Women's World Banking

Health Microinsurance: An Inclusive Approach

ABOUT WOMEN'S WORLD BANKING

Women's World Banking is the global non-profit devoted to giving more low-income women access to the financial tools and resources essential to their security and prosperity. For more than 35 years we have worked with financial institutions to show them the benefit of investing in women as clients, and as leaders. We equip these institutions to meet women's needs through authoritative market research, leadership training, sustainable financial products and consumer education.

ABOUT AGENCE FRANÇAISE DE DÉVELOPPEMENT

Agence Française de Développement (AFD), a public financial institution that implements the policy defined by the French Government, works to combat poverty and promote sustainable development. AFD operates on four continents via a network of 75 offices and finances and supports projects that improve living conditions for populations, boost economic growth and protect the planet. In 2015, AFD earmarked EUR 8.3bn to finance projects in developing countries and for overseas France.

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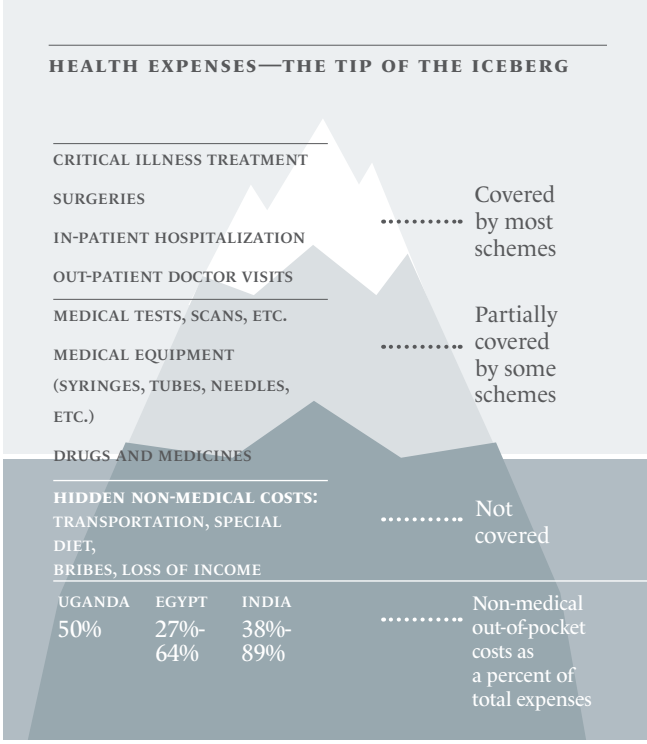
Introduction

Low-income households the world over cite health emergencies as one of the biggest risks to their financial security. Low-income women in particular, are the worst affected. They have more difficulty accessing healthcare than men and face additional health risks due to pregnancy and childbirth. Invariably across all countries, Women's World Banking has observed that women don't prioritize their own health, putting the well-being of their children and their work first. When they feel unwell, they tend to ignore the symptoms, rely on home remedies or use over-the-counter drugs to control the symptoms. They only seek healthcare with the pain is unbearable and at that point, surgery may be the only option. The one time they actively seek healthcare is for pregnancy and childbirth—a behavior common in women globally that has significant implications for designing meaningful health insurance for this market.

Further, research has shown that the burden of healthcare goes beyond the cost of treatment or hospitalization. Out-of-pocket expenses on medicines and medical equipment are recurring and burdensome. Women's World Banking research with low-income households in various countries also reveals that there are certain "hidden" non-medical expenses, such as loss of income, transportation, special food and bribes paid at the hospital. These expenses are significant and can amount to almost 70 percent of total treatment expenses.

In the absence of suitable health financing options, low-income households tend to dip into their savings, sell their assets, decapitalize their business, borrow from friends or family, or reach out to informal money lenders. While there are social security schemes for the low-income segment in some countries, these schemes have not been fully effective in meeting the needs of the target segment. And since most of these schemes do not cover out-of-pocket expenses, low-income families become exposed to greater risk of falling deeper into poverty.

Women's World Banking knows that health microinsurance can provide a critical financial safety net for low-income families and prevent them from becoming vulnerable to the risks of health calamities. Unfortunately, most health insurance products offered by commercial insurers are just scaled down versions of their mainstream products. They do not account for the distinct health financing needs of the low-income population. Women's World Banking works to bridge this gap by designing a product that is as inclusive as possible.



Women's World Banking began designing its flagship microinsurance product *Caregiver* in 2006 with network member Microfund for Women (MfW), one of the largest microfinance institutions in Jordan with more that 120,000 clients, mostly women. Since then, Women's World Banking has worked with network members in Peru, Egypt, Morocco, Uganda and India to develop similar health insurance products that respond to the different stakeholder needs and contexts in these countries. Women's World Banking works directly with financial institutions to help them deliver health insurance solutions that are simple, affordable and relevant for low-income clients' needs, especially women. This publication outlines Women's World Banking's approach to developing inclusive health microinsurance products in varied markets.

What is Caregiver*?*

Caregiver is a hospital cash product, designed to be offered by a financial institution, as an intermediary[1] that aggregates clients (or "beneficiaries" in the parlance of insurance) for a formal insurance company that will act as the ultimate risk carrier. It provides a fixed cash amount to the client for every night that she is hospitalized, regardless of the actual expenses incurred. The only document required at the time of claims filing is the discharge certificate from the hospital to check the number of nights spent at the hospital. The product is simple and easy to understand. Most importantly, clients receive money directly (unlike other insurance products which reimburse hospitals for part of the treatment costs) and they are free to use this money for any purpose. *Caregiver* is a supplementary product, meaning it can be used with other health insurance or social security schemes to which they are enrolled. This enables clients to use the extra money to meet some of their other expenses and maintain their consumption levels.

KEY BENEFIT	Fixed amount paid to the client for every night of hospitalization
TERM	Linked with the loan term/ flexible
OVERALL BENEFIT LIMIT	Cap on maximum number of nights per year, no limit per incident of hospitalization
LIFE INSURANCE BENEFIT	Can be provided
EXCLUSIONS	None
COPAYMENT/ CO-INSURANCE/ DEDUCTIBLE	None
WAITING PERIOD	None
CHOICE OF HOSPITALS	Any registered hospital
CLAIMS DOCUMENTS REQUIRED	Original hospital discharge certificate only

1 While Women's World Banking has exclusively worked with financial institutions to offer health microinsurance to low-income women, this product can also be offered by non-financial institutions such as mobile network operators, non-government organizations, cooperatives, corporations, factories and the like.

Research

The product development process of Women's World Banking starts with research. The research team collects information from secondary sources to understand the healthcare context of a specific country. Then the team conducts primary client research (focus groups and personal interviews) to identify specific behavioral trends, challenges, and the impact of health emergencies on their households.

The insights derived from this work guide the first two pillars of Women's World Banking's product development process: Product Design and Marketing & Consumer Education. Developing the Operating Model, the third pillar in the process, involves in-depth analysis of the financial institution and competitive selection of the insurer. Women's World Banking then pilots the product, testing it across all three pillars to optimize the product and delivery model/operations prior to rollout.

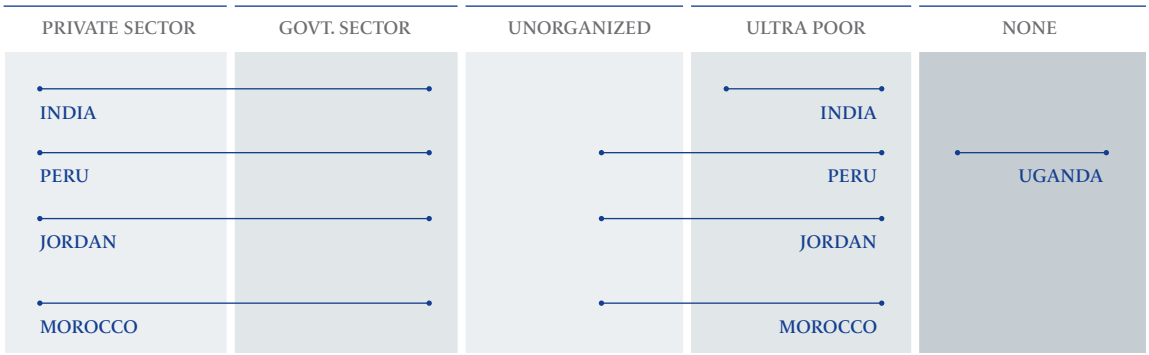
UNDERSTANDING THE COUNTRY CONTEXT

Secondary research and due diligence on a country helps to understand the broader landscape, opportunities, risks and challenges of offering health microinsurance in a particular country. It is critical to know the profiles of the target population segments, their associated health risks as well as access to, and quality of, healthcare services. It is also important to be aware of the existing players in the market and available insurance and social security schemes, their outreach and effectiveness. This research helps in determining the overall context of the demand-supply gaps in the market to develop the overall strategy for launching *Caregiver*.

Having a complete understanding of the existing regulations also helps in guiding the launch strategy. In certain countries, it may be necessary to first create favorable regulatory provisions to permit a financial institution to offer an insurance product to its clients. Developing a relationship with regulators is helpful to be able to explain the objectives of the product and work with them to remove barriers, if any. For instance, when Women's World Banking was conducting its due diligence in Jordan, the team engaged with local regulators to draft policies that paved the way for MfW to offer *Caregiver*. In order to be effective allies in bringing microinsurance to all their constituents (especially women), regulators can:

- Develop principle-based[2] regulation
- Develop and foster in-house expertise on microinsurance (both on the product and actuarial side)
- Coordinate gender-disaggregated data collection and sharing among insurers and distributors
- Reduce licensing costs and product approval times (if applicable)
- Remove administrative barriers, especially those that impact women (strict ID or birth registration requirements) and increase efficiencies (e.g. allow digital claims filing)

Women's World Banking's research found that most social security schemes exclude the unorganized sector



2 Principle-based regulation takes direction from clearly stated objectives, as opposed to rule-based regulation which must exhaustively list all possible scenarios and conditions.

Key questions in understanding the country context

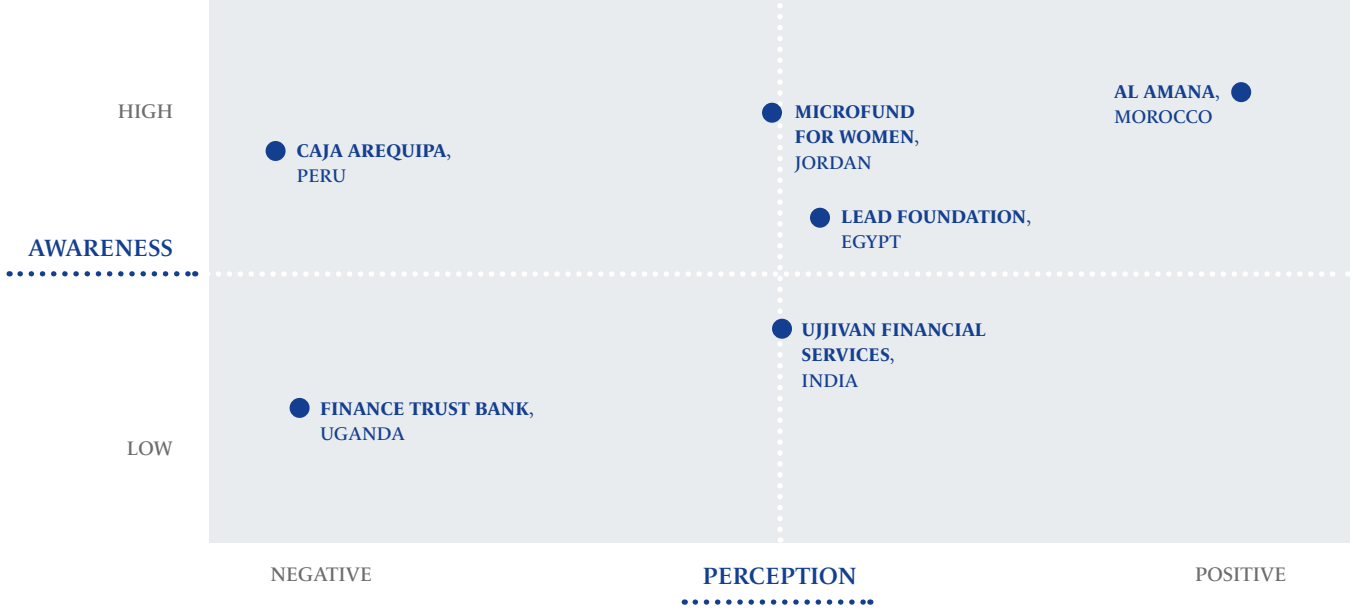
- Who are the key stakeholders?
- What are the salient features of microinsurance regulations, if they exist and how will they impact the product? If no regulation exists, how does existing insurance regulation apply?
- What are the regulatory boundaries and where does market practice start?
- Are there any restrictions or special provisions in the regulations?
- Can group insurance be provided to clients of the financial institution to provide economies of scale?
- What kind of other health insurance do clients have access to?
- What are the insurance gaps that clients face?
- What kind of health facilities do clients have access to?

Women's World Banking's country assessments for Jordan and Uganda shown below[3] demonstrate how much country health risk profiles can vary. These findings, combined with inputs from client research (next section) inform the customization of *Caregiver*'s standard features.

	JORDAN	UGANDA
	Middle-income	Low-income
	Mostly urban	Mostly rural
HEALTH INFRASTRUCTURE PER '000	1.8 beds 2.56 physicians	0.5 beds 0.12 physicians
AVERAGE AGE OF CHILD-BIRTH	24	19
PERCENT OF INSTITUTION-ALIZED DELIVERIES	100 percent	42 percent
MATERNAL MORTALITY RATE	58 per 100,000 live births	343 per 100,000 live births
INFANT MORTALITY RATE	15 per 1000 live births	59 per 1000 live births
HEALTH RISKS	Lifestyle and chronic, i.e. asthma, allergies, kidney diseases, heart disease, cancer	Communicable, i.e. malaria, fly, typhoid, HIV/AIDS, as well as diabetes, ulcers, fibroids (in women), accidents
REGULATORY ENVIRONMENT	Supportive, with high focus of the government to bring in healthcare reforms and implement National Health Policy	Microinsurance regulation in preparation. High interest of regulator to foster microinsurance. Offering bundled products a challenge.
AVAILABLE SCHEMES	Social security, Military insurance, civil insurance, nearly 68 percent population is covered[4]	None

3 CIA World Fact Book, World Bank data.

4 http://apps.who.int/medicinedocs/documents/s17296e/s17296e.pdf



UNDERSTANDING THE CLIENT

Following the country assessment, Women's World Banking conducts client research to understand who the client is and the health concerns and challenges she faces. These insights are essential to designing a product that responds to her needs. Beyond broad data gathered from the country research, it is important to drill down to the household level to understand how these macro trends play out. Through client focus groups and in-person interviews, Women's World Banking gathers information on her health needs and behaviors, available financing options and the impact of a health emergency on a household's cash flow. These insights help in developing several client profiles which ultimately inform product design.

Given the additional challenges that women face in seeking healthcare, Women's World Banking's research also reveals the reasons that prevent them from either seeking or accessing it when they want. Research has found that there are three broad dimensions to the barriers women face in accessing healthcare:

- Physical, e.g. distance from healthcare providers, especially in rural areas
- Financial, e.g. transportation costs; lack of savings to meet expenses; lack or limited access to social security or health insurance
- Psychological, e.g. lack of awareness of health issues; not prioritizing one's health; anxiety about losing income; household responsibilities

Another important area of client research is to gauge the target segment's awareness levels, understanding and perception of insurance. These levels vary largely based on the availability of insurance or social security schemes for the low-income market. For instance, in countries with well-established social security systems (e.g. Morocco, Jordan), clients were found to be more aware of the concepts of insurance and knew how it worked. However, the perception of insurance (i.e. whether insurance itself is beneficial or not) varied based on the efficiency of the social security schemes, the reputation of insurers and their own past experience with using the scheme. In countries that don't have any social security schemes (e.g. Uganda), clients had limited information about insurance and they did not believe that a product like insurance could work for them.

Key questions in understanding the client

- Who are my clients (age, gender mix, literacy levels, geographic presence, occupations etc.)?
- What kind of financial products are they using currently?
- Do they have access to competitors' products?
- What kind of technology do they have access to?
- Do clients have a good understanding of and experience with insurance?
- How will their needs impact the product features (price, benefit, etc.)?
- Do clients require a large amount of "handholding" (close guidance, instruction or aid) from the financial institution?
- What's the nature of the relationship between the clients and the financial institution? Is it transactional or long-term?

UNDERSTANDING THE FINANCIAL INSTITUTION INTERMEDIARY

The financial institution intermediary is the link between the clients and insurer. Given its central role in the delivery of microinsurance, reviewing its strategic alignment with the product and assessing its capabilities is paramount. Examples of assessed capabilities include, but are not limited to: management information/ information technology systems (MIS/ IT); branch infrastructure and

facilities; training capacity and branch staff awareness, understanding and perception of insurance. It is at this point that any areas for institutional capacity-building are identified (such as IT upgrades or changes to operational processes) and built into the product development timeline.

Key questions in understanding the financial institution

- What are the strategic priorities of the institution?
- How does microinsurance fit into these strategic priorities?
- Does the institution own the relationship with the clients?
- What are the IT capabilities of the institution?
- How much investment in IT will be required to facilitate 100 percent fully owned microinsurance operations?
- How much microinsurance-related technical expertise does the institution have?
- What kind of resources will be required by the institution to manage and service claims?

It is also important to note that implementing a new and different product such as microinsurance requires an institution to drive change and innovation from within. Often, human factors such as institutional culture (service delivery, change management capabilities, leadership style and risk culture) play a more important role in successful implementation of microinsurance and failure tends to be driven more by human than technical reasons.

UNDERSTANDING THE INSURER

Women's World Banking's *Caregiver* delivery approach requires having a formal insurance company act as the risk carrier, while bringing in its wealth of experience and expertise in actuarial pricing and risk management. However, as most of the commercial insurers have little to no experience in serving the low-income market, they perceive this segment as 'high risk' and therefore, unprofitable. Women's World Banking's experience has shown that a meaningful, yet sustainable health microinsurance product is possible, however it takes time and a significant initial investment to make the product sustainable in the long run. Both the insurer and the financial institution will experience a substantial learning curve in the process. Women's World Banking recommends looking to look for an insurer who has patience and the long-term vision for microinsurance. Both these stakeholders must be open to challenging the status quo through learning and adapting their processes and systems to serve their clients effectively.

The Tender Process

Insurer selection during the tender process is a critical information-gathering point in the development of a microinsurance product. Sharing accurate and detailed information about the client profile on the tender document is important as this will allow insurers to assess the risk in a more comprehensive manner. It also allows both parties (insurer and financial institution) to have frank and open discussions, which will enable insurers to submit their pricing quotation as well as other support items. Tender documents usually contain information about the financial institution, the product(s) and/or services it already offers to its clients and the rationale for microinsurance. It provides a thorough profile of the market, insights from client research, product prototype, including theoretical operational processes and roles. The tender process itself and award criteria also need to be clearly articulated so there is full transparency about the decision-making process.

Key questions to ask the insurer

- What are insurer's reasons to offer microinsurance?
- Is microinsurance a strategic priority for the insurer?
- Does the insurer have long-term commitment on microinsurance?
- Is the insurer willing to learn and, adapt and challenge market practice?
- What kind of prior experience does the insurer have in offering microinsurance?
- What is the insurance company's capability to manage a microinsurance business with its current level of IT and operational systems?
- Is the insurer physically present in all/most of the locations of the financial institution?

Ultimately, the strongest foundation of developing the right microinsurance product is built on asking the right questions.

Research that breaks down biases

The in-depth research done by Women's World Banking has helped break down some of the pre-conceived notions that insurers and financial institutions have about health insurance for low-income clients. Presenting data about clients' needs and financial behaviors has allowed Women's World Banking and its partner financial institutions to challenge the conventional wisdom about their clients' capacity and willingness to pay for a meaningful insurance product. More importantly, it has allowed Women's World Banking and its partner financial institutions to question the assumptions made by insurers on actuarial pricing for this 'perceived' high-risk segment as well as the opportunity to educate insurers about the unique needs of low-income clients and what they value. For example, many insurers are concerned that adding a maternity benefit makes the product expensive and unsustainable, and that women who are already pregnant should be excluded from the benefit. Insurers also usually want to exclude chronic diseases, if they are pre-existing. However, Women's World Banking's research has shown that pregnancy is one of the few times women prioritize their own health. The low-income population are also particularly vulnerable to chronic diseases. A product would be meaningless if these conditions are excluded.

If the product is not meaningful and not meeting the needs of the low-income clients, no one will use it and ultimately, it will not be possible to scale up. Removing complicated health questionnaires, examinations or exclusions simplify and speed up the process. At the same time, to address insurers' concerns, making insurance mandatory for the clients removes the risk of anti-selection and helps in building scale quickly. Based on its experience in Jordan, Women's World Banking has been able to demonstrate to insurers that maternity coverage provides a clear market differentiator while having minimal impact on pricing, ultimately showing how a health insurance product for low-income women can be affordable and sustainable at the same time.

By working with both the insurers and financial institutions to adjust product features and operational mechanics, Women's World Banking has been able to create a win-win-win for all stakeholders.

MOROCCO

UGANDA

The Three Pillars of Product Development

PRODUCT DESIGN

Premium amount must be affordable

Benefit must be meaningful

Policy terms are not excluding or limiting

By linking to loan products, adverse selection is mitigated and product is accessible

Insurance partner understands microinsurance/ the low-income market and is flexible and responsive

MARKETING AND CONSUMER EDUCATION

Communication tactics and materials are adapted to clients' accessibility and level of literacy

Strategies are effective at increasing clients' awareness and understanding of insurance

Increased education leads to appropriate utilization of the product

Customer satisfaction and feedback identifies any gaps

OPERATING MODEL

Enrollment process is simple and has no distorting impact on loans

Claims are paid quickly with a simple, effective process

Insurer interaction is effective and smooth

Staff are incentivized and/or penalized to effectively sell and operate the product

Product and processes build on current MIS capacity, with ability to expand for new products or features

Regular and informative monitoring tools and key performance indicators are integrated

Program is financially sustainable for the financial institution and the insurer

Product Design

Women's World Banking's product design approach is guided by three principles:

1. Relevant – *Caregiver* is adapted to the unique needs of the market. The product covers maternity as well as all pre-existing conditions, whereas most other insurance schemes typically exclude them. The benefit amount is also designed to cover a meaningful portion of the health cost, whereas other schemes only provide reimbursement of inpatient treatments. The product can also be further tailored to meet market-specific needs. For instance, in Morocco, access to an ambulance is a critical requirement at the time of hospitalization given the lack of access to transportation. Thus, the ambulance benefit was incorporated in the product.

2. Simple – Low-income clients, especially women often have low literacy levels and limited understanding and experience with complex financial products like insurance. *Caregiver* is therefore kept extremely simple with minimal documentation requirements. Other schemes typically require most or all of the following: diagnosis, test reports, doctor's certificate, and previous reports.

3. Affordable yet Sustainable – While the product has to be affordable for the clients, *Caregiver* is priced conservatively during the pilot. This gives both the institution and the insurer the flexibility to monitor client behavior and product performance trends to make adjustments. Based on Women's World Banking's experience, changing benefit levels instead of the premium is preferable as price changes are more difficult to communicate to the clients. This approach helps ensure that client value is maximized while awarding moderate profits for the insurer and financial institution to cover their operating costs—a cornerstone of the product's sustainability.

Caregiver *in Two Countries: Adapting to the Market's Unique Needs*

Based on research to understand the target segment's country context, client profile, financial institution capability and insurer profile, Women's World Banking, together with its local partner institution adapted *Caregiver*'s product features to the local needs of the market. While the essential features are similar, the product is slightly different in the two markets in terms of the benefit levels, premium and client needs that it addresses:

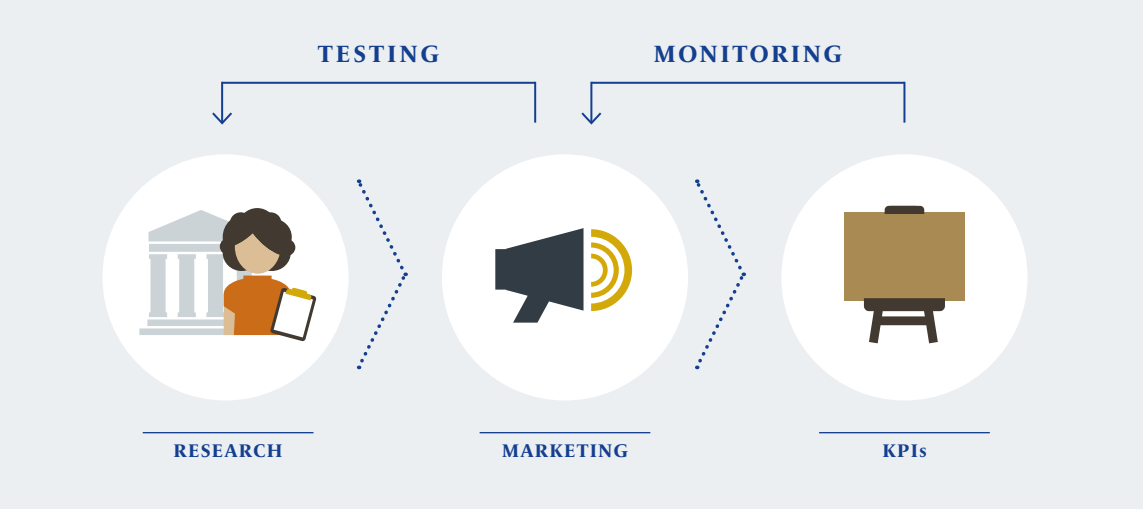
	JORDAN	UGANDA
PER NIGHT HOSPITALIZATION	15 JD ($2.1)	USh 80,000 ($22.8)
MAXIMUM NUMBER OF NIGHTS	36 nights/ year	40 nights/ year
LIFE INSURANCE BENEFIT	Included in pricing of Caregiver Death of client: loan forgiveness + 1,600 JD ($2,258) Death of spouse: 750 JD ($1,059)	Separate life insurance policy for clients from another insurance company
MONTHLY PREMIUM	15 JD ($2.1) for Single 2.5 JD ($3.5) for Family	USh 5,500 ($1.6) *Family coverage not yet available*
CLIENT NEED ADDRESSED	Additional money for small expenses (medicines, loan installment, transportation etc.)	Hospitalization expenses
BUNDLED VS VOLUNTARY	Bundled with loans, all clients are automatically covered	Bundled with loans, all clients are automatically covered
HEALTH CARE PROVIDER PARTNERSHIPS	Network of registered hospitals	Network of registered hospitals. *Ex gratia* for non-registered in certain areas.

Dollar amounts as of November 3, 2016

Marketing and Client Education

Client education and product marketing are almost interchangeable when it comes to health insurance. Research shows that low-income clients usually don't have deep understanding of insurance products; they also don't believe that insurance will pay them any benefit. These information gaps need to be addressed through client education programs. Marketing on the other hand, is a way to convince clients that insurance works for them. A well-designed marketing program shows results in terms of high client awareness and uptake of the product, thus ensuring client satisfaction and usage. Conversely, microinsurance products not supported by proper marketing are not consistently used, tend to be more volatile and less controlled, negatively impacting the institution's reputation as well as its bottom-line. Because marketing drives some key performance indicators (KPIs), such as the claims frequency and claims ratios, it is a critical element in the delivery model. Beyond developing client-tailored assets, an institution's marketing approach should include an iterative process of learning and adapting to clients' information needs.

Like all the pillars of Women's World Banking's product development process, research forms the basis of developing effective marketing strategies and the client education roadmap. The marketing collateral and communication elements (product name, brochures, posters, etc.) are designed after the client research and are tested again with the clients prior to and after the pilot in order to ensure that the clients understand these tools well and can get the required information with ease.



Well-designed marketing programs accomplish two things:

1. Build trust and awareness of the product

2. Ensure understanding of the claims process

The concept of insurance is complex, not just for the clients but also for staff of the financial institution. This unfamiliarity breeds resistance in clients and if branch staff, as front-line sales representatives of the product, do not understand it themselves, they will find it extremely difficult to convince the clients. A well-designed marketing plan must communicate the product value to both clients and staff (addressed in the training and change management section).

Case Study: How Al Amana transformed its marketing to improve client awareness

Al Amana Microfinance launched its first health microinsurance product, *L'Assistance* in 2012. The product provided an ambulance service, a cash payout in cases of childbirth, critical illness, disability and death and was bundled with clients' loans. However, after a year in operation, the claims frequency and claims ratio were lower than expected. Women's World Banking worked with Al Amana to help them understand the product's underutilization and find ways to improve it.

Women's World Banking started by speaking with Al Amana's clients to understand their health needs, their perceptions and knowledge of insurance, and of the current *L'Assistance* product. The research indicated that there was a high level of awareness about insurance among the clients; they had a positive perception of insurance and had high interest in having a health insurance product. However, when probed about the understanding of the already available *L'Assistance* product, many clients revealed that they were not aware of any such product being offered by Al Amana to them. The information on the insurance product was given to the clients only at the time of loan disbursement and in the form of a text-heavy brochure that they did not pay attention to as they were illiterate.

It was clear that while the product was rich and meaningful in the content and coverage, it was necessary to simplify the product communication and make it more engaging.

Transforming Al Amana's marketing approach happened in three phases:

1. Brand positioning. Research revealed that many Al Amana customers speak Arabic, not French, hence the name *L'Assistance* had poor recall. The team chose a new name in Arabic, "Tayssir Al Amana" which means "facilitated by Al Amana," positioning Al Amana as a relaible partner for the clients.

Women's World Banking identified the top three benefits which had the highest relevance and recollection among the clients: childbirth, hospitalization and death. The new communication plan and collateral were developed around these three key benefits. Relevant images and icons for each key feature were chosen and messages were developed in the local Arabic dialect to ensure that even illiterate clients understood them easily.

Further, Women's World Banking and Al Amana designed a comic strip that explained the claims process. This comic strip became the basis of a brochure, sales tool and a short video shown in all the branches to reinforce product benefits whenever clients visit a branch.

2.Testing. After developing the new marketing approach, Women's World Banking and Al Amana conducted a second round of focus groups with clients to test the new approach to make the last set of modifications prior to finalizing the name, content, key messages and collateral. This was done to ensure that the new approach was aligned with clients' literacy and understanding levels and provided them the right information.

3. Training. Women's World Banking, Al Amana and the insurer Saham conducted a two-day training program for all branch staff to familiarize them with the new communication tools and refresh their knowledge on the key features.

The new communications campaign was launched in January 2015. Product monitoring shows that there has been a significant increase in the claims frequency and claims ratios, suggesting that the new approach has been effective in creating better client awareness. A post-campaign assessment conducted by Women's World Banking through a telephone survey and focus sessions confirmed the positive influence of the new communication campaign.

AL AMANA MARKETING MATERIALS: BEFORE TRANSFORMATION

AFTER

While marketing tactics vary depending on product features and the target segment's levels of awareness, understanding and perception of insurance, Women's World Banking's experience in six markets has found six principles that characterize effective microinsurance marketing to low-income women.

1. Identify three key features that clients must remember and develop product positioning around those key features.

2. Choose a brand name that resonates with the clients and boosts trust with the organization.

3. Create multiple touchpoints to reinforce key messages on a regular basis.

4. Prioritize the use of imagery as most low-income women have low literacy levels.

5. Use clear, simple language to explain product terms and benefits, preferably in the dialect of the target market.

6. Highlight successful claims at branches to stimulate positive reputation and word-of-mouth publicity. Women often trust the opinion of their friends and so word-of-mouth is a good way to win their trust of the product.

Marketing is an iterative process: it follows the cycle of design, testing, application and feedback. Clients are the best source of feedback on the relevance of the design and content of the product, as well as how they perceive the overall messaging and emotionally associate with the product.

Operating Model

A common challenge that institutions face in delivering microinsurance is maintaining efficiency within limited operating margins. Thus, while competitors can easily copy a simple health insurance product design, they would find it difficult to replicate a well-designed and efficient operating model. Efficiency is a prerequisite to scaling up the business, attaining better profitability to add value for the clients, and gaining an advantage while negotiating with insurer.

Deciding on the operating model draws on all four of the research components highlighted in the product development process: Country Context and Market Regulations; Client Profile; Financial Institution's Capacity and Insurer Assessment. The information gathered from this work informs the three key components which are the backbone of any insurance operating model:

1. Claims Management
2. Fraud Management
3. IT Systems

CLAIMS MANAGEMENT

From the institution's perspective, claims management can be organized in three different ways.

The most common approach is the **Shared** model, where the financial institution owns the relationship with clients and handles part of the claims management responsibilities. The insurer is responsible for the scrutiny of claims documents and making decisions on the claims. This model is appropriate when insurance is newly introduced and both the institution and insurer are still undergoing the learning process.

In the **Outsourced** model, the insurer (or a third party) manages all claims while the financial institution is primarily responsible for client education and enrollment. This model is most relevant when the market is mature, the product is evolved and clients have high awareness levels about insurance. Clients reach out to the insurer directly when filing claims and the insurer handles all operations. This model is appropriate for institutions with a large client base or when the volume of the microinsurance business is not large enough to justify investment in IT and operations.

The **Owned** model is another possible approach, however this has not been tested with *Caregiver*. The financial institution takes full responsibility of the end-to-end claims process. The insurer's primary responsibility is to act as a risk carrier and provide guidance on the product pricing. This model is appropriate for institutions who have a strong relationship with their clients and who consider insurance as one of their core offerings. The institution must have a long-term commitment to building its own capacity to manage insurance operations and the insurer is confident about the institution's capacity to manage large scale operations and identify fraud cases on its own.

COMPARISON OF CLAIMS MANAGEMENT MODELS

	SHARED	OUTSOURCED
MARKET PROFILE	Microinsurance is new or untested, and/or Product is in pilot stage, and/or Product is simple with limited documentation	Market is mature, and/or Required by regulations, and/or Insurance is voluntary, and/or The product is evolved or the claims documentation is complex
CLIENT PROFILE	Clients do not have full understanding and experience of microinsurance Clients have long-term relationship with financial institution Clients require handholding for claims process	Clients have high insurance awareness and good experience in using insurance Insurance and insurer's perception is positive The nature of the financial institution's relationship with clients is transactional
FINANCIAL INSTITUTION PROFILE	Insurance is a new product offered by the financial institution Institution has evolved capacity in managing high scale operations and is willing to invest in IT, capacity building, training and additional resources (or allocate responsibilities) at branch and central level	Institution has a huge client base spread over a large geographic region Offers more than one insurance product from multiple insurers Institution may not have fully developed capacity to manage claims on its own
INSURER PROFILE	Insurer has some experience of working in microinsurance / high willingness to learn and adapt Insurer has good IT platform and quick response time	Insurer has strong reputation, with proven track record of working in microinsurance Insurer has a well-established network of hospitals Insurer has physical presence in most locations

	SHARED	OUTSOURCED
BENEFITS	Adequate control in the hands of financial institution on data and service quality levels Positions financial institution at the center for clients and helps in strengthening the relationship	Limited operational burden on the institution Clients get access to superior customer service
RISKS	Longer turnaround times for claims processing due to delay at insurer's end Ineffective project management at both ends can quickly complicate the relationship and jeopardize the business Operating costs could be high and may affect profitability	If the service quality is poor, the relationship between clients and financial institution can be affected Institution does not have much visibility on the data – the data is owned by the insurer
NECESSARY MITIGATION STEPS FOR FINANCIAL INSTITUTION	Mention the turnaround times at both ends in the service contract Identify the right personnel at each end and clearly define their roles and responsibilities Have weekly and monthly meetings to discuss all open items Prepare financial tracker and monitor operating costs for microinsurance separately on monthly basis	Build research capability to gauge clients' satisfaction levels with the product and service Review insurer's operations regularly and flag gaps, if any Ask for raw data and dashboards from insurers on a monthly basis and build internal capacity to analyze the information at own end
EXAMPLES	MfW (Jordan) Lead (Egypt) Al Amana (Morocco) (for birth and death benefits)	Al Amana (Morocco) (ambulance and hospital benefit) FTB (Uganda)

FRAUD MANAGEMENT

Fraud in insurance is inevitable. In fact, if there is no fraud detected in the system, it is an indication of weak fraud management practices rather than having a completely trustworthy base of clients. It is broadly acknowledged that fraud follows the 20-60-20 rule[5]: around 20 percent of the target segment will never commit fraud, whatever the circumstances are. 60 percent of the clients are fundamentally honest but "undecided". This means that if the opportunity arises and the risk to be caught is perceived as low they may cross the line. The remaining 20 percent are dishonest and will commit fraud if the opportunity arises; even worse they may search for and create the opportunity themselves.

Each fraud case increases the operational burden and cost of operations, reducing the sustainability of the product. Fraud is, unsurprisingly, insurers' sore point. In a product like *Caregiver*, because claims documentation has to be kept simple, there is a higher risk of fraud. At times, this becomes a non-negotiable for insurers. For example, during the tender process in Egypt, one global insurer admitted that it was not ready to participate further in the process as it did not believe that fraud can be controlled in this segment. Even though insurers build projections for fraud in their pricing estimates, high levels of undetected fraud have a negative impact on the pricing and sustainability of the product. For financial institutions with an eye on the double bottom-line, this deprives genuine clients from getting more value from the product through an optimal, lower price.

Financial institutions that can demonstrate their ability to control and prevent fraud effectively strengthen their relationship with the insurer. Providing the insurer with complete and accurate information on fraud also helps in making adjustments in pricing which helps the product's path to sustainability.

Women's World Banking's experience has shown that the bulk of fraud can be effectively caught and controlled by designing a strong fraud detection framework and fraud action policies. A financial institution's fraud detection framework covers three areas:

1. Prevention. It is important to develop fraud policy and client communication around it. Client communication should be handled sensitively and while the message should be strong, it needs to be worded in a way that is positive (or neutral at least). It is important to provide staff with a prepared script to go by and ensure that the message does not make field staff uncomfortable when they speak with the clients. The message should also be delivered with one single, simple example (e.g. "changing information on the discharge certificate is considered fraud") and with a clear consequence statement (e.g. "if a client commits fraud, the organization will not make the claims payment and will blacklist the client forever").

2. Detection. Fraud detection can be made more effective by building checks in the IT system (e.g. alert on date mismatches, client going to unregistered hospitals etc.), involving staff members who are not involved in the sales process and defining the roles and responsibilities of each team member to build accountability. Because investigation is intensive, manual work, it is costly. Thus, it is essential to prioritize and check fraud on a sample basis. Criteria determining the sample are usually defined during the pilot phase; examples include claims filed within 20 days of coverage, repeat claims for the same individual, mismatch between the length of hospital stay and diagnosis, claims filed for a hospital that has not yet been visited.

3. Action. Each fraud case is unique and provides new learnings. It helps in identifying gaps in the processes and in turn improving efficiency of the system. Therefore, once fraud has been suspected, it is imperative to document the proceedings through record keeping. Select fraud cases should be also included in staff training to further build their knowledge in this evolving area. After the investigation is complete and the fraud is confirmed, the concerned branch and staff members should be given an update before the message is delivered to the client who made the fraudulent claim. Clients who conduct fraud will not admit doing so in public and may spread rumors about the financial institution among other clients. Therefore, it is essential to develop a communication plan in advance and involve senior staff, such as branch manager, to deliver this message in the most appropriate way. Necessary actions should be taken against the client, depending on the context.

5 "Anti-Fraud Risk and Control Workbook," Peter Goldmann (2009).

UGANDA

Case Study: Finance Trust Bank Teams Up with the Insurer

Many insurers are skeptical as to whether microinsurance can work at scale and whether there are profits to be made in this sector. Thus, success in working with an insurer requires that the relationship be a true working partnership with the intermediary. As both institutions will have to go through a learning curve, **sharing information and maintaining a high level of transparency** is key so both can understand and support each other while building trust through the process. Lastly, providing clear roles and responsibilities for each party will help ensure that the project remains on track.

The case of Uganda shows how flexibility and perseverance can be fruitful and that a leap of faith can be rewarded. Finance Trust Bank (FTB) worked with the insurer, UAP, to directly address their challenges and create a relevant, sustainable Caregiver product for their clients.

Challenge 1: Pricing adequacy. Pricing in insurance has to be signed off by appointed actuaries and reviewed by regulators. However, the absence of actuarial data or health statistics about the low-income segment makes it difficult for insurers' actuaries to price this type of product appropriately. Insurers such as UAP must literally take a leap of faith before the pilot phase of the project. Women's World Banking helped bridge this gap by providing data on loss experiences in other countries and working with their actuaries to formulate specific assumptions on hospital visit habits, typical local disease patterns (frequency) and length of stay (severity) to provide enough confidence in the model.

The pilot evaluation revealed that the claims frequency was lower than expected, owing to a lack of awareness of the product and clients' lack of trust in insurance. It also revealed that the severity was more volatile due to the absence of nearby facilities and the poor health condition of clients. Close monitoring of KPIs allowed the project team to identify these issues early and adapt the process and product. For example, information exchange between the insurer and FTB on loss ratio calculations and claims targets allowed Women's World Banking and FTB to negotiate *ex gratia* payments to clients who visited otherwise excluded non-registered facilities[6]. Constant, transparent communication throughout the pilot period also created a favorable environment for successful negotiations between FTB and UAP on cost-sharing of marketing measures to address awareness and understand-

6 Registered facilities are facilities that have received an operational license from the Ministry of Health and have undergone a costly certification process. Due to the limited health infrastructure in Uganda, many unregistered facilities have emerged to fill this gap. These facilities often have poor hygiene, limited or no availability of medicines and employ inadequately trained nurses or part-time doctors. Consequently, these facilities do not issue proper diagnostic and discharge forms and effectiveness of treatment is often limited, further imperiling low-income client's health and financial well-being.

ing issues. Having an insurance partner that did not focus only on the bottom-line, along with transparent information-sharing practices allowed both stakeholders to articulate profit expectations and maximize value for clients.

Challenge 2: Anti-Selection. Insurers are particularly concerned about anti-selection in the low-income market. Anti-selection is when clients with serious health problems elect insurance in order to file claims. To mitigate this, FTB's microinsurance product was designed to be offered as a service in conjunction with a client's loan so that the primary motivation for taking up the product is the loan and not insurance. This helps ensure health risks are smoothened across the portfolio, an outcome supported by Women's World Banking research.

However, this requires premium payments to follow the loan installment schedule, i.e. while insurance coverage starts from the date of loan disbursement, clients pay the first monthly premium along with the loan repayment installments, a full month after the coverage begins. Early discussions with the insurer showed that they were not willing to enroll clients from day one with the premium paid in arrears. Their concern was not only driven by the fear of anti-selection but also by IT systems that are designed such that a policy number is not generated until after the client has paid the premium, making clients unable to file a claim even if they are technically covered.

Success in working with an insurer requires that the relationship be a true working partnership with the institution. The case of Uganda shows how flexibility and perseverance can be fruitful and that a leap of faith can be rewarded.

FTB and UAP originally agreed to receive monthly premiums in advance, with a one month waiting period. After a few months of observing a low claims rate directly after enrollment, confirming Women's World Banking research on negligible anti-selection, Women's World Banking and FTB engaged UAP to revisit the issue. This approach of creating a joined learning environment gave the insurer the time and opportunity to learn and build trust in their counterparts, gather relevant facts and gain experience. Following this approach, UAP agreed to waive the waiting period altogether.

Challenge 3: Claim turnaround time and payouts. Women's World Banking experience in Jordan and Egypt shows that, compared to the middle and high income segment, low-income clients tend to spend more days for treatment in the hospital because of multiple, untreated diseases. This is not related to fraudulent behavior, but rather to the complexity of their health problems, some of which they are not aware of *until* treatment of other conditions. Nevertheless, when clients file claims, they expect a positive experience with the claims process and turaround time for payment. For insurers and financial institutions, fulfilling clients' expectations while enacting fraud protection policies is a delicate balance to maintain. Longer stays in the hospital often trigger additional scrutiny, without adding value and increasing operational costs. This is a very sensitive situation and requires a shift in the insurer's mindset as well as sometimes dramatic changes to internal payment and sign-off processes that are often not designed for small claim amounts and higher volume. Instead of being a barrier, this situation is in fact an opportunity for "out of the box thinking."

FTB and UAP partnered on a system where claims are filed over UAP's hotline. The hotline team is trained to answer questions in simple language and to remind clients that the filing process requires a discharge form. Scanned copies of the claims documents are sent to the insurer on the same day a client files the claim at the FTB branch. Claims where there is a high suspicion of fraud are investigated through physical records. The insurer discusses each open case with FTB prior to reaching a decision. By creating this process, the insurer can gain confidence in the quality of the institution's internal fraud detection and learn more about the health conditions and behaviors of this segment. This client-centric approach also helps build clients' trust and satisfaction in the product.

IT SYSTEMS

IT is often cited as a bottleneck in making any operational upgrades. However, very often, it is the result of a lack of thorough planning and prioritization. For financial institutions and insurers who have to record and access a large amount of client information, having a means to effectively manage and use this data is indispensable. In order to make IT work for its microinsurance program, an institution must first ask the following questions:

1. What are the long-term and short-term objectives of the project?

2. What kind of information will help in making business decisions effectively?

3. What are the costs and benefit of the alternatives available?

Four Essential IT Components:

1. Policy administration systems capture the client information necessary for the issuance of the insurance policy. Efficient systems can be built by identifying and capturing only additional fields needed for the product and avoiding duplication of information.

2. Claims administration systems keep track of the claims at the various stages from reporting to final settlement, i.e. date of admission, date of discharge and illness. For Shared operating models, this system also includes the transfer of information between the financial institution and the insurer.

Offering microinsurance requires the effective collection, use and storage of confidential client information. Thorough planning and prioritization of this area of the operating model is indispensable to the product's success.

3. Finance administration systems deal with the flow of money in terms of premium and claims amount for each client. This system also helps track operational turn-around times for each process.

4. Monitoring and Evaluation systems help in the compilation and reporting of key metrics through the institution's MIS. This can be manual (for institutions introducing a new product) or automated (for mature programs). More detailed information on this system can be found in the performance management section.

- Parameters such as monthly premiums, tax or benefit levels should be integrated into the MIS. The more flexible this module is, the easier it is to make future adjustments in the product and processes. It is helpful to have the ability to download meta-information such as the dates at which claims were filed, sent or paid, which can be pulled into the performance management dashboard. It can also be used to prepare fraud analysis metrics.

- Exception Reports are designed prior to rollout and scaling of the product. These reports are usually prepared manually and they help flag certain process risks (defined by the criteria set out initially) and allow the project team to make course corrections. Sample criteria could be "clients in arrears on their premium payment," "claims in backlog per branch," "all claims that are unpaid with the insurer for more than 5 days," "all claims received at specific branches."

Almost all of the client data handled by the IT system is sensitive and personal in nature. Therefore, it is important to set clear boundaries around data ownership between the financial institution and the insurer. It is also important to build robust infrastructure and policies around data security, integrity and access for client protection, as there are reputational risks involved should there be a data security breach. The risk management section provides an overview of these risks.

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Case Study: Lead Foundation's IT Overhaul

Lead Foundation piloted the *Caregiver* program in November 2015 and has been rolled out to all the 18 branches around the country.

Lead's senior management considers microinsurance as one of the core products provided to every loan client and other client offerings in the future. Further, Lead intends to scale up microinsurance and provide enhanced benefits (such as family coverage), thus building their competitive advantage in the market. The centrality of this product to their operations thus requires Lead to fully own the business from end to end and build internal capability in managing operations as it scales. This required a massive overhaul of their IT infrastructure.

Women's World Banking and Lead identified three core areas for IT investment:

- Data entry module at enrollment
- Claims management
- Monitoring and Evaluation

Lead piloted *Caregiver* using a shared operating model, where insurers manage claims processing. Lead integrated data entry and claims module into their MIS prior to the pilot to ensure smooth operations. Because Lead has an in-house IT development team, they were able to save about 50 percent of the development and IT consultancy costs for the organization.

Monitoring and evaluation on the other hand, is a more gradual process. Since the institution intended to move into a fully owned model, Women's World Banking recommended that the project team begin with manual, spreadsheet-based dashboards. While time-consuming, it allowed Lead to build internal capacity for processing and analyzing insurance KPIs.

As the pilot wound down, Women's World Banking and Lead developed an IT roadmap for the transition from a manual dashboard system to a fully integrated IT system that serves the institutions, data entry, claims management and monitoring needs.

Training and Change Management

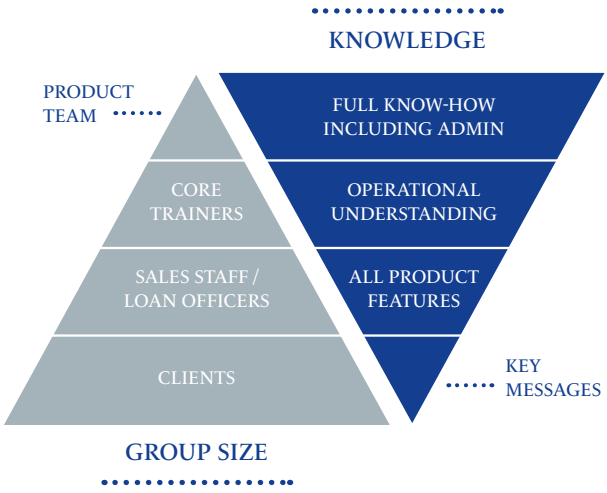
As mentioned in the Marketing and Consumer Education section, insurance is often an unfamiliar product for both clients and the field staff of the financial institution. Since *Caregiver* is being distributed through financial institutions, Women's World Banking recommends bundling the product with loans. While branch staff and loan officers are familiar with credit as a product and need little explanation for its value proposition or how it works, the same is not true for insurance. Insurance is a product where clients have to pay upfront for a service which they do not know whether or when they will claim benefits. This is what the branch staff finds most difficult to sell to their clients.

Branch staff is usually responsible for client enrollment, selling and servicing all products, including insurance. Therefore, getting their buy-in and understanding is the first step. If they are not convinced about a product, they will not be able to convince their clients to enroll in that product.

Women's World Banking's training evaluation programs have shown that more than the product features, branch staff want to understand how to sell an insurance product and handle clients objections adeptly. More importantly, staff want to understand why they should sell insurance, i.e. what value they are offering to clients. Thus, a good onboarding plan educates staff on the value of the new product while providing them with a robust set of tools and tips to help them succeed in driving uptake and usage of this product.

Well-designed insurance trainings must achieve three objectives:

1. Inform. "What is the product?" Because microinsurance is often a new concept, training content should incorporate examples that the branch staff can relate to, e.g. their own employer sponsored schemes, their experience with using such insurance schemes, what benefits appeal to them, etc. It is also useful to share insights from client research that guided the product design so that the staff can understand the context and appreciate the rationale for product design.



KNOWLEDGE MANAGEMENT. *Levels of understanding of the product correspond to an individual's role in descending order: product leads must have full understanding of the products whereas branch staff must only be aware of the information they need to sell the product, i.e. product features and claims process.*

2. Empower. "How do I sell it?" Given the product's unfamiliarity and complexity, staff will experience confusion or even opposition to the product from clients. Training should incorporate interactive sessions (i.e. role playing) that can help hone their sales skills and handle client objections with confidence. Sales tools such as a standard script and list of FAQs with a comparison with competing products must be provided.

3. Convince. "Why should I sell it?" An organization's strategic objectives should be linked to the personal goals (and incentives) of the staff. Thus, it is important to convey how insurance can help them achieve their goals. This will create a sense of ownership of the new product and a desire to execute successfully. Women's World Banking's research has demonstrated that clients who have benefited from *Caregiver* tend to pay their loan installments on time. This implies that the product provides a business case to the loan officers to manage their portfolio-at-risk (PAR) more effectively. Timely payment of claims also helps in strengthening staff's relationship with the clients.

Furthermore, introducing a new product always requires a change management approach. It is important to understand that change is emotional for people who are affected directly by it. To overcome any resistance from staff, it is essential to make them feel included in the product development and rollout process by regularly obtaining their feedback and building ownership throughout the rollout period.

Incentives. While incentives can help build momentum for the product, Women's World Banking recommends using them selectively and building adequate measures to control mis-selling. Incentives are useful in situations when the insurance product is voluntary or there is a need to drive a certain kind of behavior in the staff, such as data entry quality. Incentives can be non-monetary as well, e.g. recognizing exceptional client service, identifying insurance champions, etc. Such incentives are effective when coupled with recognition programs and help in the career growth of the staff.

Monitoring Training Effectiveness. Training is a continuous cycle which includes the collection of feedback from the trainees, monitoring individual and branch level performance to identify key gaps, refining the program to address those gaps and providing regular refresher trainings to ensure that staff's learning gaps are fulfilled. Effective training results in higher client awareness, better usage of the product as well as higher client satisfaction.

Phone surveys with clients and systematic interviews with branch staff are two very useful and cost-effective tools to measure training effectiveness. The results of these surveys can be further analyzed to identify variances across branches, age groups, gender, literacy levels etc. Ideally, training evaluations are conducted at least once every six months and refresher programs delivered to the staff at regular intervals to identify and address their learning gaps in timely manner.

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Setting up the pilot

Piloting a product is a critical step in all of Women's World Banking's product development work. During this period, the financial institution and the insurer are able to identify issues and correct course before fully rolling out the product. Women's World Banking typically pilots an insurance product in two to five branches for six to nine months, closely monitoring pilot targets and other KPIs. Throughout this period, the project team continually evaluates and adjusts the product based on feedback from staff and clients, making incremental improvements prior to finalizing the product for rollout.

The pilot period allows the financial institution and the insurer to identify issues and correct course before fully rolling out the product.

Selection of pilot branches. The branches for the pilot are selected based on criteria such as number of clients, client mix, location (distance to head office), availability of health infrastructure as well as the branch manager's attitude, previous experience with pilot of other products, and geo-political risks in the location. The aim is to test a variety of variables that have been identified as potential problem areas and work out solutions in a smaller context.

The project team. When identifying the members of the project team, a financial institution must look beyond product expertise to softer skills. The project team should consist of staff members who are self-driven, resourceful, creative and motivated. They should also enjoy good relationships with the stakeholders (branch staff, department heads within the organization as well as insurer), have high willingness to learn and adapt, and demonstrate high client-centricity. The project team should also have the interest, ability and discipline to work with numbers and simple quantitative analysis tools. Finally, the project should offer career opportunities to strong performers outside of their comfort zone.

Setting targets. It is important to note that it takes time for insurance KPIs (i.e. IBNR (incurred but not reported) claims, Claims Ratio and Claims Frequency) to fully develop and stabilize, thus enabling the insurer to correctly adjust the pricing. Women's World Banking also prepares a pilot protocol which defines the cut-off boundaries for the pilot, i.e. if the results on the indicators are very different from the acceptable limits, then the pilot is called off. Some of the quantitative and qualitative indicators used in the pilot protocol are:

- Percent of client non-renewal of loans because of insurance
- Anti-selection measured through claims frequency much higher than expected
- Claims rejection, cost and turnaround time
- Client awareness
- Fraud patterns and control effectiveness

These KPIs will form the foundation of the ongoing performance management of the product.

PERFORMANCE MANAGEMENT

Performance management is the most critical aspect of running a microinsurance business. Carefully made pricing assumptions on the KPIs need to be monitored every month and appropriate adjustments in the program need to be made to achieve the desired strategic objectives. These KPIs help the institutions answer three key questions:

- Is the product appropriately priced?
- Is it meeting the institution's clients' needs?
- Are the clients using the product?

Performance management is only as good as the data and resources dedicated to it. The financial institution and insurer's MIS are key sources of client and claims information, complemented by anecdotal data from client surveys and staff interviews, as well as market news and updates and periodic competition tracking. In order to use this information, an institution must invest in staff (employees dedicated to the project that possess basic analytic skills and knowledge of analytic tools such as MS Excel) and technology (high-performance computers and appropriate software).

Effective performance management also requires commitment from the senior management to build the culture and discipline of quality data entry, data management and performance tracking through dashboards. Senior management should invest quality time in discussing the KPIs and dashboards and guide the project team in making informed business decisions. Financial institutions often neglect to build internal capacity about insurance monitoring on the grounds that the insurer will provide this insight. By doing so, they miss an opportunity to proactively steer the product into maturity by leveraging their unique combination of client, data and process knowledge. They also miss the opportunity to build a peer dynamic with the insurer about pricing assumptions and product features. Neglecting this capability may force institutions to change product pricing or reduce certain benefits at the insurer's request, when an informed look at the data would have ruled it out.

Women's World Banking's technical assistance approach of building an institution's capacity to collect and analyze data allows each institution to independently conduct breakeven analysis, monitor profitability and handle risks with an eye toward the future. This allows institutions to better plan and decide on future investment for this product, while keeping an eye on its social impact.

Women's World Banking works with partner institutions to track what Women's World Banking considers the eight non-negotiable KPIs for microinsurance. These are 'non-negotiable' because they provide the most fundamental level of information about the product's performance.

1. No. of lives covered (per gender, spouse, children, loan type)
2. Percent of clients enrolled
3. Claims Ratio (a.k.a Pure Loss Ratio)
4. Claims pattern (frequency, average size)
5. Claims rejection ratio
6. Claims process Turnaround Times (TAT)
7. Percent of detected fraud
8. Operational margin (Cost/Commission)

RISK MANAGEMENT

While insurance is about covering the health risk of the clients, financial institutions and insurers in fact *incur* risks that need to be carefully considered and swiftly mitigated if they are to offer a sustainable product. The universe of risk is large but can be categorized under six broad areas[7]:

1. External Risks

a. Regulatory risks refer to the impact regulatory changes can have on the ability of the institution to offer the product. They should be identified early by analyzing current and future regulation to identify hurdles and by regularly engaging with regulators to identify their priorities and how they influence the product.

7 Comprehensively listing all risks is beyond the scope of this publication. Nevertheless, the areas shared here will allow the institution to kick-start the discussion and determine which risks are material in their current environment and which mitigations are most appropriate.

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b. Natural disaster or pandemic risks can cause a sudden surge in claims frequency. They can be mitigated by addressing accumulation in the policy, agreeing on a cash-call with insurer for certain events, stress testing the process to work out potential backlogs and incorporating the insurance process in the business continuity management plan of the institution.

2. Financial Risks

a. Default risks (the risk of the insurer defaulting on claims payment) can be mitigated by checking the insurer's financials periodically, setting maximum turnaround times prior to scaling, setting up claim reserves from the premium where allowed and maintaining relationships with other insurers as a fall-back.

b. Treasury risks (the risk of not having enough cash to pay out claims at the branch) can be mitigated by providing electronic payments (where clients have bank accounts) and extrapolating liquidity requirements based on claims experience (using the pilot to correct calculations).

c. 'No breakeven' risks can be mitigated by setting up KPI dashboards with warning targets, separating out often invisible operational costs in the budget, adjusting financial projections before launch, locking in pricing on a yearly basis and keeping 'back doors' in the product (e.g. time limits for declaration)

3. Human Capital Risk

a. Institutions are particularly exposed to the risk of losing key people in the early stages of product launch. Producing clear job descriptions and comprehensive process documentation, adjusting incentives, assigning deputies in case of absence and using rotating staff can mitigate this risk.

b. Internal fraud risks arise when personnel create fake claims or collude with clients to file or inflate claims. This risk can be mitigated by requiring double-signature controls at the branch manager level, monitoring controls on data, as well as implementing clear disciplinary measures within the human resources framework.

4. Process Risk

a. The main risk of delayed claim payment can be mitigated by adjusting the process to meet target turnaround time prior to launch; creating exception reports (e.g. list of claims older than 3 days) to trigger corrective action and prepare staff hiring plans aligned with the volumes projected from a phased launch.

5. Technology/ System Risks

a. Confidentiality risks can be mitigated by including minimum standards in the IT specification (e.g. using a secure File Transfer Protocol (FTP), IP whitelisting) and assigning a unique client ID at enrollment so that the health information exchange does not contain identifiable clients' personal information.

b. Data integrity risks can be mitigated by regularly reconciling data between the finance department and the insurer.

c. Availability risks can be mitigated by using back-up data, integrating IT into the maintenance process and setting up an alternate means for data transfer in case of breakdown (e.g. making physical claim forms available and spreadsheet templates to submit claims manually to the insurer).

6. Project Launch Risks

a. Timeline delay risks mainly arise through competing priorities internally or externally. Internally, they can only be mitigated by positioning the product within the overall institution's respective processes so as to receive proper resources, time, staff and budget. Externally, they mainly arise from IT readiness, marketing collateral production, or approval processes with the insurer or regulator. They cannot be fully mitigated but discipline on follow-up with appropriate escalation and having a "Plan B" can help.

b. Staff resourcing risks can be mitigated by allocating dedicated staff from the project start and establishing a migration strategy that transfers them into a new role at launch.

SCALING

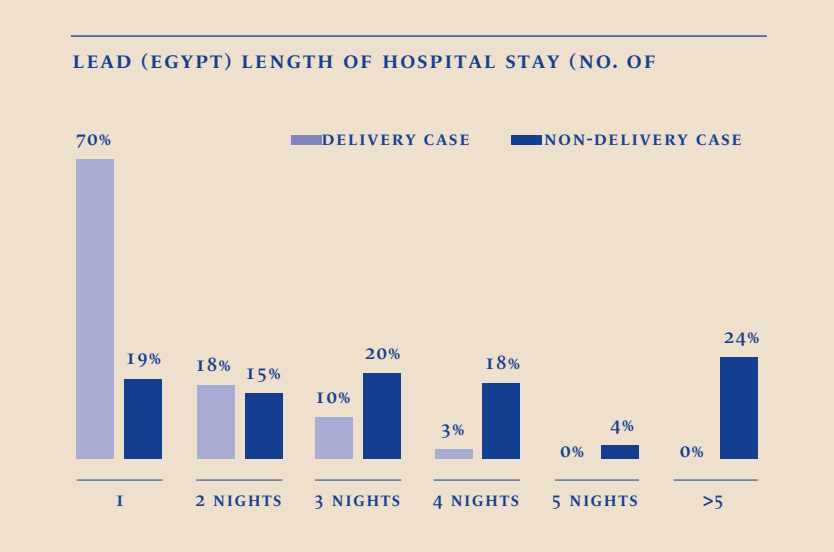
Once operational components are optimized after the pilot, the financial institution and insurer will be positioned to scale the product via rollout to the entire branch network. The key activities that facilitate a smooth scaling up of the insurance program are:

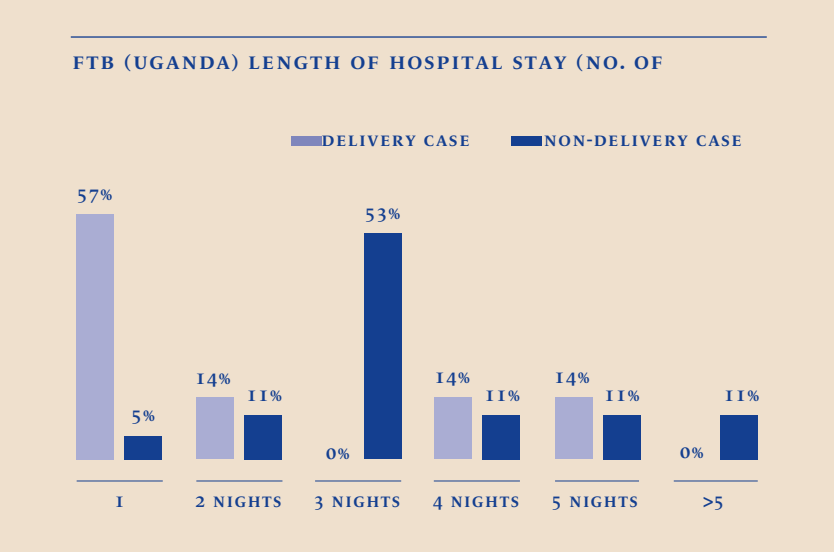
1. Develop a scale-up plan – Based on the pilot, Women's World Banking prepares a scale-up plan aligned with the institution's KPI targets. It includes recommendations for timelines for rollout to all branches, training schedule for the new branches, marketing roadmap, operational and IT enhancements. The objective is to estimate the workload of the core project and operations team and overall resource requirement to manage the scale of operations efficiently. Monitoring through exception reports allows the team to respond quickly to any issues that emerge.

2. Revise financial projections – Financial monitoring of the program at regular intervals helps in determining the operational cost of managing the program and is critical in understanding the sustainability of the program. Women's World Banking prepares customized financial trackers for the institutions to help monitor revenues from insurance operations and track fixed and variable costs such as commission income, staff time cost, IT development expenses, marketing and training-related expenses. Financial tracking helps estimate breakeven and operational margins to revise initial assumptions as necessary in the lead up to scaling activities.

3. Set up IT systems – Women's World Banking recommends institutions to set up fully automated enrollment, claims management and fraud record keeping systems for the scale-up in order to limit errors and manual work in preparing exception reports. This will also free up time for doing for closer monitoring and evaluation and capacity building in the institution.

How Performance Monitoring Helps in Make Informed Business Decisions





Women's World Banking places special emphasis on building institutional capacity for creating, reading and interpreting KPI dashboards. Internal capacity will allow the institution to have immediate access to and understand actual product performance and flag potential risks or deviations from original assumptions, without relying on external input. Internal capacity can also serve as a check to an insurer's interpretation of data and attempts to change terms. In addition, dashboards form the basis of further research and evaluation of the long-term impact insurance has made on the lives of the clients. These insights are immensely useful in further enhancing the product and delivery model, enhancing the value proposition for the clients and helping institutions achieve their sustainability and social objectives. A close look at some of these KPIs shall serve as a case in point.

Severity. In the case of Lead (Egypt) which has over 80 percent women clients, Women's World Banking found that the maternity/delivery-related claims were in fact not very severe, i.e. 70 percent of the clients who were hospitalized for delivery got discharged within one day. This indicates that maternity-related claims do not put a huge burden on the claims ratio.

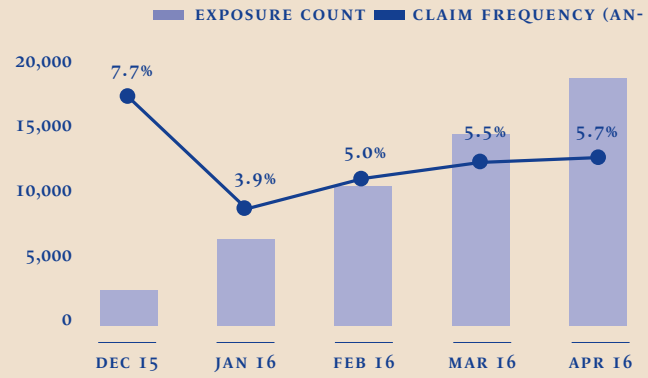
However, the severity pattern for FTB in Uganda is quite different. Maternity-related cases are more severe in Uganda compared to Egypt (likely due to poor conditions of health facilities and clients' limited health awareness levels in Uganda). However, compared to non-maternity-related cases, their severity is moderate.

Claims frequency. Lead's dashboard during the pilot suggested that the claims frequency started to reach a stable level in the first five months of the pilot. This information helped the institution predict the future claims volume and in turn prepare itself for the operational resource requirements and IT enhancements required to manage the amount of work more efficiently.

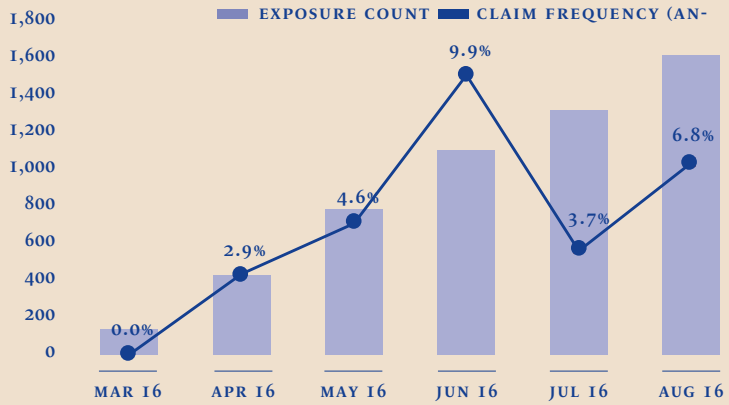
This indicator formed the basis of a phone survey to gauge client awareness and understanding of the *Caregiver* product as the claims frequency was lower than original pricing assumptions. Survey results showed that there were variations in clients' awareness and staff's understanding of the product across the three pilot branches. It highlighted where the gaps in the marketing and training processes were, which enabled Lead to take corrective action. Further research by Women's World Banking suggested that there was improvement in clients' awareness levels of the product and claims frequency after these measures were enacted.

Similar analysis with FTB revealed that while the product was scaling up at a good pace, the claims frequency had not stabilized even after six months into the pilot. A follow-up phone survey was initiated to understand these fluctuations, and it revealed that a significant number of clients were not aware of the *Caregiver* product. Among those clients who were aware, their degree and level of understanding of product's features and terms varied across locations. A significant number of clients also did not remember receiving the product brochure. Furthermore, the net claims rejection ratio (total rejected claims minus fraudulent claims) was higher than expected. This indicated that even if the clients were aware, they were not able to fulfill the claims process requirements fully. In the pilot evaluation, Women's World Banking recommended strengthening the organization's marketing and training approach as well as updating their claims and IT processes.

LEAD (EGYPT) HOSPITAL CASH CLAIMS FREQUENCY



FTB (UGANDA) HOSPITAL CASH CLAIMS FREQUENCY



Measuring Client Outcomes: Achieving the Double Bottom Line

Financial institutions serving the low-income market have "double bottom-line" targets – achieving financial sustainability and their social mission. Measuring the performance of *Caregiver* along both dimensions is important in order to understand if the product has achieved its desired objectives: 1) analyzing financial performance to understand the profitability of the product and 2) conducting outcomes research to understand the difference the product has made in the lives of women.

Microfund for Women's Mission: To provide sustainable financial and non-financial services to the entrepreneurial poor, especially women, in order to empower them socially and economically, and to help them achieve a better quality of life.

While the financial performance of *Caregiver* is measured as a part of overall KPI performance measurement, measuring social performance requires the institution to conduct rigorous research at the client level. For instance, Women's World Banking conducted an outcomes study in 2015 to measure the effect *Caregiver* had on MfW's clients' lives and by extension, whether it was effective in helping the institution achieve its social mission. The study looked at the following parameters in particular: clients' socio-economic status and access to finance, women's agency, business outcomes, achievement of savings goals, and household outcomes such as consumption smoothing, housing conditions, health and children's education.

The study was conducted through a mixed methods approach: the quantitative evaluation was conducted through analysis of five years of accumulated data on client loans and claims behavior, supported by qualitative research using focus groups and one-on-one interviews. The strength of Women's World Banking's qualitative sample is that it matched quantitative trends, enabling the analysis to align to behavior patterns of use and life outcomes one would expect to see in the broader client population.

Women's World Banking specifically sought to understand the "empowerment" effects, if any, that *Caregiver* had on the clients; empowerment here defined as "the process by which women take control and ownership of their lives through expansion of their choices[8]." To measure empowerment, the research team followed Martha Chen's Empowerment Framework[9], which considers four dimensions of empowerment: Material Change, Cognitive Change, Perceptual Change and Relational Change. Women's World Banking then devised research questions based on this framework:

Material: Are there any increases or decreases in her income, earning capacity and access to resources due to utilization of the *Caregiver*?

Cognitive: Are there any differences in her knowledge, skills and awareness of insurance due to *Caregiver*?

Perceptual: Is she more or less self-confident, have a greater sense of self-worth and clearer vision of her future?

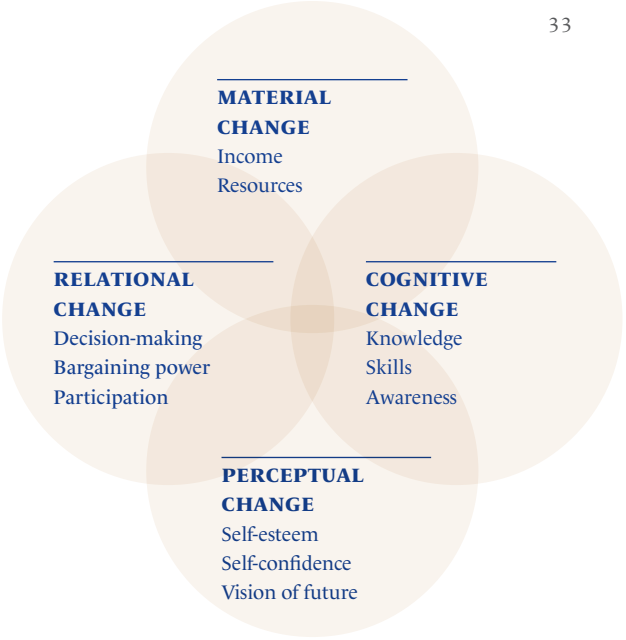
Relational: Does she have a greater bargaining power in the household? Is she more self-reliant?

The in-depth quantitative analysis established that the clients who submitted claims following hospital care services and received benefits from *Caregiver*[10] had higher rates of on-time loan installment payment, thereby reducing the PAR for MfW. The research also provided encouraging insights on the outcomes of *Caregiver* along each dimension of the empowerment framework:

8 "Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment. Development and Change," Naila Kabeer (1999).

9 "Assessing Change in Women's Lives: A Conceptual Framework," Martha Chen & Simeen Mamud (1995).

10 Comparison groups of women who had access to Caregiver and received hospital services but did not elect to participate in Caregiver services by claim submission and women that had access to Caregiver but did not have a health incident that resulted in a health care expense.



Material Change: *Caregiver* benefits allow clients to repay MFW loans as a result of hospitalization, avoid additional debt and pay for medicine, food and transportation costs.

"*Like the hospital, we don't have the money for medicine. So, with payment, we have the money and it makes it easier." (client quote)*

Cognitive change: Women understand the insurance concept, product terms and conditions, as well as calculations related to the cost of loan renewal and the *Caregiver* product.

"*When I enter hospital,1 JD is not much, it's symbolic, it's worth it… 12 JD a year. If you're in the hospital 5 or 6 days. It's worth it.*" (*client quote*)

Perceptual Change: Women with income-generating activities who have accessed credit and claimed *Caregiver* benefits have a strong sense of self-confidence as well as vision of their future.

"*When you have money, you can use your own money and not depend on husband. I can go to hospital for treatment. Not wait for his money.*" (*client quote*)

Relational change: Women with income-generating activities who have accessed credit and claimed *Caregiver* benefits have increased perception of decision-making within their household.

"*When a woman has money, she's strong in everything. If you have an opinion and your husband has an opinion, you can talk to him.'Money is strength'.*" (*client quote*)

It is critical to note that at MfW, *Caregiver* is linked to the credit and life insurance products (as well as other MfW services) and therefore some outcomes are influenced by a combination of products and not *Caregiver* alone. Nevertheless, this evaluation demonstrated that *Caregiver* does indeed contribute to improving the quality of life of MfW's clients and to their overall sense of empowerment.

JORDAN

The Way Forward

With support from donors such as AFD and the Swiss Capacity Building Facility (SCBF), Women's World Banking has succeeded in answering the question: "can we make health insurance work for women for $2 a month?" This work has demonstrated the business case for institutions, including insurers, that health insurance *can* be sustainable for institutions and meaningful for clients at the same time, creating a win-win-win for all. With the participation of like-minded institutions, these models can be scaled up and replicated to provide simple and effective health financing solutions for low income populations in other geographies. Women's World Banking looks forward to collaborating with both financial and non-financial institutions to increase access to health insurance for more low-income women worldwide.

Women's World Banking delivers an innovative and commercially viable insurance product that is meaningful for clients and is sustainably profitable for insurers and financial institutions. Women's World Banking's experience has shown that when a product is executed properly and monitored effectively, breakeven for health microinsurance can be reached within two to three years. Women's World Banking looks forward to introducing *Caregiver* to new markets and developing innovative distribution models using the new digital finance platforms to increase insurance penetration and maximize value for low-income women.

	MICROFUND FOR WOMEN, JORDAN	AL AMANA, MOROCCO	FINANCE TRUST BANK, UGANDA	LEAD FOUNDATION, EGYPT
PRODUCT NAME	Afitna	Tayssir Al Amana	TrustCare Hospital + Cash	Hemaya
PRODUCT HIGH-LIGHT	Hospitalization coverage for family members and life insurance for client and spouse	Ambulance benefit for the clients	Hospitalization coverage for clients	Hospitalization and life insurance coverage for clients
LAUNCH DATE	2006 for Life coverage, 2010 for client hospital cash, November 2015 for family coverage	2012 for client coverage, January 2015 for family	February 2016	November 2015
LIVES COVERED *AS OF AUGUST 2016*	226,000+ (Total) Of which 192,000+ in the family policy.	1.177+mn Of which 1.124+m in the family policy.	2000+	53,000+
NO. OF CLAIMS	34,500+ *Since 2006* 1,900+ claimed under the new family policy	33,000+ *Since 2012* 23,000+ claimed under the new family policy	40 *Since February 2016*	714 *Since November 2015*
NAME OF INSURER	Jordan Insurance Company	SAHAM Assistance	UAP	Egyptian Life Takaful Company

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