applications must be simple for beneficiaries to complete, requiring only documentation sufficient to confirm the occurrence of the insured event. Frustrating policyholders or their beneficiaries only hinders the expansion of microinsurance.

Figure 17 Microcare and Opportunity International claim form

**Insurance Claim Form – Group Credit Life**

Name of lender: \_\_\_\_\_ Branch name: \_\_\_\_\_

Name of contact at branch: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Deceased's family name: \_\_\_\_\_ Other name(s): \_\_\_\_\_

Cause of death: \_\_\_\_\_

Date of death: \_\_\_\_\_ (day) \_\_\_\_\_ (month) \_\_\_\_\_ (year)

**Total value** of claim: UGS \_\_\_\_\_

Of which UGS \_\_\_\_\_ is for outstanding loan/interest

**Details of the borrower who has died or whose family member has died**

**Borrower** family name: \_\_\_\_\_ Other name(s): \_\_\_\_\_

**Date** of loan disbursement: \_\_\_\_\_ (day) \_\_\_\_\_ (month) \_\_\_\_\_ (year)

We hereby confirm that the details contained in this claim form and attached proof of death are true and accurate to the best of our knowledge:

Signature of claimant: \_\_\_\_\_ Date: \_\_\_\_\_

Name of claimant: \_\_\_\_\_

Signature of loan officer: \_\_\_\_\_ Date: \_\_\_\_\_

Name of loan officer: \_\_\_\_\_

Signature of branch manager: \_\_\_\_\_ Date: \_\_\_\_\_

Name of branch manager: \_\_\_\_\_

Please attach the entire claim supporting documents as required under Condition No. 12 of the Policy namely:

- Death certificate or certified copy thereof;
- Police Report in case of accidental death;
- Copy of the loan agreement;
- In case of a Member's death, original passbook and loan amortization statement;
- Letter from Local Council member;
- Letter from Branch Manager or Group Leader concerned.



### 2.3 Delays with claims applications

Slow submission of claims to the insurer can be due to a variety of causes. At Madison, late claims are frequently related to documentation problems. It was reported that these stem largely from the loan officers, who are expected to assist with the documentation, yet are too busy chasing delinquent borrowers to spend time ensuring that the claims paperwork is in order. In addition, the MFI's field staff indicated that Madison's claims settlement paperwork was demanding and they wished it were simpler.

In contrast, VimoSEWA's insurance-dedicated *Vimo Aagewans* ensure that members know how to claim and they facilitate the claims process where necessary. VimoSEWA has found that official documents are occasionally not forthcoming, as the local officials request "speed money" to prepare or sign required documents. In these cases, the *Vimo Aagewans* intervene to ensure that the document is procured without additional cost.

The delays in submission to MUSCCO stem from two areas. The first is the difficulty in Malawi in obtaining a death certificate, which MUSCCO requires. The second is more interesting. MUSCCO works through local credit unions which service the insurance policies. To combat the problem of the credit unions severely delaying premium transfer to MUSCCO, claims payments are withheld until the payments are up to date. As a result, the credit unions delayed submission of the claims applications.

AIG Uganda has similar problems with its distribution channels. Although the insurer settles most claims within 30 days of the time it received the claim, the total time between the insured event and the claims payments reaching the beneficiary has been dramatically longer. Claims presented by the beneficiaries to some of the MFIs were being batched – held for weeks – before they were transferred to AIG Uganda's claims department.

For accidental death, where such cover provides an additional benefit, a police report is generally required. Columna in Guatemala further requires a certificate from the forensic doctor, as well as the ambulance report (if an ambulance was involved). The elimination of specific differences between "natural" and "accidental" death would help to eliminate such requirements.

To reimburse healthcare expenses, ServiPerú requires only the policyholder's identification, the medical report, and the invoices, all of which can be collected upon discharge from the provider's care. Having this documentation on discharge makes submission of the documents easier for the policyholder, and because there is the incentive of reimbursement, the policyholders submit their claims quickly.

With TUW SKOK's savings completion insurance, it takes an average of 60 days to receive the claims documentation, in part because the beneficiary is often unaware of the coverage. Additionally, the claims are first presented to TUW SKOK's credit union partners and their incentive to disburse these funds to people who have forgotten about the existence of the benefit has been limited. With its AD&D policy, an average 56-day delay in claim submission is often the result of technical rather than memory problems. TUW SKOK and AIG Uganda have found it takes more time to confirm an accidental death or disability claim because confirmation relies on others, like the police or doctors, who have no incentive to rush with their paperwork.

### 3 Settlement

#### 3.1 Settlement mechanisms

Several MFIs and credit unions arrange to pay all or part of the claims almost immediately upon being notified of the claim. The Kashf Foundation in Pakistan, for example, originally promised claims payment within one day of the occurrence of the insured event. This worked well for beneficiaries since they could get the funds they needed without having to present the documentation required until later. However, the beneficiaries no longer had an incentive to collect the documents and Kashf was left with receivables and no documentation to use to collect them from the insurer. Subsequently, the MFI changed its policy to payment within five days, but after submission of the documents.

To provide funds to claimants quickly, while still maintaining the incentive to provide the documents, some of Columna's cooperative partners make partial payments when beneficiaries provide the initial documentation. These beneficiaries must meet certain criteria (*see Box 40*) to gain access to the partial payment. Additionally, to protect themselves, the co-ops contact Columna to verify the insured status of the policyholder.

*Box 40*

#### **Requirements for an advance payment at Columna**

The claim will not be rejected if the following conditions are satisfied:

- The policy must be in force.
- The policyholder must have been current in premium payments.
- In case of natural death, a waiting period of 180 days between the effective date of the contract and the death must have elapsed. This period does not apply for accidental death.

- The cause(s) of death stated in the doctor’s post mortem certificate must not include HIV/AIDS.
- In the event of suicide, the policy must have been in force for at least two years.

*Source: Adapted from Herrera and Miranda, 2004.*

To speed up the settlement process, TYM, CARD MBA and MUSSCO have created decentralized systems that allow branches or agents to pay claims based on receipt of full and proper documentation. Most of the others, including UMSGF, VimoSEWA and Tata-AIG, have a more centralized system that requires presentation of the documentation to the head office claims department for processing. Often this processing includes sample testing of the documentation for validity, and sometimes, as with VimoSEWA, a review of the claim by a claims committee (*see Chapter 4.5*). Medical claims may also be subject to a clinical review as at VimoSEWA and Microcare in Uganda, which is intended to both confirm appropriate care and control over-treatment.

Many microinsurers have their management deliver the claims settlements to the beneficiaries. This activity enhances their public image and promotes the scheme and its benefits to their members. The resulting demonstration effect, whereby others are enticed to join the insurance scheme because they see that claims are actually paid as promised, is a critical element in creating an insurance culture since it enhances trust between the insurer and prospective policyholders.

Disability claimants frequently express dissatisfaction with settlements because of disputes on the extent of the disability. TUV SKOK has developed an appeals process where beneficiaries can, and do, appeal settlements. During the first nine months of 2003, the board considered 69 claim complaints, in respect of which 16 decisions were modified or reversed, 48 were upheld, and five were still in process. Likewise, VimoSEWA has a grievance committee to which people can appeal their settlement.

### 3.2

#### Claims rejections

As underwriting requirements are frequently applied to claims submissions rather than initial policy applications, rejections can be an issue for microinsurance. In the case studies, claims rejection rates, where available, were generally between 5 and 22 per cent. The higher rates reported by TUV SKOK’s property insurance, MUSCCO and La Equidad – 22, 15, and 14 per cent respectively – may reflect better record-keeping at the credit union-related

microinsurers. It may also reflect a higher reliance on sorting out underwriting issues through claims. The high rate at TUV SKOK is directly related to water damage claims for which TUV SKOK has implemented a 15-day waiting period to counter a problem with people purchasing policies after their property was damaged by water leaks. This also relates to TUV SKOK's implementation of a US\$27 deductible to minimize frivolous claims.

Claims rejections often occur on several levels, leaving the actual rejection rates rather ambiguous. For Madison Insurance, with a rejection rate of about 5 per cent, it was possible to reject the claims at various levels, including the field officers, their supervisor, head office management or the insurer's claims department. It is only the latter that actually tracks the rejections, but it is likely that most questionable submissions have already been rejected by the time they get to the claims department.

The main reasons for rejecting health claims are related to policy exclusions and the client not understanding, or not being aware of, such exclusions. For example, with VimoSEWA, certain medical procedures and medications are not covered; because members are submitting for reimbursement, there is significant potential for claim rejections. VimoSEWA has worked to combat this through extensive training of its field agents.

Another common reason for rejections among microinsurers has been that policyholders do not realize that they must pay premiums every year to keep their policy in force, so they often believe that they are still covered even though the policy was not renewed. With many schemes, policyholders are not sufficiently informed or they have forgotten the details.

Delta Life has a rejection problem that is common among microinsurers with long-term policies – lapses. For the three years including the period 2000 to 2002, only about 43 per cent of its policies were in force. Thus, on the death of more than half of its policyholders, there would actually be no insurance cover, although the beneficiary would probably receive some of the savings accumulated over the years. It is likely that growth has been restricted by the negative public image of these rejections.

To reduce the rejection rates, two improvements are needed. First, policyholders must be fully knowledgeable about the product they are buying. Besides providing client education, microinsurers should be giving their customers a brochure or simple policy document that states the dates of coverage, the benefits and the claims processes. Second, microinsurers must deal with the root causes of non-renewals and lapses; it is sometimes necessary to develop alternative premium payment options to address the variable and often seasonal nature of household income (*see Chapter 3.3*).

### 3.3 Time to settlement

On average, settlement times can be anywhere from seven to 60 days, with the longest time to settlement about two years. The average of those case study insurers who were able to provide this information was 24 days.

Claims settlement is often delayed by critical snags in the process. At Delta Life, the snag is simply the policy of the institution itself, since it has not made timely settlements a priority (*see Box 41*). An estimated 10 per cent of death claims take six months or more to be settled because of problems with the mail, manual data systems, insufficient documentation and the centralization of claims processing.

*Box 41*

#### **The many steps in claims settlement at Delta Life**

It is interesting to note the number of staff involved in checking and approving a claim, which has a direct impact on claim settlement efficiency as well as cost. At Delta Life, besides the three people in the unit office who review the claim, there are one or two people from the ZOC's servicing department, and then at least three at head office, along with the MD if the claim is above US\$180. This does not even include the role played by the control and compliance department which ensures that all required signatures are on the form. It is no wonder then that claims settlement takes at least a month, and often much longer. In the future, Delta hopes to decentralize the entire claims process to the ZOCs, but such a change does not appear imminent.

*Source: Adapted from McCord and Churchill, 2005.*

When working with MFIs, the delay may be due to the MFI agent not concentrating on the delivery of microinsurance products. In one case study, the time to settlement was tracked for several specific policies (*see Table 25*) and it was apparent that the MFI was creating substantial delays. The insurer should intervene to address this problem. However, because these are related to a group policy through the MFI, the insurer believes it has satisfied the policy requirements once it pays the MFI. Though this may be technically correct, it is important to recognize that when receiving queries from beneficiaries, the MFI's staff blame the delays on the insurer. Indeed, even with the rejected Case 6, the MFI's staff continue to report to the beneficiary that they are waiting for the insurer to pay the claim.

Table 25

## A sample of claims durations

	<i>Days from death to claim reaching the insurer</i>	<i>Days from claim arrival at insurer to payment to the MFI</i>	<i>Days from MFI receipt to beneficiary receipt</i>	<i>Total days from death to beneficiary receipt</i>
Case 1	91	38	280	409
Case 2	60	26	101	187
Case 3	46	21	101	168
Case 4	75	33	221	329
Case 5	77	31	Loan only	108
Case 6	86	30	Rejected	N/A
Average	72.5	29.8	175.8	278

Source: McCord et al., 2005a.

Several of the case study institutions aim to achieve “rapid” claims payments. The partnership document of Madison Insurance gives the commitment that it “shall expeditiously settle claims within a maximum of seven working days”. Shepherd’s insurer has committed itself to settling claims within 15 days. For ServiPerú, the government has taken the lead by mandating that all claims be paid within 30 days. AIG Uganda has agreed to pay claims within 14 days, though its average is much longer. An interesting alternative approach to assurances on claims was implemented by Gemini Life Insurance Company in Ghana; if it takes longer than 14 days to settle a complete claim, a penalty of 25 per cent of the claim amount will be payable to the beneficiary. Microcare provides a similar offer.

Delays with LIC’s claim settlements were unacceptable to the clients of VimoSEWA, as they were often taking one month or more after all documentation was submitted. VimoSEWA management decided to explore alternatives. Aviva Insurance was selected to replace LIC in 2005 because it permitted VimoSEWA to pay the life claims, reducing reimbursement time to one week. For health and asset insurance, VimoSEWA has worked with the private, non-life insurer ICICI Lombard since 2003. This relationship improved claims settlement through the provision of a reimbursement fund, out of which VimoSEWA pays the claims and is then reimbursed by the insurer.

It is when they submit a claim that policyholders find out if their premium has been well spent. All clients expect claims to be paid quickly. However, “quickly” means very different things to different people. For example, in Zimbabwe (*see Box 42*) or South Africa, where people have become used to informal burial societies, paying claims quickly may mean within one day; whereas in Zambia, where burial societies are less prevalent, quickly means

within a week or two. These different perceptions have a huge effect on the claims process, the cost of delivery and the level of client satisfaction.

Box 42

### Efficiencies of informal insurance

Zambuko Trust, a Zimbabwean MFI, conducted market research to explore possible insurance opportunities. The research revealed that over half of Zambuko's clients had contributed to an informal burial society. These burial societies are organized by a person in the community who collects small regular contributions from members. The contributions are saved in a bank (or sometimes in a tin) and in the event of the death of a member or someone in their family, the burial society pays a sum from the saved contributions.

Due to the limited number of people in each burial society and the limited geographical scope, the claims are often paid within hours of the death. Since these burial societies are common in Zimbabwe, most low-income people are familiar with funeral insurance and expect claims to be paid within 24 hours.

*Source: Adapted from Lefitley, 2005.*

Efficient controls are critical to any insurance product. As the experience at Delta illustrated, having more people review a claim does not necessarily lead to better control. There are significant advantages in having claims payment decisions close to the beneficiary. The success of the India examples shows that even with a regulated insurer as the backbone of the scheme, durations can be reduced by creating structures within the delivery channel to facilitate these transactions. However, the data in Table 1 shows that MFIs are not always the best arbiters of client needs, and thus insurers must ensure that the final client is being satisfied.

## 4

### Controls

Insurers are not successful just because they can get claims paid quickly. They must ensure that the claims are legitimate and correspond with the policy requirements. For example, for an accidental death claim, they do not just need a document from the police confirming death, but they must also ensure that:

- the document is legal
- the death was an accident
- the person who died is actually covered by the policy
- the death occurred within the policy period, and
- the policyholder was up to date with premium payments when the death occurred.

Insurers make promises to cover risk events under certain circumstances. Their policyholders, and indeed even their intermediary agents, are motivated to try to cheat this system, especially if the policyholders are not the owners of the scheme. If insurers are to stay in business, they must maintain strong yet efficient controls.

#### 4.1 Claims adjustment

Some microinsurers, like TUV SKOK, work with professional claims adjusters. TUV SKOK does this with property claims where valuations may be rather complicated. Those offering health or disability insurance often use physicians to review and adjust claims. For life insurance, most microinsurers utilize a combination of paperwork and the relationships of the intermediary agents. TYM for example, uses the local Woman's Union to help with claims adjustment; MUSCCO uses its SACCO partners.

MUSCCO has found claims adjustment a challenge because Malawi lacks a national identification system. Consequently, it is unable to confirm that the claimant is actually a policyholder. Several institutions overcome this, or reinforce the confirmation of identity, by requiring agents who know the deceased to actually view the body. CARD MBA uses its volunteer coordinators, selected from among their membership, to visually confirm the loss. Others, like VimoSEWA, require a photo of the deceased. Opportunity International Bank Malawi overcame the lack of national identity cards by introducing smartcards that record clients' fingerprints.

Confirming the cause of death as HIV/AIDS has proven elusive, especially in high-prevalence countries, as illustrated in Box 43.

*Box 43*

#### **Claims adjustment and HIV/AIDS**

In the face of high potential loss rates from HIV/AIDS, several microinsurers implemented specific exclusions for deaths caused by HIV/AIDS. Both AIG Uganda and MUSCCO have come to realize that excluding HIV/AIDS is an impractical solution. Both institutions provide insurance mostly or entirely to borrowers who must fulfil the credit criteria of the lender. The loans are almost always short-term. Thus, due to the fact that the borrower has been able to qualify for the loan and its short duration, much of the likelihood of a claim due to HIV/AIDS has been removed. Also, in Uganda and Malawi, HIV/AIDS is rarely listed as the official cause of any death. Deaths of HIV/AIDS sufferers typically result from pneumonia or TB or some



other opportunistic disease. These factors basically render the unpopular HIV/AIDS exclusion ineffective. Thus, the exclusion has been removed from AIG Uganda and MUSCCO policies.

*Adapted from Enarsson and Wirén, 2005; and McCord et al., 2005a.*

In 2004, VimoSEWA improved its approach to claims adjustment when it trained three office staff in claims investigation techniques. The cell was trained by the COO for the purpose of discreetly procuring correct ground-level information from hospitals, doctors, nursing staff, and relatives and neighbours of the claimants. They were also trained to analyse healthcare bills and information on claimants' income, work and family, depending on the details of the claim. Investigation results are discussed only with the claims coordinator and COO along with the CEO for final decisions.

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#### 4.2 Other general controls

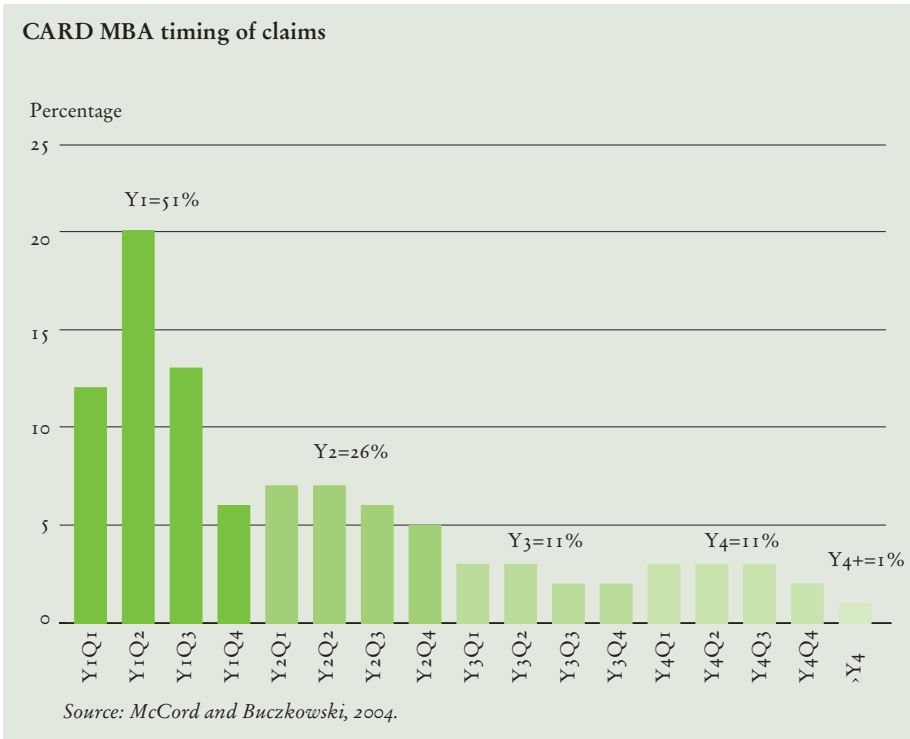
Some controls relate to the structure of deductibles and co-payments, which limit the volume and value of claims. Additionally, these play an important role in limiting the incentive for fraud by the policyholder. For example, with property claims, TUW SKOK limits settlements to 50 per cent of replacement value. In this way, the policyholder still takes a 50 per cent stake in the risk of loss.

Sometimes common controls cannot be implemented; for example, Tata-AIG could not introduce a waiting period because the national insurance regulations prohibit it. The regulators feel that such a provision can cause ill will among policyholders with little knowledge of insurance when a claim arises within the waiting period. Tata-AIG has paid claims within the first month of policy activation.

At Grameen Kalyan and BRAC in Bangladesh, staff members frequently interact with clients and get to know their families personally, which works as a moral deterrent against fraud and false claims. Many MFIs have observed that borrower groups tend to exclude those individuals that have a history of poor health or are known to be sick. Group members fear that such individuals will struggle to repay their loans, leaving other members to repay them under the mutual guarantee. Opportunity International has used this observation in negotiating with insurance companies in Africa and the Philippines to remove waiting periods and existing illness restrictions from their life insurance products.

In addition to other methods, CARD MBA uses data to control claims. The microinsurer has examined at what point in time during policyholders' relationships with CARD claims are being submitted. As shown in Figure 18, over half of all claims arise within the first year of membership, which suggests an adverse selection problem. However, this finding must be analysed in context; due to the rapid growth, 40 per cent of all CARD members were in their first year and 40 per cent of its members were responsible for 51 per cent of claims.

Figure 18



As mentioned in Chapter 2.1, the risk of fraudulent claims in life insurance is relatively low because it is hard to fake a death, especially in a rural community where people tend to know one another. However in health insurance the risk is much greater. Common fraud problems that occur with health microinsurance include:

- physicians submitting invoices for care never provided, possibly splitting the settlement with the policyholder,
- policyholders obtaining cover for persons not covered by the policy,
- over-treatment by providers,
- submission of fraudulent invoices by policyholders.

Countering these fraud problems calls for close claims analysis, but even more importantly, requires that controls be built into the systems to stop fraud before it occurs. For example, to control fraud, Microcare places a receptionist in the waiting room of the approved healthcare provider. These qualified nurse receptionists ensure that only covered individuals receive treatment by checking the identification cards; the photos on the card are matched to both the patient and the database available to the nurses.

Using this technology, Microcare can ensure at each stage that only covered care is provided, and the insurer has an immediate record of the treatment costs that can be compared to the hospital's invoice when it arrives. Thus, Microcare can make sure that its policyholders receive the care they buy, and is able to keep the premiums lower. However, although this extensive system mitigates policyholder fraud, it does little to encourage true managed healthcare because Microcare has no control over the physicians and clinics.

As a means of controlling the financial transaction, Delta Life pays about half of its claims with crossed cheques (requiring the payee to deposit the cheque into a bank account). This is a common procedure at insurance companies. However, frequently the beneficiary does not have a bank account into which to deposit the cheque, and many banks are not prepared to open an account since they know that the payee will deposit and immediately withdraw the proceeds, and then close the account. Even when banks agree to open an account, they impose heavy service charges that make the insurance transaction more expensive for the beneficiary.

The bottom line with microinsurance is that controls must be strong, yet must reflect both practicality and the market situation. It makes little sense to implement expensive controls that the market cannot comply with, or that cost more to implement than the likely cost of the aggregate loss. As margins are smaller with microinsurance, the cost-benefit analysis is particularly critical.

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## 5 Claims considerations in product design

A simplified product design will greatly aid the claims process. Microinsurance product designers must think through the steps policyholders will go through to make a claim. When CARD MBA tested a health insurance product, it found the risk management and paperwork simply too costly and onerous for the MBA and its members, so it pulled the plug on the product. Claims processes and costs must be addressed and honestly recognized in the product development process.

In general, life policies are relatively easy because there is one obvious insured event – the death of the covered person. Several programmes offer simple policies where if the person dies (and is covered, and the death is proven), the beneficiary is paid. Other programmes add complexity with exclusions for suicide, death due to civil strife or acts of nature. The author's favourite microinsurance exclusion is one for policyholders who die "while a passenger in a rocket-propelled vehicle". The greater the number of exclusions, the more complex the settlement process will be.

A range of benefit options also adds complexity. Some microinsurers offer an additional benefit (double indemnity, for example) for accidental death; Columna has special accidental death benefit for certain causes of death, for example while travelling as a passenger in public transport or in a lift, or as a result of fire in a public building, where the insured sum is multiplied by three. With accidental death policies, two problems occur. First, there is significant ambiguity surrounding the definition of an accident, which can lead to conflicts in the adjustment process – something that public relations-sensitive microinsurers should want to avoid. It is difficult and unpleasant to explain to expectant beneficiaries that something they see as an accident, or a special accident, is not one.

A second issue with accidental death claims is that people have an incentive to convert a death due to illness into an accidental death. Microinsurers have reported cases of beneficiaries creating fraudulent police reports and bribing physicians for fraudulent post mortem reports. The incentive generated by a potentially significant claims settlement has led many people to indulge in fraudulent activities. The problem is eliminated when there is a simple death policy where any death leads to a common settlement. Comparamos, for example, uses the slogan "death is death"; with its insurer partner Seguros Banamex, it treats all deaths in the same way. Policies with simply-defined benefits and simple claims procedures are critical for efficient microinsurance operations.

Tata-AIG has developed a broad strategy in designing its microinsurance products. Its objective is to limit costly underwriting, and to focus instead on claims verification. While reducing its operating costs, the problem with such a strategy has been that its products have been mis-sold by commission-seeking agents who have sold products to people who do not qualify for them. When such people make a claim, it may subsequently be rejected during claims verification. This does not create a good impression of Tata-AIG, nor does it help create an insurance culture.

In some mutual and community-based programmes, like ServiPerú, the scheme managers found that it was important for members to self-limit their claims behaviour and worked to raise awareness among policyholders of the

benefits of prevention and minimizing claims so that prices could be kept low in the future. This reduces the volume and value of claims, ultimately allowing for a potential reduction in premiums. BRAC takes an interesting approach to this type of limitation for their health insurance, allowing each cardholder only one referral reimbursement per year.

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## 6 Conclusions

In summary, the following key lessons and recommendations about claims management are worth considering:

- To be efficient, insurers should streamline their controls for the smallest policies, since the effort needed to enforce the controls may be more costly than the actual benefit.
- Efficient microinsurance must have simply-defined coverage, appropriately rapid claims settlement and controls that can be easily applied.
- The closer the settlement is to the policyholder, the faster it can be provided, though there are potential issues of control and inconsistent application of claims rules that need to be monitored.
- Claims must be based on documentation that is appropriate for the clients.
- The overall microinsurance processes are more efficient and cost-effective when the underwriting is conducted through claims rather than at the point of purchase. However, where the controls are minimized for the masses of insurance purchasers, there is a heavier burden on the claimants and a risk of mis-selling.
- With health insurance, the greatest benefit for policyholders is when the insurer settles directly with the provider. Procedures and controls can be more efficient when the providers are responsible for initiating the claims.
- A settlement appeals committee is important to offer beneficiaries an opportunity to have their claim results reviewed and clarified.
- Distribution agents such as microfinance institutions are not always the best arbiters of client needs, and thus insurers must make sure that the final client is being satisfied.
- Computerization greatly enhances the potential of developing and implementing efficiencies, and may be the most important input to efficient processes, especially for health insurers.
- A simple brochure for each client showing the breakdown of fees and benefits, the coverage period, and describing the claim settlement process, would be a worthwhile consideration.

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## 3.5 Pricing microinsurance products

John Wipf and Denis Garand

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Commercial insurance companies employ actuaries, specialists trained in the mathematics of insurance and risk management, to calculate the financial impact of contingencies for which policyholders are insured. More specifically, the actuary ensures that the company's premium rates are prudent and sufficient, that its reserves for future liabilities are adequate, and that the policy dividends paid to its policyholders are equitable.

Similarly, a microinsurance programme should also contract the services of an actuary to derive the premium rates for its products and to assist with other aspects of managing the scheme. In the beginning, many unregulated microinsurers underestimate the technical rigour required to price products correctly. They often yield to the temptation of duplicating products and rates from the commercial insurance market or from other microinsurance programmes without considering the underlying assumptions behind those rates.

The main objective of this chapter is to illustrate how insurance products are priced and how to design and maintain databases so that they can be used for pricing purposes and sound management, and to highlight some good and bad examples of microinsurance pricing derived from the case studies. This chapter is particularly relevant for unregulated microinsurance schemes that carry their own risk, but also for organizations that distribute products underwritten by insurance companies – if distribution channels understand pricing, they will be more adept in managing data and negotiating with insurers.

The discussion is limited to life and health insurance, although many of the issues and points made apply to pricing other products as well. It is by no means an exhaustive treatment of the subject – indeed, an entire book could be written on microinsurance pricing.

For the information to be useful, parts of the discussion are by necessity somewhat technical – this should also convey the message that professionals are needed to price products correctly. The example illustrated in Box 44 is a

common occurrence. Informal insurance schemes that do not rely on actuaries to price their products, including several of those depicted in the case studies, tend to be too cautious and charge too much, or they under-price the product and threaten the viability of their scheme – neither of these results contributes to successful microinsurance.

*Box 44*

### **Pricing problems**

An MFI in India started its microinsurance programme with a single-level premium for life insurance coverage for all of its clients. In February 2003, GTZ sponsored a training session on pricing. When the rate components discussed in this chapter were reviewed, the MFI realized that its scheme would be bankrupt within a few years. The session helped managers understand their data needs, how data are used in pricing, and that all of the components of pricing must be considered when deriving the appropriate rates needed for long-term MI sustainability.

Aside from the direct underwriting impact of pricing, it is important to note that appropriate pricing can help build trust in the microinsurance product, while a poorly-priced product can lead to abrupt adjustments in premium rates and an erosion of confidence in the scheme.

## **I Database design requirements for pricing (and sound microinsurance management)**

Premium rates are established by the actuary using available **experience data**. In the early days of a microinsurance scheme, when there is still no specific data available on the proposed participants for calculating their expected claims, population statistics and data from similar programmes have to be used to the extent that they are available. The actuary must then rely on observations of and assumptions about the participants and their proposed or ongoing insurance scheme to adjust that information in the calculation of the premium rates.

Actuaries prefer to use the specific data of the group or population to be insured since this will result in more reliable and accurate rates. Credibility of the data increases with volume. In deriving crude group mortality rates for example, the actuary would consider a minimum of 10,000 life years of exposure<sup>1</sup> to be necessary for the data to be considered fairly credible – less credibility would be attributed for smaller data amounts.

<sup>1</sup> One life-year exposure is equivalent to a person being exposed to the risk of dying for exactly one year. The crude mortality rate is the number of observed deaths divided by the number of exposures.

From the beginning then, it should be clear that one of the key determinants of a scheme's long-term success is a properly designed and well-maintained database and management information system (MIS) for capturing and screening the data used in subsequent pricing reviews. The main objectives of an MIS are to accumulate data and to assist with managing the insurance scheme in a professional, efficient and technically prudent manner. The database design should be based on the relational database model, built with the help of IT professionals, and with inputs from an actuary and the management of the scheme (*see Box 45*).

*Box 45*

### **Database design problems**

TYM in Vietnam operated its microinsurance scheme for several years. However, the database was not properly designed and maintained, which made it very difficult later on to analyse and re-price products. For example, the relational database table with loan information could not be properly linked to the table containing member information, making it impossible to calculate risk exposures by age and gender.

Grameen Kalyan's micro health insurance has kept detailed information at each of the health centres. This information could have been very useful for analysis and pricing purposes if each client's membership number had been retained from year to year rather than assigning a new number on each renewal, or if the records had had another unique identification field for each member. This unique identifier would have allowed the actuary to track the exposure and claims for each member through the years.

*Source: Tran and Yun, 2004; Ahmed et al., 2005.*

Great care and time must be invested in the design phase of the database since it is the foundation of a good MIS. The following tables of information must be included:

#### *a) Institutional and branch information*

If the scheme is servicing several institutions then the details of each institution needs to be maintained.

#### *b) Participants' information*

Who is covered? What are the attributes of the participants? As a minimum, the following attributes must be included:



- |  |  |
|--|--|
| – Unique identifier or key   | – Name   |
| – Gender   | – Date of enrolment in the scheme  |
| – Date of birth  | – Primary occupation / livelihood  |
| – Marital status   | – Residence: urban or rural, city, province                                      |
| – Number of children<br>(calculated field if beneficiary<br>and covered dependants<br>history is kept) | – For health coverage, a recent photo<br>should be on file for printing ID Cards |

These data are used to prepare a demographic profile of the group, which is needed for projecting future mortality trends. If the country has a national ID number then that could be used as the unique identifier; otherwise, the scheme will have to generate its own unique ID number that clients should retain throughout their history with the scheme.

*c) Beneficiaries and covered dependants*

For health insurance, some of the same data should be maintained for each covered dependant, including name, unique identifier, gender, date of birth, relationship to the participant and a photograph.

*d) Coverage history*

What are the coverage details? A coverage history for each enrolled person has to be kept, not just the coverage currently in effect. If a change is made to an individual's coverage then a new record should be created in the coverage history table with the effective date of the change as one of the fields in the record.

Apart from monitoring and for administration purposes, the main objective of keeping a coverage history is to permit the reconstruction of a complete history of each person's exposure to every covered risk so that expected claims can be calculated for comparison with actual claims experience (this will be further discussed in the next section). In fact, software applications can be developed to monitor the expected claims in relation to actual claims on an ongoing basis – this is a powerful tool to assist microinsurance managers. For example, at Yeshasvini in India, management noticed that one of its accredited hospitals was performing an unusually large number of hysterectomies. On further investigation, it found that the medical management of patients was not appropriate, resulting in termination of the relationship with the hospital. AssEF had a similar experience, as described in Box 46.

## Box 46

**Importance of a health insurance MIS: Experience of AssEF**

For its health insurance scheme, AssEF in Benin carefully monitors actual claims in relation to expected claims. In some cases, substantial differences between projected and actual figures emerge. Once it identifies the discrepancies, then management can determine how to address them. From the results in 2004 (*see table below*), two issues captured management's attention: the high rate of prenatal consultations and nursing services.

	<i>Expected frequency (%)</i>	<i>Actual frequency 2004 (%)</i>	<i>Estimated cost</i>	<i>Average cost 2004</i>
General practitioner's consultations	107	102.4	392	231
Gynaecological consultations	10	3.3	1 400	1 525
Prenatal consultations	12	33.1	259	368
Postnatal consultations	4	0	370	-
Minor outpatient surgery	8	1.2	1 694	1 960
Outpatient nursing services	100	175.9	1 050	1 011
Deliveries (excluding caesareans)	4	3.7	3 360	8 655
Caesareans	0.5	0.6	35 000	35 000
Hospitalization	10	20.1	2 327	1 373
Surgical procedures (excluding caesareans)	2	0	34 320	-
Laboratory tests	20	58	2 730	2 938
Radiographies	5	4.2	4 865	3 589
Ultrasounds	5	8.1	4 284	4 069
Generic and essential drugs	144	157.1	2 954	2 281

At AssEF, a three-month waiting period for new members is the principal barrier against adverse selection. This safeguard appears to be sufficient to reduce opportunistic behaviour with regard to outpatient consultations and hospitalizations; however, it remains to be proven in terms of planned health services. For example, by monitoring claims, management identified a strong adverse selection phenomenon with respect to prenatal consultations (subsequently affecting deliveries in 2005).

This phenomenon was heightened following the numerous drop-outs that began in mid-2004, since many of the remaining women were pregnant. Specific measures could have been implemented to curb adverse selection, such as increasing the waiting period for prenatal consultations and deliveries. However, a decision was made to use the phenomenon for marketing purposes. As the claims in question were not out of control, they could be used to increase the visibility of the scheme, particularly with a target group made up of women. The frequency of utilization is very carefully monitored

and measures could still be implemented if the risk of adverse selection becomes too significant.

As for the nursing services, the frequency of utilization was also monitored according to the healthcare provider, and these results showed that one clinic had a much higher claims experience. In this case, microinsurance clearly led to a behaviour change. As the beneficiaries were insured, the clinic asked them to come back several times during the same illness to receive treatment; the first visit is recorded as a consultation and the subsequent ones as nursing services. The scheme's management approached the clinic and discussed the anomaly in treatment patterns, and this resulted in a return to more normal claims experience. Had the management not monitored the situation, the claims would have exceeded the financial resources of the plan and possibly resulted in its bankruptcy. A well-designed database and MIS is crucial for microinsurance management.

*Source: Adapted from Guérin, 2006.*

#### *e) Premium history*

For each product, a premium payment history must be kept for each insured, including the following fields: payment date, payment amount and receipt number if applicable.<sup>2</sup> Besides being needed for administration purposes, the premiums history will be used to study the pattern of drop-outs (lapses and surrenders), which in turn will affect the pricing of many products (*see Box 47*). For products with savings and equity accumulation features, the payout values will depend on the premium history since interest must be credited accordingly.

#### *Box 47*

#### **VimoSEWA's renewal rates**

VimoSEWA in India implemented a new MIS system in 2001, which permitted it to measure its renewal rates. Management was quite surprised to learn that the organization had a very low renewal rate – just 22 per cent for members paying annual premiums. Having been made aware of the problem, management took steps to increase the renewal rate by communicating the value of maintaining insurance to members and by setting target renewal rates for each *Aagewan* (sales promoter).

<sup>2</sup> Some group plans enrol all members of the organization, such as a dairy cooperative, and in some of these cases only collective group records can be maintained in practice.

A proper database is required to measure renewal rates. The renewal rate for Year X is the number of members that renew in Year X+1 divided by the number of members from the same cohort that were insured in Year X.

*Source: Adapted from Garand, 2005.*

#### *f) Claims history*

Who claimed? When did they die, or become sick or hospitalized? What amount did they claim? What was the incurred cost, covered or not? What was the method of treatment? What was the cause of death or hospitalization? When was the claim received? What was eventually paid, and on what date? For health claims, the cause of the claim should be recorded in International Claims Diagnostic (ICD) format and charges should be broken down by benefit category.<sup>3</sup> The claims experience is crucial for ongoing management and monitoring purposes and is also a primary source of information for pricing (*see Box 48*).

#### *Box 48*

#### **VimoSEWA's claims processing**

VimoSEWA's MIS recorded the date of the claim incidence, the date the organization received the claim and the date the benefit was paid to the member. This data showed that there were long delays in processing claims. Further analysis showed that part of the problem was due to members not knowing how to submit claims. Armed with this knowledge, VimoSEWA increased its efforts to educate members and to reduce time for claims reimbursement. Over three years, time for claims payment was greatly reduced – from three months to two weeks. Members acknowledged the improved service.

*Source: Adapted from Garand, 2005.*

#### *g) Product rules/policy history*

The coverage rules for each product must be defined and kept. Although the coverage history described above could also be used to capture product rules, it is much more efficient to separate general types of coverage information that does not vary too much between individuals and maintain it in a separate set of tables. This is needed to complete the expected claims information mentioned above.

<sup>3</sup> The ICD table was developed by WHO and assigns a code to various disease categories. The most recent ICD table is available on the WHO web site.

All records should be kept indefinitely, either in the current database or in an archive, for cumulative experience and actuarial analysis. The data should be carefully managed just like any other resource of the microinsurance scheme.

Actuaries attach great importance to the way data is collected and managed because erroneous and incomplete data can be more of a liability than an asset if misinterpreted. To ensure the completeness and integrity of the data, robust controls and thorough cross-checking should be built into the MIS. Standard coding values and formats should be used to simplify queries and to improve consistency. For example, participants' occupations should be selected from a menu of standard occupation codes rather than being typed in each time.

All data should also be verified as far as possible against other independent systems such as accounting. For example, premiums, commissions and claims must be balanced against the accounting system at the end of each accounting period to make sure that there is consistency between the two systems (which is also a very useful integrity check for the accounting system). Furthermore, database changes should be monitored and confirmed regularly against manual systems.

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## 2 Pricing components, key factors and methodology

The primary objective of any pricing exercise is to ensure that premium rates are sufficient to realize the scheme's aims and meet its obligations in the long run, while maintaining equity among the participants. For life and health insurance, rates can either vary by age (age-structured) or, as is most common, remain the same for all participants (sometimes described as "community rating"). If level rates are used, it is advisable to impose a maximum entry age and perhaps also a maximum coverage age (otherwise the rates will probably be too high, which in turn will affect the marketing of the product). An alternative to a maximum coverage age is a declining schedule of benefits for the older participants.

Several components should be considered in establishing premium rates. Each component must be carefully calculated from the experience data and/or from other available information. As mentioned above, to the extent that specific data is unavailable, the actuary must make reasonable assumptions based on experience, industry studies and observations from similar programmes.

It is very important to note that in microinsurance product design, communication methods, management practices, and many other factors will impact the observed experience. In populations where insurance awareness is low, it may take much more time for claims rates to stabilize and to reach

predictable levels. For example, even though it was serving a similar insured population, Yeshasvini's claims experience increased from Rs. 65 (US\$1.43) per insured in Year 1 to Rs. 86 (US\$1.89) in its second year of operation. The most likely reason for the higher claims cost in Year 2 is that there was a greater awareness of the insured benefits and claims procedures.

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## 2.1 Life and savings products

The main components for pricing life and savings products are the following:

### *a) Rate of mortality*

Typically the actuary chooses an appropriate mortality table prepared by collaborating companies within the insurance industry and adapts this to the microinsurance group. In the absence of industry tables, population tables prepared by World Health Organization (WHO) or others may also be used and adapted to the particular group of microinsurance participants, although this is not the optimum approach.

The selection and adaptation of the mortality table is a critical step in the pricing process for life insurance. Ideally, the final table should be tested against the database of participants by calculating the expected claims and the number of deaths over a selected retrospective study period, and then comparing these results with actual experience in the same period. This comparison should be conducted over each risk subgroup if possible, such as those defined by a combination of age, gender and geographic location. This test will determine the appropriateness of the mortality model and is only possible if the scheme has accumulated reliable data, as described in the previous section. The actual-to-expected claims test can be performed iteratively until the selection of mortality table and required adjustments are completed. The final result is the mortality pricing model for the group.

Whenever possible, the actuary should use a demographic profile of the prospective insured group when calculating the expected aggregate mortality rate instead of simplifying the calculation by using an expected average age. The latter approach is not very reliable (*see Chapter 3.6*).

The participation level is a very important consideration in preparing the mortality model. **Mandatory participation of all eligible members of the target group is recommended.** If participation is optional, then adverse selection will significantly increase the expected mortality rate.

Another important factor is the **expected trend in mortality**. In that regard, the actuary must take into account the influx of new participants in the next few months or years. For example, if the projected growth rate of the scheme is "high" and if new participants are a targeted segment of the

population such as younger women entrepreneurs, then the aggregate mortality rate will probably decrease or remain stable over time. Conversely, low growth rates are likely to result in an increased aggregate mortality rate as the group ages. For age-structured rates, this is less of a concern. However, for level premium rates, the future trends in expected mortality must be incorporated carefully.

For example, with VimoSEWA's voluntary scheme, the rate of mortality changed dramatically in a few short years as a much larger proportion of younger women entered the programme, and due to wider participation compared to the earlier years (*see Table 26*).

Table 26

#### Evolution of life mortality rate at VimoSEWA

<i>Year</i>	<i>Number insured</i>	<i>Rate per thousand</i>
1998	25 000	19.3
1999	31 000	14.2
2000	30 000	12.1
2001	29 000	11.6
2002	93 000	4.3
2003	110 000	3.7
2004	104 000	4.7
2005	117 000	3.2

*Source: Garand, 2005.*

HIV/AIDS is a major factor introducing long-term changes and trends into mortality rates. In regions with significant epidemics, the mortality rates can double or even triple, particularly in the income and age bands typically served by microfinance institutions and community-development NGOs.

Upon completion of the mortality model, the actuary will calculate the **expected claims** component of the premium rate, taking into account the product features and benefits payable contingent on death.

Other products like disability or health insurance will also require pricing tables, though based on contingency rather than mortality rates. Most of the above considerations will still apply.

#### *b) Drop-out rate*

The drop-out rate (lapses and surrenders) is another very significant factor in price determination. A lapse means that premium payment is late beyond the grace period (which is normally 30 to 60 days), whereas a surrender is notice of termination or non-renewal beyond the allowable reinstatement period.

It is important for the actuary to be able to prepare a schedule of drop-out rates by age, gender and time since enrolment, and correspondingly, to understand what proportion of the lapses will reinstate their coverage within the allowable reinstatement period. This information can be derived from the premium history database described above.

Depending on the product, the drop-out rates and the pattern can either improve or decrease the profitability of the microinsurance programme. For all products, a high rate of drop-out will increase expenses. However, if the product has an equity or savings component of which a portion is forfeited through early surrender, then a high surrender rate can actually improve profitability. The actuary may choose to use some of the projected forfeited equity to fund other benefits and thus reduce the overall premium rates.

#### *c) Risk loading*

Actuaries use risk mathematics to compute an appropriate risk premium, which is meant as a **provision for adverse deviations** (PAD) from expected claims over the short to medium term. Expected claims computed from experience and mortality tables will probably never be realized exactly<sup>4</sup> and the risk loading is a provision to increase the probability that the actual claims will not exceed net premiums over a predefined time period.<sup>5</sup>

In general, experience with larger groups of homogeneous participants (in terms of age, gender, health, occupation, etc.) and with identical coverage is less likely to deviate significantly from the expected claims (i.e. smaller variance) than that of smaller groups, groups with diverse participants, or groups with several coverage options.

#### *d) Uncertainty loading*

The actuary may include an amount to compensate for uncertainty. In general, the more assumptions that have to be made, and the less reliable and sparser the data, the greater is the uncertainty.

#### *e) Profit or contribution to microinsurance surplus and equity*

To expand the scheme, some profits are needed. The desired profit may be expressed either as a loading or as a separate component of the net rate.

<sup>4</sup> Technically, the expected claims computed from the data can be regarded as an estimate of the mean of the true underlying aggregate claims distribution.

<sup>5</sup> The risk loading is computed based on a desired probability of having sufficient net premium to cover all claims over a defined period, typically 1 to 5 years. A loading that ensures adequate net premium with a probability of 95 per cent is higher than a loading that ensures same with probability of just 90 per cent, for example.



*f) Expenses*

The expected expenses incurred for marketing, underwriting, claims payment, premium collection and administration must be loaded into the final net rate. To do this correctly, a thorough analysis should be made to determine how the expenses of the entire scheme are incurred, and then the expenses should be projected and allocated to the various products on an incurred basis. Arbitrary expense allocation will result in cross-subsidization of products (although this may be desired in some cases).

Recently Grameen Kalyan's health insurance programme was analysed to compare premium by health centre to the cost of operating the centre. The analysis showed that some centres were producing a surplus after taking account of only their local costs, but before factoring in the head office cost allocation and the depreciation of their equipment. Future pricing reviews of its products must include the costs of running the entire programme.

*g) Expected investment earnings*

Expected investment earnings are used in combination with expected mortality rates to prepare the net rates for life insurance before expense loading.<sup>6</sup> For example, Yeshasvini invested the initial annual premium and earned interest of Rs. 2 (US\$0.04) per insured person, which helped cover some of the administrative expenses. The actuary, therefore, needs to consider how excess premiums will be invested before they are used to fund the scheme's expenses and incurred claims. Moreover, the timing and frequency of the premium payments (*see below*) affect the investment earnings as do the quality, liquidity and rates of return of the selected investments.

As discussed in Chapter 3.6, the main risk in pricing long-term insurance products is the accuracy of assumed investment earnings. Long-term fixed rate guarantees are especially dangerous if the asset used to invest premiums (such as 20 to 30-year bonds) is not identified and purchased at the time the guarantee is given. Interest rates can drop relatively quickly, so it may be impossible to invest in assets that provide the returns needed to fund the rate guarantees. A shortfall of just a few basis points may well lead to eventual bankruptcy due to the effect of compound interest. One solution is to link rate guarantees to investment instruments such as government-issued bonds or five-year average term deposits in commercial banks.

<sup>6</sup> More precisely, expected investment earnings in combination with expected mortality rates are used to calculate the actuarial present value of expected claims, which is then used to derive the rates.

*h) Product design*

Product design features affect all the pricing components. For example, one common product is level-term life insurance. If the coverage is linked to loans from an MFI, the risks covered are predominantly women's lives (where women are the target clientele of the MFI). By also providing coverage for the clients' spouses and children, the risk pool is significantly altered, especially since most male spouses are often older than their wives and because males usually have higher mortality rates. Product features such as **waiting periods** and **pre-existing illness exclusions** are also important pricing considerations (see *Chapter 3.1*).

*i) Timing and frequency of premium payments*

These have to be factored into the premium rates. For example, if the annual premium payable at the beginning of the coverage year is  $P$ , the equivalent monthly premium is higher than  $P/12$  for three reasons: 1) the additional collection expenses (twelve transactions rather than just one), 2) lost interest earnings and 3) the fact that those dying will not complete the monthly premium payments.

*j) The size of the microinsurance group*

This affects the expense levels due to economies of scale, and it will greatly influence the required risk loading discussed above.

*k) Participation rates*

These affect the mortality rates, morbidity rates and the expenses. A community with 100 per cent participation will have lower per-capita claims expenses than a community with only 10 per cent participation. In the latter case, adverse selection comes into play because the families who believe that they will receive a benefit are more likely to enrol in the insurance programme.

*l) Growth of the microinsurance scheme*

This, together with inflow of new participants, is a critical factor in mortality trends. The addition of older or younger insured populations can dramatically change the expected aggregate mortality of the group.

*m) Stability of the group*

A group with low renewal rates is likely to experience higher mortality and morbidity as an element of adverse selection takes hold.

*n) The livelihoods, occupations and activities of the participants*

These greatly affect the health, mortality and morbidity rates and thus the expected claims.

*o) Inflation rates*

These will affect expenses and perhaps benefits depending on the product design. Inflation rates will usually have an effect on investment earnings as well.

*p) Reinsurance*

This can be used to manage some pricing risks. Theoretically, and all things being equal, reinsurance can result in lower net rates due to the reduced risk-loading requirements, but this depends on the design of the reinsurance programme and on the reinsurer. However, in many cases the reinsurance programme adds an additional cost.

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2.2

## Pricing health insurance

Most of the discussion in the previous section also applies to pricing health insurance. However, there are some additional considerations and issues which make pricing health insurance especially challenging.

**Expected claims costs** are computed using a combination of morbidity rates, claims incidence for each benefit category, and claims amount distribution by benefits category – claims must be separated in the database because this will enable separate pricing of each benefit category. Claims costs should ideally be segregated by age, gender, and geographic location. For this purpose, there is nothing which compares to an extensive and consistent database to estimate claims distributions.

**Incidence rates** are dependent on the insureds' utilization rates and utilization trends – and these can change significantly in a very short time. Utilization is dependent on prevailing characteristics of the insured, including their overall health, access to services, understanding of how to use services, the dignity with which services are provided and many other factors. For example, VimoSEWA introduced a child benefit in its hospitalization plan in 2002. In analysing the experience, it was observed that there was an increase in the number of families participating in the child health coverage and the increased participation decreased average utilization rates (*see Table 27*).

Table 27

### Claims experience of VimoSEWA's child benefit

Year	Actual claims cost per insured
2002	Rs. 97
2003	Rs. 85
2004	Rs. 70

Source: Garand, 2005.

**Inflation rates of benefits** are a key consideration for health insurance – they are very difficult to predict and are usually much higher than the Consumer Price Index (CPI). To decrease the uncertainty in pricing, the product should be designed with maxima for each benefits category as well as an overall annual maximum.<sup>7</sup> Alternatively, one could follow the approach used by UMSGF and Yeshasvini, and negotiate fixed tariffs for services, such as surgery, with healthcare providers.

**Co-payments** have an enormous effect on the rates because they result in decreased incidence and shorter hospitalization confinements. The claims database can be utilized to determine the effects of deductibles and co-payments on the premium rates. In many cases, the poor are hesitant to use health services as they lose several days income and incur increased travel expenditure, effectively creating a “hidden” co-payment or deductible.

The **geographic location** of the insured normally has a significant effect on access to service, thus affecting the pricing.

### 3 Modelling techniques

Actuarial modelling is an excellent approach to business planning and pricing, since it captures the numerous and complex interactions of many different parameters. Models are not a substitute for credible data, but enable the actuary to leverage the available data. Comprehensive models can reveal issues that are otherwise difficult to imagine, allow the user to test “what if” scenarios, and can be used for ongoing monitoring and detection of developing trends. In addition, a model allows for pricing multiple products at the same time.

For example, the pricing actuary may ask, “What would be the compounded effect on the premium rates and on long-term microinsurance solvency 5 to 10 years from now if the waiting period for Product A were reduced from one year to six months, and if the maximum entry age for the microinsurance programme were lowered from 64 to 60 but the exit age

<sup>7</sup> An overall annual maximum will also limit the number of claims of higher risk individuals or families within a defined period.

raised from 65 to 69, and if a death benefit of US\$50 for the member's children aged 90 days to 21 years were added?", and so on. Such complex questions may arise during the business planning stages of a microinsurance programme or may be raised by the management at any time – a good model can be used to test these types of scenarios.

The model should use the current database for evaluating key parameters. For example, demographic profiles, incidence rates and lapse rates should be updated before running the model. The expenses of the organization based on past experience and on the microinsurance business plans should be loaded into the model.

The output of a quality model includes prospective income statements, balance sheets, and cash flow statements. These outputs are indicative in nature and one must be careful to limit their interpretation. Generally, the user adjusts the premium rates and product features until the projected statements look reasonable.

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## 4

### Conclusions

The key messages in the chapter are as follows:

- Pricing microinsurance products is very technical and requires assistance from an actuary.
- The actuary has to consider the whole package – target market, product design, marketing and communication, administration and claims service – to set an appropriate premium. These parameters must be monitored periodically to anticipate changes in pricing.
- Accurate pricing begins with a quality database. The database should be designed by an IT professional with inputs from an actuary to ensure that the data are relevant for pricing purposes.
- Data, like any other resource, must be carefully managed.
- Health insurance is more difficult to price than life insurance. Rates should be reviewed every six to 12 months because utilization and inflation trends can change rapidly.
- Microinsurance modelling techniques can be used to price products more accurately, produce business plans and detect developing trends.

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## 3.6 Risk and financial management

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Sound financial management is one of the most important requirements for long-term success in the insurance business. It is an especially complex task because the bulk of an insurer's assets are used to back future benefits that are payable contingent on the occurrence of insured events.

Many microinsurers – particularly those with roots in the development community – fall short of having an adequate level of financial and risk-management skills. Many of these, however, offer only short-term, lower-risk products, although a few carry higher-risk, long-term products (*see Chapter 2.2*).

The aim of this chapter is to provide a brief overview of the major financial management issues that the insurer must master, as well as to offer practical and important financial management suggestions specific to microinsurance. In particular, this chapter discusses: 1) the risk of insurance, 2) capital requirements, 3) reserves, 4) reinsurance, 5) investment management and 6) profit distribution.

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### I The risks inherent in insurance products

Insurance is the business of risk management and therefore requires a thorough understanding of the nature and degree of the various risks present in the products being offered. Most of these risks are also inherent in microinsurance products. For microinsurance to be sustainable, four major categories of risk have to be managed and understood. The quantification of these risks is the basis for determining the actuarial reserves and the amounts of capital required for the long-term sustainability of a microinsurance programme (*see Box 49*). The four major categories of risk are: 1) pricing inadequacy, 2) asset depreciation and default, 3) interest rates and investment mismatch and 4) general contingencies and management.

<sup>1</sup> The references to Kasagana Ka (Philippines) come from the authors' experiences.

Box 49

### Actuarial reserves and capital defined

In this chapter, actuarial reserves are assumed to reflect the actuarial present value of expected liabilities<sup>2</sup> less actuarial present value of expected premiums inclusive of the appropriate margins as determined by a pricing actuary. These reserves are assumed to be reflected as a liability on the balance sheet. Furthermore, to simplify the discussion, the term “capital” here includes retained earnings, surplus, claims fluctuation and contingency reserves, guarantee funds deposited with regulators, etc. **It includes all assets over and above those funding the actuarial reserves.** Capital is assumed to be accessible in the event of deficiency in actuarial reserves.

#### 1.1 Pricing risk

Pricing is such an important topic that Chapter 3.5 is devoted to it. As pointed out in that chapter, pricing requires an accurate projection of the claims expected to be incurred, preferably based on specific experience data.

Many microinsurance programmes have inadequate and inappropriate data and therefore have difficulty obtaining an accurate projection of claims, which could lead to an erroneous pricing of their products. In other words, a lack of experience data exposes these programmes to a pricing risk. As discussed in Chapter 3.5, a good MIS together with a well-managed database enables the pricing actuary to derive the expected claims cost and other pricing components. The chapter also describes the specific data elements that must be included in the database.

It is important to understand that actual mortality and morbidity costs vary by age, gender, region, socio-economic status and other parameters. In the absence of good data and in places where the demographic profile of the target market is not well understood, microinsurers that charge level rates to all participants in life and health insurance schemes are exposed to a significant pricing risk since this practice requires an inherent assumption regarding the risk profiles of the target market. Removing exposure to erroneous risk profile assumptions would necessitate premiums being fixed according to age, sex and other parameters.

For simplicity and popular marketing appeal, or due to legal requirements such as in South Africa, most microinsurance programmes price on a community basis, which means that all risks within a specific scheme are charged the same premium. Consequently, the microinsurance scheme is exposed to a

<sup>2</sup> Put simply, it is the value of the expected amounts payable at various times in the future due to contingencies such as death or due to policy maturity, discounted to the present date by the application of particular interest rates.

much greater pricing risk since both the current profile and the future trends in the target population's demographics become major factors in the expected claims. Even more importantly, the **participation rate** becomes a crucial determinant of success because it, in turn, affects the demographic profile of the participants (a subset of the target population) and the aggregate risk exposure.

In general, a low participation rate will result in much greater risk exposure since older and higher-risk individuals tend to enrol first and participate more readily. Conversely, a higher participation rate generally means that a larger proportion of lower-risk individuals are also participating. This is clearly demonstrated by VimoSEWA's experience, where the mortality rate declined from 19 per thousand in 1998 to five per thousand in 2004 (see *Table 26 in Chapter 3.5*). This positive trend is largely the result of the organization expanding from 30,000 to more than 100,000 lives covered, and this wider participation involving an increase in younger members.

One of the most common pricing risks for microinsurers is deriving a community rate for group products based on an average age of a group, rather than basing it on the actual age-sex demographic profile of the group. The mortality rate for the average age of a group, for example, is a poor substitute for the weighted average mortality rate since the latter measure takes into consideration the demographic profile of the group.

For instance, the average age of the 8,500 members of Kasagana Ka (KSK), an MFI operating in Manila, is 39.95 with 98.67 per cent women. The mortality rate for KSK using an average age of 40 is 2.292 per thousand per annum, while using the more appropriate weighted average mortality rate based on the MFI's age-sex profile results in 3.395 per thousand. Since the expected mortality rate using the average age is just 67.5 per cent of the weighted average mortality rate, if the average age were used as a basis for deriving the level rate for a compulsory life product, for example, the product would be significantly under-priced.

Although mortality rates usually vary by region,<sup>3</sup> the geographic parameter is much more important for many risks covered by non-life insurers. In health insurance, for example, not only do morbidity rates vary by region, but more significantly, access to treatment, manner of treatment, and costs of treatment can vary greatly between hospitals.<sup>4</sup> Regional claims costs vary for other products as well, such as those offering protection against natural disasters.

<sup>3</sup> This fact is generally accepted by most actuaries and due to numerous factors such as diet, living conditions, lifestyle, cultural practices, livelihoods, access to medical treatment, etc.

<sup>4</sup> In some countries such as in India, expected claims costs are higher in urban areas than in many rural areas partly due to increased incidence resulting from better access.



Even if all the correct information were available for projecting claims, actual claims patterns usually change from the expected pattern assumed by the pricing actuary. Since higher than expected claims could severely impair the insurance programme, a certain amount of capital is required in case the underlying risk is underestimated. While this pricing risk is generally present in all insurance programmes, it is much greater for microinsurance since the risks are not as well understood by the actuaries.

Another significant pricing risk for longer-term life and savings products is the assumed interest rates. Projected claims, other benefits and expenses are discounted to their present value using assumed prospective interest rates – the lower the assumed interest rates, the higher the present value of future costs reflected in the premium rates, and vice versa. The pricing actuary may sometimes assume an overly optimistic interest rate to lower the present value of claims and the resulting net premium rate. This error, however, could jeopardize the programme later on when the assumed interest rates are not achieved. On the other hand, the actuary could be overly conservative and assume too low an interest rate, thus making the price uncompetitive. Either way, the interest rate assumption results in a significant pricing risk for longer-term products. This and other pricing risks need to be backed up by extra capital.

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## 1.2 Asset depreciation and default risk

Investment income from the assets of an insurance company is an important source of overall income. An error in managing investments can therefore be a major cause for the failure of insurance companies. One common error is excessive exposure to assets that do not generate the expected interest and dividend payments. This is known as “asset default risk”.

In capital markets, asset quality is generally rated inversely to its promised returns; this reflects the situation that, all other things being equal, assets promising a high rate of return also carry a greater risk of default. High interest is often associated with a higher risk rating of the investment instrument. So, prudent investors may prefer safer investments. However, an over-investment in perfectly safe investments could lead to erosion of real portfolio value over time, since returns are not much higher than (or may even be lower than) inflation rates. On the other hand, overexposure to high-risk investments could lead to a severe decline in portfolio value due to asset default. The challenge of good investment management is to achieve a balance between these two extremes through a diversified investment policy. The objective is to optimize investment returns while maintaining an adequate level of security and the required degree of liquidity so that assets can be available when required.

Most microinsurance schemes do not accumulate significant assets because they provide only short-term products, such as credit life or health insurance. However, for those offering long-term products, such as endowments and pensions, it is necessary to build up substantial assets since benefits are paid out in the distant future. Surplus accumulation of a successful programme over the years may be another significant source of assets.

Whatever the source, assets must be invested and monitored diligently. Adequate controls have to be in place to ensure that funds are not diverted for personal use by managers and the board of directors. Financial institutions usually introduce the following measures in their investment policy:

- permitted investments
- permissible asset classes for diversification
- maximum investment permitted with any one financial entity or in a particular asset
- discretion permitted to persons responsible for investments
- procedure for modifying policy
- reporting requirements

Even with a good investment policy in place, however, the choice of investments is very limited in many developing countries, which may also lead to problems.

There is sparse information in the case studies on how assets are managed. Few microinsurers have built up substantial assets, although the exceptions include VimoSEWA (India), CARD MBA (Philippines), Delta Life and Grameen Kaylan (both Bangladesh). The first two have invested the majority of their assets in related organizations, which could lead to problems due to the covariant risk.

One microinsurer in India was granted funds to invest in order to generate interest revenue to cover operating expenses. These funds were all invested in the stock market. The picture seems rosy at the moment because the markets have risen substantially of late. This investment policy is however extremely risky due to lack of diversification by asset class and could come back to haunt the organization. Stock markets can be extremely volatile and some good luck is required to exit just before a major decline.

As the other extreme, an example of overly cautious investment policy is employed by ALMAO in Sri Lanka. Its investment strategy requires that 30 per cent of all assets be invested in treasury bills and the balance in fixed deposits. The yields of this portfolio are below the current inflation rate in Sri Lanka. Over time, this will erode the real value of the investments.

In summary, diversifying assets appropriately over different investment vehicles and durations is one of the most practical and important practices in managing the asset default risk.

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### 1.3 Interest rates and investment mismatch risk

Investment mismatch risk can be illustrated by an example. If an insurer offers a savings product that guarantees that deposits will double in five years, this guarantee can be fulfilled only if the insurer consistently earns a 14.8 per cent return on investment. Any insurance product that has an implied interest rate guarantee would require the insurer to match asset flow with liability flow at the correct investment earnings rate. Failure to do so exposes the institution to future losses if interest rates change. This is called investment mismatch risk.

Using the above example, an investment yielding higher than 14.8 per cent over five years is needed to meet obligations, to cover expenses, and to generate a surplus. Just how much higher depends on the efficiency and objectives of the insurer. The section below on investment management discusses this in more detail.

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### 1.4 General contingencies and management risk

Insurance operations always have to be actively and professionally managed. Poor management can lead to eventual dissolution or bankruptcy. A lack of skills and understanding of how to operate the programme is a substantial risk for a microinsurer. This risk is compounded further if the board of directors is inadequately skilled in overseeing management (*see Chapter 3.8*).

Inadequate management and governance is perhaps the biggest risk for many microinsurance programmes (*see Box 50*). As described in Chapter 3.10, benchmarking can help to overcome some of this risk, though it can never be completely eliminated. For this reason, greater efforts should be made to increase the expertise of directors and managers.

Keeping the above risks in mind, the microinsurer has to manage its financial resources in such a way as to meet its obligations in a timely fashion. An essential function is to maintain appropriate accounting records and prepare financial statements, including balance sheets and cash flow statements.

Box 50

### Management risk illustrations

Over the years, the International Cooperative and Mutual Insurance Federation (ICMIF) has had several members that have experienced difficulties and even failed. A review of their experiences often exposes management and governance problems, such as:

**Company 1** started as an agency to serve the insurance needs of various affinity organizations<sup>5</sup> and businesses – agricultural, marketing and financial – in a developing country with a centralized economy and a state insurer. When the market was liberalized, the agency was converted into an insurer owned and controlled by the affinity organizations. The company lasted barely five years.

**Company 2** was set up as the first mutual society after a 50-year break in a country in transition where the insurance industry, until the Second World War, had followed the mutuality tradition. A principal sponsor is a farmers' organization. A persistent challenge has been competition from stock companies selling products at lower prices, particularly to farmers. The company is still struggling to survive – with a perpetual shortage of capital.

Established in the mid-seventies, **Company 3** provided protection to middle- and low-income earners. Group life insurance showed early promise, but the company got into individual life insurance which is a significantly different product. The company mistakenly thought it needed a vast network of branches spread across the country in order to distribute the product. It died a long, slow death in the 1990s.

**Company 4** is owned by a large number of savings and credit cooperatives and their national federation. Together they have controlled – and run – this insurer for a dozen years. Managers have come and gone through a revolving door rotated by the board of directors, whose ambitious forays into unfamiliar lines of business have not failed to oblige – with stunning losses.

*Source: Adapted from ICMIF, 2005.*

<sup>5</sup> The term affinity organization or group refers to an association organized according to cooperative or democratic principles, such as farmers' associations, savings and credit unions, housing cooperatives, trade unions and the like.

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## 2 Capital requirements

Microinsurance programmes should aim to accumulate capital to deal with the risks discussed above. Since microinsurers generally start out with insufficient capital, the pricing actuary should initially increase the risk and uncertainty loadings described in Chapter 3.5. These loadings can be used to build up surplus and contingency reserves over time. Interest rate margins should be used to reduce the assumed and expected rates of return in pricing longer-term products – the margins can be used to at least partially fund asset default and mismatch risks. The premium rates should also include a small loading for catastrophe reinsurance, as discussed below.

Mathematical ruin theory can be used by actuaries to describe the capital needed for long-term solvency. In practice, modelling techniques are superior and can be easily customized for testing the long-term capital requirements of specific microinsurance programmes.

There is also the possibility of having too much capital. Although one could always create scenarios that consume all the accumulated capital, the question of scenario plausibility then arises. Commercial insurers in Canada are required to test their capital adequacy annually under all scenarios that the insurer is exposed to where there is at least 1 per cent probability of the scenario being realized.<sup>6</sup> Life insurers are required to test their capital adequacy using five-year scenarios and non-life insurers use two-year scenarios.

MUSCCO and CARD MBA have accumulated significant capital due to very good current operating results. For MUSCCO, there is a possibility of higher future claims due to HIV/AIDS and the organization no longer has reinsurance, so capital accumulation is certainly justified. CARD MBA, on the other hand, has possibly accumulated too much capital over the years. Microinsurers such as CARD MBA may have to consider reducing premium rates (or increase benefits) and determine a strategy to pay out excess capital equitably to clients and members.

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## 3 Reserves

The most general technical definition of a reserve is the actuarial present value of future liabilities less the actuarial present value of future premiums. In practice, there are many different kinds of reserves on the books of insurers, generated by the features of their various insurance products and by the nature of their operations.

<sup>6</sup> Assigning probability to a scenario involves professional judgment on the part of the Chief Actuary of the insurer.

Like other insurers, most microinsurance programmes maintain reserves to ensure that they can pay their obligations when claims are submitted. To get a true picture of the financial condition of a programme, the reserves must be calculated using actuarially acceptable methods. They must then be reflected in the financial statements; the reserve levels are reflected as a liability in the balance sheet, while increases and decreases in reserve levels should be treated as an expense in the income statement.

Insurers often use proxy and simplified methods to estimate the true actuarial reserves, although regulators may prescribe the methodology and the limits of the assumptions that may be used. For example, the regulator may specify a mortality table and interest rate assumption to be used in the valuation of whole life products in the insurer's annual report.

One of the most common microinsurance products is credit life. In the case of credit life, the future premium payable is usually zero because a single premium is collected by the microinsurer at the time the loan is issued. If the premium is collected up front, the accepted practice for reserve calculation is as follows:

*Actuarial Reserves =*

Gross Unearned Premium Reserve (GUPR) + Incurred but not Reported Claims (IBNR) + Claims in Course of Settlement (CICS) + Provision for Adverse Deviation (PAD)

A good practice for microinsurers is to calculate GUPR on a loan-to-loan basis at each reporting period. This applies to the other reserve components as well. PAD is usually determined at the discretion of the actuary. The method of calculating these values is beyond the scope of this chapter.

As mentioned above, to get a true picture of the financial condition, reserves must be calculated accurately and this is best achieved by a good actuarial system accessing a clean and current database. Software tools for calculating reserves should be programmed by an actuary. If a product has guarantees beyond one year, the reserves should be calculated directly by the actuary.

Calculating the reserves is only the first step. The microinsurer must make sure that the reserves are fully funded at all times and that the investments backing the reserves are properly managed.

## Reinsurance

Reinsurance is a risk-management tool that should be used by the microinsurer if possible. It is generally used to stabilize the financial condition of the insurer. Chapter 5.4 deals with this subject in greater detail, but a brief discussion is warranted here since reinsurance is an important aspect of financial management.

In commercial markets, reinsurance is used to meet regulatory capital requirements or even as a source of capital for companies with limited means. Sometimes, insurers buy reinsurance in order to receive professional advice from reinsurers.

**Reinsurance is not a magic wand you can wave to turn a losing proposition into a viable entity.** The a priori condition for reinsurance to add value to the business results is that the insurer has a viable product or one that can be made viable if appropriate measures are taken. This requires the maintenance of appropriate records of the insured, claims management, financial reporting and an appropriately articulated business plan.

There are several types of risks faced by an insurer which can be managed through reinsurance. **Catastrophe risk** is a rare and asymptomatic risk such as an earthquake or tsunami, which particularly affects asset security and life insurance portfolios. Similarly, a major epidemic such as the widely expected avian flu could affect health insurers. A portfolio that is too geographically concentrated is much more susceptible to the financial impact of a catastrophe.

There is no single and universal definition of the dimension of damages that constitute a “catastrophe”; the term has a different meaning for climate extremes than for health impacts or wild fires. In some cases the catastrophe is measured in relation to the size of the portfolio, while in others it may be expressed relative to household annual income. Generally, a single catastrophic event could impair the financial condition of the insurer due to the unusual number of claims.

Catastrophe coverage is available to most commercial insurers – the premium is usually very small in relation to the cover due to the very small probability of occurrence. Reinsurers can take on this risk because they spread the risk across the globe by, in turn, reinsuring with other reinsurers. The international nature of reinsurance enables risks to be spread across national boundaries.

**Claims severity risk** refers to a disproportionate risk within a pool of homogenous smaller risks. A credit life programme covering 20,000 loans of US\$500 and one loan for US\$10,000 is a very clear, simple example. In this case, the insurer should only retain a small portion of the single large risk, say

US\$500 of the US\$10,000, and cede the remaining US\$9,500 to a reinsurer because a claim from that particular borrower would severely impact or even wipe out the entire surplus of the programme. Such a reinsurance cover is termed surplus or individual excess-of-loss reinsurance.

Aggregate claims are affected by **claims incidence risk**, which is a fluctuation around the mean of the claims distribution, i.e. the expected number of claims. In practical terms, the actual value of claims is greater than the expected value factored into the rates. A microinsurer can manage this type of risk through quota share and/or aggregate stop-loss reinsurance.

For pension or disability plans, **duration of claim** or the probability of someone collecting a pension or disability benefit longer than expected is a risk that impairs the financial results. Individual excess-of-loss cover could be used to manage this risk if it is available.

Reinsurance is also used to even out **irregular claims patterns**. Over a certain period of time, such as a year, an insurance company may be able to pay all its claims. However, these claims may not be spread evenly during the year and may instead come in irregular patterns such as a flurry of claims or a large claim in a particular month. Reinsurance allows the reinsured to smooth out its claims obligations and to reduce the uncertainties of irregular claims. Reinsurance also enables insurers to limit year-to-year fluctuations. Essentially, the reinsured borrows from the reinsurer in bad years and pays back when its loss experience is good.

For some microinsurers there is little need for surplus or quota share reinsurance. A specific example of this is when a microinsurer covers a “large” number of “homogeneous risk” clients with a simple term life product that has identical “low” coverage for all. In this case, the number of claims is likely to remain stable from one period to the next since the number of clients is large – in other words, the variance for claims incidence is small due to the Law of Large Numbers. The actual number of claims should be close to the expected number of claims if the pricing has been done properly. Since the insured amounts are assumed to be identical for all participants there is no claims severity risk (i.e. zero variance in benefit payout when a claim does happen).

Other microinsurers, however, do need surplus or quota share reinsurance because they cover a relatively “small” number of lives (hence they have a larger variance in incidence than for a larger risk pool) or because they have little or no capital. Reinsurance would also be necessary if a few individuals represent a significant portion of the total sum insured. Some actuaries use the rule of thumb that individual risk retention should not exceed 0.5 per cent of the microinsurer’s capital and surplus. So, for example, for a microinsurer with US\$100,000 capital and US\$20,000 surplus, the



maximum retention should be 0.5 per cent of US\$120,000 or US\$600 – the remaining risk should be reinsured. This formula is too simplistic because it does not take into account the number of risks covered, but it provides an initial indication.

It is very prudent for microinsurers to take out catastrophe reinsurance if it is affordable and available. However, one of the major hurdles is reinsurers' reluctance to provide reinsurance to microinsurance schemes because they do not understand the microinsurance market. In addition, many microinsurers are not legally registered and the reinsurer is restricted to doing business only with licensed insurers.

The case study on AIG Uganda illustrates the limited relevance of reinsurance for some microinsurance products. For this commercial carrier, the decision not to reinsure is logical as the sums insured are small and spread over 1.6 million people living in a large geographical area. Perhaps catastrophe cover would be a suitable risk-management strategy for this pool.

MUSCCO in Malawi, however, could not buy reinsurance even if it wanted to because it is not a registered insurer. Furthermore, although it does not appear vulnerable to an imminent and sudden risk of increased mortality rates, it has built up a large fund to cover future claims increases that could also cover claims fluctuations. As with AIG, however, catastrophe reinsurance would be advisable if it were available.

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## 5 Investment management

As mentioned above, the objective of a good investment programme is to optimize the value of the investment earnings while maintaining appropriate liquidity and asset security to meet obligations as they arise. This is achieved by diversifying by asset type, with a cap on any one investment. Many organizations define their vision of a sound investment policy by outlining the objectives, responsibilities of managers, monitoring reports, categories and permitted asset types.

A tendency and common mistake made by developing insurers is to overinvest in property, often for reasons of prestige or in the (speculative) hope that its value will rise and produce a large capital gain. As a general rule, property should not exceed 10 per cent of invested assets, especially since it is very illiquid.

A critically important function for any insurer exposed to longer-term liabilities, such as endowments and pensions, is matching anticipated positive cash flow generated by assets (such as anticipated maturities, interest earnings and dividends) to expected negative cash flow arising from liabilities (largely expected benefits to be paid). This is known as **asset-liability**

**matching.**<sup>7</sup> The objective is to ensure that the pattern and magnitude of positive cash flow closely matches that of the negative cash flow. This must be constantly monitored and in practice requires a projection of the liability stream consisting of expected claims and expenses (for example), which is then compared to the expected inflow stream made up of scheduled interest payments and asset maturities (for example) arising from the asset portfolio. The ideal is to have an exact or near match of the two streams so that they compensate each other. If the streams are significantly mismatched, the insurer will experience cash flow problems in the future.

To correct a mismatched situation requires a reshuffling of assets, but this creates a new risk: finding an asset with equal or better returns and with similar quality. If an asset is traded for another asset, the investment yields assumed in the pricing must be retained.

Another risk related to longer-term products is the **reinvestment risk**. This arises when the insurer takes on a long-term liability or a fixed guarantee, but does not have assets with the required returns and equal durations to cover the guarantee.

For example, suppose a microinsurer promises a fixed endowment 20 years in the future and the actuary has assumed a 6 per cent interest rate over the entire 20-year period to determine the premium rate. If the microinsurer is limited, for example, to investing in five-year term deposits currently yielding marginally higher than 6 per cent, it faces a very significant pricing and reinvestment risk because of the uncertainty in reinvestment interest rates as the five-year term deposits mature. If five-year term deposit yields drop below 6 per cent in later years, the microinsurer could be wiped out, depending on the size of that portfolio and on the degree of mismatch. Even a few basis points can be devastating due to the effect of compounding interest. **The only sure way to manage this risk is to match interest rate guarantees (both interest amount and duration of the guarantee) with the available assets at the time that the guarantee is made.**

Recently, the Provident Fund of CARD MBA was prone to this risk because it had promised an 8 per cent return over 20 years to members on their Php 5 per week savings deposits. This guarantee was not covered appropriately because the organization was limited to short-term investments or investments in related organizations.

<sup>7</sup> Increasingly, computer models are used to devise portfolios of assets most appropriate to anticipated payout needs. This enables a series of “what if” scenarios to be produced, contrasting the implications for various asset mixes and assumptions.

CARD's loan portfolio yielded a net rate of approximately 8 per cent in late 2003, after deducting 20 per cent investment tax and expenses. However, the risk was reduced because members dropping out of the scheme before three years of continuous membership forfeited their savings – the forfeited savings increased portfolio yield and this covered some of the mismatch risk. The danger was that the organization was not measuring the net degree of risk that it faced at the time (and will continue to face until the policies mature). The organization has since remedied this risk and is now advising members that interest credited will depend on the actual net investment yields.

Table 28 illustrates the potential effect when actual net yields are below 8 per cent. The illustration assumes that 100,000 members deposit Php 5 per week for 1,044 weeks (20 years) and then claim their deposits at the guaranteed 8 per cent per annum. The calculation also assumes that the forfeited savings of early drop-outs have been factored into the 20-year net yields.

Table 28 Potential effect of investment mismatch on CARD's Provident Fund – An illustration

Actual 20-year net yield (%)	Cumulative actual value (Php)	Cumulative actual payout (Php) at 8%	Cumulative shortfall (Php)	Cumulative shortfall (US\$)
8.00	1 241 123 685	1 241 123 685	0	0
7.90	1 226 889 442	1 241 123 685	(14 234 243)	(258 804)
7.80	1 212 836 564	1 241 123 685	(28 287 120)	(514 311)
7.70	1 198 962 701	1 241 123 685	(42 160 984)	(766 563)
7.60	1 185 265 529	1 241 123 685	(55 858 156)	(1 015 603)
7.50	1 171 742 756	1 241 123 685	(69 380 929)	(1 261 471)
7.40	1 158 392 119	1 241 123 685	(82 731 566)	(1 504 210)
7.30	1 145 211 384	1 241 123 685	(95 912 301)	(1 743 860)
7.20	1 132 198 345	1 241 123 685	(108 925 339)	(1 980 461)
7.10	1 119 350 826	1 241 123 685	(121 772 859)	(2 214 052)
7.00	1 106 666 676	1 241 123 685	(134 457 009)	(2 444 673)

Note: Php 55 = US\$1

## 6 Profit distribution

Most microinsurance programmes today are still too new to start distributing profits; in fact, many are still struggling to become viable. Others such as CARD MBA are not permitted to pay out dividends due to the legal restrictions of a mutual benefit association, even though they are in a financial position to pay back some of the accumulated profits over the years.

Before profits are distributed, a target should be set to maintain a certain level of contingency reserves. The level of this contingency or surplus should be based on the risk the insurer faces. For example, in health insurance, many organizations such as AssEF aim for six to nine months premiums as a contingency reserve.<sup>8</sup> For credit insurance, the level of contingency reserves may be calculated using risk-based capital measures, i.e. a capital measure that links risk and capital adequacy, as practised by commercial insurance companies.

Some organizations have bylaws or are subject to legal requirements that determine profit distribution based on a prescribed formula. For example:

- La Equidad in Colombia complies with the cooperative law and allocates 20 per cent of profits to education, 10 per cent to its solidarity fund, 20 per cent to members' reserves, and 50 per cent to members' dividends based on premiums paid and claims paid.
- Spandana in India uses its profits to fund scholarships for its members' children.
- Yasiru in Sri Lanka distributes 40 per cent of its profits to members with at least five years of membership, 10 per cent to a welfare fund, and 50 per cent to a contingency fund.
- UMSFG in Guinea is building up reserves to a level of 75 per cent of prior year claims. Once this is attained, it plans to use surpluses to fund a health promotion campaign and improve health facilities.
- MUSCCO is considering profit distribution to SACCOs with good performance or claims experience. However, it will only be paid when a SACCO pays its premiums on time – one third of the SACCOs are behind with their premium payments.
- By law, 90 per cent of Delta Life's profits must be returned to its endowment policyholders and the remaining 10 per cent may be paid to shareholders. Microinsurance is no exception.

In the partner-agent model, the agent usually works on a commission basis, and the insurer's shareholders benefit from the company's overall performance. However, there is another way to structure the relationship. For example, the distribution channel could negotiate a surplus share with the insurer, as Pulse has done with Madison Insurance in Zambia. In this case, after paying claims, Madison deducts 30 per cent of the premiums for its expenses, and then shares the balance 50-50 with the microfinance institution. This approach seems to be more in line with the spirit of microinsurance

<sup>8</sup> Other microinsurers target a contingency reserve based on the claims paid in the past 1,2,3,... x months.

since at least a portion of the surplus comes back to the community. It is also better risk-management practice for the insurer, since it gives the agent a financial incentive to produce a quality risk portfolio and not to be indifferent to adverse selection or fraud.

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## 7

### Conclusion

The main messages in this chapter are as follows:

- Sound financial management is one of the most important requirements for long-term success in the insurance business.
- Insurance is the business of risk management. The quantification of these risks, which should be done by an actuary, is the basis for determining the amount of reserves and capital required to sustain the scheme.
- For marketing purposes it makes sense to charge the same price for each client, at least for small policies; the applicable rate should be derived from the weighted average mortality or morbidity rates to take into consideration the actual age-sex demographic profile of the group.
- The objective of good investment management is to achieve a balance between risk and return, matching anticipated inflows from investments to expected outflows, while maintaining appropriate liquidity to meet obligations as they arise.
- Long-term products are vulnerable to reinvestment risk. To manage this risk, it is necessary to match interest rate guarantees (both in amount and duration) with the available assets at the time that the guarantee is made.
- Microinsurers should have investment policies and controls to ensure that the policies are implemented.
- Reinsurance cannot take a losing proposition and turn it into a viable entity. It is particularly appropriate for small risk pools and those with heterogeneous risks and irregular claims patterns; it is also extremely relevant for all microinsurance schemes, big and small, to cover catastrophe risk.
- Microinsurance programmes should aim to accumulate capital to manage risks, and only distribute profits or surplus once an actuary determines that the scheme has sufficient reserves.

Craig Churchill and Richard Leftley

*The authors appreciate the feedback and suggestions from Toon Bullens (Interpolis), D'Arcy Delamere (CUMIS) and Zahid Qureshi (consultant).*

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Organization development is a planned effort to increase an organization's effectiveness by intervening in the operational processes. The organization development field, which emerged in the first half of the 20th century, has since evolved to sharpen its focus on change to emphasize the notion of a learning organization.

Warner Burke (1992) stresses that organization development is not just anything done to improve an organization, but a change process designed to bring about an intentional end result, requiring organizational reflection, system improvement, planning and self-analysis. Leadership theorist Warren Bennis (1993) describes organization development as a complex strategy to change the beliefs, attitudes, values and structure of organizations so that they can better adapt to new technologies, markets and challenges.

Indeed, such changes are required, in both insurers and delivery channels, if they wish to offer insurance to the poor effectively.

A basic measure of an organization's success is the extent to which it meets the changing needs of its clients and stakeholders. Service industries depend on the effectiveness of frontline staff who interact with, and are expected to provide value to, the customer. This is particularly true of insurance which, as an intangible service, is often not well regarded and understood. Microinsurance has an added complexity because there may be different levels of customers, such as the holder of a group policy and the end-users. Moreover, since the risk-carrier and the distributor can be different organizations, the insurer may have little or no control over the staff who interact with persons covered by a group policy.

The lack of control over frontline staff, coupled with a reluctant and uninformed market, necessitates some creativity in deploying, training and rewarding staff for delivering microinsurance. This chapter considers five aspects of organization development: 1) organizational structure, 2) recruitment, 3) training, 4) compensation and 5) institutional culture.

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## I Organizational structure: Where does microinsurance fit in?

Microinsurance is often just a small piece of a larger organization's business activities. In an insurance company, it may be a product line or even just a few policies. For organizations involved in distribution, such as microfinance institutions, microinsurance tends to be treated as an additional financial product, but one that has less importance than the organization's core savings and credit services.

The only exception to this general characterization is the community-based model (*Chapter 4.3*), the sole purpose of which is to provide microinsurance to a defined group. Perhaps if the market had more organizations that were only or primarily focused on providing microinsurance, greater energy and attention would have been harnessed for structural innovation.

For organizations that are only marginally involved in microinsurance, there are still some simple and clear lessons about how it can be structured within a larger organization – both the distribution channel and the insurance company – to achieve the best results.

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### I.1 Distribution channels

When considering the structure of microinsurance in a distribution channel such as an MFI, it is necessary to consider how it fits into both the front and back office structures.

#### *Head office*

To ensure that sufficient attention is given to microinsurance, distribution channels should have designated staff members or even a small department at head office to enable them to focus on insurance. Obviously, this will depend on the size of the organization and the functions that the distribution channel has assumed from the insurer. For example, if it is involved in claims processing, it will require more personnel. In general, however, when microinsurance is just a piece of someone else's job, it too often has a low priority.

In a distribution channel, a microinsurance department acts as a first line of response to queries from field staff and clients. It consolidates all premiums from the branches and arranges monthly payments to insurers. It acts as a filter for claims, by ensuring that they are valid and that the documentation is in order as claims pass through from the field to the insurance company. To simplify the administration, often the microinsurance department will hold insurance application forms and only submit them to the insurance company if there is a claim. The department also performs a vital record-keeping function and might therefore require a bookkeeper. In addition, the department

may need training specialists to provide field staff and clients with sufficient information and expertise.

At ASA in India, for example, of the 350 people that work for the MFI, seven work exclusively on its microinsurance activities. ASA needs this level of commitment because the MFI assumes responsibility for claims management. If a delivery agent anticipates trying to create a formal brokerage or even an insurance company in the future, then it would be wise to assume a greater role in the delivery of insurance, especially claims processing.

Besides having a dedicated microinsurance department, it is also essential to have a champion within the senior management team and on the board. While these persons are not involved in the day-to-day insurance operations, they can represent and promote the product in management and governance circles, giving insurance a voice at a strategic level in the organization. These champions should receive regular updates from the department handling the business.

### *Field structure*

As for field operations, there are two main ways to structure responsibilities when insurance is not the organization's core business. The more common approach is to integrate insurance into the activities of the frontline staff, such as tellers and loan officers. When they are opening up savings accounts or marketing credit products, they could also encourage clients to buy insurance.

However, if the frontline operations become sufficiently large, the recruitment of an insurance specialist at the branch level may be justified. For example, when insurance operations in credit unions collaborating with TUW SKOK (Poland) and La Equidad (Colombia) generate a certain number of policies per year, they employ a credit union staff member to work exclusively on insurance. This person is trained to handle the more complicated questions and solve problems that typical frontline staff cannot handle. This arrangement tends to have a compounding effect on sales; premiums in credit unions with insurance specialists tend to grow faster than in those without specialists.

The choice between generalists and specialists in the field is not just a matter of scale. TSKI in the Philippines has over 150,000 borrowers, but it relies only on its loan officers to sell insurance. The other factor involved is the product type. If insurance is integrated into the distribution channel's other services, such as savings and credit, and is never offered on its own, the organization may not need an insurance specialist in the field.



Specialists are also appropriate if the insurance product is complex. For example, VimoSEWA (India), which offers a basket policy covering death, hospitalization and property loss, switched from general SEWA organizers to specialized staff to manage its annual mobilization campaign. These *Vimo Aagewans* are community leaders who are taught how to sell and service the insurance product. By specializing in insurance, *Vimo Aagewans* are expected to be more effective than generalists. Given the increase in volumes, higher retention rates and significant improvements in after-sales service in recent years, it appears that this switch is beginning to pay off despite the resultant higher distribution costs, although the data is not yet available to reach conclusions on whether this is an appropriate strategy.

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## 1.2 Insurers

Insurance companies serving the low-income market might also want to consider creating a special unit concentrating on microinsurance. This focused effort will enable them to get a better understanding of the micro market and find creative ways to respond. This was not the arrangement at AIG Uganda, where no one had an overview of the insurer's relationships with MFIs, and there was no information about the contribution of the microinsurance policies to the company's profits. Consequently, there was little investment in the microinsurance product, hardly any innovation over six years, and a lack of training provided to the MFIs' employees.

In contrast, Tata-AIG created a special department for the Rural and Social Sector, with a budget and flexibility to act creatively, and a mandate from senior management. Perhaps the result of the unique regulation in India mandating entry into the low-income market, this arrangement allowed the insurer to experiment with products and delivery channels that may be more appropriate for the low-income market than the accidental death and disability cover provided by its sister organization in Uganda.

According to ICMIF (2005), the expansion strategies of Company 3 in the case study also illustrate the pitfalls of an inappropriate organizational structure (*see Box 51*). Serving middle- and low-income earners, its group life insurance showed early promise, but the company got into individual life insurance which is a significantly different product line. To deliver individual products, Company 3 created an organizational structure that it ultimately could not support.

Box 51

## Organization development: How not to do it

**Company 1** operates in a transition country with an annual net premium income of US\$3.5 million, 27 staff members and no service centres other than its head office. In the same country, **Company 2** has a net premium income of US\$5.8 million, 210 full-time employees plus 85 part-timers, and 23 regional offices with 32 sub-offices “for sales and loss adjusting”. **Company 3**, in a developing country, had (the past tense is no mistake) a net premium income of US\$2.8 million, a full-time staff of 705 plus 1,825 part-timers, and 58 service offices all over the country.

Even making allowances for the difference in products, market segments and geography, it is not hard to tell which insurer can look ahead to a stable future and which is likely to continue struggling, and why the third bit the dust. A basic, albeit rough, measure of productivity says it all: premium per employee. It is US\$129,629 for one and US\$19,661 for the other, and it was a mere US\$1,106 for the third. The one with the highest number of employees also, understandably, had the crippling overhead burden of the highest number of service outlets.

Company 3, the one with huge overheads that died before reaching maturity, wanted to be close to its customers spread across the country. So it put all the required functions – underwriting, claims settlement, premium collection and marketing – in each of its 58 service offices, without distinguishing between frontline and support services. Good for creating jobs, but temporary ones at best.

*Source: Adapted from ICMIF, 2005.*

## 2 Recruitment: Where to access appropriate expertise

### 2.1 Field staff

The screening and selection of frontline staff involved in distributing insurance usually depends on the criteria for their main responsibilities, such as granting loans. Rarely does the fact that they will also be involved in selling insurance affect the decision to employ them. However, the characteristics required to sell credit are somewhat different from selling insurance. When someone gets a loan, it is much more tangible – cash in hand – than the peace of mind and security associated with insurance.

As a result, the demand for loans is generally much higher than for insurance, so loan officers do not have to have the sales expertise that insurance requires. In addition, the poor understand credit better than insurance,

so there is less of a need to explain how it works. This requirement for client education calls for a different skill set from that which a typical loan officer may have.

If an organization is interested in recruiting people just to provide insurance, it might be useful to consider the selection criteria established by Tata-AIG for its micro-agents, who focus exclusively on insurance sales (see Box 52). Tata-AIG also involves non-governmental organizations (NGOs) in the process of identifying micro-agent candidates since locally they are often in a good position to assess the extent to which individuals are respected in their communities (see Chapter 4.5).

Box 52

### Criteria in the selection of micro-agents at Tata-AIG

The criteria for the selection of a leader of a community rural insurance group (CRIG) include:

1. Must be a resident of the community in which she will sell and service policies.
2. Should preferably have passed the 12th school year or at least the 10th – this is to ensure that she is eligible to be licensed (an IRDA requirement).
3. Married: since microinsurance is a long-term commitment to policyholders, an unmarried CRIG leader may migrate to her (future) husband's village, leaving the CRIG and the policyholders in the lurch.
4. Ability to write English: since underwriting at head office is in English, it is imperative that the proposal forms are completed in English.
5. Good track record of integrity: handling money is an integral part of her duty as a leader.
6. Effective leadership qualities: she has to manage a group of four other women.
7. Public speaking ability: she will be required to address gatherings to promote the products.
8. Training skills: since she is the only one trained in insurance, she has to train the other four.
9. Must have a positive influence among the target market: each leader should be admired for her integrity and have a forward-looking and progressive nature, and must be able to use her influence to enable her CRIG members to achieve their targets.
10. Preferably, she should have some previous work experience in the social sector.

Source: Adapted from Roth and Athreya, 2005.

The agents for CARD MBA in the Philippines, called coordinators, are elected by the membership rather than being recruited by the institution (*see Box 53*). Similarly, the selection of frontline staff in the community-based model has the advantage of involving members directly in deciding who will manage the scheme. If this decision-making process is facilitated properly, members usually select someone they trust who has sufficient aptitude to learn the administrative responsibilities.

Where frontline staff do specialize in insurance, it may be useful to consider giving them more specialized responsibilities. For example, ServiPerú has some agents that focus on sales, and others that collect premiums and process claims. This separation of responsibilities is justified given the very different skills required for these functions.

*Box 53*

### **Frontline staff at CARD MBA**

Frontline staff or coordinators at CARD MBA are members of the scheme, elected by their peers to fulfil a customer service function. Their activities include claims verification and payment, educating current and potential clients and addressing questions from CARD's staff or clients. They also work with branch managers to ensure timely collection and transfer of premiums as well as document compliance.

According to the MBA's immediate past president and former coordinator Pilar Garcia, a coordinator's tasks are delegated to trusted members with good standing at CARD. Coordinators commit to working at least one day per week on MBA business, although the responsibilities often demand more time. The work involves irregular hours, as claims verification must be done immediately to ensure that settlements are processed in three days.

People are selected to be coordinators for a one-year term. Although this short period requires a lot of training, the term limit reduces fraud since it does not allow coordinators time to get too clever. Perhaps more importantly, by involving many members in the insurance operations, it generates more knowledgeable policyholders, improving their effectiveness in MBA governance.

New coordinators undergo a day's training at the March annual membership convention; in the period between their election (in December or January) and the training, they perform their duties in cooperation with, and under the supervision of, the outgoing MBA coordinator for their region. The bulk of the training occurs on the job, which is possible because the business processes and products in the MBA are simplified.

*Source: Adapted from McCord and Buczkowski, 2004.*

## 2.2 Back-office staff

As for management and back-office staff, given that microinsurance is a new field, insurers and their distribution channels are unlikely to find too many existing microinsurance specialists. So organizations can act in one of two ways: either they can recruit intelligent people with development experience and teach them about insurance or they can employ insurance specialists and help them understand the low-income market.

Delta Life (Bangladesh) and Tata-AIG both took the first approach, staffing their initial microinsurance operations with social-sector specialists since the organizations already had insurance expertise. In both cases, the organizations realized that they needed new thinking to overcome the obstacles to extending insurance to the poor, which was not likely to come from traditional insurers. CARD MBA, on the other hand, needed to hire insurance expertise to solve the problems that were created when microfinance specialists were running the insurance operations. SEWA essentially adopted both approaches, handing the reins of VimoSEWA to a long-time SEWA manager, but recruiting someone from the insurance industry as Chief Operating Officer.

Of course, microinsurers do not have to have all of the expertise in-house as long as they can access it. In fact, many conventional insurance companies do not have in-house actuaries, but rely on actuarial consultants. TUV SKOK, for example, used an actuarial consultant for years. When it was granted a licence to start a life insurance company along with its general insurance company, the organization felt that it had sufficient need for actuarial services to employ an actuary; yet at the same time, it decided to outsource its investment management since life insurance investments required greater expertise than it had in-house (*see Box 54*).

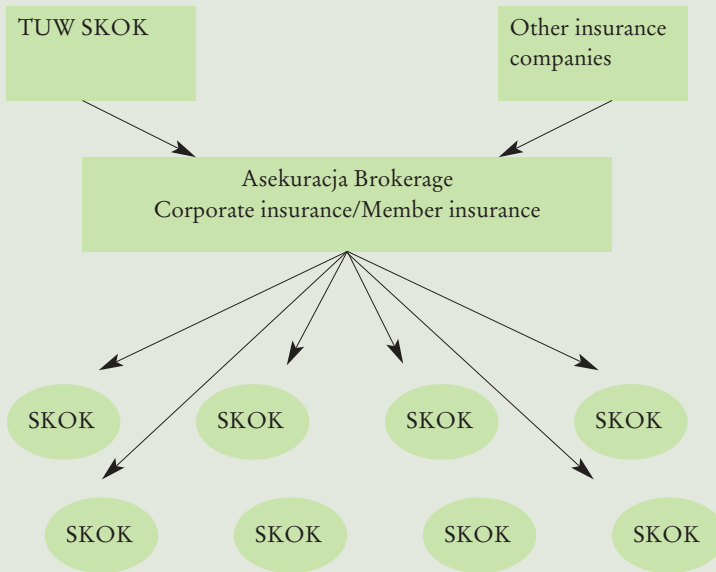
It may not be possible or cost-effective for each microinsurance provider to retain full-time experts. However, identifying suitable sources of expertise in the areas of product design, client-needs analysis, processes mapping, product costing, distribution, reinsurance and actuarial support would be prudent prior to launching a new microinsurance venture.

*Box 54*

### **TUV SKOK's outsourcing model**

TUV SKOK's structure is largely organized around an outsourcing model. The central agency in this model is Asekuracja, a brokerage company owned by TUV SKOK, the National Association of Credit Unions (NACSCU) and the Foundation for Polish Credit Unions. The brokerage serves as the link between the credit unions (SKOKs) and insurance companies, including but not limited to TUV SKOK. Where possible, the insurance provided by

the brokerage to credit unions comes from TUW SKOK, but as the insurer is not licensed to offer all types of insurance, the brokerage will go to the open market if TUW SKOK does not offer the required product and issue a tender for services to several insurance companies.



This arrangement allows the SKOKs to offer products, such as car insurance, for which TUW SKOK is not licensed. Besides the relationship with the brokerage, TUW SKOK outsources other key activities:

- *Market research*: TUW SKOK undertakes modest market research activities in-house, but it outsources larger studies to a market research firm.
- *Actuarial services*: When it was a relatively small insurer, TUW SKOK contracted an actuarial consultant for a few days a month. With the recent purchase of the life insurance company, the business has grown to a sufficient size to justify recruiting an in-house actuary.
- *Software development*: TUW SKOK is part-owner of the software firm that develops the MIS for the credit unions. H&S Software, housed in the same building as TUW SKOK, NACSCU and the Foundation, also develops some of the software used by the insurance company.
- *Sales*: Besides the corporate sales outsourced to the brokerage firm, TUW SKOK (via Asekuracja) outsources the retail sales activities to credit unions and their staff.

- *Claims adjusting*: For its property insurance policies, TUW SKOK relies on independent claims adjusters to assess and document the damage. For disability products, the insurer also has a list of medical doctors whom it trusts to determine the degree of disability.

Source: Adapted from Churchill and Pepler, 2004.

### 3

## Training

Since organizations are unlikely to be able to recruit people with microinsurance experience, they need to compensate by making significant investments in staff training. However, this is not borne out by experience in the field thus far. The case studies show that staff training remains one of the greatest areas for improvement.

One of the main causes of the problem is the prevalence of mandatory products. Where insurance is compulsory, training is largely overlooked or limited to basic product issues. This experience was most clearly seen when FINCA and AIG Uganda switched from voluntary to mandatory insurance, and soon after neither staff nor clients had a particularly good idea of the costs, benefits or claims procedures (McCord et al., 2000).

Even when the product is voluntary, many microinsurance providers admit that the training of frontline staff is one of their most significant challenges. At Delta Life, for example, microinsurance salespersons learn on the job, without any formal training. TUW SKOK, Columna (Guatemala) and La Equidad all try to train the credit union staff, but high turnover undermines their efforts. To overcome this problem, TUW SKOK has set up regional offices that are primarily responsible for providing training, usually in the evenings or weekends when credit union staff are not busy with their primary responsibilities.

VimoSEWA is taking the training challenge seriously. With the assistance of an outside expert, it has developed training plans for each staff member. The process was to document existing skills and those which were lacking, and then prioritize the needs of each individual. The *Vimo Aagewans* had particular emphasis placed on product knowledge, claims processing and sales skills.

In general, training for frontline personnel should include:

- basics of insurance, providing staff with the ability to answer difficult questions;
- specifics of the products' policies and procedures;

- details of the pilot test results (for new products);
- familiarity with the operations manual;
- strategies for adult education, including how to use educational tools;
- demonstrations on how to use marketing materials, such as pamphlets and posters;
- role-play exercises enabling staff to make mistakes in the classroom rather than in front of clients;
- customer-service training and
- an examination to ensure that a level of understanding has been achieved and to identify those that require re-training.

It is important that insurance training is not limited to frontline personnel. For example, before launching a pilot test, Opportunity International provides loan officers, supervisors, branch accountants, branch managers, MIS operators and heads of department with a one-day course covering the basics of insurance, answers to frequently asked questions (FAQs) and specifics of how the new product will perform. Since microinsurance is a new field, international exposure for managers and directors is also advantageous as it enables them to share experiences with others involved in similar schemes.

Lastly, training is not a one-off phenomenon. Microinsurers should regularly upgrade staff skills with the intention of creating a career path that will enhance staff retention.

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#### 4 Compensation

The staff turnover problem identified above is largely associated with compensation. For microinsurance to be affordable for the low-income market, costs have to be low. Yet labour-intensive delivery systems that manage large volumes of small transactions can easily become expensive. Consequently, microinsurers try to keep staff costs as low as possible (*see Table 29*), which may result in high turnover and low productivity.



Table 29

## Average monthly earnings for frontline staff (US\$)\*

<i>Microinsurer (Country)</i>	<i>Agent's average monthly earnings</i>
Delta Life (Bangladesh)	16
UMSGF (Guinea)	7
VimoSEWA (India)	38
Tata-AIG (India)	15
CARD MBA (Philippines)	11

*\*Note: These agents often only work with insurance on a part-time basis.*

Indeed, one of the more interesting questions about microinsurance revolves around appropriate compensation mechanisms for field staff and agents. For voluntary insurance, how does an insurer reward sales to achieve greater outreach and impact without pushing insurance onto poor people? Delta Life recognized this problem and initially created a stepped salary structure based on monthly premiums (average for the previous quarter). Its incremental rather than linear incentive system was intended to reward good performers without creating a strong pressure to sell. Yet today, after a period of poor sales, Delta's management is experimenting with a commission-only approach used by the conventional insurance scheme to boost penetration.

As discussed in Chapter 3.2, there will always be a danger that remunerating people to sell voluntary insurance will cause them to sell products that people do not really need. However, the danger of not compensating field staff adequately is that they will either not sell the product, or they will minimize their efforts, leading to ill-informed or misled clients. The remuneration should motivate sales and provide customer service. To ensure that policies are not mis-sold, management should regularly interview clients as part of its market research or needs analysis programme to assess their understanding.

A related issue is who should receive the incentive – the delivery channel or field staff (or some combination)? Where insurance is mandatory, it does not make sense to reward individual agents, but the situation is different with voluntary products. For example, since TUW SKOK is not in a position to force credit unions or their staff to do anything, its primary means of influencing performance is through incentives. With different products, the insurer has tried different means of structuring commissions to reward credit unions and agents. Although there is not yet sufficient evidence to assess which combination of incentives is most effective, TUW SKOK is tilting the incentives more towards credit unions than individual agents to garner

greater management support for insurance sales.<sup>1</sup> In contrast, La Equidad is achieving greater market penetration when agents, and not just the credit union, receive a commission. Yasiru in Sri Lanka pays a commission of 25 per cent of the premiums, 10 per cent to the organization and 15 per cent to the field agent.

With long-term insurance products, commissions are often frontloaded. For example, ALMAO in Sri Lanka uses the official, regulator-approved commission structure for long-term insurance (*see Table 30*). With such an incentive structure, there is a danger that the retention rate for microinsurance will go down when the agent's commission is reduced. When the agent earns three to six times more to enrol a new client, it will be much more attractive to sign up new members instead of collecting premiums from the old ones.

Table 30

Commissions (% of premiums) on long-term policies at ALMAO and Tata-AIG

<i>Policy year</i>	<i>ALMAO</i>	<i>Tata-AIG</i>
1	30	26 to 30
2	20	5.5 to 6
3	15	5.5 to 6
4	10	4 to 5
5 to 10	5	4 to 5

Tata-AIG has a similar declining incentive structure.<sup>2</sup> Such commission structures may make sense when the work is frontloaded, which is the case when premiums are paid through electronic transfers in the banking system. With mainstream products, after year three, most clients in India pay premiums directly to the insurance companies, not via the agent. However, when agents are manually collecting premiums and the workload is therefore spread more evenly throughout the policy term, a more even distribution of commissions would also be appropriate. Consequently, Tata-AIG is trying to get the Indian regulator to agree a flat commission structure for its agents to reward ongoing service, not just sales.

In contrast, ServiPerú offers health and life insurance on a one-month, renewable basis. Salespersons earn a commission during the first three months of a policy at the following rates: 56 per cent in the first month, 28 per cent in the second month, and 42 per cent in the third month. The commission in the

<sup>1</sup> TUV SKOK has introduced additional commissions for achieving volume thresholds. When a credit union sells 1,000 policies, the brokerage firm pays it a bonus of US\$1,200.

<sup>2</sup> In addition, Tata-AIG pays a bonus of Rs. 10,000 (US\$222) to CRIGs that build a client base of 600 policies; there is no time limit for achieving this goal.

third month is higher than in the second month to create an incentive for agents to encourage clients to budget accordingly. After the third month, there are no further commission payments to the sales agent. This is possible because of the separation of responsibilities between sales and premium collection. Seventy per cent of the premiums are collected door-to-door, not by the sales agent, but by a premium collector.

In general, since the sums insured are very small, it is difficult for commission amounts to be large enough to influence agent behaviour. The commission of 10 to 20 per cent, which is the typical range, amounts to relatively little for microinsurance agents. Other techniques are therefore also required to motivate sales. For example, Tata-AIG organizes an annual conference and invites its most successful micro-agents. The insurer also has contests from time to time to enhance persistency and stimulate new business, such as the one depicted in Figure 19. To stimulate competition among its agents, TUW SKOK rewards the top 20 salespersons with a trip to Rome or Paris for two (thus also rewarding spouses or partners for their support and sacrifice).

In designing microinsurance compensation, it is useful to consider a **differentiated approach**. The salary structure at Grameen Kalyan is based on the distance of the work place from the capital city – the more remote the area, the higher the salary – encouraging people to work in rural areas. In contrast, VimoSEWA recruits its *Vimo Aagewans* to work near their residence and pays more to urban than rural promoters because of the higher cost of living. At ServiPerú, agents are classified into four categories depending on how long they have been with the organization and their sales record: New Executives, Junior Executives, Master Executives and Premium Executives. The basic monthly salary varies according to category; Premium Executives earn more than Master Executives, etc. Each category has a different minimum number of plans to sell each month: the higher the category the greater the target.

From ServiPerú's experience, setting customized targets for each salesperson is an appropriate way to control exaggerated enthusiasm for sales, achieving a manageable growth pattern. VimoSEWA plans to experiment with incentive compensation based on the renewal ratio, sales targets and the number of family packages sold. Indeed, incentives that reward client retention and persistence are likely to be more appropriate for microinsurance than incentives strongly linked to sales.

Figure 19 Kharif Hungama sales prizes

**Kharif  
HUNGAMA**

Scheme Period: 10th June to 10th September 2005

**Scheme for Specified Persons & Agents**

No. of Issued Policies		Prize		
From	To	Option 1	Option 2	Option 3
Upto 30		Umbrella 	Table Clock 	T shirt 
31	75	Foldable Travel Bag 	Calculator 	Beete Phone Instrument 
76	125	Wall Clock 	Stainless Steel Utensils 	Iron 
126	200	Melaware dinner set 	Gents SunGlasses 	2 Chargeable Battery Lights 
201	500	Gold Coin 	Radio 	Chargeable Battery cum Fan cum Radio 

Only issued policies with quarterly or semi annual or annual mode of payment will be considered during the scheme period.

• Qualification can be only in the categories as mentioned above • No cash will be given in lieu of prizes • All prizes will be given only on basis of Issued Policies  
 • Prizes that expire and are cancelled during the free-look period will not be considered • Queries with regard to qualification must be brought to the notice of the  
 Distribution Operations - HQ within 10 days from announcement of final qualification • Only this scheme is valid for the period mentioned above • Any other  
 programme launched for the period stands null and void • Tata AIG Life's decision will be final and binding • All rewards are indicative. Actual prizes will be subject to availability.

For details visit website or call 1800-102-1021

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## 5

## Institutional culture

Although microinsurance has to abide by the same basic principles as traditional insurance, it needs to do so with a keen appreciation for the unique characteristics of its target market, in particular the reluctance of low-income households to spend their very limited resources on something that lacks a tangible benefit. The culture of a microinsurer has to marry a social concern with an appreciation for the bottom line.

Any organization that strives to serve both the poor and mainstream markets will need to take positive action to ensure that its field staff are actively serving the poorer segments. Incentives based on sales volume will always reward those that sell larger-value policies, so staff will be tempted to sell fewer, larger policies rather than many small policies. One way to overcome this is to separate the sales forces, with different standards and reward systems for different market segments. The means of distribution will also differ, with poorer clients requiring more frequent field visits, and wealthier segments requiring fewer but longer contacts, typically in an office setting. Combining service for the poor with serving the not-so-poor will be difficult unless the board and management are fully committed to serving the low-income market.

This hybrid of insurance and social development was clearly recognized at Delta Life, which sought to create a distinct culture for its microinsurance activities. It completely separated the microinsurance and Ordinary Life staff, both in the field and in the head office, to create distinct working environments. A key reflection of the different cultures is evident in the responsibilities of field staff. Microinsurance field workers, known as “organizers”, manage the entire relationship with the policyholder, including premium collection, loans and loan repayments and claims, whereas Ordinary Life agents, working on a commission basis, fulfil primarily a sales function.

Other manifestations of a microinsurance culture include:

- **Relationship building:** Microinsurance requires field staff to focus more on building a relationship than making a sale. Delta and VimoSEWA have structured their activities so that agents are responsible for sales as well as service. This emphasis can be reinforced through retention-based incentives.
- **After-sales service:** VimoSEWA emphasizes after-sales service, ensuring that members know what is covered and receive any assistance they require in preparing claims documents. The higher costs of these activities are expected to be offset by enhanced customer retention.

- **Claims processing:** Many conventional insurers find ways to discourage policyholders from submitting smaller, so-called nuisance claims, by specifying exclusions, including deductibles, making claims documentation difficult, charging a claims service fee or imposing a graduated increase in premiums for the number of claims made. In microinsurance, providers have to enhance the market's trust of insurance by minimizing exclusions, making it easy to submit valid claims and even seeking out beneficiaries who may not have realized that they can claim.
- **Claims rejections:** Microinsurers need to minimize the likelihood of claims rejection. If VimoSEWA's insurance partners reject a claim that it feels should be paid, it assumes the liability for these extra-contractual claims. If claims have to be rejected, microinsurers need to find a way of communicating that result in a way that makes the decision acceptable to the claimant. For example, to lessen the impact of a rejected claim, VimoSEWA may send out head office staff members to explain the reasons for rejection to the members and to the community, while trying to strengthen trust and confidence in the scheme.

Perhaps this microinsurance culture is easier to create in a mutual insurance company or a community-based scheme than in a private, for-profit company. By definition, member-owned schemes are intended to maximize member benefits rather than shareholder profits, and are therefore more likely to go to greater lengths to provide appropriate microinsurance service. Plus, any profits that are generated are returned directly or indirectly to policyholders.

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## 6 Conclusions

For microinsurance to provide more people with better services over the long term, current and future risk carriers and delivery channels will need to consider their beliefs, attitudes, values and structure. Given the current dearth of good practices, there appears to be significant room for improvement in this area. The organization development of microinsurance is a high priority, and should take into consideration the following lessons:

- Microinsurance requires its own space in the organizational structure of both risk carriers and distribution channels to ensure that there are people who are committed to making it work better.
- Commitment from senior management and the board is instrumental to the success of microinsurance.

- Outsourcing can be an effective way of accessing (micro) insurance expertise.
- For both insurers and distribution channels, when introducing microinsurance, consider the implications it might have on existing job descriptions and recruitment criteria.
- A greater emphasis must be placed on staff training, particularly for field staff. One way of testing the effectiveness of the training is to independently assess the clients' knowledge of insurance and the products after interacting with the staff.
- Compensation and incentives that reward client retention are likely to be more appropriate for microinsurance than incentives strongly linked to sales.
- A microinsurance culture has to take into consideration the characteristics of its target market. It should strongly emphasize relationship-building and after-sales service, while ensuring the organization minimizes claims delays and rejections.

## 3.8

# Governance

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Zahid Qureshi

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Governance is the act of planning, influencing and monitoring, through policy, the affairs and direction of an entity. It involves systems and processes ensuring accountability and openness in the conduct of its business, whether the entity is a country, community, corporation or another organization. Governance involves the exercise of power and decision-making that reflects the interests of those who have a stake in the entity and those with whom the entity interacts or over whom it may exert influence.

At the organizational level, governance refers to the actions of its board of directors – the official group of persons, elected or nominated, who set and oversee the long-term direction of the organization. Like other enterprises, microinsurance schemes will not fully succeed without good governance. However, good governance for microinsurance providers is hard to come by, and it will be achieved in different ways depending on their ownership structure.

This chapter begins by introducing the concept of governance in general, and describing its unique characteristics in the context of microinsurance. It then covers the important issues of composition and expertise of the board. The bulk of the chapter describes five case studies that illustrate lessons for microinsurance governance.

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### I Governance in microinsurance

Is there anything singular or special about governance of an organization involved in microinsurance? The answer is yes and no. No, because corporate governance, like management, has core principles and objectives that would apply for a multinational corporation or a community-based organization (see Box 55).



Box 55

### What is corporate governance?

Corporate governance involves a set of relationships between a company's management, its board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined. Good corporate governance should provide proper incentives for the board and management to pursue objectives that are in the interests of the company and its shareholders and should facilitate effective monitoring. In addition, factors such as business ethics and corporate awareness of the environmental and societal interests of the communities in which a company operates can also have an impact on its reputation and its long-term success.

*Source: Adapted from OECD, 2004.*

And no again, because governance of both mainstream insurers and microinsurers involves corporate social responsibility (CSR) in addition to commercial objectives. Few annual reports these days neglect to tout CSR and an earnest pursuit of a triple bottom line, benefiting the consumer and community as well as the shareholder.

Yet microinsurance governance is different because the microinsurer cannot just dispense with its CSR by a do-good programme or project on the side. Microinsurance has CSR at its core, and its board of directors must ensure that a social or development perspective is coupled with commercial objectives to sustain the organization. Social protection, as the other face of microinsurance (*see Chapter 1.1*), is ever-present and cannot be put away for occasional attention.

The United Nations Conference on Trade and Development (UNCTAD), in its study "Selected Issues in Corporate Governance", draws the main elements of governance from several definitions. From the financial perspective, a fundamental of corporate governance is that it must assure an adequate return on investment to the suppliers of capital. More capital will flow to the company to help it grow to its potential if its governance mechanisms produce a good return for investors. This definition, applied to microinsurance, must encompass not just the financial returns on investment, but also the social returns. Indeed, the suppliers of capital for microinsurance schemes, including the policyholders in cooperative and mutual schemes, want to see evidence that such a scheme enables poor households to be less vulnerable.

Perhaps another way of defining governance is to consider the **mandate** of the board, which is responsible for guiding the institution in fulfilling its corporate mission, for protecting the institution's assets over time, and for ensuring that it respects the laws, rules and regulations pertaining to the type of business it transacts. The board sets the strategic direction of the organization, ensures that it complies with all legal and regulatory requirements (including any industry codes of practice to which it subscribes), and carries out a fiduciary or stewardship function to guard the institution's assets. In achieving that mandate, a microinsurer's governing body would not steer and direct it effectively without being mindful of the universal prerequisites of governance (*see Box 56*).

Box 56

### The four pillars of governance

1. **Accountability**, or the capacity to call officials to account for their actions.
2. **Transparency**, entailing low-cost access to relevant and material information.
3. **Predictability**, resulting primarily from laws and regulations that are clear, known in advance and uniformly and effectively enforced.
4. **Participation**, needed to obtain reliable information and to serve as a reality check and watchdog for both government and corporate action.

*Source: Adapted from ADB, 1997.*

One of the great challenges of governance is understanding the **boundary between management and supervision**. The board provides the strategic direction; management is responsible for implementing a programme of activities to achieve that direction. In practice, however, the distinction between management and governance often gets blurred, to the detriment of successful operations – usually with some board members crossing the line into the management's area of responsibility or management pursuing a strategic course without the board's knowledge or approval.

## 2 Board composition and expertise

Another distinct feature of microinsurance governance is that it can take place within a range of different institutional and delivery models, as described in Part 4 of this book. Each model has specific governance challenges, particularly with regard to the composition and expertise of the board.

Corporate insurers that are going downmarket to serve low-income households – either on their own or in partnership with delivery channels – are likely to be entering uncharted waters. Invariably, the effectiveness of a board depends on the mix of individual directors, their experiences, risk appetite, causes and agendas. The chair and the chief executive should jointly ensure that officials nominated to the board have expertise that will complement rather than duplicate that of other directors, and will be appropriate given the direction of the organization. For example, if microinsurance is an important strategic direction, the board will need guidance to respond to the special needs and buying behaviour of the low-income market and someone who can have an effective voice on the board to balance the insurer's natural commercial orientation.

Cooperative, mutual or other popularly based microinsurers have an advantage over corporate insurers because they are closer to and more familiar with, and often themselves are, the target market. However, their natural social focus must be balanced with a commercial orientation. Development experts who have helped establish popularly based insurance programmes in a number of countries over the years identify **leadership training** as a key factor. This is a euphemism for two “room for improvement” items that they find among many organizers and elected officials of grassroots financial service providers:

- a) technical understanding, and
- b) grasp of a board member's responsibilities.

Except for those elected or selected by virtue of education and experience in financial services, board members of popularly based organizations have no more than a cursory knowledge of insurance. They display leadership too, but it is driven more by a populist cause or belief than by an in-depth knowledge of financial services.

Not having the proper mix of skills and expertise on the board is not only hazardous for an organization but potentially fatal. Many popularly based organizations, among them financial cooperatives, have struggled and gone under because of a lack of the required skills in the people running them. Their managers were not up to par on technical elements of the business and elected officials on the board were high on ideology, but had no more than a modicum of business acumen.

Even when in some cases the board had the foresight to hire a technically qualified manager, it tended to put him or her on a short leash, with frequent conflicts leading, before long, to the manager's resignation or dismissal (*see ICMIF, 2005*).

Even though the governance challenges for corporate and popular microinsurance organizations appear quite different, they have three key issues in common. First, to succeed, an enterprise needs a **champion**. Each board of directors involved in microinsurance can use at least one such entrepreneur as a member – this is particularly an issue where microinsurance is just one product or set of activities in which the organization is involved. These boards also need others who can complement the champion’s advocacy of the cause with a good understanding of the business and their own responsibilities.

Second, **external directors** can bring expertise that a board may be lacking. This is particularly relevant if microinsurance is quite different from the organization’s core services, or the target market is quite different. An external independent director does not represent any particular shareholder, but rather has relevant experience and skills to help shape the board’s guidance. In situations where the legal or corporate structure does not allow for external directors, this function could be addressed through an advisory committee.

Third, board members need to know what they are supposed to do. While this seems obvious, not all directors are aware of their responsibilities and how they should be carrying these out. Intensive training of new directors, with regular updates on governance issues, is essential. A good starting point is a “**job description**” (*Box 57*).

*Box 57*

### **Responsibilities of the board of directors**

- To establish and review the aims and long-term objectives of the organization;
- With the recommendation and participation of management, to develop policies and plans whose implementation will establish the basic character and direction of the organization;
- To ensure the development, review, approval and evaluation of the corporate planning process;
- To maintain the continuity of a viable organization that delivers needed products and services to members and policyholders, and is managed in their best interests;
- To ensure adequate representation with and involvement of sponsors and other appropriate organizations;
- To oversee the management’s role in ensuring compliance with the governing statutes and by-laws;

- To delegate specific aspects of decision-making to board committees; and
- To ensure the continuity of management.

*Source: Adapted from Co-operators Group, 2005.*

For example, not all board members may be aware that their position entails **legal responsibilities** and obligations to govern, that they may be held liable for misusing or neglecting their legal duties, and that they have to declare a conflict of interest if they (or relatives, business associates or friends) stand to benefit financially directly or indirectly from any decisions or actions. Decisions regarding the awarding of contracts to third parties must be taken objectively and at arm's length – and be perceived as such.

Besides being mindful of their own conflicts of interest, board members need to attend to **relationships with external agencies**, including supervisory, government and industry bodies and associations. They need to take into account the effects of decisions or proposals on customers, suppliers, advisers and members of the public, because corporate governance must also be concerned with impacts outside the company.

Recent scandals involving boards of directors of some major corporations have spotlighted the role of auditors. Where external auditors are engaged, they may need to meet the board of directors in the absence of management. In many jurisdictions, auditors now have a legal duty to directly inform relevant authorities of malpractice or failure to respect good corporate governance principles.

Board members are expected to attend meetings regularly and review and question the reports and correspondence provided. The chair should ensure that management distributes agendas and operational reports in good time to directors to help make their meetings productive. Formal minutes of items discussed and decisions taken should also be distributed.

### 3

#### The foundation stone

For those instances where the vehicle for the microinsurance operation is a joint stock company, the Memorandum and Articles of Association of the company are the critically important foundation stone of good governance. They are sometimes referred to as the company's "Initiating Documents". With some modification, they should be mirrored in other governance structures such as cooperatives, mutual societies and NGOs. They are often accompanied by, and refer to, a Shareholder's Agreement, which may have to be revised when a significant shareholder either disposes of or acquires capital in the company.

These documents establish the intent of the initial providers of capital to a company and cover a number of important points with regard to how the company operates. In particular, the documents differentiate between, and prescribe the limits on, the powers of management and the powers of the directors – with the ultimate power lying with the shareholders and owners of the company. They thus establish three tiers of operational control: management, directors and shareholders (principal stakeholders).

They very clearly prescribe the following:

1. The areas of business in which the company is expected to operate.
2. The uses to which the capital of the company may be put.
3. The procedures for appointing (and dismissing) management (usually just the managing director or chief executive, but possibly also the chief financial officer and others) and the decisions that management is allowed to take without reference to the board of directors. The annual budget is usually an important tool by which directors control management's use of the company's money.
4. The procedures for the appointment of members of the board of directors (as well as dismissal procedures). Generally, these days a number of directors are appointed who do not represent the shareholders, and these directors are expected to represent the interests of non-represented stakeholders at board meetings as well as the interests of the public and the economy in general. The appointment of a director usually requires approval by a majority of the shareholders at a formal shareholders' meeting. The maximum and minimum numbers of directors allowed are also specified.
5. The powers the board of directors is allowed to exercise without reference to a meeting of the shareholders. Usually, the board exercises almost total control over the company's use of existing funds and assets, as well as the use of revenues coming in from operations. However, it has to refer to the shareholders with regard to new money coming into the company, in particular if it relates to any change in the percentage shareholdings and/or if it exceeds the prudential norms (described in point 7) for borrowing or otherwise putting the shareholders' capital at risk.

6. The way the directors' votes are used to make a decision (e.g. on some decisions unanimity is required but for others just a majority vote).
7. The financial prudential norms (i.e. financial limits) within which the company must operate, including borrowing limits, solvency ratios, exposure to certain coverage risks, reinsurance, and capital adequacy. These may also be prescribed by the government's appointed regulator (e.g. superintendent of insurance), but there is nothing to prevent the company from having norms that are more conservative.
8. The procedures for shareholders entering and leaving the company.
9. The procedures for shareholders exercising their votes to make a decision entrusted to them. Often a 75 per cent majority is required.
10. The decisions over which the shareholders have control are:
  - any change to the nine points above covered by the Memorandum and Articles of Association of a company,
  - the sale, liquidation or disposal of the company and
  - the appointment of auditors.

The Initiating Documents are, therefore, the reference by which the company is governed. It is particularly important in empowering both directors and shareholders if management (which may have little financial stake in the company) deviates from what the owners originally wished. The owners (shareholders) may, however, amend anything prescribed in these initiating documents, as mentioned in point 10, if they are persuaded to do so by either management or the directors. In this way the Initiating Documents are a foundation stone for company governance, but can still be modified with time as the company and its environment evolve.

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#### 4 **Microinsurance governance in practice**

To illustrate some of the governance issues faced by microinsurers in different institutional categories, here is a look at five cases.

#### 4.1 Step ahead – if groundwork points the way

Delta Life, founded in 1986 to provide endowment insurance to Bangladesh's middle and upper classes, launched Grameen Bima (village insurance) two years later to enter the low-income market in collaboration with a microcredit NGO. Delta underwrote a scaled-down endowment product and the NGO delivered it to the poor along with its loans. The partnership soon dissolved because NGO staff members were more interested in selling their own loans than Delta's insurance.

Delta then developed its own delivery network and did well selling insurance directly. In 1991, it added microenterprise or project loans to its product menu, with its agents offering credit as well as insurance, and collecting repayment instalments as well as premiums.

In 1993, Delta launched Gono (urban) Bima for the poor in cities. Together, the two microinsurance schemes grew by leaps and bounds – a 1,025 per cent increase in new policies from 40,000 in 1994 to 450,000 in 1998. In insurance, growth of this magnitude, unsupported by a proportionate growth in equity capital and retained earnings, always spells trouble. And it did for Delta, revealing major problems – in information systems, internal controls and administration. In addition, bad debts had mounted with the exponential growth, as agents had been using loans as a marketing tool: buy a policy, get a loan.

In 2002-2003, Delta took decisive corrective action, including consolidating microinsurance under a single Gono-Grameen Bima division and eliminating the project loans. These and a number of other adjustments resulted in clear benefits for the company and its roughly one million poor customers.

If Delta Life's milestone decisions and actions were ascribed to appropriate structural components, this recap would say that Delta's board of directors decided to launch Grameen Bima and the partnership with the NGO. Later, too, the decision to end the partnership and choices of subsequent courses of action were made by the board of directors.

Management had a role to play as well, but mostly in researching available options and preparing briefs to help the board analyse and assess them, and then carrying out and following up on the strategic decisions. Indeed, since management was part of the problem, the 2002-2003 restructuring was led by a consultant who was hired by and reported to the board.

The board of directors was ultimately responsible and accountable for the direction Delta Life took and its consequences, as it had been in favour of launching the venture and starting and ending the partnership with the NGO.



The board's role, in a word, is stewardship – and that is the case in all jurisdictions.

How did Delta's board fare in its stewardship of the company? The case study concludes: "Over the years, Delta Life's social motivation has evolved into a commercial motivation, benefiting the company as well as its...customers. Along the way, Delta Life has learnt a number of valuable lessons, many of them the hard way." The study then lists several institutional lessons, including:

- Cross-subsidize start-up of microinsurance
- Manage microinsurance with the same business approach as traditional insurance
- Focus on core competencies
- Develop a good management information system for large volumes of small policies
- Establish internal controls, for where money is involved fraud will not be too far behind (*see Box 58*)

One underpinning lesson the case study, not to mention Delta Life itself, could have drawn is that the board of directors could have done its homework better – including the competence to understand that growth must not be out of proportion to the increase in the company's financial strength. Perhaps, if it had not had 36 members, the board might have been more effective. Indeed, Delta Life could have avoided chalking up lessons the hard way. For starters, solid research and careful analysis of the buying behaviour of the client base, and of the marketing approach of the microcredit NGO as the intended delivery channel, could have averted the first error – a partnership destined for dissolution.

*Box 58*

### **Trust is good, but control is better**

After Enron, WorldCom and Parmalat, it was not the role of external auditors alone that came under the spotlight. Internal auditors were also mobilized. The global Institute of Internal Auditors based in Florida, United States, for example, has been focusing on how its members can better support compliance with corporate governance standards. Insurers in their formative years may not be able to afford an internal audit unit, but it would serve their boards well to direct management to assign that responsibility to a suitable staff member who can then work closely with the board's audit committee. Credit unions have a time-honoured structure ensuring not only democratic participation but also control through their boards and committees, and other popularly based financial service providers would do well to adapt it.

The point to keep in mind, however, is that there have been a number of instances where credit unions have encountered serious financial difficulties, which, almost invariably, have been due to the failure of good supervision and undue trust placed in key senior (and sometimes junior) staff and management.

## 4.2 Counterbalance “too much good heart”

The mission of CARD’s Mutual Benefit Association in the Philippines is to promote *“the welfare of marginalized women, to extend financial assistance to its members in the form of death benefits, medical subsidy and pension and loan redemption packages, and to actively involve the members in the direct management of the association including the formulation and implementation of policies and procedures geared towards sustainability and improved services”*.

Today CARD MBA offers life and disability insurance, and a pension savings plan (see Chapter 2.2) to 600,000 low-income people. It is a success story – the story of an MBA that was created by a microfinance institution (MFI), but not before the MFI nearly went bankrupt by offering insurance without the needed professional and technical expertise. As one of its leaders explains, “It is fair to say that CARD MBA...arose from a severe miscalculation resulting from too much good heart.”

What happened?

In 1994, several years before it created the bank or the insurance company, the CARD NGO began offering basic life insurance packages to its members. As these services were popular, CARD offered additional and more complex insurance products. In 1996, it decided to introduce a retirement annuity that proved to be extremely popular with members. However, CARD had not evaluated its impact on the institution. An assessment later showed that a member would have to pay premiums for two years just to cover one month of benefit. The institution was at risk of losing its entire capital.

CARD learnt that an insurance business must be run by professionals and should not be tied to the capital of a microfinance institution.

Management extricated CARD from the liability and transferred the assets of the fund to members, who then started a separate company with a separate board.

It appears that, when CARD NGO entered the insurance business, it was being administratively managed, but not governed.

From the management perspective, combining the readily accepted insurance services and a pension plan made sense. However, not much thought was given to the new products' impact on the direction and future of the organization – until the chickens came home to roost.

To its credit, CARD learnt its lesson well. The case study says: “When the board of an insurance company comprises only members or policyholders who have virtually no experience in corporate governance, it is necessary to have an advisory group that is experienced and has the authority to guide the board. Such an advisory committee has been critical to the successful supervision of CARD MBA.”

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### 4.3 Steer an organization with a strategic bent of mind

It is the vision thing. If vision and strategy permeate board meetings – more so than political squabbles and operational details – one can count on an organization's survival and success.

TUW SKOK, an insurer of credit unions in Poland for eight years and of their members and other individuals for the past five years, owes its assured presence in the market to the foresight of the credit union movement's leaders, who charted its entry into insurance services in the early 1990s.

In Poland, other than the government's social protection initiatives for healthcare and retirement, there are no specific efforts to extend insurance to the low-income market. As in most other countries, there is, however, a market niche below what is of interest to mainstream insurers, which is what TUW SKOK is targeting. How it was set up and has been steered holds lessons for those contemplating microinsurance elsewhere – in particular, two strategic decisions that made it virtually foolproof against failure.

The idea of getting into insurance came to the board of the credit unions' apex body not long after the credit unions were re-established in the country and began collecting savings in the early 1990s. A life insurance company was set up with technical assistance and 90 per cent ownership from CUNA Mutual, a United States-based credit union insurance group. It offered three basic products: loan protection, life savings and funeral insurance.

Soon, a brokerage company was added to provide credit unions and their members with covers not available from the joint venture itself. The brokerage is regarded in the case study as one of the most significant steps in the evolution of insurance services for the credit union movement. From the vantage point of governance, however, the strategic decision of stature really came after the joint venture fell apart in 1997.

When CUNA Mutual bought out the local 10 per cent ownership and sold the company to a foreign investor interested in entering the Polish market, the credit union apex's board could have gone ahead with business as usual by replacing the joint venture with a wholly owned operation of the same nature – a life insurer targeting individual members of credit unions. Instead, it opted for a strategic re-evaluation. Based on this analysis, the apex body decided that the greatest priority and most immediate market potential lay in insuring the credit unions themselves rather than their individual members.

So, instead of remaining in life insurance, it chose to have a general (property and casualty) insurance company.

Then came the second key strategic decision: should a new company be launched, which requires business plans and licence approval procedures, or should an existing insurance company be purchased and then restructured to meet the needs of credit unions? The board again made what turned out to be the right choice: to go for an acquisition. Soon the right opportunity came in the form of TUW Praca, a failing mutual insurer under a two-week ultimatum from the regulator to find new capital or be liquidated. The apex convinced the regulator to let it inject new capital into the failing company and reorient it to the needs of credit unions, and TUW Praca became TUW SKOK (*see Box 59*).

*Box 59*

### **Read the writing on the wall**

TUW Praca's reincarnation as TUW SKOK is not its only legacy – for its terminal illness was caused by a virus infecting many boards of directors – one that should serve as a warning as well as a lesson to microinsurers.

In the early 1990s, as unemployment in Poland began to rise, a group of trade unions launched an initiative intended to offer some protection to workers in state-owned enterprises targeted for restructuring. The idea was to create a mutual insurance company owned by trade unions and their members, which would offer unemployment insurance to workers.

Efforts to raise capital for the insurance company from trade unions did not come close to achieving their intended targets, which should have been a warning sign. Instead, the initiative's backers turned their attention to the Ministry of Labour. The timing of their request was fortuitous because the Ministry had some additional resources and needed to be seen to be doing something about the growing unemployment problem. With US\$500,000 from the Ministry's Job Fund, amounting to 90 per cent of the share capital, the trade unions were able to get a licence to launch TUW Praca. Unfortunately, the effort was essentially stillborn. After a couple of years, the insurer had only 100 policyholders, operating costs had eaten away most of its capital, and regulators were threatening to close its doors.

In hindsight, it appears that TUW Praca's sponsors had not done their homework. Market research would have shown that workers considered unemployment as government's responsibility rather than the responsibility of individual workers. Consequently, trade union members were not interested in buying their own unemployment insurance because they believed that the government should provide that type of social protection.

*Source: Adapted from Churchill and Pepler, 2004.*

#### 4.4

### Clients' interest is the key to results

The role of the board of directors (or the supervisory board as it is known in some European countries) is to oversee the insurer's operations and management. Its central purpose is to act on behalf of the shareholders/sponsors of the company and to direct the organization's activities to attain its corporate objectives. To ensure focus, and checks and balances, the board delegates key tasks, such as audit, investment and executive matters, to its dedicated committees. In the case of mutuals more so than other corporate forms, a key responsibility of the board is to make sure that management's use of funds and other operating decisions are not in conflict with the interests of stakeholders.

The responsibility for managing and looking after the day-to-day affairs and implementing policies rests with the executive management (or the board of executive directors). Serious problems and debilitating conflicts arise when the line between supportive and overseeing responsibilities and managing responsibilities is blurred. A microinsurer whose board of directors has done a notable job of keeping these lines clear is Tata-AIG in India.

India requires what some other countries only encourage: that each insurer have a percentage of its business in the low-income market, locally known as the rural and social sectors (*see Chapter 5.2*). To fulfil these regulatory obligations, Tata-AIG realized that microinsurance is not just normal insurance with lower premiums and benefits, but that the microinsurance customer base has its own distinct profile that requires creative approaches and new distribution mechanisms. It therefore established a specialized microinsurance department, called the rural and social team, and gave it autonomy as well as the needed support and resources to innovate. The important space the team occupies in the corporate structure is reflected in the organizational chart (*see Figure 20*).

As described in Chapter 4.5, one of the team's innovations is a new distribution channel using people like the customers themselves to advise and serve them. A number of these "micro-agents" form a community rural

insurance group (CRIG), which operates as an insurance agency. The micro-agents are essentially handpicked low-income women from the communities they are assigned to serve. Initial results seem promising.

Having a microinsurance champion at board level made the difference.

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#### 4.5 Government in governance: Know when to loosen strings

Karnataka, a state in southern India, is known for its software industry and biotechnology, but 75 per cent of its roughly 60 million people earn their income from farming and could be classed as poor. Since 2003, it has also attracted international attention as the home of an unusual and successful micro health insurance scheme that appears to be a model of collaboration among the cooperative sector, government and the private corporate sector.

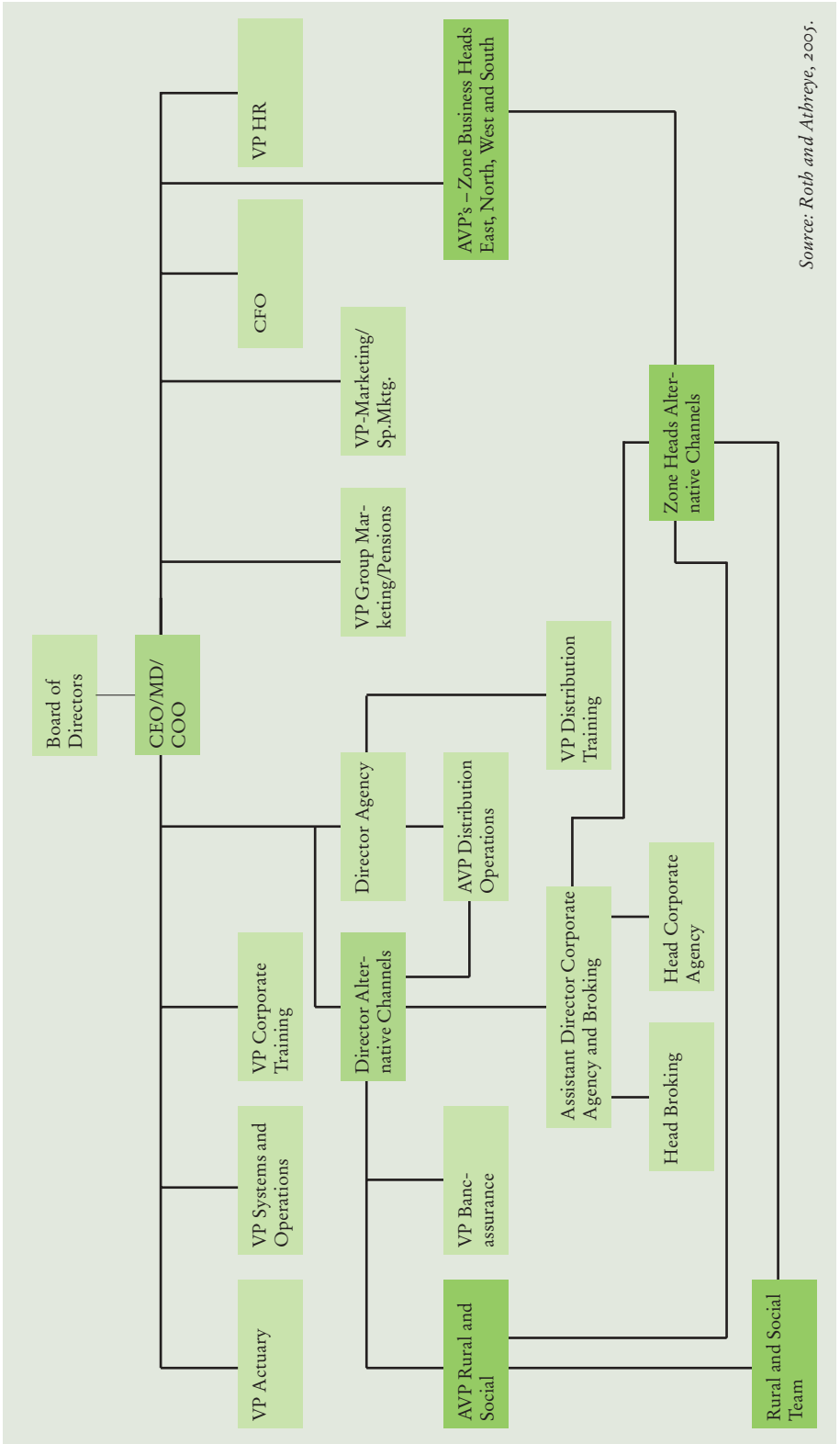
The Yeshasvini Cooperative Farmers Health Care Trust was designed to enrol a large number of people for very low premiums, providing coverage for more than 1,600 operations provided by a network of mainly private hospitals throughout the state.

The state's cooperative movement, dating back to the early 1900s, has some 31,000 societies in sectors ranging from silk production and textiles to animal husbandry, horticulture and agricultural credit. It is estimated that 78 per cent of the state's adult population is connected to a cooperative in some way. Given its tremendous scope of outreach, especially to the rural poor, the cooperative movement was the natural choice for mobilizing the health scheme's potential subscriber base.

The cooperative sector in Karnataka, and other states in India, is publicly sponsored, with the government providing capital, subsidies, loans and technical assistance to cooperative societies. Yeshasvini's collaboration with the state-sponsored cooperative movement has been a mixed blessing, although overall it has been quite advantageous.

Yeshasvini Trust is governed by a 12-member board chaired by the Principal Secretary of the government's Department of Cooperatives. Five other board members are also employees of the Department. Another five represent the network hospitals and are well-known health professionals. The 12th member is the director of the government's Health Department. Representatives of the third-party administrator and the cooperative sector at the federation level may attend meetings, but are not board members. Governing the whole scheme, the board of trustees is responsible for its further development, monitoring performance, listing new hospitals, reimbursing claims and final decisions on claims.

Figure 20 Organizational chart of Tata-AIG



Source: Roth and Athreya, 2005.

The heavy involvement of the Department of Cooperatives on Yeshasvini's board has made it possible for a significant amount of grant funding to find its way to the microinsurer. The government of Karnataka supplemented the Rs. 60 (US\$1.36) premium paid by policyholders in the first year with an additional Rs. 30 (US\$0.68) per person. Although the per capita subsidy was stopped in the second year, the government did provide additional funding. Altogether, the government provided Rs. 45,000,000 (US\$1,022,727) in the first year and Rs. 35,000,000 (US\$795,454) in the second year.

The other main advantage that the Department of Cooperatives brought to the table was the ability to encourage cooperatives to enrol their members. In the first year alone, 1.6 million low-income persons subscribed to the scheme, in part because the Department of Cooperatives issued membership targets to its district offices, which issued a target to each cooperative society, which in turn used its own method of signing up members. Some discussed the scheme with members and encouraged them to join; some signed up all in the society, using their dues; others automatically enrolled everybody with outstanding society loans.

The combination of subsidized premiums and marketing pressure from the government resulted in a membership increase to 2.2 million in the second year. In Year 3, however, when the premiums had to be doubled to replace the subsidy, membership dropped to 1.45 million, which means that 750,000 people were not sufficiently satisfied with the product or price to re-enrol! Given this error of judgement, the case study wonders whether the composition of the board needs to be reconsidered:

*Although the Department of Cooperatives facilitates the contact with the cooperative sector, it has to be borne in mind that the cooperative societies have the main burden. It might therefore be advisable to replace trustees from the government by elected representatives of the cooperatives to better reflect their important contribution. As India is currently de-linking the cooperative sector from the government structure, it might be adequate to reflect this in the board of trustees as well (Radermacher et al., 2005b).*

The cooperative movement, internationally, has long taken umbrage at government intervention, and the use and misuse of cooperatives in developing countries as a tool for development. In India, where the central government is responding to cooperative societies' calls for democratic reform in their regulation, supervision and functioning, the movement will undoubtedly strengthen as state intervention decreases. India is not a typical case of arbitrary government interference in activities of cooperatives subject to diktats from politicians and civil servants.



In Yeshasvini Trust's success story, the government deserves significant credit. Government involvement in getting Yeshasvini Trust up and running may have compromised the cooperative societies' autonomy, but has not undermined it. The cooperatives appear to have paid a small price for gaining a necessary and well-provided service for members.

There is also comfort for the case from the thoughts of the cooperative movement's ideologue and futurist, Dr Alex Laidlaw. In a "classic" presentation, he said:

*Cooperatives tend to take their ideological colour from the economic environment in which they exist. In countries dominated by capitalist ideology, they tend to be judged, and to judge themselves, by the norms of profit-making business. In countries dominated by communist ideology, they are assigned a certain place and role in the economy by State planners and serve as instruments of government policy. In developing countries, they often seem to have the worst of two worlds: they must be competitive with entrenched private business, including multinational corporations, and at the same time follow the dictates of close government control (Laidlaw, 1974).*

He added that no business in a national economic system is completely independent and self-sufficient but operates in conditions of dependence and interdependence. Both capitalist business and cooperatives depend to some extent on the state and services provided by the state. Similarly the state and public enterprise depend greatly on private enterprise and cooperatives.

Yeshasvini Trust seems set to go down in history as an example of this dependence and interdependence.

## 5

### Conclusions

Corporate governance ensures the integrity of corporations, financial institutions and markets, building public and investor confidence. To alleviate poverty through microfinance and microinsurance, good governance is essential.

Good governance starts with knowing what it is to manage and what it is to govern. To govern a microinsurer effectively, one must devote time to understand insurance for the poor and take the director's responsibilities and obligations seriously. Some things are better left to management to decide and follow through.

The board of directors is ultimately accountable for the company's success. And success means producing results for sponsors, shareholders and customers so that the insurer is not left short of the capital and surplus required to maintain its financial strength.

The chair and the chief executive should jointly ensure that officials nominated to the board have expertise and skills that make for a proper mix, including a well-balanced composition in representation of various stakeholders. In microinsurance, some key questions should be considered, such as:

- Is there a microinsurance champion to advocate the special needs of the low-income market?
- What is the proper balance between the social/development and commercial/financial orientations?
- What strategic direction makes the most sense to achieve both social and commercial objectives?

## 3.9

# Loss control

Zahid Qureshi and Gerry Noble<sup>1</sup>

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*The authors would like to thank Thomas Loster (Munich Re Foundation) for his valuable comments on this chapter.*

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In insurance literature, loss prevention, loss minimization and loss control are used almost interchangeably. Reflect on each of these terms a moment and, at the risk of mathematical oversimplification, they boil down to a simple equation:

$$\text{Loss control} = \text{loss prevention} + \text{loss minimization}$$

Loss prevention is initiatives to avoid the occurrence of risks, especially insured events, whereas loss minimization strives to reduce the impact of risks when they do occur. Together, these two activities amount to loss control.

Although not all microinsurers pay attention to loss control, it is a key element of success. Carefully conceived investment in loss prevention can easily pay for itself through reduced claims. Indeed, incentives in insurance are structured in such a way as to encourage private-sector risk carriers to undertake development initiatives – such as promoting safe drinking-water and appropriate sanitation – not to fulfil a social responsibility, but because it makes financial sense.

The purpose of this chapter is to encourage more microinsurance providers, both risk takers and delivery channels, to approach loss control in a systematic and targeted manner. The focus is more on loss prevention than minimization since the former is likely to have a greater impact on reducing the claims costs of microinsurers.

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### I **A retrospective look at loss prevention**

A snapshot of a typical multi-line insurer three or four decades ago would have shown the loss prevention function tucked away in the commercial or business insurance department. Loss prevention specialists, typically engineers, were a key part of the process of insuring business premises and prop-

<sup>1</sup> The references to Microcare come from the authors' personal experiences.

erties, including office buildings and factories. This is true to this day. Loss prevention specialists work closely with underwriters in shaping premium levels.

The job of the underwriter is to analyse, assess and price the risk exposure for a specified coverage. The loss prevention specialist evaluates the risk management practices and procedures the business has in place, advises the client on any improvements needed, and shares the information with the underwriter for use in understanding and pricing the account. Underwriting research and analysis are done internally; loss prevention, handled in the field, has been underwriting's "eyes and ears".

Over the years, insurers have pursued loss prevention for personal lines too – but most have not called it that. The responsibility is usually built into the marketing and corporate communications function. Off and on, safe driving is promoted to help reduce motor claims, smoke alarms and security measures are recommended to home insurance policyholders, and the benefits of not smoking and a healthy diet and lifestyle pointed out to those who have their lives insured.

The safer the policyholders' driving, the more fire-proof and theft-proof their homes; and the healthier their lifestyles, the fewer claims the insurer will have to pay out and the better able it will be to keep the cost of insurance down. Who could argue with that! It is loss prevention, pure and simple – and no less important than ensuring that a factory is up to code or an office building is maintained properly, in helping keep premiums down.

"All this is good to know," a microinsurance practitioner is likely to say, "but how is it relevant to what we do?"

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## 2 Converging interests

Microinsurance largely involves a variety of products in the life and health insurance lines. Indeed, long life and good health are not a matter simply of staying away from harmful substances, but of warding off hazards hidden in the air, water and food, and maintaining a healthy lifestyle. While many diseases are a global phenomenon, prevention remains largely a priority that local communities are often better placed to pursue. In this fashion, microinsurers – small as well as not so small – can be significant "corporate" players in the communities they serve, and can lead a sustained effort to promote hygiene and other "better health" conditions among customers.

Poverty need not necessarily be characterized by a lack of good health. Loss prevention and good health promotion could become key elements of customer education, which is a prime objective in a microinsurer's marketing strategy. Besides promoting healthy lifestyles to prevent non-communicable

diseases, microinsurance providers could take a cue from the fight against HIV/AIDS and try to increase customer awareness of how pandemics take root, how they could be prevented and how they could be nipped in the bud.

According to a consultant who has worked with a number of microinsurance schemes:

*Besides poor hygiene and a poor diet, the greatest health risk for the poor is not seeking appropriate care. A microinsurer's support of public health measures can go a long way in reducing this risk for the poor. For example, SEWA Health in India has worked to improve the training of midwives. This has resulted in lower maternal and infant mortality rates, which in turn have reduced claims costs in the insurance programme. For health insurance, primary care together with health promotion strategies can reduce claims costs and improve the health and productivity of the clients. I have not seen any micro health programme succeed without a health promotion element.*

A desirable side effect of such preventative programmes is that it could help grassroots organizations cement working relationships with established insurers that may already be inclined to extend their CSR outreach beyond their existing clientele. Furthermore, microinsurers need to recognize that they are not the only ones with an interest in loss prevention. In an overall win-win approach, partnerships with specialized NGOs working on health issues or with government vaccination programmes can go a long way toward achieving mutual objectives (see Box 60).

Box 60

### **Taking the societal perspective**

Neglecting prevention invariably results in illness and injury to some, but the financial burden is borne one way or another by virtually everyone. Medical expenses affect the income not just of victims and families, but also of their employers and insurers. Care and recovery involve costs to community and public institutions, which governments pass on to taxpayers.

Promoting and practising prevention should also call for a societal perspective and collective action. Microinsurers can be an integral part of partnerships including various organizations and government agencies already engaged in campaigns such as HIV/AIDS awareness, using mosquito nets to prevent malaria and digging wells for safe and clean water. Often a good starting point is a community immunization programme. Case studies provide a few examples:

- **Seguro Basico de Salud (SBS)**, Bolivia, and **Seguro Integral de Salud (SI)**, Paraguay, actively promote the national immunization programmes, including vaccinations specified in the benefits package.
- Several community-based schemes in West Africa have introduced a mandatory vaccination programme for infants. Those not vaccinated are not covered if they get diseases the vaccination programme was designed to prevent.
- **UMSGF** in Guinea plans formal “partnerships with programmes offering efficient prevention measures for diseases covered, particularly malaria and HIV/AIDS”.

Care for the environment, which is capturing increasing attention in insurance and reinsurance circles, is closely related to loss prevention in life and health insurance. Poor environmental conditions not only adversely affect people’s health, but they can also trigger climate change and some catastrophic losses such as droughts. An issue for future consideration is how “going green” might reduce losses and, in particular, how taking greater care of the environment would in the long run help arrest climate change.

### 3 Pinpointing prevention

While non-life insurers, through their loss prevention specialists, have over the years contributed greatly to safety systems and standards for insured properties and transportation of goods, as well as home and road safety, the same could not be said of life and health insurers (save for readily jumping on the non-smoking bandwagon). Historically, they have not demonstrated as keen an interest in preventing losses.

All accidents and losses seem to have an underpinning cause and effect. Even so-called natural calamities, such as droughts, floods, tornadoes and hurricanes, are now believed to have a root cause: climate change. So, preventing a loss should not be hard once its cause is known.

Loss prevention specialists have built their discipline in non-life insurance by zeroing in on causes of industrial accidents and finding remedies, and so can life and health insurers. Table 31 illustrates the point by analysing an industrial fire, an injury, a communicable disease and a non-communicable disease. The loss prevention column for each specifies remedial action. All call for improved training and increased awareness. Therein lies the crux of loss prevention in microinsurance: counselling and educating customers in ways of taking good care of themselves and their families and possessions.

Table 31

<b>Non-life and life insurance loss prevention</b>					
<i>Loss-making condition</i>	<i>Host/Risk</i>	<i>Agent/Flaw in the system</i>	<i>Vehicle of interaction</i>	<i>Interaction/Operation of hazard</i>	<i>Scope of loss prevention/Control activity</i>
Fire	Textile factory	Carelessness of worker	Lighted cigarette end thrown in the wrong place	Fire from the cigarette spreads to cotton fluff	Worker training, installation of smoke detectors, automatic sprinklers, fire alarm, CO <sub>2</sub> flooding systems
Skull fracture	Human	Managing mechanical energy	Speeding, skidding of motorcycle	Crash	Increasing awareness of safe driving, traffic rules, enforcing road discipline, use of helmet
Malaria	Human	Vulnerable to infection	Mosquito	Bite	Creating awareness of breeding places of mosquitoes, clearing cesspools of stagnant water, fumigation, mosquito nets and other repellents
Lung cancer	Human	Body cannot tolerate intake of smoke	Habitual and excessive smoking	Increasing damage to lungs	Creating awareness of the harmful effects of smoking, and ways of dealing with addiction

*Source: Adapted from Thomas, 2004.*

On the surface, such an undertaking may appear superfluous to microinsurers struggling to build and maintain a book of business. However, if they take a holistic view of the business – not just income, but also the institution’s viability – loss prevention emerges as life-sustaining. The obvious, short-term benefit is that it reduces the frequency and severity of claims, and helps control the insurer’s expenses. But the real advantage is that it protects the insurer’s income over the long term: ensure that customers remain healthy and productive, and the organization will be sure of their continued patronage.

JA Zenchu, the Central Union of Agricultural Cooperatives of Japan, has long recognized the value of such a seemingly extracurricular service that, in effect, adds value for the business as well as the customer. Its chain of multi-purpose cooperatives in rural communities provide a popular “better-living guidance” service in addition to the core business lines: marketing of farm products, supplies of production inputs, credit and mutual insurance, and farming advice. The better-living guidance to members and their families

includes health management, lifestyle counselling and advice, household budgeting, recreational activities and joint purchases of high-quality daily necessities.

Health promotion and prevention activities have a long way to go in the developing world. Indeed, the scope of the work that could be carried out by life and health insurers in this domain is quite different in developed and developing world markets. Microinsurers are perhaps at an advantage in this respect, since they could encourage their clients to do many simple things that do not reduce their capacity to meet basic needs and may over time even enhance their ability to cope (*see Box 61*).

*Box 61*

### Promoting well-being

A number of microinsurance schemes, or related organizations, actively promote healthy living to reduce illness among policyholders, and therefore reduce claims. For example:

- **Karuna Trust** (India) runs herbal gardens in six villages used to train clients to produce herbal medicines.
- **Bienestar Magisterial** (El Salvador) has special programmes for cancer detection, family planning and prenatal care.
- **Shepherd** (India) runs medical camps for check-ups. It also runs cattle-care camps with free immunization and de-worming. The camps serve a marketing and recruitment purpose too.
- **Grameen Bank** (Bangladesh) has its “16 decisions” that members recite at meetings, including pledges “to look after our health”, “grow and eat more vegetables”, and “keep our homes and environment clean”.

It makes sense for conventional insurers to remind customers how stress affects the heart and the nervous and digestive systems, to ask them to recognize stress symptoms that can ring the alarm bells before a burnout, and to encourage them to join walking clubs and fitness centres. For microinsurers, however, the focus is likely to be on different issues. For those in Prahalad’s BOP market, loss-prevention initiatives may concentrate on hygiene and cleanliness – how simple things like keeping the “kitchen” clean and washing hands and vegetables before eating can prevent diseases.

## 4 Practising prevention

How exactly insurers should go about engaging customers in loss prevention also needs to be put in the proper perspective. Those serving the top of the pyramid may make their staff and meeting rooms available after hours for



counselling sessions, or set up wellness centres to dispense advice, assistance and referrals. However, these measures would hardly be appropriate for the microinsurance market.

Loss prevention initiatives for the low-income market are likely to look quite different. The approaches might include the following:

- **Outreach by sister organizations:** VimoSEWA of India, and Grameen Kalyan and BRAC MHIB (both Bangladesh) all have sister organizations involved in healthcare initiatives, such as barefoot nurses and midwives, which are natural partners in prevention campaigns (*see Box 3*).
- **Use of non-formal adult education methods:** In some countries, the target market for microinsurance may be illiterate or have limited education. To communicate loss prevention to this audience, innovative techniques are required, such as illustrated posters (*see Figure 21*) and street theatre. Learning conversations, a technique promoted by Freedom from Hunger, are based on real stories that illustrate the daily problems of the target market. Discussions about the story serve several purposes: to help participants to become aware of a specific problem, to collectively solve a specific problem faced by members and to reinforce cohesion among group members and enable them to take collective action.

Figure 21

#### Illustrating Grameen's 16 Decisions

Decision 10: We shall drink water from tubewells. If it is not available, we shall boil water or use alum.



- **Hammer home the core messages:** Effective campaigns are continuous, relying on a variety of communication channels to ensure that the main messages are absorbed and, hopefully, change behaviour. Indeed, each time a Grameen Bank centre meets, the members recite the 16 Decisions.
- **Target the children:** One of the most effective ways of changing the behaviour of adults is by educating children, who can then nag and cajole their parents into less risky practices.

Box 4

### Prevention through sister organizations: VimoSEWA

Mainaben, a fish seller, has been a SEWA member for 27 years, borrowing for her business and for her house. Six years ago there was a plague epidemic in some parts of India. SEWA arranged a special community clean-up awareness programme to protect communities against the plague. Mainaben was made an organizer to promote community cleanliness in Chamanpura. She spoke to the local people about keeping their houses clean, and she petitioned the Municipal Corporation and the State to clean up rubbish. The Corporation was so annoyed with her constant petitions and her threats to demonstrate against them that on one occasion they even sent the police to scare her. However, Mainaben prevailed, new rubbish bins were provided, and regular rubbish clean-ups were organized.

Mainaben's hard work caught SEWA's attention, and she was trained and employed as a health worker. She covers a community of 200 households. She sits at SEWA's clinic from 10:30 in the morning to 1:00 in the afternoon. From 1:30 to 4:00, she makes the rounds of her neighbourhood. She visits each house at least once a week. She provides information on disease prevention; she provides basic medicine to SEWA members (at a cost of two rupees, or four and half a US cents, for children and four rupees for adults), makes referrals to doctors and hospitals and follows up on patients.

Mainaben encourages everyone to take out health insurance. She tries to convince women to enrol in the fixed deposit programme. If they cannot, she tries to convince them to pay annual premiums. A few women save with her to accumulate the money for the fixed deposit. Women will contact Mainaben for all their insurance claims. Women in the community say that they appreciate Mainaben and her healthcare advice. She has assisted the people in her community to obtain better and, more importantly, more affordable healthcare.

*Source: Adapted from McCord et al., 2001.*

- **Rely on peer pressure:** One of the more effective ways of creating sustainable behaviour changes is by using the peer pressure from groups to continue to encourage (or enforce) the new conduct.
- **Provide tangible benefits:** Sometimes behaviour changes involve artefacts. For example, SEWA has on occasion provided market vendors with umbrellas to reduce the chances of heat stroke. Microcare subsidizes insecticide-treated bed nets (*see Box 64 in Section 6*). These tangible benefits help make intangible insurance more acceptable to the poor.

## 5

### Minimization: A stitch in time

Prevention, obviously, precedes a loss. Steps to minimize the impact of the loss – that is, reduce it to the smallest possible degree – are taken after it occurs. However, prevention usually involves anticipating or foreseeing a loss, and that process may entail at least a modicum of minimization, actually doing something about the foreseen loss – which may be one reason why the two terms are often synonymous in talk of risk management. Semantics aside, the point is that the more the insurers can do to prepare a policyholder to respond quickly and efficiently to a setback, the better off both the individual and organization will be.

Minimization is particularly relevant for health insurance. Thomas (2004) specifies how the ill effects of an illness or injury might be minimized through better management of time and process from the moment and point of occurrence to admission to the hospital. Most of the steps he described (such as an SOS to ambulance and prompt action by paramedics) were meant for deep-pocketed insurers with a wealthier clientele, but they would give those involved in microinsurance an indication of how one might approach minimization. Some of these measures could be adapted and scaled down to fit the budget, resources and community contacts accessible to microinsurers.

The following are key aspects of loss minimization:

- **Recognizing body conditions is critical.** The insured should be able to recognize ailments and the body's warning signals. They should know the dos and don'ts in the event of a health condition, and take steps to prevent the condition from worsening.
- **Correct information is needed for correct action.** Policyholders armed with the right information are better prepared. They should be given brochures containing addresses and telephone numbers of doctors, trauma care centres, and specialized hospitals, and details of procedural formalities on admission.

- **Help when needed.** In an emergency, unprepared policyholders can only wring their hands. Even normally efficient people may become panic-stricken and find themselves unable to make the right decisions. A 24-hour telephone help-line service would:
  - give policyholders step-by-step guidance,
  - locate a convenient ambulance service,
  - direct them to appropriate medical attention, and
  - alert the hospital about the patient's arrival.
- **Creating own infrastructure.** A group of insurers together can create a support-services infrastructure for education, counselling, tie-ups with hospitals and related medical units and mobile trauma care.

While one cannot prevent a natural disaster from happening, it is possible to minimize its effect on the insured population through disaster preparedness. Japanese insurers have taken the lead in developing techniques to raise awareness among the general population about disasters and disaster preparedness (*see Box 63*).

*Box 63*

### **Coping with disaster: The Japanese experience**

In Japan, the 1995 Kobe earthquake gave rise to civic-mindedness, with quick action by families at the heart of the collective response to the crisis. Perhaps this should not be so remarkable since a distinctive feature of Japanese society is the strength of cooperatives, including cooperative insurers. Zenrosai, the National Federation of Workers and Consumers Insurance Cooperatives, helped victims with money, counselling, and psychological services; the Japanese Consumers' Cooperative Union (JCCU) led trade and business groups in lobbying for a national security system for disaster relief.

Meanwhile, disaster mitigation activities remained focused on the family. The General Insurance Association of Japan designed a programme targeted at elementary school children to raise their awareness of disasters and to increase their ability to cope with them. The interactive pedagogical tool is not only informative, but is also fun for the children. They are first briefed on the basic idea behind the activity and then are divided into small groups and taken around their town. The children go to facilities that play an important role when disaster occurs, such as police stations and hospitals, and talk to the people who work there. Upon returning to the classroom, the children draw a map of their town's disaster-related facilities, and decorate the map with photographs and leaflets gathered during their trip.

The Kobe earthquake also led to an uptake in natural catastrophe coverage. Zenrosai and another cooperative insurer Zenkyoren (National Mutual Insurance Federation of Agricultural Cooperatives), one of the world's largest insurers by assets, now have more than 15 million policies with add-on natural catastrophe insurance. The policies offered by these cooperatives are “multiple-step policies”, where insurance payouts are tiered or stepped up as a function of the damage ratio.

*Source: Adapted from the General Insurance Association of Japan and Zenrosai and Zenkyoren websites.*

## 6 Evaluating the return on investment in prevention

How should a microinsurer go about determining what prevention measure is needed, whether it would be worthwhile, and how its value might compare with other measures that could possibly be taken? In general, this exercise boils down to a four-step process:

1. **Identify claims trends:** The first step is just basic insurance management: monitoring claims to see if there are any patterns or trends in causes of deaths, types of illness or other risks and perils.
2. **Develop prevention strategies:** If there are claims trends, which ones could be controlled by what kind of prevention programme? Are the proposed measures within the insurer's capacity to implement? What is the cost of the measures and what is the expected return in terms of lower claims?
3. **Implement prevention activities:** If particular measures appear to be cost-effective, the human and financial resources required need to be identified and the activities implemented.
4. **Monitoring the results:** To justify investments in prevention, the insurer needs to see the corresponding reductions in claims. Has the programme resulted in any reduction in losses? This is more or less what Microcare did in Uganda, as described in Box 64. In assessing the effectiveness of a prevention measure, the microinsurer might want to consider the intangible marketing or promotion value of the activity, besides the tangible benefit of lower claims costs.

Box 64

### Microcare: Using insecticide-treated bed nets to reduce malaria-related claims

Microcare is a unique microinsurance organization, having been transformed from a not-for-profit background to become a fully fledged insurance company in Uganda specializing in health insurance. Microcare focuses on the low-income market, drawing from the formal and informal sectors and span-

ning urban and rural locations. Microcare's objective is to provide "affordable access to quality healthcare".

Malaria is endemic throughout Uganda and the commonest diagnosis for Microcare's health insurance clients, particularly in rural areas. Cumulatively, the claims cost paid by Microcare for malaria is more than that of any other diagnosis. To make matters worse, the cost of treating malaria in Uganda is set to increase as its resistance to chloroquine becomes widespread. Chloroquine has been the cheapest treatment commonly used for malaria, costing less than US\$1 for a full course. Drug resistance has forced the Uganda Ministry of Health to change the recommended first-line treatment protocol to regimens based on Artemether compounds accompanied by one other drug (to discourage rapid emergence of Artemether resistance as well). These Artemether-based combinations cost about US\$7 for a course of treatment.

In Uganda, the prevalent form of malaria is falciparum, the most dangerous type, which can cause cerebral malaria and death, particularly in the non-immune (e.g. children). Falciparum malaria frequently leads to hospitalization if not treated quickly in the early stages. The epidemiology of the disease is complicated further by the continuing emergence of new strains to which local people are not immune. The insect vector for the disease, the female anopheles mosquito, thrives in Uganda, particularly during the rainy season. This factor, combined with the emergence of new strains, leads to severe intermittent seasonal epidemics of this already pandemic disease.

The use of insecticide treated nets (ITNs) is a widespread and well-documented malaria prevention measure. Commonly, these nets are treated with permethrin-based compounds (a derivative of the pyrethrum plant). Bed nets can be treated by incorporating long-acting forms of the insecticide into the mesh during the manufacturing of the fabric which are released slowly over the two-to-three-year lifespan of the net, or by regular immersion of the bed net in a solution of insecticide after washing.

By acting as a physical barrier, the net prevents mosquitoes from making contact with and biting the sleeping person. The net is treated with an insecticide, so when mosquitoes are attracted to the potential human victim, they land on the outside surface of the net. While resting on the net, the mosquitoes absorb a dose of the insecticide adequate to either kill or debilitate them. Since anopheles mosquitoes do not usually bite people during the day, treated bed nets make a substantial contribution to malaria containment. However, people are still vulnerable in the evenings before going to bed and when getting up early in the morning – an unavoidable limitation of the effectiveness of mosquito nets for malaria prevention. In Uganda, a treated double-bed mosquito net costs around US\$6.

Microcare has already started to provide subsidized (half price) insecticide-treated nets to rural clients and has experienced a good uptake. The logic of subsidizing nets, as opposed to making them free, is that people value something more if they have paid for it, and are more likely to use it properly if they value it.

Since clients frequently suffer more than one attack of malaria per year and more than one person will sleep under a double-bed net, the economics make a compelling argument. A US\$3 subsidy to prevent two or more people getting a frequently occurring disease that would, with the new drug regimens, cost US\$7 to treat. The nets should last for several years and have become a popular marketing tool for Microcare.

At this point (six months since the start of the subsidized net programme) assessment of its impact cannot be done accurately because it is necessary to complete a full year of the intervention to allow for seasonal variations in epidemiology. However, the “buy-in” of the client community for preventive measures has already been seen. Prevention helps neutralize the argument “I paid my premium, but I didn’t get sick,” because the insurer can reply: “The reason you didn’t get sick is our prevention programme!”

So Microcare is now turning its attention to preparing programmes targeting other diseases amenable to prevention and education. Sexually transmitted infections (including HIV/AIDS), sanitation-related water-borne diseases and the emerging “Western diseases” such as obesity and the resultant adult onset of (Type II) diabetes are all under active training material development by the Microcare Preventive Health Department.

A basic programme like Microcare’s, and those highlighted in Boxes 60 and 61, show that a range of simple and effective loss-control programmes can be implemented by microinsurers under various local conditions, possibly in partnership with other organizations and government agencies.

In mainstream insurance, putting a value on a loss-control measure in the physical damage line is relatively simple. If a non-life insurer expects a million motor claims in a certain year for windscreen replacement, and if a preferred body shop quotes a three-dollar discount on each, the insurer would save US\$3 million minus the cost of a communication programme to ensure that all branch offices require claimants to go to the chosen body shop.

However, how can an insurer determine the value of a prevention measure designed to lower the cost of claims for personal sickness or injury? The Microcare programme in Uganda, using comparative figures for claims experience before and after the programme’s implementation, points the way for microinsurers. However, when it comes to evaluating the cost-effectiveness

of a number of programmes more precisely for the purpose of choosing the most suitable one, the calculation becomes complicated, and experts such as statisticians and actuaries need to be involved.

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## 7 Conclusions

The main points and recommendations from this chapter are:

- Loss control has two key elements: loss prevention and loss minimization.
- Loss prevention has evolved into a professional discipline in non-life insurance, and has resulted in improved risks and safety standards as well as savings in claims costs for insurers and in premiums for the insureds.
- Life and health insurers can also achieve these benefits as the world faces new threats of viral pandemics and environmental hazards.
- Microinsurers can adapt the industry's loss-prevention and loss-minimization measures and benefit from helping policyholders become less prone to diseases and better prepared to deal effectively with setbacks in health. These measures help reduce costs for the insureds (lower premiums) as well as the insurer (fewer claims).
- A wide range of simple and effective loss control programmes can be implemented by microinsurers under various local conditions, possibly in partnership with other organizations and government agencies.
- To calculate the value and cost-effectiveness of prevention measures, microinsurers could diligently analyse comparative figures for claims experience before and after a prevention programme's implementation.
- Loss prevention can demonstrate that insurance is not only about collecting money and paying for a loss. It is a comprehensive package which both protects and cares for people.



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## 3.10 Performance indicators and benchmarking

Denis Garand and John Wipf<sup>1</sup>

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Microinsurance has the potential to provide much-needed protection for the poor. Since microinsurance is relatively new, it presents an opportunity for the insurance industry to learn new and superior skills, such as developing low-cost delivery mechanisms to grow this market effectively. A realistic set of benchmarks in the form of operational standards and performance indicators can be an excellent guide for microinsurance managers aiming at continuous improvement and excellence.

In mature insurance industries, for example, rating agencies and regulators use key insurance ratios to monitor and flag companies that are at risk of failing. This permits timely intervention that may save the insurance company. Similarly, many insurance companies use industry performance benchmarks to compare themselves to their competitors, and this helps them understand areas that require improvement. A relevant set of indicators paired with industry-accepted benchmark values (standards of performance) can be a signpost for management, boards and other stakeholders, helping them to ensure that the company remains solvent and that performance continues to improve.

Developing key performance indicators for microinsurance and periodically publishing the performance of all participating microinsurance schemes relative to an established set of benchmarks should be a priority, as this contributes to the development of a robust, transparent and sizable microinsurance market. Performance standards are operational goals that help a microinsurer achieve viability, while indicators are used to measure the extent to which the established standards are achieved. These indicators, both qualitative and quantitative, should be primarily focused on key financial measures since these provide a rapid assessment of the organization. They should cover the entire range of operations, including marketing and distri

<sup>1</sup> The references to Bungwe (Rwanda), TYM and Dong Trieu (Viet Nam), Confederation Life (Canada) and the pre-need insurance industry in the Philippines are based on the authors' experiences.

bution, investments and risk management. Managers should measure the performance of their operations and compare it to that of similar organizations at least annually. Donors may also want to evaluate the current position of a partner relative to others in the industry.

The main objective of this chapter is to discuss some of the more important indicators that should be included. In addition, the chapter touches on why these selected indicators are useful in evaluating the general health of a microinsurance programme and highlights areas that may require further development. For these to be useful and manageable, there should only be five to twelve initial key indicators. If major concerns are identified, then managers can drill down to more detailed indicators designed to isolate more specific issues.

Since microinsurance implementation varies greatly between countries, cultures and affiliated sectors, the indicators reviewed here are intended to cover most situations and apply to microinsurance as a whole – that is, a scheme consisting of one or more of the following players: a delivery agent of an insurance company, a service provider, a third-party administrator, an insurance company or a stand-alone risk-bearing microinsurance organization.

The basic assumption is that an organization promoting microinsurance has an interest in understanding all aspects of the insurance programme and is aiming for its long-term sustainability. This chapter covers indicators in four key areas: 1) marketing and distribution, 2) financial management and viability, 3) efficiency and client value and 4) investment management.

## 1 Marketing and distribution

Marketing and distribution effectiveness is one of the most important requirements for the long-term sustainability of a microinsurance scheme. Without successful marketing, the organization is unlikely to reach or retain the critical mass that it needs to survive. Successful marketing in turn largely depends on the client's satisfaction with the services and perceived value of the products. In this category, there are three key ratios: participation, renewal and persistency.

As an indicator of marketing effectiveness, the **participation rate** refers to the proportion of eligible members of a target population participating in the microinsurance programme at a given point in time.

*Participation rate = total number of members/eligible members  
of the target population*

The ideal situation is when a very large proportion of a target population voluntarily participates in a microinsurance programme, which generally indicates that the population has accepted the concept of pooling risks and resources. It is also likely that these participants have a good understanding of the benefits package and know how to access the benefits.

In Rwanda, Bungwe health microinsurance scheme, launched in 2001, achieved a 24 per cent participation rate in its first year of operation. This rate has increased each year and in 2005 a remarkable 95 per cent of the community was participating. This scheme was viable in its first year of operation. The success of the programme may be due to clients understanding the solidarity aspect and seeing great value in the scheme since it provides access to the village's health centre and ambulance services, and to the developers of the scheme being well-attuned to the needs of the population.

Conversely, at TUW SKOK in Poland, just 10 per cent of targeted credit union members enrol in the insurer's voluntary services. This low participation rate may indicate that the product lines are not attractive to most members or that members consider the company's products and services offer poor value, or possibly that the marketing skills of the distribution channel are ineffective. In any case, management should take notice of the low value of this indicator and aim to understand why it is unable to attract a greater percentage of their target market.

One way to attain a high participation rate is to make cover compulsory. This is only possible in certain cases, such as for the borrowers of an MFI or when cooperative members vote for mandatory coverage at their general membership meeting, but it is virtually impossible to enforce in a community scheme. CARD in the Philippines requires all its eligible borrowers to join the mutual benefits association (CARD MBA). Similarly, TYM and Dong Trieu in Viet Nam require that their microfinance borrowers participate in the microinsurance scheme.

Mandatory coverage does not mean that the microinsurer can become lax in its marketing efforts. These products and services must be continuously sold and good value maintained, otherwise resistance to the compulsory participation will escalate. CARD appears to be successful at this, with many MBA members stating that the insurance products are their principal reason for joining CARD (*see Box 65*). Furthermore, in 2004, Dong Trieu clients in focus group discussions expressed satisfaction with the microinsurance programme despite its limited benefits, mainly because the clients felt honoured to contribute to a fund that may someday help fellow clients facing difficulties. In both cases, the organizations successfully implemented microinsurance programmes with compulsory participation.

## Box 65

**Great value placed on insurance**

In a 2002 qualitative survey conducted by Freedom from Hunger, 12 out of 27 focus groups interviewed named MBA insurance as *the most valuable aspect of the entire CARD product portfolio*. Such a result runs contrary to experience with similar arrangements in other countries where mandatory insurance is never rated highest on a scale of product value for an institution that offers savings and credit facilities, often because of its intangible nature.

*Source: Adapted from McCord and Buczkowski, 2004.*

The **renewal rate** is a related indicator but applies specifically to term products (products with a fixed term of coverage such as one year). It is defined as the percentage of clients who had coverage in the previous year and are still eligible for renewal, who are renewing their term coverage. It reflects (among other things) the satisfaction of the client once the term product has been purchased.

$$\text{Renewal rate} = \frac{(\text{number of clients from Year X continuing coverage in Year X + 1})}{(\text{number of clients in Year X})}$$

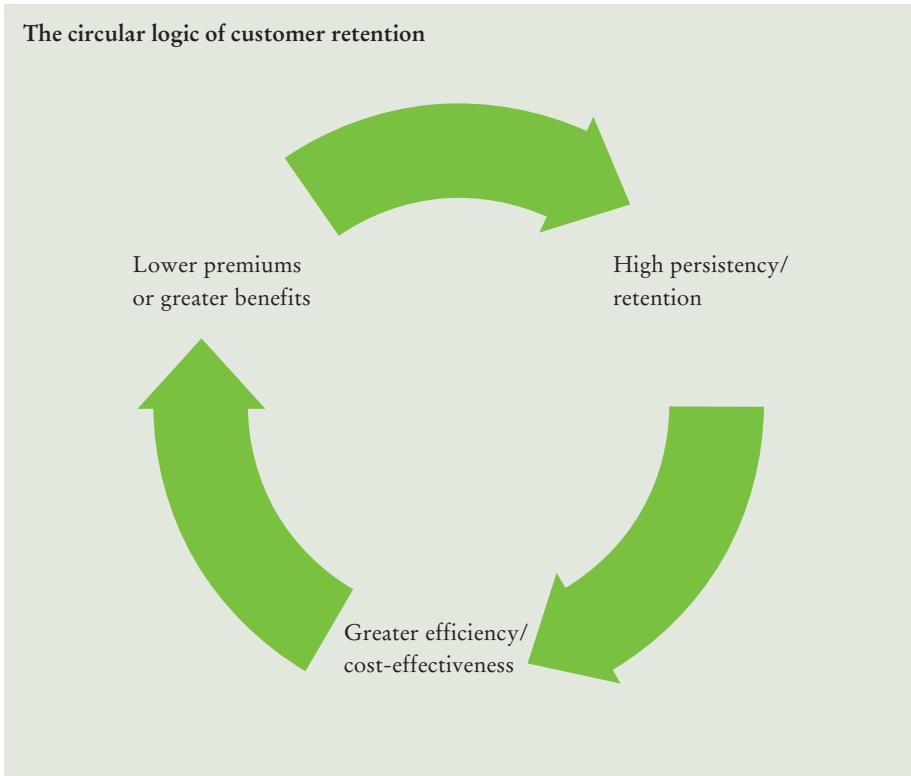
A more general measure is the **persistence rate**, which refers to the number of clients from a cohort continuing their coverage at a later date divided by the number of clients from the same cohort with coverage in Year X. It is more general than the renewal rate since it applies to both term and continuous coverage.

For schemes with voluntary participation, low renewal and persistence rates are often indicative of client dissatisfaction, possibly due to poor communication, unacceptable product value, unsatisfactory claims payment, and so on.

Operationally, high participation and persistence rates help to reduce administrative expenses. This adds value to the product since a larger proportion of the premium can be returned as benefits, which in turn encourages even wider and longer-term participation (*see Figure 22*). For example, in Guinea, UMSGF's relatively high renewal rate of 81 per cent and a 30 per cent participation rate among the targeted population helps achieve a low expense ratio of just 18 to 20 per cent of gross premium. This low expense ratio enables the scheme to offer more attractive benefits and may be a reason for the high rate of renewals.

Figure 22

## The circular logic of customer retention



In contrast, low renewal rates over extended periods will increase costs per unit of insurance since the fixed costs of the programme must be distributed over fewer insurance units, which dampens participation and persistency even more since high expenses result in reduced product value. It is very likely that the ambivalence of Delta Life (Bangladesh) towards its low persistency rate contributes towards its high (although improving) expense ratio and equally likely that the high expense ratio reinforces the low persistency rates due to poor value.

The reader may wonder at this point, “What are acceptable participation and renewal/persistency rates?” There is no straightforward answer to this question since it depends on factors such as the type of microinsurance scheme, the size of the target population, the distribution channel and how long the programme has been set up. An MFI-linked scheme such as CARD’s, for example, cannot be compared fairly to a programme such as Delta Life’s which relies on foot soldiers selling individual policies, without some sort of calibration of the scoring mechanism.

This suggests that the scoring formulas for the proposed set of indicators should consider as parameters the microinsurance scheme’s type, the time that has elapsed since it was established, its product lines, target market, distribution channels and so on. For example, it may well mean that a commu-

nity-based health insurance scheme achieving a 30 per cent participation in Year 5 would score just as well or better than a credit union achieving a 65 per cent penetration rate in Year 4 with its voluntary credit life product being marketed to its narrowly defined target market, i.e. its borrowers.

Perception of good value results not only from a high benefit-to-premium payout ratio, but also from satisfaction with the servicing. It is likely that VimoSEWA's low renewal rates have improved in recent years in part because of better servicing and shorter claims turn-around times (*see Table 32*). On the other hand, detailed client satisfaction surveys would probably confirm that Delta Life's low persistency rate is not at all helped by extensive delays in claims payments, minimal efforts on policy services and high claims rejection rates.

Table 32

#### Improved service enhances retention at VimoSEWA (India)

<i>Period</i>	<i>Renewal rate (%)</i>	<i>Time to pay health claims (days)</i>
2002	Not available	90
2003	48	70
2004	51	62
2005	59	59

*Note: The time in days taken to reimburse health claims is measured from the date of hospitalization. The average time for a member to submit a claim is 40 days.*

Unfortunately, in some environments low persistency rates may actually result in higher profits for the company. For example, the commercial pre-need industry in the Philippines (offering mainly education, pension and pre-paid burial plans) profits greatly from the low cash value payouts upon surrender of pre-need policies.<sup>2</sup> The strategy of some unscrupulous companies is to offer very high commission rates to individual agents in the initial policy years, but then drastically reduce the commissions in the third and subsequent years of a five- or 10-year plan. This results in very aggressive selling, often to reluctant buyers who then cancel their policies or allow them to lapse in droves in the third and fourth policy years when the agents turn their attention elsewhere. The company then profits from the early cancellations since the surrender payout requirement is very low.

<sup>2</sup> The pre-need industry in Philippines is a special sub-sector of the insurance industry where companies offer savings plans with insurance features to address future needs such as retirement, children's weddings, burial expenses, education and so on. It is currently regulated by the Securities and Exchange Commission, but there is a pending bill to transfer it to the Insurance Commission.

Obviously, these sales practices run counter to the spirit of microinsurance. In some countries, the low-income market has exposure to dishonest insurance schemes and, as a result, real microinsurers have to work extra hard to demonstrate that they are indeed different.

## 2 Financial management and viability

One of the most important indicators is the microinsurer's net financial result or **net income** since this reflects performance in all activities in the period reviewed (*see Table 33*). It should be computed net of subsidies and grants received. To measure net income, an accurate profit and loss statement on an accrual accounting<sup>3</sup> basis has to be produced, which takes account of all costs of administering the scheme, depreciation of equipment, reserve increases, and so on.

*Net income (prior to non-permanent subsidies) = Earned premium + investment income – claims incurred – operating expenses – reserve increases.*

Producing accurate financial statements is an important management function of a microinsurance scheme. Results should be shown by product line to make it clear where the programme is losing or making money. This requires proper allocation of expenses on an accrual basis and by product line, as well as correct calculation of actuarial reserves since reserve increases must be recognized as an expense. The ability to produce a profit and loss statement, a balance sheet, and a cash flow statement by product line should be a standard requirement for all microinsurance schemes and it should be possible to monitor this ability using qualitative indicators.

Some products such as credit life are usually profitable within the first year if implemented properly, while others such as health insurance may take several years to reach profitability. Obviously a positive net income over several years suggests viability of the microinsurance scheme, at least in the short term, while an organization with significant and consecutive negative net incomes will have difficulty surviving for very long since its capital and surplus will be eroded to a point where it becomes insolvent.

<sup>3</sup> **Accrual accounting** is a method that measures the performance and position of a company by recognizing economic events as they occur, regardless of when related payments take place.

Table 33

## Selected examples of net income

<i>Organization</i>	<i>Microinsurance start date</i>	<i>Type of product</i>	<i>Net income as a percentage of earned premium</i>
CARD MBA	1994 informally, 1999 formal registration	Credit life, whole life, and savings products	31 (2003)
MUSCCO	1980	Credit life and life savings	40-45 (2003; incomplete information on earned premium)
Spandana	1998	Life and hut insurance	20 (2003-2004)
AssEF	2003	Health	-24 (2004) before subsidies
VimoSEWA	1992	Life, accident, health, and asset protection	-51 (2004) before subsidies

The amount of net income should reflect the desired goals of the scheme. The goals of a start-up scheme are typically to provide good value for the participants and to remain viable in the medium to long term. For more mature programmes however, the goals may be expanded to reflect a desire for a competitive return on the shareholders' or members' surplus and capital, or to transform the scheme into a fully capitalized insurance company.

The net income has a direct effect on the **solvency ratio** defined here as the total liabilities of the microinsurance scheme divided by its admitted assets.<sup>4</sup> Clearly this needs to be below 1 for the scheme to be technically solvent. For example, MBAs in the Philippines are required by the Insurance Commission to maintain a solvency ratio of 0.80 or lower.

$$\text{Solvency ratio} = \text{total liabilities} / \text{total admitted assets}$$

Another important indicator for this category is the **liquidity ratio**. Even if a microinsurer has a healthy solvency ratio, it could still have problems paying claims and expenses if it does not have adequate cash or cash equivalents in the short term (*see Box 66*). Too much cash, on the other hand, usually means that the scheme is forgoing investment opportunities, which will result in higher premiums or lower benefits for the participants.

<sup>4</sup> **Admitted assets** are those allowed by the regulator to be included in the solvency ratio calculation; typically, these are higher-quality assets, but may also include such items as the residual value of the company's equipment.



*Liquidity ratio = cash and cash equivalent investments / probable payouts within a year.*

Box 66

### What doomed Confederation Life of Canada?

For developed insurance companies, a classic reason for failure is illiquidity. A large insurance company in Canada, Confederation Life, failed mainly due to the high proportion of its funds invested in illiquid property. By 1990, Confederation Life was one of the largest life insurance companies in Canada. Its over-investment in property led to problems however, when the booming real estate market began to fall, resulting in large losses in value for Confederation Life. Even more importantly, it generated a liquidity crisis. On 12 August 1994, the regulators declared the company insolvent. Many years later, the bankruptcy administrators were able to pay all outstanding obligations of the insurer after they had had sufficient time to sell the company's property assets.

3

### Efficiency and client value

As mentioned above, good product value is one of the most important catalysts for the participation rate and for the programme to remain viable. Good value, however, can only be achieved with a low **expense ratio**, which is the proportion of the premium earned in a given period consumed by incurred operating expenses in the same period.

*Expense ratio = Incurred operating expenses / earned premium*

By definition, microinsurance premiums are small and are usually collected in frequent instalments. The result is a very large number of transactions relative to premium amounts, which makes it difficult to maintain a low expense ratio. Because of this, viability can usually be achieved only if an existing collection system is utilized (see Chapter 3.3). The best example is a microinsurance programme linked to an MFI, where premiums are collected together with the microfinance loan repayments. Another example is Yeshasvini (India), which collaborates with milk-producer cooperatives by collecting directly from the co-ops, which then deduct the premiums from the proceeds that the farmers earn from daily milk deliveries. Voluntary products aimed at the wider community also require some mechanism to reach large numbers of participants efficiently, such as using savings and credit groups.

As a rule of thumb, to be effective in microinsurance the target expense ratio should be below 30 per cent in the early years of the scheme, but with a trend towards 20 per cent or less after the programme has stabilized. CARD MBA achieves an expense ratio well below 20 per cent by riding on the collection system of the associated MFI. This target is much more difficult to achieve for schemes like Delta Life, which offers individual life products with premium collection carried out by field staff going door-to-door.

A good complement for this indicator is the **incurred claims ratio**, defined as total incurred claims divided by earned premium in a given period. Good product value requires that as much of the premium as possible be returned to the members in the form of benefits. **Maintaining a high claims ratio while at the same remaining viable is the crux of the microinsurance challenge.** Clearly this can only be achieved with maximum operational efficiency resulting in a low expense ratio and by maximizing the investment returns on the scheme's reserve funds (*see Table 34*).

*Incurred claims ratio = incurred claims / earned premium*

Even though CARD MBA has an expense ratio below 20 per cent, its claims ratio for credit life is approximately 16 per cent which is very low. If this low claims ratio is maintained over time, many members may question the value of the insurance programme. The MBA should consider either lowering the credit life rates or providing some additional benefits since both dividend payouts and cross-subsidization of products are not permitted for an MBA.

Delta Life with its high expense ratio of over 40 per cent and a very low claims ratio calls into question the value of providing endowment products to the low-income markets – perhaps individual endowment products may not be the best savings vehicles for the poor (*see Chapter 2.2*).

Another measure in this category is the **time to payout** – how many days it takes for a client to receive a payment after the occurrence of an event. Paying claims promptly is an important aspect of service and good value. Health microinsurance models using a cashless system provide immediate relief to the client, and such systems would score highly on this indicator.

Table 34 Expense and claims ratios for selected schemes

<i>Micro-insurance scheme</i>	<i>Expense ratio (%)</i>	<i>Incurred claims ratio (%)</i>	<i>Comments</i>
CARD MBA	17	16 (credit life) 60 (whole life)	CARD MBA is extremely efficient, but not enough of these gains are paid back in the form of benefits, resulting in the rapid growth of its surplus – yet clients perceive the programme as excellent value. This cannot be expected to last indefinitely.
Spandana	4	91	Spandana combines low expense and a high payout ratio, which provides outstanding value to members.
MUSCCO	15	40	There is some value to clients, but after the scheme has built up reserves, it needs to improve the value.
AIG Uganda <sup>1</sup>	41	37	Poor value.
Delta Life	41	10	The combined high expense ratio and low benefit level raises doubts as to the long-term viability of this product.
Yeshasvini	10	140	The claims ratio is high because the plan received a government subsidy in 2004; it should decrease in the next year as the premium was doubled. The programme is still too new for an assessment of its likely future viability to be made.
AssEF	28	71	With these ratios, the programme has very little margin for building up reserves to protect itself from claims variation.

<sup>1</sup> These ratios only take into consideration the premium paid by the MFIs to the insurer, but not the additional fee retained by the MFIs to pay for their expenses.

## 4 Investment management

As discussed in Chapter 3.6, whenever there is an accumulation of funds, investment management needs to be such that it optimizes value. The incorrect management of assets is a major reason for the failure of commercial insurance companies. Microinsurers offering long-term asset accumulation products have to be extremely vigilant in managing their assets professionally.

Asset diversification and quality are the best ways to protect an investment portfolio and therefore both are important indicators for measuring sustainability. The **asset diversification** measure should reflect the amount invested in a particular asset including a related organization, whereas the **asset quality** measure should reflect the overall quality of the portfolio. For example, as a general rule no more than 10 per cent of assets should be in any one investment or in a related organization. Over-exposure to property is another danger since this will ultimately impair liquidity and make it difficult for the scheme to meet its claims and expense obligations in a timely manner.

CARD MBA and VimoSEWA recently had a high concentration of investments in a related organization, the loan portfolio of the parent MFI.<sup>5</sup> This is a well-known danger, and both microinsurers are rated low in this category. Most of the case studies have very little information on asset diversification, asset quality and investments in general.

If the organization has given long-term guarantees, then it must have the capacity to carry out **asset-liability matching (ALM)**. This process requires projections of liability streams (claims, expenses, maturities, etc.) and the capability to periodically shuffle investments to ensure that the required investment returns are timed to coincide with future cash flow obligations. Failure to manage a portfolio with long-term guarantees in this manner can easily result in bankruptcy. If the scheme does not have the capacity, it should outsource investment management to a professional firm. Investment management performance should be monitored by means of qualitative indicators.

A microinsurer offering long-term interest rate guarantees must have ready access to quality investment instruments with matching term and interest rates to cover payment of the guarantees. In general, it should not offer long-term rate guarantees without ensuring that they are linked to actual portfolio performance (*see Chapter 3.6*). Indicators should be developed to monitor these practices.

<sup>5</sup> Since the case studies were completed, CARD MBA and VimoSEWA have taken corrective measures and have significantly reduced their investments in related organizations.

## 5

## Conclusions

Performance benchmarking is an important way for microinsurance providers to assess their development or for donors to understand their development requirements. Some of the more important indicators for preliminary assessment of a microinsurer's operations and practices are:

### Marketing and distribution

- Participation rate
- Renewal rate
- Persistency rate

### Financial management and viability

- Net income
- Solvency ratio
- Liquidity ratio

### Efficiency and client value

- Expense ratio
- Incurred claims ratio
- Time to payout

### Investment management

- Asset diversification
- Asset quality
- Asset-liability matching
- Matching interest rate guarantees

The aim of these indicators is to point to key areas that require management attention. Once a deficiency is found, further research is required to understand the source of the problem and to develop solutions that will improve results for future years of operation.

Besides these four categories, additional important indicators should also be developed in the areas of **risk management, legal and organizational structure, operations management, community outreach and health insurance**. The latter category should address some of the special challenges involved in offering health.

The authors have devised a fairly comprehensive preliminary set of 40 indicators over nine categories and the associated scoring mechanisms. Some of the well-known microinsurers discussed in this book were evaluated on a test basis using this set – the information was extracted from the CGAP case studies.

In the illustration below, each indicator was assigned a potential score in order to give it a weighting in the overall score. The total potential score for a microinsurer is the sum of the individual potential scores for those indicators relevant to or measurable for the microinsurer. Since not all indicators are applicable to or measurable for a microinsurer, the total potential score can vary. For example, a qualitative indicator measuring whether or not tariffs for services are negotiated with health service providers is only applicable to a health microinsurer – for microinsurers without a health product both potential and actual score for this indicator were set to 0. Similarly, in cases

where data was insufficient for the evaluation of a particular indicator, both potential and actual scores for the indicator were set to zero.

Without going into the methodology of scoring and the scoring formulae used, the ratings for the microinsurers in the case studies are summarized in Table 35.

Table 35

#### Rating of microinsurance schemes – An illustration

<i>Microinsurer</i>	<i>Country</i>	<i>Potential</i>	<i>Actual score</i>	<i>Rating (%) score</i>
Yeshasvini	India	122	100	82
TUW SKOK	Poland	130	106	82
La Equidad	Colombia	86	70	81
VimoSEWA	India	86	65	76
Tata-AIG	India	89	66	75
AssEF	Benin	143	105	73
CARD MBA	Philippines	151	109	72
Columna	Guatemala	150	108	72
Grameen Kalyan	Bangladesh	132	92	70
UMSGF	Guinea	117	77	66
ServiPerú	Peru	109	70	64
Spandana	India	114	63	55
MUSCCO	Malawi	137	75	55
Madison	Zambia	77	41	53
Yasiru	Sri Lanka	117	55	47
Delta Life	Bangladesh	127	58	46
AIG Uganda	Uganda	79	35	44
Karuna Trust	India	59	26	43
TYM	Viet Nam	114	39	34