Learning Journey

Swedish Cooperative Centre (SCC)

Bima ya Jamii – Insurance for the family

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Project Basics

About the project

Cooperative Insurance Company (CIC), one of the first regulated insurance companies to serve low-income market in Kenya, provides a composite microinsurance product called Bima ya Jamii (BYJ). The BYJ product provides in-patient health, accidental death and disability, and funeral coverage for a single annual premium of 3650 KHS (approximately 50 USD). It covers the entire family with no limits on number of children, no age limit and no exclusions.

The project is a partnership between CIC and the government-sponsored National Health Insurance Fund (NHIF). The NHIF underwrites the health cover and provides access to public hospitals. CIC carries the life risk and is responsible for marketing and servicing the product. The product is delivered by Microfinance Institutions (MFIs) and cooperative channels such as Savings and Credit Cooperative Organizations (SACCOs) and other member-based organizations. The Swedish Cooperative Centre (SCC) supports all stakeholders by assisting them to streamline processes between them and by building their capacities to scale up the product. SCC is also in charge of building insurance culture in targeted areas through consumer education on risk management and insurance. It delivers the education through ‘study circles’, a learning methodology that is administered by communities themselves with supporting materials provided by SCC. People organize themselves to follow ten sessions spread over a period of 1-2 months.

To complement an extensive learning agenda managed by SCC, researchers from Oxford and Amsterdam universities designed a longitudinal impact study to better understand impact of consumer education on knowledge and product take-up as well as the impact of the product on welfare of member households.

The composite product aims to provide complete coverage at an affordable price for low-income people. The linkage with the National Health Insurance Fund provides an interesting case for using market-based mechanisms within a public-private partnership to enable workers in the informal economy to access healthcare services.

Project Summary

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Bima ya Jamii – Insurance for the family</th>
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</thead>
<tbody>
<tr>
<td>Project Start Date</td>
<td>August 2008</td>
</tr>
<tr>
<td>Duration</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Country</td>
<td>Kenya</td>
</tr>
<tr>
<td>Product</td>
<td>Composite</td>
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</tbody>
</table>
Project Updates

Key Indicators

The following performance indicators are valid as of August 2010.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Dec 2008</th>
<th>Dec 2009</th>
<th>June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach (active membership, lives covered)</td>
<td>16,144</td>
<td>13,914</td>
<td>8,279</td>
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<tr>
<td>Claims ratio for life component</td>
<td>7%</td>
<td>15%</td>
<td>40%</td>
</tr>
<tr>
<td>Claims ratio for health component</td>
<td>120%</td>
<td>120%</td>
<td></td>
</tr>
<tr>
<td>Renewal rate</td>
<td>30%</td>
<td>25%</td>
<td></td>
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</tbody>
</table>

What is happening?

As of April 2009

Based on a 2007 pilot with Kenyan Women Finance Trust, a large MFI in Kenya, the product was launched in 2008 and presented to SACCOs and other MFIs. Two key challenges were streamlining processes with NHIF and recruiting more delivery channels. SCC and CIC spent more time than planned on operationalizing the link with NHIF. They had to simplify claim procedures and improve information flows between health care providers and NHIF/CIC. CIC faced some challenges with getting MFIs on board because the same product was supposed to fit various MFIs serving different market segments. Strategies to overcome both challenges were developed. Additionally, SCC designed a consumer education strategy. The curriculum and delivery model were developed in cooperation with Microfinance Opportunities. The project got much attention from researchers and design of the Facility/EUDN longitudinal impact study was almost finalized.

As of October 2009

Three main challenges were: 1) Outreach – sales were lower than expected and renewals even lower. Partners identified a need for a dedicated team of marketers to support delivery channels. The consumer education campaign was delayed. 2) Tie up with NHIF - work was in progress to streamline claims administration and build buy-in and understanding among front-line staff and provider network. Claims procedures got complicated when NHIF required additional documents in the hospitals for Bima ya Jamii renewed policies. 3) Finalizing contracts with delivery channels – especially for MFIs the product seemed too rigid. There was a need to customize both the product and operations. CIC found it difficult to follow up with SACCOs after the sensitization meetings and to make sure that sales took place and were closed as planned. In 2009 sales were spread thin across a number of delivery channels with very low sales volumes.

As of April 2010

The project was restructured in March 2010 to help partners succeed and to overcome key challenges: low take up and renewals, ineffective sales and marketing, low capacities of SACCOs, a one-size-fits-all solution that was inadequate for various delivery channels, and lack of evidence-based analysis. The following steps had been identified to increase chances of success: budget and leadership allocated to
CIC, client satisfaction analysis by SCC, review of the CIC-NHIF relationship by local consultant, performance indicators training completed by BRS, process mapping, and a 6-month work plan and a 3-year business plan development facilitated by a senior microinsurance consultant. All these activities will be completed by end August. A consumer education campaign was launched and the baseline survey for the longitudinal impact assessment was completed.

As of August 2010

Based on a pilot, NHIF was encouraged by the government to fulfill its mandate and extend a comprehensive coverage to its members. Therefore, NHIF decided to add outpatient component on the top of currently provided hospitalization package. This should translate in significant price increase. CIC brand was put at stake as a major advertising campaign was conducted just before the announcement. Initially, CIC was granted three-month period, which was then extended to June 2011 to continue selling policies and clarify a future strategy for the product.
Project Lessons

On the business model and linkages with government-sponsored health insurance

Exclusive of pilot investments, microinsurance can be profitable. The BYJ product was profitable for CIC in 2009 with a margin similar to group life insurance business. This takes into account only operational costs in 2009 and does not consider initial investment in pilots from 2006-2008. Given recent developments and demand challenges this finding would need to be reevaluated in 2010.

Public-Private Partnerships (PPPs) are a feasible option for extending health insurance coverage to low-income households as long as they are moderated by an external party and there is willingness to share information and solve problems. Despite all the challenges described in this learning journey, CIC and NHIF still believe that in the long-term PPP is the way to go to provide comprehensive coverage. SCC played an instrumental role in bringing together two partners with totally different organizational cultures. This was definitely a success factor in building a sound partnership in 2008-2010. Other success factors are transparency and willingness to share information and solve problems as they occur.

Establishing a successful Public-Private Partnership (PPP) needs careful upfront risk analysis as he private sector partner’s reputation is at stake. PPPs can be effective in extending protection to low-income households working in the informal sector. Both CIC and NHIF put in considerable effort to build a successful partnership. However, both partners recognize that some of the risks were not identified in a timely manner and were not managed effectively. A list of unsolved issues after two years of partnership includes card issuance delays and problems with card recognition at hospitals and synchronization of systems to speed up servicing and data exchange. The recent announcement by NHIF of including outpatient coverage and subsequent change in price can have an adverse impact on CIC’s brand image.

Establishing a PPP requires senior management commitment but, more importantly, requires streamlined process and trained front-line staff. Constant communication with all stakeholders is necessary. Mechanisms should be identified to get key messages across to front-line staff. Regular weekly team meetings provided CIC and NHIF with a valuable forum to raise issues and resolve operational and budget problems. The directors of the two organizations also met three times per year during the Advisory Board meetings. This routine has been important in creating exchange, understanding and collaboration between NHIF and CIC. Lastly, additional communication with healthcare provider network was needed despite the fact that they all work with NHIF.

There is a need to review the original PPP agreement. The original partnership agreement between CIC and NHIF dates back to October 2007. Since then the needs and roles have evolved and it is time for a revision of the initial memorandum of understanding.

Moving from a small pilot to national scale up requires upfront resource allocation and readiness of all functions across the value chain. ‘Shot-gun’ approach did not work because CIC was not ready for rapid growth. They could not effectively follow up on marketing and sales activities. When a large roll-out is planned all the functions across the value chain should have capacity to process high volumes as needed.
On client value from a composite product

Client satisfaction surveys reveal majority of clients appreciated the product. Client satisfaction survey conducted in August 2010 showed that overall 79% of clients were satisfied with the product and only 3% assessed their experience as very bad. Satisfaction is even higher for those who claimed (81%), however, 10% of claimants rated their experience as very bad, which confirms some problems with servicing at certain hospitals. This is further substantiated by the fact that clients were least satisfied by claims processing and proximity of insurance and healthcare providers. They liked most staff professionalism, coverage and application process, proving that CIC got certain microinsurance principles right. Interestingly, price did not come up as an important issue, which contradicts findings from the impact study (see demand section below). One explanation might be that those who enrolled (who were surveyed to assess their satisfaction) considered the product to provide good value for money. Nevertheless, impact study and staff feedback confirm that the upfront premium payment requirement combined with low capacity to pay significantly lowered take-up and renewals.

High client satisfaction does not guarantee high renewals. Low renewal rates contradict high satisfaction and the fact that as many as 60% of surveyed clients declared that they would definitely renew their policy. Low renewals might be due to lack of information, renewal incentives and follow-ups from delivery channels. Additionally, client satisfaction is a dynamic concept that can change quickly if new offerings are available. Lastly, client satisfaction results reflect preferences of those who are currently served and do not guarantee that other groups on the market will respond to the same product in a similar way.

Benefit of composite coverage cannot be taken for granted. On the one hand, the offering seems compelling as it provides a comprehensive coverage. On the other hand, various riders increase price and make it difficult to sustain demand. Certain level of customization to introduce a choice of cover might be tested to make this product more flexible, thus adapted to various market segments.

Client value goes beyond client satisfaction. Based on the impact study by Oxford University we will know more in 2011 to what extent access to Bima ya Jamii improves risk management practices and impacts household welfare.

On key demand determinants, purchasing decisions, marketing and consumer education

Know your market before you scale up. The first results of the impact study (baseline data collected early 2010) show that target groups are very price sensitive and do not know much about insurance. Even if pilot test with KWFT was successful, it was too optimistic to assume that other low-income groups in the Kenyan market will perceive this product in the same way. Composite coverage adds complexity that cannot be underestimated in the context of low insurance literacy. A high premium and the need for the premium to be paid upfront in one installment further impede demand for this product. The target population prefers to pay in installments rather than lump sums although it is at a higher cost due to interest rates. Nearly 100% of the policies are sold through credit-linked offerings highlighting liquidity constraints. To sum up, rather than assuming that MFI clients and members of cooperatives are homogenous, a more deliberate attempt to understand the market was needed in the beginning to inform product design and need for customization as well as marketing and education campaigns.
Evaluate your marketing initiatives to come up with the best mix. CIC tried various marketing approaches to engage with the market. Low demand suggests that none of them really worked but at the same time lack of evaluation make it difficult to improve marketing. According to CIC staff, key sales factors are the mobilization of local community leaders, the regular presence of the sales staff and access to financing from the local SACCOs. According to the impact study, there was no gain from more intensive marketing tested with some treatment groups. Without more data it is difficult to say to what extent marketing is the key to higher outreach or which marketing mix is best.

Customer care, renewal incentives and a system of renewal reminders should be in place from the beginning and should be integrated in the systems of delivery channels. Acquisition costs are so high that it is hard to sustain microinsurance business with 25% renewal rate. CIC had established a system of renewal reminders during the last three months and put together a centralized customer care phone line. These mechanisms had a limited impact on renewals due to lack of integration with similar systems of delivery channels. Members preferred to first interact with their contact at the delivery channel who usually had no capacity to deal with their request. SACCOs did not have adequate systems to send reminders.

Consumer education sessions have not translated into higher take-up of products. Rigorous impact research revealed the difference in product take-up between those who participated in consumer education and those who did not. There was no impact of the consumer education on take-up. More in-depth understanding of these findings are needed to make decisions on whether and how consumer education should be integrated in product delivery. It might be that consumer education has positive impact on knowledge, skills and attitudes but this does not automatically translate into higher demand due to product design or other external factors.

On the distribution

It is hard to rely on SACCO’s staff to sell more complex products unless there is senior management buy-in. It is a challenge to introduce insurance products among the range of products offered by the delivery channels and incentivize their staff to sell insurance, which is a ‘hard-sell’ compared to credit products. SACCO employees do not know much about insurance either so it is hard for them to explain different product features to prospective clients. More importantly, buy-in and vision alignment between insurer and delivery channels at senior management level are important as is shown by the case of the Kenyan Women Finance Trust, the only channel that was successful, mostly due to much higher ownership of the product compared to other channels.

Sales processes and staff training need to be streamlined to make sure that deals are ‘closed’. SACCO staff does not have the right skills to sell insurance and lack of the final ‘selling push’ is a major issue. Many applications, especially incomplete ones, were not processed. In hindsight the project could have focused more on sales. All SACCO staff needed training and refresher courses delivered by the insurance company. However, CIC’s experience is that cost of ad-hoc training of 150 delivery channel staff in one area is equivalent to CIC’s revenue from 200 policies. A more cost-effective solution should be developed.
Field and regional sales staff need to have clear incentive system. Within CIC there has been no incentive structure for the staff to sell the BYJ as the staff and branch offices have not had the BYJ numbers incorporated into their sales targets (as compared to other insurance products).
Next Actions

Given the low product performance and recent changes by NHIF, CIC and NHIF are now reviewing their strategy; substantial refinements to product and distribution design are on the way.