



# CAN HEALTH MICROINSURANCE PROTECT THE POOR?

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- ▲ **Uplift India Association's** mutual health microinsurance program financially protect clients— shows MFO study
- ▲ **Financial value** is provided by claims reimbursements
- ▲ **But, negotiated price concessions** at network health care providers provides additional financial protection

**IS MICROINSURANCE A GOOD DEAL FOR THE POOR?** Despite significant commitment of funds into microinsurance pilots in recent years, little is known about what value microinsurance products actually deliver to their low-income target clientele. In fact, the conceptual parameters of client value are still very much under debate. (Magnoni & Zimmerman, 2010, Matul, Tatin-Jaleran & Kelly, 2011). Even for health microinsurance, the most studied of any microinsurance product, fundamental questions remain about whether it protects low-income people financially.

A new report from Microfinance Opportunities (MFO) contributes to that debate by examining a client-managed health insurance model implemented by Uplift India Association. MFO focused on one specific component of client value, financial value, and examined whether and how Uplift provides financial value to its members. The MFO report took as its starting point the definition of financial value as articulated by Magnoni & Zimmerman (2010): the value that policyholders obtain when claims are made.

Using a combination of qualitative and quantitative analysis, MFO concluded that Uplift does in fact provide substantial value to its health microinsurance clients. This value is obtained through claims reimbursements and also for some through lower costs of care due to Uplift-negotiated price concessions at participating hospitals. Based on its findings, MFO recommends an expanded definition for financial value:

*Financial value of health insurance is the degree to which membership in a health microinsurance program lowers the overall costs incurred due to ill health.*

This Brief describes how MFO reached that conclusion. It summarizes the features of the Uplift product, the methodology MFO employed to study Uplift's value, the findings from that analysis, and the implications of those findings for Uplift and for the microinsurance field.

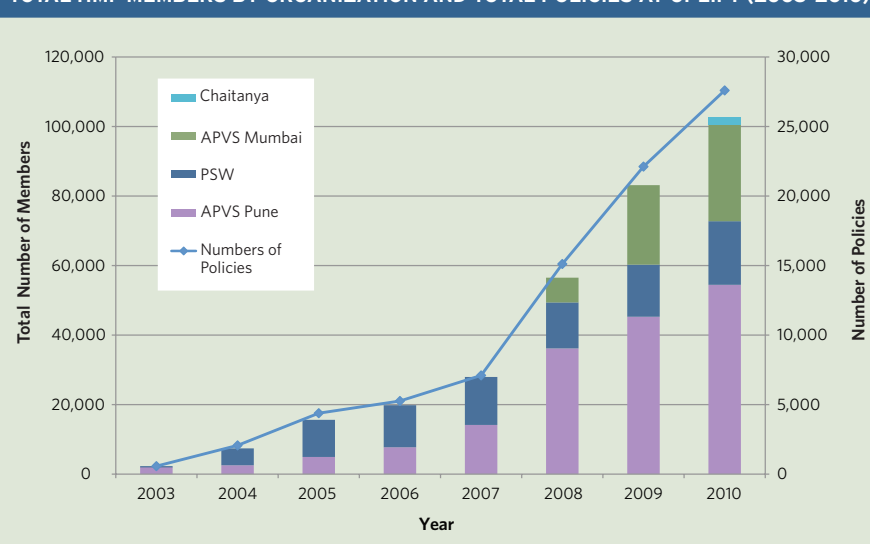
#### BACKGROUND ON UPLIFT

Based in Pune, India, Uplift was started in 2003 by Annapurna Mahila Mandal Pune (AMMP), a microcredit provider, and other stakeholders to protect borrowers (and their own portfolios) from the economic shock of medical expenses. The participatory and client-led nature of AAMP's microcredit program had a strong influence on the character of the Uplift health microinsurance program that emerged. As will be discussed in greater detail below, clients

have substantive decision- and policy-making authority under the Uplift model: committees of clients set the premium rates, approve or deny claims, and can adjust (upwards or downwards) recommended rates of reimbursement.

Today, Uplift pools risk across more than 100,000 poor and low-income members in Maharashtra state. The health microinsurance program in Pune, the subject of the MFO study, is delivered through integration with two microcredit programs, Annapurna Parivar Vikas Samvardham (APVS)-Pune and Parvati Swayamrojgar (PSW)<sup>1</sup>. When Uplift was launched, participation was open to all borrowers but was voluntary; within five years, it became apparent that the program would be financially unsustainable unless enrollment increased significantly. As Figure 1 illustrates, the total number of policyholders (blue line) begins shooting up in 2008, the year that Uplift made purchase of health insurance mandatory for all members as a precondition for access to credit.

**TOTAL HMF MEMBERS BY ORGANIZATION AND TOTAL POLICIES AT UPLIFT (2003-2010)**



<sup>1</sup> Note that at APVS-Pune, all microcredit clients must purchase the HMF. At PSW, clients must either purchase the HMF or provide proof of other insurance; the majority are in fact HMF policyholders.



In exchange for a low annual premium of INR 100 (USD 2.22)<sup>2</sup> per person, Uplift's health insurance program (referred to as the health mutual fund, or HMF) provides:

- Coverage for in-patient care on a reimbursement basis and within a large hospital network
- Negotiated price concessions at participating health facilities
- Access to lower cost outpatient care, medicines and medical tests
- Health education and health promotion services

### REPORT OBJECTIVES AND METHODOLOGY

MFO's research was designed to explore three key questions:

- Does Uplift's health microinsurance protect households financially? If so, how?
- Are out-of-pocket (OOP) costs of healthcare lower for Insured households than for Uninsured<sup>3</sup> households?
- How does the unique community-managed reimbursement process at Uplift influence the financial protection effect of the insurance?

These key questions are addressed in two ways. The first is through a case study comparing the specific experiences of 15 Insured households and 10 Uninsured households when faced with a serious case of malaria. Malaria was chosen for several reasons. Among low-income people, especially those who live in crowded and unsanitary conditions, malaria is a common and equal-opportunity disease, striking the insured and the uninsured alike. But it is also a condition of sufficient seriousness that people will almost always seek treatment regardless

of the costs. In addition, malaria is a priority target of intervention for the Bill & Melinda Gates Foundation which provided funding for the Financial Services Assessment project of which the MFO research was a component.

Although this case study yielded interesting insights into the respective experiences and coping strategies of the Insured vs Uninsured low-income households, the sample size was insufficient to make its findings widely generalizable. So to supplement the case study findings, MFO's second approach was an analysis of Uplift's claims and financial data. We examined those key performance indicators (KPIs) that tell us the most about an insurance product's value proposition from the client perspective (e.g., incurred claims ratios, rates of renewal, length of time patients must wait for reimbursements).

MFO sought, in other words, to look at the client value of Uplift's HMF program using both the zoom lens of the case study and the wide-angle lens of the KPI analysis.

### KEY FINDINGS

**The Good News: Lower Out-of-Pocket.** In response to a serious case of malaria, the case study sample of Insured households had substantially lower average out-of-pocket costs than the sampled Uninsured households. Uninsured households paid about 1.5 times as much (\$422.36 vs \$272.22) upfront. Once reimbursements are factored in, the spread widens: the \$422.23 paid by the Uninsured is more than twice the post-reimbursement OOP burden (\$182.49) borne by the Insured.

The variance largely reflects the lower direct hospital costs paid by the Insured which in turn likely reflects the price discounts to which Insured patients are entitled at network hospitals. (Of course, the variance could also be explained if the Uninsured spent more time in the hospital than the Insured, but the opposite was true: the Insured stayed in the hospital an average of 7.6 days whereas the Uninsured's average stay was only 5.8 days.)

This finding is significant for two main reasons. First, direct hospital costs are the largest single cost category related to malaria care. Second, these costs are practically unavoidable: the only alternative is the free-to-user government hospitals and in those facilities, the standard of care is such that even very low-income people will go to any lengths to avoid them.

Of course, the lower out-of-pocket costs cannot be analyzed in isolation; the Insured who enjoyed those lower costs had first paid the premium for their insurance policies. When MFO ran calculations of the estimated transaction costs each group incurred to finance the hospital care, we found that transaction costs were higher for the Insured: \$11.49 vs \$6.53. (Transaction costs are defined here narrowly as the costs of

<sup>2</sup> Reflects conversion rate of 45:1 that was an average of rates in effect at the time of the field research in February 2011.

<sup>3</sup> For the sake of clarity and visual ease, throughout this Brief (as throughout the report on which it is based), the upper case is used for all instances of "Insured" and "Uninsured," whether used as a noun or as an adjective, when the word refers specifically to the households or individuals who are the subjects of the MFO study. Elsewhere, the report uses the lower case to describe the condition of being insured or uninsured in general.

financing hospital-related expenses. For example, transaction costs include, for the Insured, the premiums they had paid; for both groups, the costs associated with any borrowing that had been necessary.) The costs of the premium represented most of this difference. But because MFO did not explore the Insured respondents' full experience with the HMF during 2010, we do not know what additional financial value they may have obtained beyond the malaria episode.

***The Less-Good News: Significant Indirect Costs Not Covered by Insurance.***

As suggested above, the HMF provided valuable financial relief to malaria-affected households' direct costs of care. But unfortunately, indirect costs are another big part of the story. Not only does a hospitalization mean more cash out, it also often means less cash in -- the patient cannot work for at least as long as he is in the hospital and often for a post-hospital recuperation period as well. Foregone income is also frequently a factor for the family member who must care for the patient (in India, a family member must provide food and perform patient-care tasks [bathing, administering medicines, changing bedpans] that would be performed by nurses or orderlies in other countries).

And finally, foregone income can be a factor for any family members who must pick up the slack on the home front created by the absence of both the patient and the caregiver. By the time foregone income on the part of the patient, the caregiver, and all affected family members is combined with related incidentals (e.g., food, transportation), the indirect costs associated with a serious illness can be quite significant.

The comparability of the Insured vs Uninsured cohorts in the MFO sample may have been skewed by an overrepresentation among the Uninsured of subjects whose loyal employers continued to pay their salaries during their hospitalization. At \$42.13, the average indirect costs for the Uninsured in the MFO sample thus might well be considerably lower than would be the experience of other, less fortunate uninsured Indians. In any event, returning to the Insured, at \$165.67 per episode, their average indirect costs (which again, the HMF does not cover) were not only much higher than the possibly distorted \$42.13 for the Uninsured. That \$165.67 sum was also almost as high as the amount (the \$182.49 noted above) they ended up being out of pocket, for their direct costs of care after getting reimbursed.

In fact, based on self-reported data from the Insured households, the HMF ultimately covered less than a quarter of the total costs of a malaria episode, once the full picture of indirect and transaction costs are factored in. But this finding comes with several caveats.

First, the inclusion of the HMF premium in the calculation of transactions costs, although clearly appropriate, does complicate matters. As noted above, MFO did not research the Insured's total experience with the HMF during 2010. Even one additional serious illness would have spread the premium cost (the greatest share of the transaction costs) across more transactions, thus lowering the costs for any single transaction. And even setting aside intangibles such as "peace of mind," the HMF provides benefits beyond claims reimbursement (provider discounts, health education, outpatient treatment). Lacking a meaningful way to assign some portion of the premium cost to the malaria



episode only, MFO erred on the conservative side and factored the entire cost of the premium into the transaction costs of the malaria hospitalization.

Second, when looking only at that portion of transaction costs that does lend itself more readily to apples-to-apples comparisons – the cost of borrowing – the Insured appear to come out ahead. They were able to borrow at more favorable rates and it seems reasonable to assume that their Insured status had something to do with that; they only needed the money for as long as it would take to get the reimbursement, and lenders knew that, as Insured, they were good for the loan.

Finally, for a population for whom every rupee counts, even a 25 percent reduction in the total burden may represent meaningful relief. And indeed, during interviews with MFO researchers, clients voiced general satisfaction with Uplift.

**KPI Analysis.** Analysis of the institutional data supported the case study finding that Uplift is providing substantial financial value to its members. The largest component of financial value is provided by the claims reimbursement, but additional financial protection is provided by the negotiated price concessions at participating healthcare facilities. The claims ratio at 63% across the Uplift program indicates that Uplift paid out in claims more than it had earmarked as earned premiums in 2010. While this raises obvious questions (addressed below) about Uplift's long-term viability, the claims ratio does support the finding of client value.



TABLE 1 - KEY PERFORMANCE INDICATORS

| INDICATOR   | UPLIFT | APVS-PUNE | PSW   |
|---|--------|-----------|-------|
| Incurred Claims Ratio   | 6.3%   | 6.1%      | 72%   |
| Claims Frequency Ratio  | 2.0%   | 1.68%     | 2.8%  |
| Claims Rejection Ratio  | 4.6%   | 5.0%      | 3.3%  |
| Renewal Ratio   | 53%    | 61%       | 72%   |
| Percentage of Claims Settled within 50 days of Submission           |        | 35.1%     | 77.8% |
| Percentage of Claims Submitted within Two Weeks of Leaving Hospital |        | 48.3%     | 22.9% |

For the year ended December 2010, Uplift's claims reimbursements reduced policyholder costs by 38 percent while price concessions reduced hospital costs for claimants by an additional 26 percent. At 4.6 %, the claims rejection ratio (see fourth row of Table 1) was in line with Uplift's targets – although MFO's analysis of the rejected claims revealed that a high percentage (30 percent of this 4.6%) of rejected claims were due to easily avoided patient error (out of network providers, preexisting conditions), indicating room for improvement in policyholder education.

Similarly, the length of wait time (between when treatment concludes and when reimbursement is ultimately received) could also be improved through education. Uplift has set a goal of 50 days from claims submission to payment. At PSW, almost 78 percent of the claims were settled within that timeframe while at APVS-Pune the comparably figure was only 35 percent. (Row 5, Table 1) The clock does not start ticking on that 50-day target, however, until the patient submits the claim, and here the picture begins to change. APVS-Pune patients, the ones who had to wait longer to get paid, appeared to do a better job at submitting their claims promptly (48 percent within the two-week timeframe stipulated by Uplift, rising to 80 percent within four weeks). At PSW, less than 30 percent were submitted on time. (Row 6, Table 1) MFO's hypothesis is that PSW claims are getting processed faster once they are finally filed because patients are taking the time to get them right before submitting, a process that could be accelerated with increased support from Uplift customer care representatives.

Institutional stability as a necessary precondition of value. Obviously, any calculations of value are moot if the institution is not around to serve clients. And Uplift's long-term sustainability is called into question by the high claims ratios and reliance on operational subsidies. Sustainability of the claims fund requires that in the long run, earned premiums be at least sufficient to cover the approved claims to the extent allowed. As noted above, however, Uplift paid out more in claims in 2010 than it earmarked in earned premiums. Premium income also has to cover all operating costs. This is not currently the case; donor funding covers the shortfall. This means that (absent permanent subsidy) either the premium price needs to increase or the benefits provided by the claim feature need to decrease. Either course

of action risks alienating policyholders, the last thing Uplift needs when it is striving to triple its customer base to achieve its stated breakeven target of 300,000 clients.

Here the client-managed nature of the HMF program, one of its most interesting features, becomes especially relevant. Not only has membership participation resulted in consistently low premium levels, but it has also shaped the financial value the program delivers. Uplift professional staff make recommendations about each claim: which ones should be rejected, which should be paid, and in what amount. But those recommendations can be countermanded by the claims committees (composed, as noted, of clients) who can, and frequently do, lower each claim's payout so as to increase the total number of claims that receive at least some reimbursement.

In essence, the HMF client members are attempting to strike a fine balance between affordability, value, and sustainability. By awarding smaller claims reimbursements to more members, the policyholders are increasing the number of customers receiving at least some value. That said, the trade-offs that members are making each month in pursuit of this fine balance do not come without tensions. Some members are understandably unhappy about receiving less than their allowed reimbursement amount. MFO research also showed that member participation is guided and in some cases heavily influenced by NGO staff. Even so, the evidence shows that members are actively participating and impacting the program.

#### IMPLICATIONS FOR UPLIFT

Uplift is already providing a significant amount of financial value to members. There are some areas where Uplift could endeavor to provide more financial value now without changing the premium or the benefits. As noted, for example, MFO's analysis of claims settlement suggests that financial value could be easily increased by processing and paying claims more quickly in order to reduce the policyholders' borrowing costs. Enhanced client education could also reduce patient error (going to out-of-network providers, failure to self-identify as an Uplift member at the time of hospital intake) and thus add value at negligible increased operating costs.

In the future, Uplift may also be able to increase the financial value it provides as a consequence of an expanded client base. As noted, the decision to make HMF purchase mandatory for borrowers led to an immediate and dramatic scaling up. Assuming demand for credit remains strong and the HMF remains mandatory, as efficiencies of scale take hold, a correspondingly higher percentage of premium income can be freed up for the claims fund.

### IMPLICATIONS FOR CONSUMER EDUCATION

MFO's research suggests that, contrary to conventional wisdom about what low-income people understand about insurance, the active HMF members understand risk pooling quite well. They may not have a sufficient long-term time horizon (or incentive) to concern themselves with guiding the program away from subsidy and towards sustainability. But they clearly demonstrate an understanding of the trade-offs between earned premiums and claims filed, at least from the data in front of them at any given time. This leads MFO to conclude that the Uplift program has successfully taught policyholders and frontline staff how to manage a risk pool. Uplift and its microcredit partners have achieved this by using participatory and transparent processes to administer the program. Seeing the risk pool in action and in fact playing an active role in its management makes this rather abstract concept tangible for members.

These findings suggest that learning by doing may be the best way to teach risk pooling. Games or simulations that provide hands-on exposure to the concept of risk pooling may thus be a good way to transfer the requisite knowledge and skills to potential policyholders.

### IMPLICATIONS FOR THE DEBATE ABOUT FINANCIAL VALUE

The findings show that Uplift provides value to its members both through discounted costs of medical care and through claims reimbursement. Additionally, there are other non-insurance member services, such as health camps, which provide free medical care to enrolled HMF members. Based on the experience at Uplift, we believe that health microinsurance deserves an expanded and specific definition of financial value. MFO proposes the following definition for debate:

*Financial value of health insurance is the degree to which membership in a health microinsurance program lowers the overall financial costs incurred due to ill health.*

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*This brief was prepared by Anne Folan based on A Fine Balance: A Case Study of the Client Value of Health Microinsurance: Uplift I.A. (July 2011) by Elizabeth McGuinness. The original report can be downloaded in PDF form from [www.microfinanceopportunities.org](http://www.microfinanceopportunities.org). The report is part of the Financial Services Assessment project, information about which can be found on the web at <http://www.fsassessment.umd.edu/>*

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[www.fsassessment.umd.edu](http://www.fsassessment.umd.edu)

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With more than 15 years of experience in the microfinance industry, **Elizabeth McGuinness** manages all client assessment, market research and microinsurance activities for Microfinance Opportunities. Since 2004, Elizabeth has played a key role in developing new programs and partnerships for the organization, as well as designing and pioneering new research tools and methodologies. Prior to Microfinance Opportunities, she worked for Save the Children, where she managed a group lending program in Tajikistan, designed and led an impact assessment program in Afghanistan, and later provided technical assistance to microfinance programs in Africa, Latin America and Central Asia while based in Washington, D.C. She also consulted with Mercy Corps International, United Nations Development Programme and the SEEP Network, and spent six years working in various management roles at the Port Authority of New York and New Jersey. Elizabeth holds a Bachelor of Arts degree in economics from McGill University, and a Master of Arts degree in economics from New York University.

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#### REPORT SERIES

This report is part of a series that will be generated by the Financial Services Assessment project. The reports are disseminated to a broad audience including microfinance institutions and practitioners, donors, commercial and private-sector partners, policymakers, and researchers.

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