Women's World Banking

Health Microinsurance: Selecting the Right Insurer

Health microinsurance can be a profitable venture for institutions and commercial insurers, if they share long-term vision.

Health microinsurance not only provides a crucial financial safety net for low-income families, especially women, but also can be a profitable value-added offering for institutions who implement it properly.

*In 2006, Women's World Banking designed and launched Caregiver in Jordan, a health microinsurance product that offers simple, affordable and relevant solutions for low-income clients, especially women. Since then, they have worked with network members in Peru, Egypt, Morocco, and Uganda to create similar health insurance products that respond to the needs of women and institutions. For more information on selecting the right insurer or other aspects of building a successful microinsurance product, see **Health Microinsurance: An Inclusive Approach.***

Microinsurance is a profitable long-term investment for financial institutions or non-financial institutions such as mobile network operators, non-governmental organizations, cooperatives, and corporations. Institutions wanting to offer microinsurance must partner with the right formal insurance company to act as the risk carrier. However, most commercial insurance carriers may see the low-income market as "high risk" and unprofitable. Meaningful, yet sustainable health microinsurance products are possible, but it takes time, a willingness to adapt processes to the unique needs of your clients, and a significant initial investment.

The tender or RFP process is a critical step to ensure both the institution offering the microinsurance product, and the insurer are transparent and in agreement about the risks and rewards of the proposition. Institutions should be careful to share accurate and detailed information about the client profile with potential insurers. This allows insurers to assess the risk in a comprehensive manner, and submit its best price quotation. Institutions should prepare tender documents with information about themselves, the product(s) and/or services it already offers to its clients and the rationale for microinsurance. It also should provide 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.

Questions to ask insurers during the tender process:

Why are they interested in offering microinsurance?

Is microinsurance a strategic priority for them?

Do they have long-term commitment on microinsurance?

Are they willing to learn, adapt and challenge market practices?

What is their prior experience with microinsurance?

Are they equipped with the appropriate IT and operational systems to offer microinsurance?

Do they have a physical presence in all or most of the same locations as the financial institution?

Case Study: A Successful Partnership

Many insurers are skeptical about the profitability and scalability of microinsurance. Sharing information and maintaining a high level of transparency to build trust is imperative. In Uganda, Finance Trust Bank (FTB) and insurer, UAP, worked together to address challenges and create a relevant, sustainable microinsurance product, proving flexibility and perseverance can be fruitful and that a leap of faith can be rewarded.

Challenge 1: Pricing adequacy. The absence of actuarial data or health statistics about the low-income segment makes it difficult for insurers' to price microinsurance appropriately. Because of this gap, insurers such as UAP often take leap of faith when piloting microinsurance. Women's World Banking helped bridge the gap by providing loss data from other countries and working with actuaries to formulate assumptions on hospital visit habits and local disease patterns to improve the insurer's confidence in the pricing model.

The pilot evaluation revealed that the claims frequency was lower than expected, but the severity of claims 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. Constant, transparent communication throughout the pilot period also created a favorable environment for successful negotiations between FTB and UAP. ***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 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 loan so the primary motivation is the loan and not making a claim. This helps ensure risks are smoothened across the portfolio. 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. After a few months of observing a low claims rate directly after enrollment, Women's World Banking and FTB engaged UAP to revisit the issue. ***Creating a joint learning environment helped build trust between the insurer and their counterparts, and eventually UAP agreed to waive the waiting period altogether.***

Challenge 3: Claim turnaround time and payouts. Women's World Banking's experience in Jordan and Egypt shows that, compared to the middle and high income segment, low-income clients tend to spend more days 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 they are treated for other conditions. Nevertheless, when clients file claims, they expect a positive experience with the claims process and a quick turnaround time. For insurers and financial institutions, fulfilling clients' expectations while preventing fraud requires a delicate balance. Longer stays in the hospital often trigger additional scrutiny. This sensitive situation requires a shift in the insurer's mindset, 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 to think "out of the box."

To address this challenge, FTB and UAP partnered to implement a system to file claims 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 claim is filed at the FTB branch. Where there is high suspicion of fraud, claims are investigated through physical records. The insurer discusses each open case with FTB prior to reaching a decision. ***This process not only gives the insurer confidence in the institution's internal fraud detection, it also builds clients' trust and satisfaction in the product.***