MICROINSURANCE

Improving risk management for the poor

N°9 March 2006

The Working Group on Microinsurance, initiated by CGAP and comprising of representatives from donors, multilateral agencies, NGOs, private insurance companies and other interested parties, was established in 2001 to promote the development of insurance services for the poor through increased stakeholder coordination and information sharing. Currently chaired by the International Labour Organization (ILO), the Working Group is organised into eight subgroups. To share information about microinsurance initiatives, the Working Group issues this quarterly Newsletter. For more information contact Craig Churchill, churchill@ilo.org

Subgroup Contacts: ➽ Subgroup Operations and Donor Guidelines: mjmccord@microinsurancecentre.org ➽ Subgroup Demand: moniquec@mfopps.org ➽ Subgroup Regulation: brigitte.klein@gtz.de ➽ Subgroup Dissemination: insurance@microfinance.lu ➽ Subgroup Performance Indicators: denis@garandnet.net; johnwipf@yahoo.com ➽ Subgroup Health Insurance: bruno.galland@groupecidr.org; Klaus.Fischer@fas.ulaval.ca ➽ Subgroup Agriculture (Rural) Insurance [tbd] ➽ Subgroup Capacity Building: gramm25652@aol.com

To receive the coming issues of MICROINSURANCE, please contact insurance@microfinance.lu
The newsletter is available in English, French and Spanish.

CGAP WORKING GROUP ON MICROINSURANCE

Concept

HEALTH MICRO-INSURANCE SCHEMES: THE IMPORTANCE OF CONDUCTING A FEASIBILITY STUDY

The term "health micro-insurance" encompasses a wide variety of schemes. These include: mutual health organizations, which are autonomous associations based on the solidarity and democratic participation of their members; insurance schemes, which are organized and managed by health care providers; health insurance schemes set up by other actors, such as NGOs, microfinance institutions, cooperatives or trade unions.

Actually, in spite of their dynamic nature, micro-health insurance schemes, in general, are quite fragile. They do not possess the hindsight and experience needed for an accurate determination of the financial risks they face. The financial safeguards of such schemes – reserves, reinsurance – and their promoters' level of competence in the area of insurance are presently still limited.

Given such a context, the foundations of these schemes – that is, the assumptions upon which they are based – must be particularly firm. A scheme will have greater chances of surviving, and subsequently of developing, if it is well designed from the outset. Therefore, conducting a systematic feasibility study appears to be essential.

One element of such a study would be data-collection. The data-collection consists of gathering the information needed to design the health micro-insurance scheme. This information will be used to select the services to be covered, benefit/premium combination(s), partner health care providers, etc.

The information gathered may also be used to put together a description of the initial situation, which will serve as a reference for later evaluating the scheme's impact on the frequentation of health facilities, the means of treatment sought in response to illness, etc.

The information should also be used for designing the health micro-insurance scheme that will subsequently be implemented.

This involves steps such as to:

1. Define the benefit plans, that is, the health services to be covered and the levels of coverage.

The health services to be covered by the scheme may be pre-selected on the basis of priority criteria. The criteria may vary from one type of organization to the next; but in general include:

- The "real" health needs of the population. Priority is given to services that contribute to reducing significantly the mortality rate and the morbidity rate of certain illnesses.
- The population's "felt" and "expressed" health needs. These are the health services that people would like for the scheme to cover on priority basis.
- The financial difficulties associated with the utilization of these services. Priority should be given to services that pose serious problems in terms of financial accessibility.
- Problems of cost recovery and financing (from the standpoint of health care providers). Priority services are those that demonstrate the highest rates of outstanding payments or whose utilization is insufficient (problem relating to the amortization of equipment).

2. Calculate the corresponding premiums. The method of calculation proposed (see figure 1) consists of six steps:

- Calculate the pure premium
- Adjust the pure premium
- Calculate the safety loading
- Calculate the unit operating costs
- Calculate the unit surplus
- Calculate the total premium

3. Verify that the benefit/premium combination(s) is balanced.

A compromise must be worked out, together with the target population, between the benefits to be provided and the premiums to be paid. In order to achieve this compromise, the actors associated with the scheme must ensure that each of the potential scenarios fulfils four criteria or requirements (see figure 2).

4. Select the partner health care providers and define the agreement(s) scheme wish to conclude with them. These may include:

- a fee agreement
- an agreement concerning patient reception procedures for insured persons or concerning treatment protocols
- an agreement concerning payment methods: fee-for-service or global fee
- and/or a third-party payment agreement

5. Define the scheme's organization and its main methods of operation.

For each operating rule, for instance, different options, with the advantages and disadvantages and the corresponding accompanying measures, are available.

Source: Health Micro-Insurance Schemes: Feasibility Study Guide Volume 1: Procedure and Volume 2: Tools (ILO/STEP 2005)

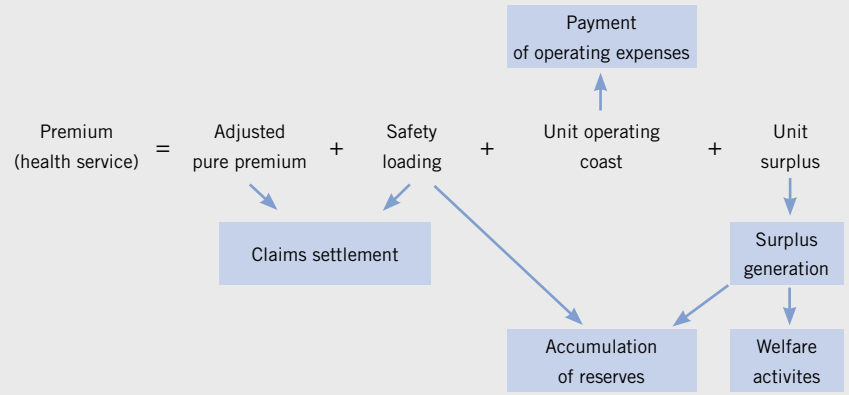

Fig. 1: Calculation formula of the individual premium for a given health service

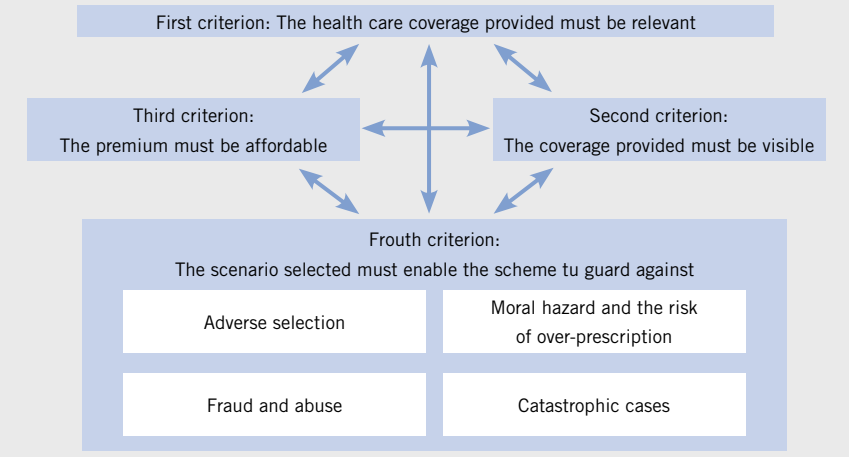

Fig. 2: Criteria for selecting benefit/premium combination(s)

This text is taken from Health Micro-Insurance Schemes: Feasibility Study Guide (2005). This guide aims to encourage promoters and operators, and support their efforts, to conduct a systematic feasibility study prior to the establishment or further development of a scheme. Volume 1 provides step-by-step instructions for carrying out a feasibility study and assists actors in organizing the process of conducting the study. Volume 2 provides examples of supporting materials, tools, practical examples and methods of analysis and calculation, which offer concrete support for each step of the procedure. This guide available in French and English was produced by the "Strategies and Tools against social Exclusion and Poverty" (STEP) programme of the Social Protection Sector of the International Labour Organization (ILO).

Concept

INSURANCE REGULATORS COOPERATE WITH CGAP ON FUTURE MICRO-INSURANCE REGULATION

Regulation and supervision of micro-insurance is a key factor for the future growth and success of micro-insurance activities. As pointed out in a previous edition of this newsletter (No. 5, December 2004), the regulatory framework consistent with insurance principles protects the rights of policyholders. Furthermore, it enables the development of the insurance market by making insurance affordable and accessible. Well-adapted regulation helps designing appropriate products for the low-income segment of the population besides ensuring the long-term stability of micro-insurance providers.

In recognition of this background, the International Association of Insurance Supervisors (IAIS) and the Regulation, Supervision and Policy (RSP) Subgroup of the CGAP Working Group on Micro-insurance have agreed to cooperate in the area of regulation and supervision of micro-insurance. The IAIS represents insurance

regulators and supervisors from more than 180 jurisdictions.

Representatives from IAIS members of developing and developed countries met with the Regulation Subgroup on 18 February 2006 in Basel, Switzerland. They discussed the current state of micro-insurance regulation and options to create more conducive regulatory frameworks for the development of microinsurance.

Regulation of micro-insurance is a challenge for most supervisory authorities. Data on the functioning of micro-insurance is scarce and a micro-insurer's business process differs from established insurance operations. Many of the micro-insurance providers do not have experience with the technical and legal aspects of insurance. Thus, they need comprehensive guidance and support in implementing legal and prudential requirements. The risk parameters used by the regulators are designed for the high-premium and high-volume business of typical commercial insurers. Micro-insurers, however, handle small policies and premiums and often work with fragmented underwriting and claiming processes.

IAIS and the RSP Subgroup have formed a Joint Working Group (JWG). More information on this in section News from the Working Group: Regulation Subgroup.

Article written by Thomas Wiechers, GTZ

Case Study

YESHASVINI TRUST'S HEALTH INSURANCE

The Yeshasvini Cooperative Farmers Health Scheme in Karnataka (India) is a young but incredibly successful microinsurance scheme in terms of membership. Having started in 2003 with 1.6 million insured right away, it covered 2.2 million lives in its second year of operation, but in the third year it dropped to 1.45 million members after doubling the premium.

This (still) amazing success is possible through a tight partnership with the cooperative sector enabled through the Karnataka Department of Cooperation. The department used its influence to encourage cooperative societies to market the product actively. The marketing strategy applied by the societies' secretaries varies: while most convince their members to join, a few simply enrolled their members.

Yeshasvini Trust decided to design a benefit package focussing on high cost / low frequency events. More than 1,600 surgeries are covered under the scheme. The maximum coverage provided for one person per year amounts to Rs. 200,000 ($4,545). The annual premium per client was recently increased from Rs. 60 ($1.40) to Rs. 120 ($2.70). A person can claim the benefits in one of 150 (mainly) private hospitals aligned with the insurance scheme. A rate for each surgery is fixed. Additionally, free outpatient department (OPD) treatment is provided. The patient does not need to handle money; the insurer pays the health care provider for pre-approved surgeries, so the service is cashless to the policyholder.

Yeshasvini is a self-funded scheme and not linked to any insurance company.

Linking to an insurance company was considered as to reinforce financial stability and terms were negotiated. This option to transform the self-funded scheme into a partner-agent model was seriously discussed in the trust. However, the trust feared losing ownership and control of the scheme and the partnership was refused. Reinsurance is the favoured option now.

Yeshasvini outsources the administration of the scheme to a Third Party Administrator, a profit-oriented company. This company authorizes surgeries, processes claims and maintains a register of the members.

The scheme received government subsidies in all years of operation. With the increased premium in the third year, the scheme is expected to get closer to financial viability.

Although Yeshasvini can use the cooperative structures to channel information to clients, many policyholders are not well informed about the benefits and how to claim them.

Some Lessons

- With the cooperative sector Yeshasvini found a partner reaching out to the rural masses and having proved to be a strong distribution network. This stable structure helps to build up a huge number of members quickly.
- Political involvement can push the development of the scheme forward; but one has to be cautious not to lose sight of the initial motivations in the scheme.
- Yeshasvini lined up with about 150 private high quality hospitals. The good reputation of these hospitals contributes to the attractiveness of the scheme.
- The business relationship between cooperative societies and their members helps in the subscription periods of the scheme: members are in regular contact with their cooperative society anyway and can deduct the premium for the insurance directly from their business income.
- Even expensive surgeries can be covered if the number of insured is big enough to avoid strong effects of adverse selection and to cross-subsidise the ill person. Single surgeries of up to Rs. 96,000 ($2182) are covered.
- Increasing premium hand in hand with insufficient information results in drastically declined membership.

The major breakthrough of this scheme is without doubt insuring so many people in such a short time, which was only possible through the strong partnership with the Department of Cooperation. It used its authority to make cooperative societies actively distribute the product in one way or the other. The network of well-reputed private hospitals made the product even more attractive.

It is remarkable that the Yeshasvini scheme is likely to be financially self-sustaining from the third year of operation. The subsidies the scheme received so far seem to be well invested.

Source: Yeshasvini Trust, Karnataka – India (Ralf Radermacher, Natasha Wig, Olga van Putten-Rademaker, Verena Müller and David Dror, Case Study No. 20, November 2005).

Download from http://www.microfinancegateway.org/files/30774_file_Yeshasvini_Trust_Good_and_Bad_Case_Study_No_1_._20.pdf

Selected Info

Glossary

Benefit plan: Consists of both the list of covered health services and the level of coverage that corresponds to each service. A scheme may offer one or more benefit plans from which members may choose: for example, a basic plan and an extended plan (including a greater number of services, and in some cases, higher levels of coverage). Each benefit plan has a corresponding premium level; the premium level of an extended formula is higher than that of a basic plan.

Fee-for-service: A method of payment in which the health care provider is paid for each health service delivered and covered by the health micro-insurance scheme.

Source: Health Micro-Insurance Schemes: Feasibility Study Guide Volume 2: Tools (ILO/STEP 2005) http://www.ilo.org/public/english/support/publ/xtextsp.htm#b571X

About IAIS

Established in 1994, the **International Association of Insurance Supervisors** (IAIS) represents insurance regulators and supervisors of more than 180 jurisdictions from around the world including emerging countries.

Since 1999, the IAIS has welcomed insurance professionals as observers of their work. Currently there are more than 100 observers representing industry associations, professional associations, insurers and reinsurers, consultants and international financial institutions.

The IAIS is committed to developing standards and guidelines that can be used by insurance supervision throughout the world. IAIS papers represent best practices, or targets, for supervisors to work towards; they can be implemented in a flexible manner depending on the circumstances within each jurisdiction.

The IAIS works closely with other financial sector standard setting bodies and international organisations to promote financial stability.

Source: http://www.iaisweb.org

More Info

Latest Publications

Health Micro-Insurance Schemes: Feasibility Study Guide Volume 1: Procedure (ILO/STEP 2005).
More information: http://www.ilo.org/public/english/protection/socsec/step/index.htm

Health Micro-Insurance Schemes: Feasibility Study Guide Volume 2: Tools (ILO/STEP 2005).
More information: http://www.ilo.org/public/english/protection/socsec/step/index.htm

Micro-assurance: Défis, mise en place et commercialisation (Marc Nabeth, Editions L'argus de l'assurance, 2006).
More information: http://www.lamicrofinance.org/content/article/detail/17313?PHPSESSID=6a3753399292d3443b384ba3357a6c2f

Agricultural Insurance Revisited: New Developments and Perspectives in Latin America and the Caribbean (Mark Wenner, IADB, October 2005).
Download from http://www.iadb.org/sds/doc/RUR%2DAgriculturalInsuranceRevisitedNOV05.pdf

Insurance of Crops in Developing Countries (R.A.J. Roberts, by FAO Agricultural Services Bulletin, Nr. 159, 2005).
Download from http://www.ruralfinance.org/servlet/BinaryDownloaderServlet/27021_Insurance_of_crops.pdf?filename=1135189287882_InsuranceCrops_withcover.pdf&refID=27021

Into Action: Microinsurance – Summary Report Microinsurance Conference (Craig Churchill, Dirk Reinhard and Zahid Qureshi, Munich Re Foundation, CGAP Working Group on Microinsurance and ILO, January 2006).
Download from http://www.munichre-foundation.org/NR/rdonlyres/A7C0E563-3F94-41A5-B7A7-1CAC19C85F96/0/IntoAction01_2006_Microinsurance_E.pdf

Microinsurance: An Overview of Client, Provider and Support Perspectives (Toon Bullens and Herman Abels, MIAN, NOVIB Working Paper Nr. 1, 2005).
Download from http://62.251.91.146/miansupport/Microinsurance_brochure.pdf

Some Articles and Websites

Get Ready for Next Phase of Reforms (Interview with C. S. Rao, chairman of IRDA, Venkatachari Jagannathan, January 2006).
Download from http://www.domain-b.com/finance/insurance/2006/20060105_reforms.html

Never too little (Dirk Reinhard, D+C, January 2006).
Download from http://www.inwent.org/E+Z/content/archive-eng/01-2006/foc_art6.html

Website **Gret - SKY Health Insurance Program of Cambodia:** http://www.sky-cambodia.org/

Website of the newly founded Belgium microhealthinsurance platform **MASMUT** (Micro Assurances Santé- Mutuelles de Santé): www.masmut.be

Website **Foundation Entrepreneurs de la Cité**: http://www.entrepreneursdelacite.org/

Website **AMIN** (Asian Microinsurance Network): http://www.ilo.org/amin

Latest Good and Bad Practises Case Studies

AssEF - Association d'Entraide des Femmes, Benin (Olivier LOUIS dit GUERIN, Case Study No. 22, February 2006). This case study is an interesting example of a health insurance scheme being implemented by a microfinance institution. Download from http://www.microinsurancecentre.org/resources/Documents/22%20-%20AssEF%20Good%20and%20Bad%20Practices%20No%2022.pdf

Yeshasvini Trust, Karnataka – India (Ralf Radermacher, Natasha Wig, Olga van Putten-Rademaker, Verena Müller and David Dror, Case Study No. 20, November 2005). This case study is interesting with regards to its scale. (See also featured case study in this newsletter). Download from http://www.microfinancegateway.org/files/30774_file_Yeshasvini_Trust_Good_and_Bad_Case_Study_No_1_._20.pdf

Karuna Trust, Karnataka - India (Ralf Radermacher, Olga van Putten-Rademaker, Verena Müller, Natasha Wig and David Dror, Case Study No. 19, December 2005). This case study is good example of pairing insurance with existing public structures. Download from http://www.microfinancegateway.org/files/30234_file_Karuna_Trust_Good_and_Bad_Case_Study_No._19.pdf

Health Microinsurance: A Comparison of Four Publicly-run Schemes - Latin America (Jens Holst, Case Study No. 18, November 2005). This case study compares four health insurance schemes in Bolivia, Peru, El Salvador and Paraguay, which were all driven in one way or another by local government. Download from http://www.microfinancegateway.com/files/30074_file_LatinAmericaHealth-GoodandBadCaseStudyNo11.18.pdf

More case studies on Microinsurance Focus: http://microfinancegateway.org/resource_centers/insurance/article/28448/

Conference and Training

National Conference on Microinsurance from April 17-28, 2006 in Hyderabad, **India**. More information: http://www.ilo.org/amin/ShowConferences.do

Designing and Implementing Microinsurance from June 22-24, 2006 in Queyon City, **Philippines**. Contact info@sedpi.com or visit www.sedpi.com

News from the Working Group

Regulation Subgroup

Joint Issues Paper with the IAIS: IAIS and this subgroup have formed a Joint Working Group (JWG) and agreed to prepare an Issues Paper on Microinsurance Regulation and Supervision, which is expected to be published in October 2006. The objective of the paper is to describe current practices and challenges in regulation and supervision of microinsurance and to point to important considerations for the design of legal frameworks for microinsurance operations. Representatives of the supervisory authorities of India, South Africa, Morocco, USA and Germany and of IAIS and the CGAP Working Group will work on this paper.

Country Studies: The subgroup (via Klaus Fischer and Lavall University) has submitted a significant proposal to IDRC (Canadian research agency) to fund a series of six to seven country studies to develop a more detailed understanding of regulatory obstacles (and solutions) for making insurance more accessible. At the same time, GTZ has approached BMZ for support for this initiative; while additional assistance is expected from FinMark and the ILO. The process of developing the project design and proposal has been very collaborative and we are keeping our fingers crossed that our efforts will bear fruit.

For further information please contact Dr. Brigitte Klein at brigitte.klein@gtz.de

Dissemination Subgroup

Conference 2006 Proposal by Munich Re Foundation: The WG has decided to join the efforts of Munich Re Foundation for a 2006 Conference. The conference will be in South Africa end of November. The conference will aim at microinsurance practitioners and experts from around the world.

Newsletter: Three issues are planned for 2006 (including this one) in English, French and Spanish. The translation into Spanish is due to a partnership with Centro Afin in Bolivia.

Other objectives for 2006: Launch of new website, finalise donor guidelines, publish topical briefs and a comprehensive book on microinsurance and review the dissemination strategy.

Feedback on Preliminary Donor Guidelines for Supporting Microinsurance:

The guidelines' objective is to guide donors thinking about launching microinsurance projects. The guidelines help donors make key decisions at all stages of the project cycle, from design and implementation to monitoring. Since the guidelines are a work in progress, the CGAP Working Group on Microinsurance is soliciting feedback on their usefulness.

Following are a few highlights of feedback collected to date:

- Strongest feedback was on the perceived bias in the guidelines on the partner-agent model.
  - Consider the question of donor support to mutuals/self-help groups. Other models can be viable and easier to put in place.
  - The guidelines over-estimate the interest/ability of insurance companies to serve the low-income markets. We cannot over-rely on insurance companies. Specific comments on this with regard to Africa.
- Criteria for selecting both MFIs and countries to work in, are not very realistic. Guidelines do not reflect the reality of countries where many donors work.
- Reinsurance is very difficult to access, and may not always be needed.
- The guidelines do not take a "systemic" enough approach—not enough guidance on the role of donors at the meso and macro levels.
- Need more discussion on the role of donors in developing training modules, building the capacity of trainers, and tools development.
- Mention more specifically that donor funding is often ill-adapted to microinsurance; microinsurance projects require small amounts of money for longer periods of time.
- The preliminary guidelines are not well known—needs a much better dissemination push.
- The packaging of the preliminary guidelines is important (shorter, more user friendly).
- It would be interesting if the working group could provide a helpdesk for donor staff to report on difficulties working on microinsurance.

The guidelines are available at: http://www.microfinancegateway.org/files/13836_Draft_Donor_Guidelines.pdf

To provide additional comments on the guidelines or contact the dissemination subgroup, send an email to insurance@microfinance.lu