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MICROCARE INSURANCE UGANDA –
CASE STUDY

Lucas Greyling

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FOREWORD

Research among low-income communities in developing economies consistently shows that there is significant demand for more affordable pre-paid healthcare. Health Management Organisations (HMOs) were the first to successfully introduce pre-paid healthcare to Uganda, but never seriously targeted the low-income market. Insurers that offer health insurance products in Africa, on the other hand, have consistently failed to achieve sustainable profitability.

This case study examines the factors that contributed to both the rise and fall of Microcare as a provider of low-cost health insurance.

I have tried not to deviate from the available facts on the Microcare story. Unfortunately, many of Microcare's records were lost or became inaccessible when it was taken over by and absorbed into the International Medical Group. This sometimes made it impossible to obtain comprehensive data that covered the full period of Microcare's business operations.

As someone who was closely involved with Microcare during the last year of its operations, my objectivity may be questioned. In spite of this, I hope that this case study will be useful.

ACRONYMS AND DEFINITIONS

Bordereau

A memorandum or invoice prepared for a company by an underwriter, containing a list of reinsured risks.¹

CBO

A community-based organisation is defined as a voluntary association of community members who reflect the interests of a broader constituency. They are generally small, informal organisations; often membership-based, initiated by local residents, and located within the communities they serve (Yachkaschi 2008).

Cordaid

Catholic Organisation for Relief & Development Aid is one of the largest development organizations in the Netherlands and has a network of 890 partner organizations in 28 countries in Africa, Asia, the Middle East, and Latin America.

Excess of loss (XOL) treaty

A reinsurance arrangement where a reinsurer assumes the risk of claims which exceed an agreed threshold level.

Financial Deepening Challenge Fund (FDCF)

The Department for International Development (DfID) launched the Financial Deepening Challenge Fund (FDCF) in 2000, with a capitalisation of GBP 18 million. The fund sought applications from private firms for grant funding, which required a matching investment ratio of at least 1:1. The FDCF supports 28 projects in Africa and Asia that help improve incomes, livelihoods, and opportunities for poor people. It is now closed. (Alwyn Chilver et al).

Financial Sector Deepening Project Uganda (FSDU)

The FSDU was designed to increase the availability of diverse, adapted financial services at affordable prices, offered by transparent and sustainable institutions, to informed consumers. The purpose of the project was to improve the supply and demand for financial services in Uganda by working at various levels - sector, MFI, and consumer.

GAAP

Generally accepted accounting principles

HMO

Health management² organisation: An organisation that provides access to healthcare and health management services through pre-paid membership. This can vary from an organisation that owns a comprehensive number of in-house clinics and hospitals, or a single clinic, to one that outsources all healthcare to contracted providers.

TPA

Third party administrator: A third party administrator is an organization that provides administration services and processes insurance claims or certain pre-defined aspects of insurance business for another organisation. This might be an employer that self-insures its employees and decides to outsource its claims processing, or an insurer that does not have the scale or does not wish to manage claims itself. In health insurance a third party administrator may also be responsible for managing the medical provider network.

MFI

Microfinance institution - an organization that provides financial services to low-income households

Microcare

A group of companies in Uganda that were involved in providing pre-paid access to healthcare and TPA services to employers. Where reference is made to "Microcare" in this document it is impossible to differentiate clearly between Microcare Limited (a not-for-profit), Microcare Health Limited (a for-profit HMO), and Microcare Insurance Limited (a for-profit health microinsurer). Where it is possible to differentiate specifically between the separate companies, the acronyms MHL and MIL will apply:

MHL

¹ <http://www.thefreedictionary.com/bordereau>

² Sometimes also referred to as Health Maintenance Organisation and referred to as Health Membership Organisation in the 2011 Insurance Amendment Act of Uganda. Where other publications are quoted their terminology was left unaltered.

Microcare Health Limited: A for-profit company in Uganda that was structured as an HMO to provide pre-paid health plans (which were discontinued after the establishment of MIL), TPA services, claims management, and managed care services, as well as preventative health interventions (such as distribution of insecticide-treated mosquito nets) and health education.

MIL

Microcare Insurance Limited: a regulated insurer under a general insurance license in Uganda. It focused on providing affordable health insurance to communities and low-income workers.

MoH

Ministry of Health

OP

Outpatient treatment

Quota share (QS) treaty

An agreement between an insurer and a reinsurer whereby the reinsurer pays an agreed percentage of all losses the insurer sustains, regardless of type. The insurer compensates the reinsurer for this agreement by ceding an agreed portion of its premium income to the reinsurer.

SACCO

Savings and credit cooperative

UIA

Uganda Insurance Association: Membership of this association is a pre-requisite for obtaining an insurance license, as stated in the Uganda Insurance Act.

UIC

Uganda Insurance Commission: The regulatory authority for the insurance industry in Uganda.

UPR

Unearned premium reserve

EXECUTIVE SUMMARY

Microcare originated out of a desire to find more effective ways to provide low-income communities with access to better quality healthcare. Pre-paid healthcare offered an opportunity to accumulate and channel resources so that poor people would get cashless access to healthcare services and service providers would benefit from better cash flows. Microcare opted to establish a regulated insurer, Microcare Insurance Limited (MIL), as a subsidiary of the health company, Microcare Health Limited (MHL), in order to access the international reinsurance market and to comply with Ugandan law.

Before Microcare came onto the scene in Uganda pre-paid healthcare products could only be obtained from two health management organizations (HMOs). HMOs were technically subject to the Uganda Insurance Act, but they argued that health insurance was sufficiently different from general property insurance to require separate regulatory treatment. They therefore refused to comply, pending the introduction of more specific legislation. This position remained unchallenged by the insurance regulator, creating an uneven playing field for MIL.

This case study examines the factors which contributed to both the success and failure of Microcare as a provider of health microinsurance. It seeks to draw lessons from Microcare's experience that will further the development of a more successful business model for health microinsurance.

Some of the key lessons that were gained from the study are summarised below:

- MIL's results seem to confirm that there is significant demand in the low-income segment for affordable health insurance which offers reasonable levels of choice over benefit levels and medical service providers.
- Single service provider plans and on-site clinics create opportunities for better control of treatment costs, although more experimentation may be needed to confirm MIL's experience.
- Insurers that aim to deploy an aggressive premium growth strategy must ensure that they have the needed capital base to maintain solvency. Adequate increases in reserves usually cannot be funded from premiums because premiums are needed to pay on-going claims.
- Both pricing strategy and solvency management need to take account of the fact that premiums are set for a year in advance. Therefore any variations on pricing assumptions, such as adverse selection or increased costs, will need to be carried by the insurer through the policy term.
- Careful tracking of claims patterns among individual health providers and among clients is critically important and must be pro-actively managed.
- Relaxing selection criteria for health providers in response to pressure from existing or potential clients should be resisted. This can lead to collusion between clients and providers that may cause significant escalations in claims costs.
- Aligning the interests of providers, patients, and the insurer through incentives and risk sharing may be a more effective way to control claim costs than elaborate control mechanisms alone.
- Typical insurers are not optimally structured to deal with the multidisciplinary challenges that arise in health insurance – such as drug formularies, pre-authorisation, managed care (pharmacy benefit and case management), and preventative care programmes. Therefore more should be done to sensitise regulators about the rationale for outsourcing these functions or to establish related companies for the specific purpose of managing the healthcare value chain.

The fact that Microcare did not succeed does not mean that it is not possible to provide health insurance to low-income households. It is not easy – that is clear from the case study – but if the enabling environment is conducive, or even supportive, viable health microinsurance is a possibility.

1. > INTRODUCTION

"It's not the critic who counts. It's not the man who points out how the strong man stumbled. Credit belongs to the man who really was in the arena, his face marred by dust, sweat, and blood, who strives valiantly, who errs to come short and short again, because there is no effort without error and shortcoming. It is the man who actually strives to do the deeds, who knows the great enthusiasm and knows the great devotion, who spends himself on a worthy cause, who at best, knows in the end the triumph of great achievement. And, who at worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and cruel souls who know neither victory nor defeat."

- Theodore Roosevelt

The Microcare story is a story about the courage to pioneer an uncharted route, and if success is seen in terms of positive impact on the lives of marginalised people, then Microcare achieved meaningful success. Unfortunately, Microcare's failure leaves us without concrete proof of the business case for health microinsurance. However, Microcare demonstrated that there is demand for health insurance among low-income communities, which can be satisfied with affordable insurance products when strong relationships are forged with suitable healthcare providers.

Microcare's objective was to provide affordable access to quality healthcare through health microinsurance. When it started providing health microinsurance no regulated insurer in Uganda was offering health insurance of any kind and the general view was that there was no business case for (regular or micro) health insurance. One in every five people employed in Uganda earned US\$ 11 or less per month from their main occupation. Therefore most of Microcare's clients who were corporate employees were also part of the low-income market segment. With very few exceptions, Microcare maintained its focus on health microinsurance throughout.

By the end of 2007 Microcare was ranked by the Uganda Insurance Commission as the 6th biggest insurer in Uganda by gross premium, with a net loss ratio of 74.86 per cent.³ A contract to provide health insurance to 250,000 Uganda People's Defence Force (UPDF)⁴ staff and dependants, awarded in 2008, provided a tremendous opportunity to expand. However, slightly more than a year later Microcare was effectively out-of-business⁵. In spite of its mistakes, Microcare was able to develop products that by the end of 2008 provided affordable insurance to more than 70 000 people (in-force insured lives) who had previously been forced to pay for healthcare services with out-of-pocket cash or to forego healthcare.

In pioneering health insurance in Uganda, the insurance company formed by Microcare, Microcare Insurance Limited (MIL), found itself in a regulatory vacuum, because regulators did not provide for health insurance as a unique class of business. MIL was able to grow as long as the regulator remained flexible about new approaches to developing its new market. However, when the regulator adopted a stricter approach, MIL's business was severely impacted. In particular, the new approach had consequences for accepted practice, such as MIL's structure and the practice of outsourcing claims processing to the sister company (Microcare Health Limited).⁶

Ultimately, Microcare suffered from the combined consequences of unrealistic service provider expectations, unreliable reinsurers, weak public sector institutions⁷, a breakdown in its internal controls, and ineffective financial management.

³ Uganda Insurance Commission Annual Report 2007

⁴ MIL emerged as the highest scoring tender and in October 2008 was invited by the Ministry of Defence to finalise the choice of proposal options and terms and conditions for providing health insurance to the Uganda Peoples Defence Force. This contract could not be implemented when MIL's insurance license was not renewed.

⁵ Although Microcare's insurance license was only officially revoked in September 2009 it had been effectively prevented from doing business from early 2009 as a result of negative media reports and its ongoing disputes with service providers and the regulator.

⁶ HMO's were, however, allowed to continue doing business in contravention of the Insurance Act and without any enforcement of reserve requirements or compulsory reinsurance.

⁷ The following extracts from media articles and a commissioned study illustrate the weakness of public institutions in Uganda:

"A High Court judge has been cited in a bribery scandal following a case in which \$8.2 million (Shs 15 billion) was awarded to a company that had taken government to court" - Africa News Service, December 20, 2004 <http://businesshighbeam.com/3548/article-1G1-126324063/judge-named-bribery-scandal> "An anonymous letter addressed to the Minister of Finance accusing two board members of the Uganda Insurance Commission (UIC) of influence peddling and conflict of interest has thrown the entire industry in a state of panic. So damaging are the issues raised against the Commission that an emergency executive meeting of the Uganda Insurance Association (UIA), the industry's umbrella organization, was hastily convened on September 5, 2008 to discuss the allegations that were feared would tear apart the industry" - by Moses Talemwa, The Observer, September 24, 2008 http://www.observer.ug/index.php?option=com_content&view=article&id=1131%3Ainsurance-sector-hit-by-influence-peddling-charges&Itemid=96 "the May

This case study examines the factors which contributed to both the success⁸ and failure of Microcare as a provider of health microinsurance. It seeks to draw lessons from Microcare's experience to further the development of a more successful business model for health microinsurance. The case starts by providing the background of Microcare's formation and corporate structure (Section 2) and its target market segment and distribution strategy (Section 3). Section 4 outlines the initial financial results and Section 5 describes the claims experience. Section 6 analyses the provider management approach adopted by Microcare and the challenges it faced in resolving disputes. Section 7 describes the in-house information technology systems used to manage over 800,000 claim verifications per year. Section 8 presents the corporate governance structure of Microcare and the problems it posed. Section 9 discusses the role of the Ugandan Insurance Commission. Section 10 presents results on solvency and Section 11 presents Microcare's experience in purchasing reinsurance. Section 12 outlines the challenges it faced in dispute resolution due to a lack of provision in the Insurance Act. The final section concludes with a call for the provision of health microinsurance to address the clear need of Ugandans.

For ease of reference Annex A provides a timeline of the key events that occurred over the course of the Microcare story.

2008 report by Inspector Andrew Sewankambo, which New Vision has seen, noted that since its inception, the UIC has completely de-linked itself from the public. The commission is run like an outdated parastatal. It lacks business approaches like those adopted by other sister regulator organisations, Sewankambo said in a July 8, 2008 memo. Sewankambo had worked for the commission, but later left. The report detailed serious loopholes that required quick response, but many of them have not been addressed to date" - by David Ssempijja, New Vision article, November 15, 2010, <http://www.newvision.co.ug/D/8/220/738262>

⁸ Success should not only be defined by profit but also by the extent to which affordable access to healthcare was provided to a significant population of previously unserved people and the way in which perceptions about health insurance in general were changed.

2. > CORPORATE STRUCTURE

Microcare Limited was established in May 2000 as a not-for-profit company that would provide administration and management services to assist low-income communities to create their own affordable healthcare provisions. Initially the focus was on developing systems and conducting pilot studies to explore pro-poor healthcare solutions. By July 2001 Microcare Limited had established relationships with two separate community groups and was assisting them with technical/administrative support services and negotiations with healthcare providers.

At this time none of the regulated insurers was providing health insurance. Only Aon⁹ Uganda Ltd (Aon), as a result of pressure from its corporate clients, had reluctantly started to provide TPA services to assist its corporate clients with the administration of self-funded healthcare schemes¹⁰ for their personnel. However, Aon was primarily an insurance broker, and it was not properly equipped to provide medical claims administration. Aon therefore contracted Microcare Limited to provide technical support and the use of its Health Services Management System (HSMS). This enabled Aon to deliver effective TPA services to corporate clients and provided Microcare Limited with additional revenue.

As a result of an international policy decision in 2003, Aon wished to divest itself of the TPA business. Microcare, on the other hand, had just received grant funding of GBP 15,000 from the Financial Sector Deepening Project Uganda (FSDU), in order to expand its activities. Following this funding, in May 2004, Microcare Health Limited (MHL) was established as a for-profit company with grant funding of GBP 730,000 from the FDCF. The funding was made available subject to supervision by Aon, which was appointed to provide administrative oversight as well as technical and actuarial support.

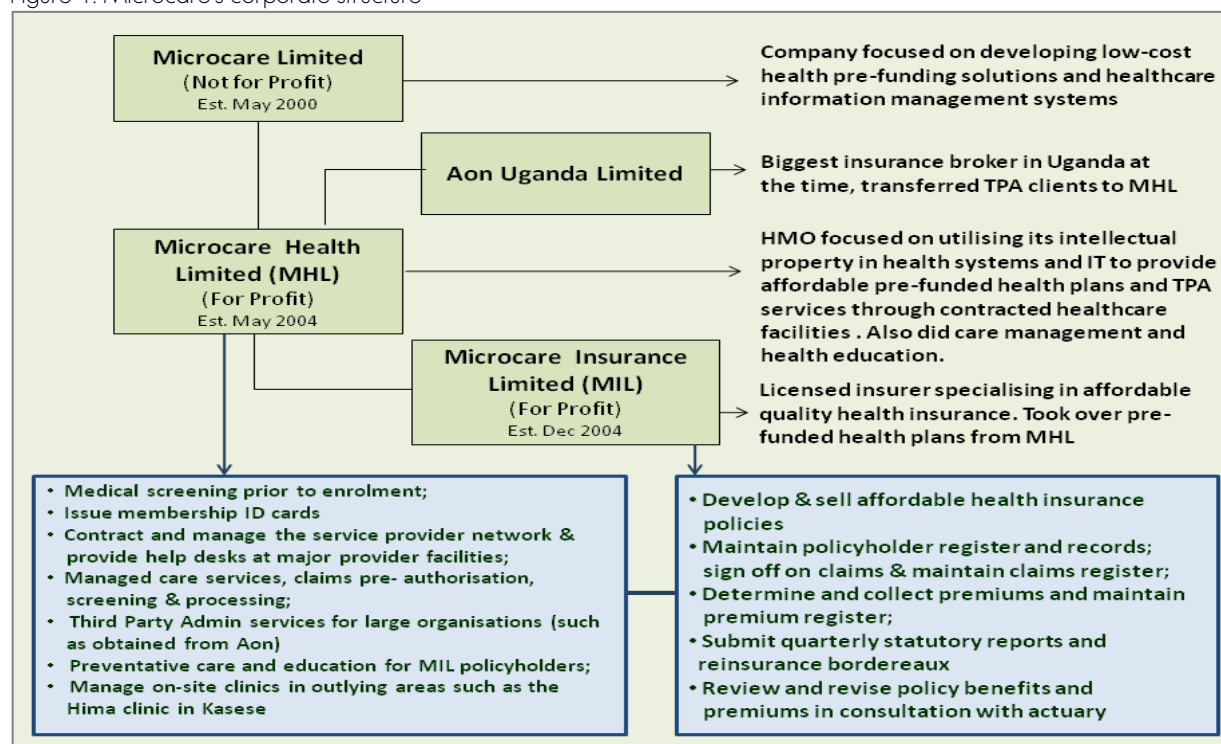
MHL was duly established and Aon's TPA business was transferred to it in July 2004 (Napier, 2010). MHL was structured as an HMO to provide pre-paid health plans¹¹, third-party administration, managed care services, preventative health interventions (such as distribution of insecticide treated mosquito nets), and health education.

⁹ Aon is a global provider of insurance and reinsurance brokerage services, insurance products, risk and insurance advice, web-based risk management information systems, and other consulting services.

¹⁰ These schemes were set up by employers who carried the risk of treatment cost subject to limits agreed with their staff. These schemes were not subject to regulation and were seen as an in-service benefit provided by the employer.

¹¹ Reference to "pre-paid health plans" in this report refers to products which provide access to medical treatment through an advance payment of a membership fee not regulated by the insurance regulator, such as those offered by the HMOs in Uganda. Where the report refers to "insurance" it implies compliance with the Uganda Insurance Act.

Figure 1: Microcare's corporate structure



Microcare Insurance Limited (MIL) was established as a subsidiary of MHL in December 2004, with grant funding from the UK's Department for International Development (DfID) and Cordaid (a Dutch donor) as well as matching investments from several local investors. It was licensed as a regulated insurance company specialising in health microinsurance.

The stakeholders in MHL opted to establish a regulated insurer as a subsidiary for the following reasons:

- A regulated insurer would have direct access to the international reinsurance market and could therefore transfer some of the risk of potential treatment costs¹². HMOs by comparison were not able to obtain reinsurance and were therefore thought to be exposed to significant risk in respect of pre-paid treatment costs.
- Initially there was also an expectation among some of Microcare's stakeholders that a regulated general insurer would be able to offer other complementary insurance products to employers, such as general accident and workman's compensation policies. However, this never became a profitable line of business for MIL and was eventually abandoned.
- As a regulated insurer MIL was also expected to gain greater support from international financial institutions.
- Many international organisations who wanted to arrange health insurance for their staff in Uganda insisted on dealing only with regulated insurers. As a regulated insurer MIL would therefore be able to secure business from these companies.
- The health company and the insurance company could each deal with its own areas of expertise and liaise with its own regulator (Ministry of Health and Ministry of Finance).
- It was expected that action by the UIC against the technically unlawful operations of HMOs was imminent and that by setting up a regulated insurer Microcare would be "future compliant".
- Donors were familiar with the trend within microfinance for MFIs to commercialise into regulated banking institutions. They expected to see the same trend in microinsurance and in this way Microcare fulfilled their expectation.

The Board of Directors of MIL included the Managing Director of the American International Group (AIG) Uganda (who had pioneered microinsurance with group personal accident cover in Uganda), a professional corporate secretary, a microfinance

¹² Microinsurance schemes, which may cover small groups with low premiums, are known to have volatile claims experience (Dror, 2001) and reinsurance was deemed appropriate to protect the capital base of the organisation.

specialist, a microinsurance consultant, a medical doctor, and, as Managing Director, an insurance specialist recommended by Aon. In mid 2005 the discovery of accounting irregularities, inappropriate re-insurance arrangements, and failure to collect significant outstanding debts placed the survival of MHL/MIL in jeopardy and led to the dismissal of the Managing Director and of Aon, who had recommended him as technical advisor/project manager, and a reorganisation of the Board of Directors. It also came to light that the Managing Director had been trying to convince the commercial shareholders of MHL/MIL to sell out their stake to his former employer, The Jubilee Insurance Company of Uganda, without the knowledge and consent of the founders. Given that The Jubilee Insurance Company of Uganda was MIL's largest competitor for the commercial health insurance client base in Uganda at the time, such a potential conflict of interest should not have been allowed. Therefore Dr Noble¹³ exercised his right of first refusal as a minor shareholder to buy out these investors. However, apart from the removal of Aon, the structure as illustrated in Figure 1 remained the same.

Microcare started off as an HMO which offered pre-paid healthcare plans providing access to a pre-selected network of service providers that were contracted for this purpose. By the time MIL was established the structures and processes that enabled MHL to provide pre-paid healthcare plans were already in place. The network of service providers contracted to deliver healthcare for the plans was also in place. It was therefore unnecessary for MIL to duplicate these. MIL simply contracted MHL to provide healthcare management and the provider network for its policies. MIL therefore became a client of MHL in the same way as employers who did not wish to buy insurance but required the management of the service provider network and claims administration for their self-funded schemes.

MIL was therefore structured and staffed to simply provide those functions, such as policyholder administration, statutory reporting, and reinsurance, which did not easily fit under MHL's remit. Marketing and sales were also established under MIL.

Microcare's founders were convinced that the design of healthcare packages, the selection and management of the provider network, and the delivery of treatment required qualified healthcare professionals who were organised and managed within MHL. They took the same approach to claims management, in which the qualified nurses employed by MHL played a key role. MIL, on the other hand, was the vehicle through which the risk of treatment cost could be legally carried and transferred to reinsurers.

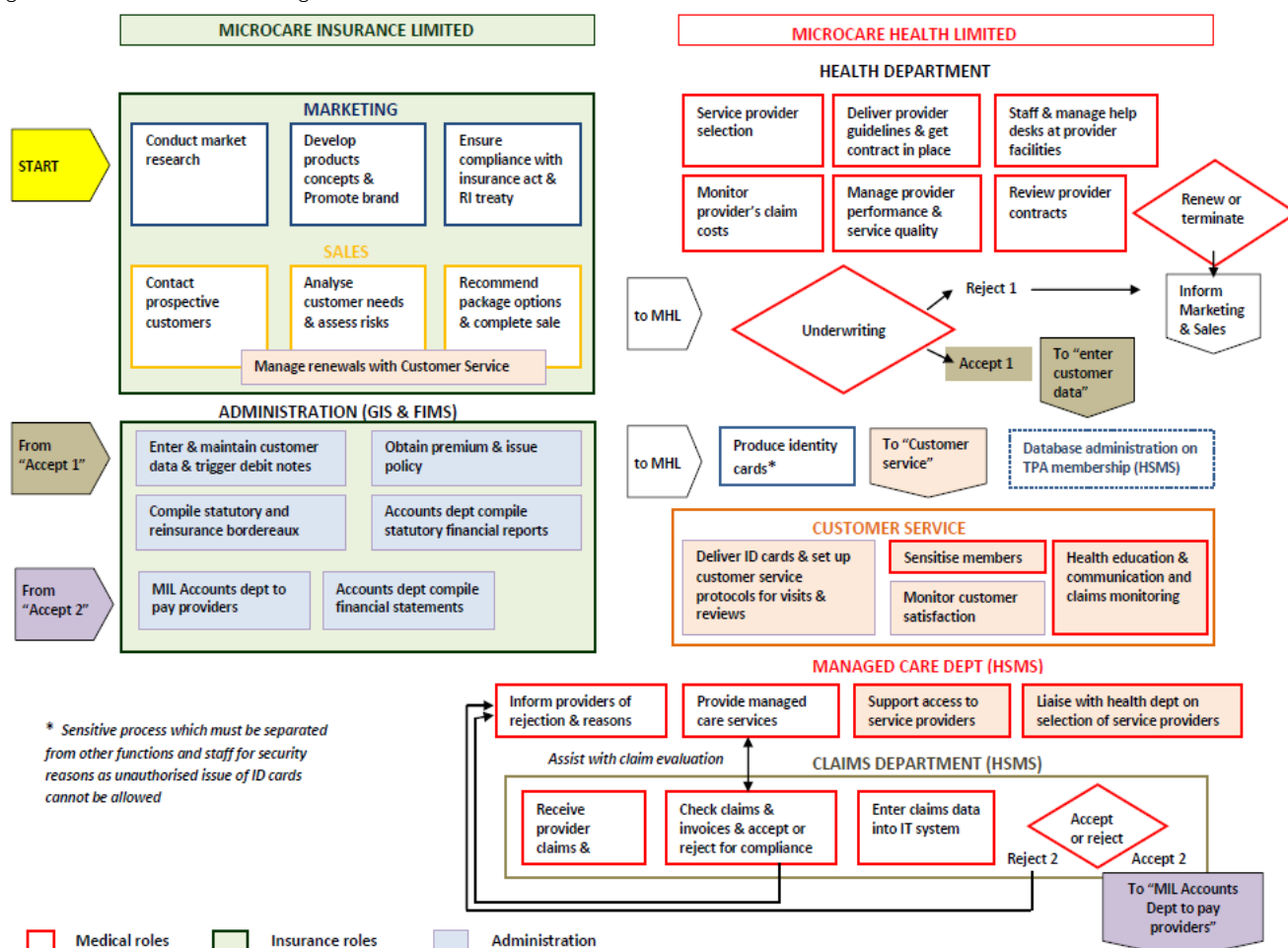
Figure 2 illustrates the process flow for tasks related to the customer life cycle and the management of the provider network that supported healthcare service delivery. This organisational structure worked well and enabled Microcare to combine the functions of insurance and healthcare in a seamless way. It also facilitated clear distinctions between the functions which were mostly subject to regulation by the MoH and those which were subject to the UIC.

Microcare's business consisted of TPA business within MHL and insurance business under MIL, which both required the same healthcare and claims management software systems and the same processes to manage the provider network and claims. This worked well when claims management was outsourced to MHL.¹⁴ This structure also facilitated better control through the physical separation of certain functions, such as the enrolment of new policyholders from the issuing of medical ID cards.

¹³ Microcare was established by Gerry Noble and Francis Somerwell. Noble, a medical doctor, had been involved during the 1990's, as an Irish government volunteer, with projects to finance hospitals and community health in Uganda and Somerwell was an information technology (IT) specialist who had experience in developing hospital management systems.

¹⁴ It is quite normal in many jurisdictions for health insurers to outsource the healthcare delivery management and medical claims assessment functions to specialist firms. It can be argued that had the insurance company and the health company had different names, the issue of inter-company transactions might not have arisen. The reason that the outsourcing of these functions to MHL became such a big issue with the Acting Commissioner has never been explained. On the other hand, had MIL simply been established to provide risk cover to MHL, whilst MHL had continued to be the main operating company, it may not have been necessary to change any processes and the company with the key relationships with clients and providers would probably have been unaffected by the UIC.

Figure 2: Process flow illustrating the close interaction between MIL and MHL



In 2008 the newly appointed Acting Commissioner directed MIL and MHL to stop "inter-company transactions" which arose from the outsourcing of claims processing and managed care functions. Since all the medical functions for pre-authorisations, care management, and claims evaluation were done by MHL medical staff (based on the original research and pilot studies conducted by Microcare Limited), the business processes and staffing had to be suddenly re-engineered. Key people from MHL had to be moved to MIL to duplicate functions which were still being performed by MHL on TPA accounts.

The attempt to re-organise the business to comply with the UIC's directive to separate MHL and MIL¹⁵ contributed to problems in claims processing and settlement and especially to a breakdown of controls¹⁶. This resulted in over claiming and over servicing that caused a significant increase in loss ratios during the second half of 2008.

To achieve a clear "separation" between MHL and MIL also required MIL to acquire ownership of the proprietary healthcare and claims management software without which MIL could not conduct business.

The valuation of this transaction subsequently became the focus of a dispute with the UIC.

¹⁵ In effect this meant that key functions involving medical staff (but not all) had to be broken off from MHL and moved into MIL.

¹⁶ This required changes to the way in which access to the claims management system was controlled and involved the actual transfer and physical move of staff from one area to another. For example, effective process flows that required medical professionals to work in close proximity with admin processing staff had to be separated. As a result additional steps were created where claim information had to be sent to medical people in a different area for approval and then sent back to insurance admin for processing (sometimes a number of times to finalise a query). This led to delays in approval and breakdowns in communication, all of which affected the efficiency of the claims controls and payment time frames.

Lessons:

- The rationale for a structure requiring different parts of the value proposition to be delivered by separate companies should be explained and documented¹⁷ and approval should be obtained to ensure that successive officials interpret it consistently. Once business activities have commenced it becomes far more difficult to alter structures and financial arrangements. Furthermore, later alterations can have a serious impact on both the operational efficiency of the business as well as the important relationship with the regulatory authority.
- Transactions between related parties should be properly governed by arms-length service contracts and transparent fees. Where this is not clearly done, difficulties may arise with regulatory authorities.
- Regulatory officials should be encouraged to explore new ways (including structural ones) to deal with new developments, especially those related to managing the risk of treatment costs in health insurance. Typical insurers are not optimally structured to deal with the multidisciplinary challenges that arise in health insurance – such as drug formularies, pre-authorisation, managed care (pharmacy benefit and case management), and preventative care programmes. This is why these services are frequently outsourced to specialist organisations. This view is supported by the fact that the Le Boeuf Report (Kearney et al., 2005) (discussed in the section on regulation), under proposed amendments to the Insurance Act related to HMOs, specifically includes a provision to allow “Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc.) between affiliates or between the health maintenance¹⁸ organization and its parent;” (Exhibit 4 section 95 (b)).
- MIL was in fact penalized by regulation that was not being applied to other providers of pre-paid healthcare plans¹⁹. When it comes to regulation, it may be wise to follow the general practice even where this is technically in violation of the law. The playing field is extremely uneven for the one institution trying to comply with legislation that was intended for other purposes.
- The overlap between regulatory jurisdictions, such as that between healthcare and insurance, must be managed more effectively by the government and the insurance industry together.

¹⁷ Memoranda of understanding, confirmatory letter, or other written proof that an agreement existed with the regulator to experiment in grey areas of the law with mechanisms that had not been envisaged when the laws were promulgated

¹⁸ Terminology as used by the Le Boeuf Report, which refers to “health management organisation” elsewhere in this report.

¹⁹ Pre-paid healthcare plans include membership-based plans such as those offered by HMO’s as well as insurance (sometimes also unregulated such as many community-based plans)

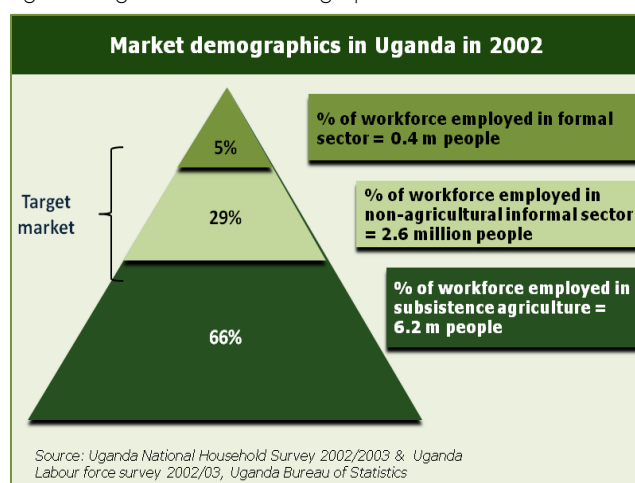
3. > DISTRIBUTION STRATEGY

This section describes the various distribution channels and products that Microcare used to reach its target market.

Target market

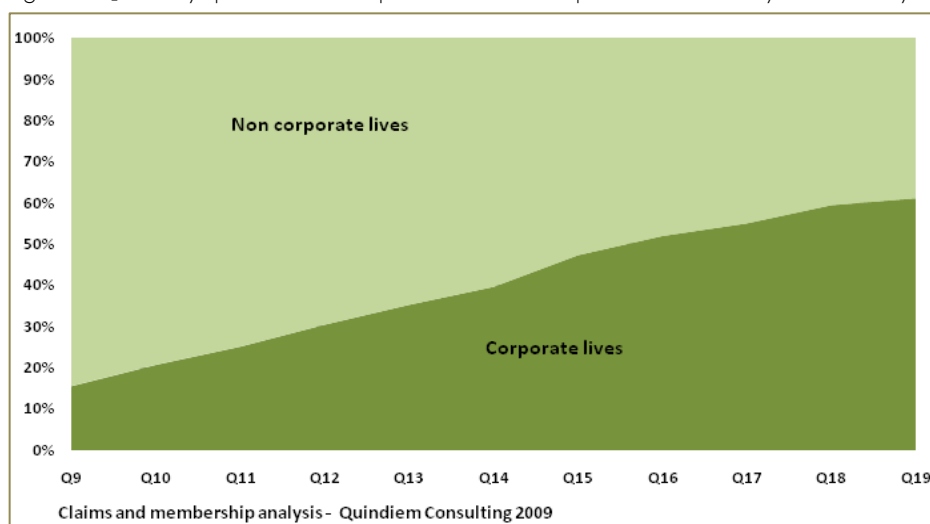
Microcare's founders wanted to make pre-paid healthcare accessible to the majority of families in Uganda. Most Ugandans were unbanked and had, up to that point, not had access to insurance other than credit life policies. One in every five people employed in Uganda was earning US\$ 11 or less per month from their main occupation. One third of the urban population earned less than US\$ 22 compared to 45 per cent of their rural counterparts (Uganda Bureau of Statistics, 2001).

Figure 3: Uganda market demographics



The majority of this market segment could not be reached through regulated banks or formal employers. For this reason, and as a result of existing relationships, Microcare initially intended to work with community-based organisations and MFIs to reach its targeted client base (see Figure 3). However, the collaboration with Aon also introduced Microcare to corporate clients that employed people largely in lower income categories. The quarterly change in exposure between corporate and non-corporate lives over time is illustrated in Figure 4.

Figure 4: Quarterly split between corporate and non-corporate lives January 2006 to July 2008



Channel mix

Microcare used a mix of distribution channels to reach its target market.

COMMUNITY-BASED GROUPS

When Microcare started in 2000 there were already several community health financing schemes in Uganda which aimed to assist the poor²⁰. These schemes were seen as potential clients, as Microcare believed that its approach and healthcare and claims management software systems would add value.

Microcare became involved with *engozi* societies²¹ in and around Kisiizi and provided support to the Kisiizi Health Insurance Scheme. This scheme was started by Kisiizi Hospital in 1996 with support from DfID in cooperation with the MoH and was the first health microinsurance scheme in Uganda. In Oct 2002, due to withdrawal of the donors, Microcare Limited was appointed to take over the running of this scheme. Although premiums were very low (see section on products and pricing), the benefits were quite comprehensive and payments for services under the scheme made a significant contribution to the cash flow of the Kisiizi Hospital. This hospital was surrounded by a population of approximately 152,000 people served by 12 clinics – a mixture of private for-profit, private not-for-profit and government health facilities.

This scheme was converted to an insured scheme when MIL was established, and by mid 2008 it covered approximately 35,000 members with comprehensive health cover. Microcare established a similar scheme in Kisoro in 2003, which was aimed at public-service employees from the District Town Council. Although this scheme achieved reasonable success, cooperation with the St Francis Mutolere Hospital was never as close as that with the Kisiizi Hospital. The scheme came close to, but never exceeded, 2,000 members.

The Kisiizi scheme became the testing ground for organising low-cost health insurance through collaboration with a strong community organisation and a key healthcare service provider. Challenges with record keeping in remote areas, premium collection, and customer service were addressed by establishing an office in Kisiizi. This office was responsible for collecting data and premiums and sending them on to MIL in Kampala. It was also responsible for ongoing interaction with the Kisiizi community and medical service providers. The scheme benefited from limited grant funding that helped to cover some of the development cost.²²

Although a number of similar schemes were under discussion with other community organisations, the winding-up petition and the dispute with the regulator prevented Microcare from finalising any other broad-based community schemes. Had Microcare been able to continue, community-based schemes may have achieved a higher number of participants within the MIL portfolio.

However, in spite of MIL's inability to continue, Kisiizi remains a valid example of how affordable health insurance can be arranged – particularly in remote rural communities. It may also serve as an example for how an insurance mechanism can be used to collect and allocate resources to fund the development of healthcare facilities in other remote locations.

MICROFINANCE INSTITUTIONS

Among East Africans the dominant methods for responding to financial shocks are borrowing from MFIs, ROSCAs or money lenders, depleting assets such as savings, or selling assets (such as a bicycle or cow). Working with microfinance institutions to reach Microcare's target market therefore made sense. Microcare's founders already had a strong relationship with FINCA Uganda and Microcare also worked under a much less formal arrangement with Pride Africa. FINCA Uganda introduced

20 Community-based health financing had been introduced in Uganda in 1995, as part of the MoH drive to pilot community health financing in the country. Community-based health insurance provided a means for families to ensure that they could pay for health services at local facilities, public or private. What had started as the Community Health Financing Project became the Uganda Community Health Financing Association, which was established by the MoH and managed by seconded personnel of the Department for International Development (DfID). This project established several healthcare financing schemes.

21 A traditional health insurance system, known as *engozi*, has existed for at least 100 years in South Western Uganda. The system provides care for individuals who are ill and unable to support themselves, and for their family members. *Engozi* also extends to families with pregnant or breastfeeding mothers, to elderly people who need care, and provides burial ceremonies for its members

([http://www.lancet.com/journals/lancet/article/PIIS0140-6736\(05\)75256-9/fulltext](http://www.lancet.com/journals/lancet/article/PIIS0140-6736(05)75256-9/fulltext))

22 Obtaining a viable number of participants in community-based insurance requires a significant investment in time and resources to explain the insurance concept (even where a basic insurance scheme had already been established) and to build trust within the community. This is a critical success factor which takes time.

Microcare to members of FINCA's Village Banking groups, and Microcare offered these groups affordable health microinsurance.

Another targeted community group was the Makindye Community Association (MCA). This association encompassed a variety of interest groups including women's groups and youth groups. A member of the association could belong to any or all of these groups. New members had to pay a membership fee (US\$ 6.25) and open an account with the MCA SACCO. Most of the microinsurance activities took place at the SACCO.

Microcare also formed relationships with Uganda Agency for Development Limited (UGAFODE) and the Uganda Women's Finance Trust.

Efforts to sell policies through MFIs proved surprisingly challenging. Although the MFI clients wanted insurance, Microcare's sales representatives failed to develop sufficient levels of trust. Sales representatives underestimated the amount of time needed to convince a group to buy health insurance and were discouraged by the small commissions that the small premiums generated. Microcare's sales staff was generally provided access to the MFIs' clients but little support from their field staff, who was not trained to sell insurance.

This lack of involvement by the MFIs resulted in limited sales success among MFI clients. It became clear that direct involvement from the MFIs' field staff was critical. Eventually FINCA also agreed to provide groups that wanted to enrol in the health insurance scheme with a loan to pay the annual premium²³. This intervention improved sales, but sales through MFIs never lived up to expectations and ultimately contributed little to the expansion of MIL's business.

Table 1: Microcare's initial results from the MFI channel²⁴

Indicators	Jul- Dec 2001	Year 2002	Jan - Jul 2003
Number of organisational partners	6	7	7
Number insured	796*	7 318	7 852
Claims ratio	71%	70%	77%

* 89% were MFI clients Source: MicroInsurance, Improving risk management for the poor No 2.

DIRECT GROUP SALES

Microcare also employed a direct sales force that focused largely on employers in the formal sector. Group-based health insurance provided better cover and better value than the limited reimbursements schemes employers would normally offer.

It must be noted that the majority of formal-sector employees still qualified as un-served poor and formed part of MIL's target market. More than 70 per cent of formal sector employees earned less than US\$ 2 per day at the time. Although employers were able to obtain pre-paid healthcare plans through the HMOs, these plans were expensive and mostly only designed for higher earning personnel²⁵. Microcare's entry into the corporate market enabled low-paid workers who were previously excluded to get access to affordable pre-paid healthcare.

Ultimately this channel proved the most successful in generating sustainable cash flows for Microcare. However, the corporate market put pressure on MIL to provide more comprehensive (i.e. more expensive) benefits and to include up-market medical facilities in its provider network. This made it difficult for MIL to maintain its close relationship with a small provider community that shared MIL's values. The inclusion of higher-value benefits also made it more difficult to control claims costs as service providers started providing expensive treatments which were often medically unnecessary. Some providers also provided high-cost treatment to people who were not covered for it, and insisted on being paid for it by threatening to stop services to the staff of key corporate clients. This will be discussed in more detail in the sections on service provider management and claims.

²³ These were ordinary loans which provided no preferential terms which could simply be used to pay the annual premium in advance as required by the Uganda Insurance Act.

²⁴ Since this data is quoted from an early field study a complete data set for MFI business over the life of MIL could not be obtained

²⁵ AAR's most basic corporate cover cost between US\$ 140 and US\$ 160 per year per person compared to Microcare's Corporate Basic product, which only cost US\$ 84 per year per person.

BROKER SALES

As a result of the relationship with Aon, MIL also started obtaining business from brokers after it became a regulated insurer. Brokers tended to have established relationships with some of the very large employers, and MIL was therefore able to access them through this channel. However, apart from the initial business that was introduced into MIL via Aon, brokers were never a dominant channel for MIL, particularly since the market was dominated by only two large brokers, Aon and Alexander Forbes. Additionally, in order to keep premiums affordable MIL paid a sales commission of only 5 per cent. This was viewed as too little by brokers who were accustomed to larger commissions and were neither inclined nor able to take on the substantial workload required to service corporate health insurance clients.

Product mix

Microcare started with two community products that were provided through MHL. MHL acted as an HMO that managed the delivery of healthcare services through contracted medical service providers. These plans were converted into insured plans, Social Plus and Social Basic, after MIL was licensed. Medical service providers were selected in accordance with the benefits covered and the agreed fee base. Annual premiums are shown in Table 2.

Table 2: Annual premiums (payable in advance) for Microcare's community products

Category	Premium per family* (US\$)	Additional adult (US\$)	Additional child (US\$)
Social Plus	124.38	45.00	22.50
Social Basic	93.13	32.50	16.25

* "Family" is defined as the head of household plus nominated spouse and two children

Policyholders were also given two treated mosquito nets per family free of charge at enrolment and net treatment tablets upon renewal in subsequent years. Patients were expected to make a co-payment per visit, which varied by provider and ranged from US\$ 0.56 to US\$ 1.68, with after-hours consultation costing slightly more. Families who covered more than eight members or wanted to make changes to the ID card within the period of cover were expected to pay a one-off additional fee of US\$ 3.00. Services were available at four hospitals in the Kampala area. Clients were able to select a facility each time they used one.

MIL also provided insurance products for the corporate market with annual premiums ranging from US\$ 84 to US\$ 308 per person (see Annex B for more details). These products were in essence the same as those targeting the community market, but with higher benefit limits and serviced by more up-market healthcare providers.

In addition MIL offered single provider schemes which could be very basic (Kibuli) or a bit more comprehensive (The Surgery). Single provider schemes allowed more direct alignment between the pricing of the benefits and the cost of service delivery. These service providers could also see clearly the direct financial benefit which they derived from such a product.

Lastly, MIL provided the option of insuring corporate employees in remote areas with service delivery provided by MHL through an on-site clinic. This arrangement addressed the lack of medical facilities in remote areas and provided maximum control of treatment cost.

MIL's pricing strategy and wide range of options gave rise to much speculation about the extent to which under-pricing contributed to MIL's problems²⁶. This will be examined further in the section on claims experience.

Lessons:

- Partner-agent distribution arrangements must be well researched and ensure that each partner's priority needs and objectives are properly addressed. The assumption that MFI clients would be eager to buy insurance from Microcare with limited commitment from the MFI's field staff meant that initial sales were far below expectations and unable to achieve sustainability.

²⁶ Other products available in Uganda at the time were priced between US\$ 140 and US\$ 700 per person per year, and treatment was usually limited to clinics owned and run by the HMO.

- Microinsurance margins are thin and long value chains easily result in a situation where no partner is able to make a profit. This results in loss of interest and often contributes to failure of the partner-agent model. In this case the problem was somewhat mitigated by loans being made available by FINCA to allow people to pay the annual up-front premium, which they would not otherwise have been able to afford.
- Community schemes take a long time to gain traction and significant resources are needed to gain trust within the community and to achieve meaningful participation.
- Single-service provider plans and on-site clinics create opportunities for better control of treatment costs, although more experimentation may be needed to confirm MIL's experience.
- Both pricing strategy and solvency management need to take account of the fact that premiums are set for a year in advance and any variations in pricing assumptions, such as adverse selection or higher than expected costs, will need to be carried by the insurer through the policy term.

Box 1: Rendek's conclusion about managing partnerships

Rendek (2012) concluded the following in a study about managing partnerships:

"Selecting a distribution partner requires a careful analysis of the potential partner's client base and its relationship with the client. The distribution channel may have greater access to the target market than the insurer, but this may not translate into access for selling insurance products."

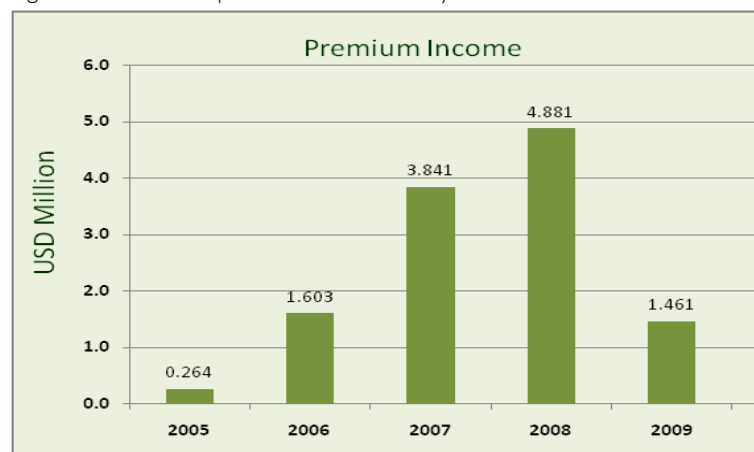
"A key insight from the study is that microinsurance partnerships must provide benefits to the distribution channel in addition to commissions in order to be successful in the long term. This is true even when the distribution channel is the prime driver for the microinsurance programme. Commissions from microinsurance policies are generally small, and in themselves may be unlikely to be sufficient to ensure commitment from the distribution partner."

4. > BUSINESS RESULTS

MIL's combination of reasonably-priced products, combined with choices about where treatment could be obtained was well received by the market and allowed MIL to achieve significant growth in policyholders and premium income in a relatively short period of time.

The growth in gross premium income is illustrated in Figure 5.

Figure 5: Microcare premium income history



MIL's share of the total Ugandan insurance market is illustrated in Table 3. In spite of being a specialist health insurer, by the end of 2007 MIL was the ranked 6th by gross premium out of 21 insurers, who were all insuring multiple classes of risk.

Table 3: MIL's share of total market premium

Year	Total Market Premium in US\$ million *	MIL Premium in US\$ million	MIL share of total insurance market
2004	43.31	0	
2005	47.25	0.264	0.56%
2006	53.15	1.605	3.02%
2007	75.86	3.841	5.06%
2008	92.5	4.881	5.28%
2009	91.1	1.461	1.60%

* Uganda Insurance Commission

From 2006 onwards MIL also had one of the lowest expense ratios of all the insurers in Uganda.

Table 4 provides a summary of the main financial results achieved by MIL. By 2007 MIL was starting to show a small profit and the claims ratio of 75 per cent was at a sustainable level. However, during 2008 the claims ratio deteriorated and MIL made a loss for the year. This result should not have been viewed as unusual since claims fluctuations in the establishment phase can be expected, particularly where individual premiums are very small²⁷.

These results can be compared with the results achieved by health insurers in Kenya for 2010²⁸ and 2011²⁹:

- In 2010 there were 15 health insurers of which only 5 made an underwriting profit;

²⁷ Microinsurance schemes, which may cover small groups with low premiums are known to have volatile claims experience (Dror, 2001).

²⁸ The first year in which the Kenya Insurance Regulatory Authority reported medical insurance as a separate class. Earlier figures are not available.

²⁹ The latest available figures published by the Kenya Insurance Regulatory Authority.

- In 2011 there were 18 health insurers of which only 5 made and underwriting profit;
- Only 3 health insurers made an underwriting profit in both 2010 and 2011;
- Total profits transferred to Profit and Loss Statements represented only around 3 per cent of total gross premiums.

Table 4: Microcare financial results

Year	Gross premium USD '000	RI ceded USD '000	Net premiums USD '000	Net earned premiums USD '000	Net incurred claims USD '000	Claims ratio	Expense ratio (C+ME)/gross premium	Profit after tax USD '000
2005	264	57	207	96	45	47.47%	123.38%	16
2006	1 603	169	1 434	888	740	83.29%	15.72%	-99
2007	3 841	1 134	2 707	2 296	1 719	74.86%	15.31%	234
2008	4 881	2 093	2 788	2 659	2 668	100.33%	9.95%	-32

Notes: Figures for 2005 to 2007 are as per audited financials reported in the UIC Annual Reports for the relevant years. Figures for 2008 have been reconstructed by the author from un-audited records.

MIL management commissioned an actuarial study on claims and pricing as soon as it became apparent that claims experience was deteriorating. Management also conducted a claims audit, which reviewed claims by service provider as well as by client, in order to identify the causes of the deteriorating claims experience and potential abusive behaviours that required intervention. This will be dealt with in more detail in the sections on service provider management and claims experience.

The contract to provide health insurance to 250,000 Uganda People's Defence Force (UPDF)³⁰ staff and dependants, awarded in 2008, would have finally provided MIL with the critical mass it needed. In particular, the increased scale would have allowed it to establish clinics in remote areas and buy drugs in bulk at lower prices. Investors were also ready to provide the required capital backing that would have underpinned such an expansion of MIL's business.

The vast majority of dependents of defence force personnel were poor rural communities. Aside from the revenue generated by this large scheme, it would have enabled MIL to make a significant national impact on poor communities' access to healthcare.

MIL's failure to stay in business unfortunately means that we will never know what may have been possible.

Lessons:

- Insurers who aim to deploy an aggressive premium growth strategy must ensure that they have the required capital base to maintain solvency.
- Volatility in claims experience in the establishment phase of an insurer which has not yet reached critical mass must be expected. The capital to maintain solvency under such conditions must be provided for.
- On the positive side, MIL's results seem to confirm that there is significant demand in the low-income segment for affordable health insurance which offers reasonable levels of choice of benefit levels and of medical service providers.

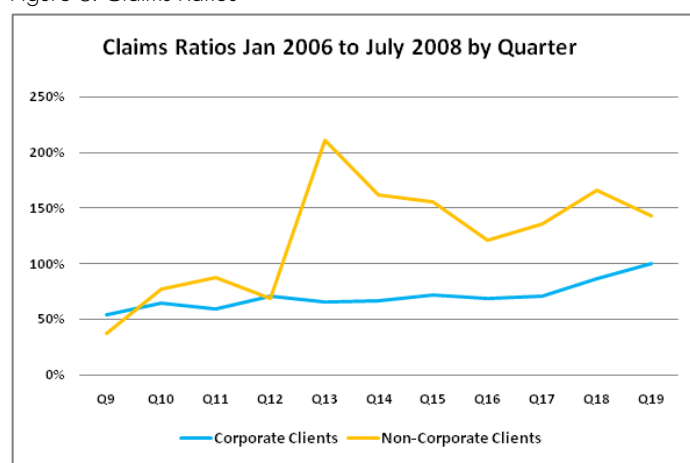
³⁰ MIL emerged as the highest scoring tender and in October 2008 was invited by the Ministry of Defence to finalise the choice of proposal options and terms and conditions for providing health insurance to the Uganda Peoples Defence Force. This contract could not be implemented when MIL's insurance license was not renewed.

5. > CLAIMS EXPERIENCE

Whereas a claims ratio below 50 per cent is common in general insurance classes, it is virtually unheard of in health insurance, where claims ratios of more than 70 per cent are common and management expenses are high (given the large volume of claims and labour intensive client servicing requirements when compared with other general insurance lines). During 2007 MIL maintained a claims ratio of around 75 per cent, which was acceptable for a young health insurer.

In the second half of 2008 it became clear that both claims frequency and costs were increasing at an alarming rate. MIL management therefore undertook an in-depth audit of all paid claims to establish where immediate interventions could bring claims costs under control in the short term. MIL also commissioned its actuaries to conduct a detailed analysis of claim trends to identify whether changes to underwriting practices and pricing were required, and to make recommendations to reduce claims volatility in the longer term.

Figure 6: Claims Ratios



Source3: Quindiem Consulting

The management audit immediately highlighted the fact that, while corporate accounts made up around 40 per cent of the lives covered from January 2006, they made up well over 90 per cent of the claim costs. The claims ratio on 25 per cent of the corporate accounts exceeded 100 per cent and in a few cases it exceeded 200 per cent. Six corporate clients were responsible for 35 per cent of total claims in 2008. Of particular concern was the increase in the claims ratio of the low-cost Social Basic product from 22 per cent in 2006 to 176 per cent by July 2008³¹.

The audit also showed that a small number of service providers were submitting claims for procedures that could not have been done³² and regularly charging fees that exceeded those agreed by a considerable margin. Six of the seven service providers who subsequently launched the application for the winding up of MIL (described in section 6.2) were responsible for 52 per cent of the total paid claims in 2008. A significant number of claims from these service providers were connected to the six high-claiming corporate clients referred to above.

The steps taken by MIL to counteract over claiming resulted in a breakdown in the relationship between MIL and a small group of influential service providers. This had a cascading effect that ultimately impacted all of MIL's business relationships. This is discussed in more detail in the section on service provider disputes.

The Uganda Insurance Act required insurance premiums to be fixed a year in advance. However, treatment costs escalated on an on-going basis as a result of medical inflation and currency fluctuations. It became clear in 2008 that this mismatch between

³¹ This trend resulted from a combination of expanding the number of service providers (mainly urban) that were made available to provide treatment on this product (which created more opportunities for over servicing and over claiming) as well as a reduction in the minimum group size allowed.

³² Such as a hysterectomy which was purportedly performed on the same patient on two separate occasions and "medication on discharge" which was billed in respect of a patient who had passed away five hours after admission. Many similar cases emerged and were disclosed and discussed with the providers involved.

premium income and claim costs was far greater than MIL had anticipated.³³ This discrepancy particularly impacted on the corporate accounts, given the higher value of premiums and claims related to these accounts.

The consistently high claims ratio of the non-corporate business should be viewed in the context of the small nominal amounts as well as the experiments with minimum group sizes and other enrolment criteria (such as extended family members). The total amount of claims on non-corporate business in 2008 represented only 5 per cent of the total paid claims, and some of this was offset by grant funding.

Non-corporate business consisted of urban and rural schemes. The differences in claims experience between corporate (largely urban) and non-corporate urban and rural business is illustrated in Table 5.

Table 5: Average claims from July 2007 to June 2008

Client group	Annual claim frequency	Claim size (US\$)	Monthly cost per member (US\$)
Corporate	4.85	32.55	12.98
Non-corporate urban	2.69	23.80	5.26
Non-corporate rural	0.3	5.63	0.14

Source: Quindiem Consulting

The analysis of membership and claims showed that single-service provider products performed much better than those that allowed members to choose from a wide selection of service providers. It was found, for example, that in 2008 Kibuli Hospital (through a single-service product) provided treatment to 7 per cent of all patients but only made up 4 per cent of MIL's claims cost. Paragon Hospital (through open products), on the other hand, provided treatment to 13 per cent of patients but was responsible for 22 per cent of the total claims cost. Table 6 compares MIL's claims experience on single-service provider products with open products and shows that both claim frequency and claim costs tend to be lower in single-service provider products.

Table 6: Illustration of single-service provider claims experience compared with open products
July 2007 to June 2008

Scheme	Type	Annual claim frequency	Claim size (US\$)	Monthly cost per member (US\$)	Claims ratio
Kibuli Hospital	Single SP	2.89	21.51	5.11	83%
Surgery IN&OP	Single SP	1.83	30.29	4.56	25%
Surgery Indiv OP High	Single SP	0.77	25.17	1.59	13%
Surgery Indiv OP Low	Single SP	3.31	24.82	6.76	9%
Corporate Comprehensive	Open	5.80	34.29	16.34	86%
Corporate Standard	Open	4.86	30.12	12.03	48%
Corporate Basic	Open	3.06	22.16	5.58	64%

Source: Quindiem Consulting

MIL also set up a scheme for the Hima Cement factory, where MHL managed an on-site clinic that provided treatment for factory workers who were insured by MIL. This scheme commenced in July 2007. Since the results in this case only cover one year and rely on the behaviour of a single company they should be interpreted with some caution. However, this scheme had the lowest loss ratio in MIL's portfolio at 49 per cent. Table 7 shows the differences in claim behaviour where there is an on-site clinic compared to having no on-site clinic. It also shows that, in spite of having a higher cost per claim, the total cost per

33 e.g. Headline inflation increased from 5.9 per cent p.a. in June 2007 to 12.4 per cent p.a. in June 2008 (Bank of Uganda Annual Report 2007/08) and the impact of the fall in the value of the Uganda Shilling against the US\$ on medicine prices, more than 90 per cent of which was imported, was even greater.

member was significantly lower in the on-site clinic scheme – demonstrating that cost per member is driven more by frequency of claims than claim sizes.

Table 7: Comparison of on-site and no on-site claims experience

July 2007 to June 2008			
	Annual claim frequency	Claim size (US\$)	Monthly cost per member (US\$)
On-site clinic	1.46	41.17	4.94
No on-site clinic	5.01	32.44	13.36

Source: Quindiem Consulting

The significant increase in claims costs that occurred in the second half of 2008, in spite of MIL's extensive claims controls, were partly a result of the following factors:

- The restructuring of MIL and MHL to comply with the UIC's directive caused a slowdown of key tasks. This created bottlenecks in claims processing and delays in claim settlements. It also created gaps in the control system which allowed claims that were not compliant with the rules to slip through. This situation was exacerbated by an increase in the number of claims per member, the average costs per claim, and the number of insured lives. This had a multiplier effect on the volume of claims to process.
- Collusion between some service providers and a small group of clients³⁴.
- The mismatch between premiums, which were fixed annually in advance, and the escalation in claim costs, which was far greater than had been anticipated by MIL³⁵.

Lessons:

- The on-site clinic which was managed by MHL achieved quality healthcare delivery with a loss ratio below 50 per cent. It was likely to be sustainable, since treatment cost could be controlled more easily and because there was no incentive for over servicing and over charging in such an integrated arrangement.
- The single-service provider schemes also experienced lower claims, both for low-cost and more comprehensive benefit plans. This supports the proposition that giving policyholders more choice of providers is likely to increase the cost of claims.
- Relaxing selection criteria for providers in response to pressure from existing or potential clients should be resisted. Where clients make their business relationship with the insurer conditional on inclusion of a specific medical facility in the service network, the likelihood of collusion between the client and the service provider increases significantly.
- Careful tracking of claims patterns among individual health providers and among clients is critically important.

³⁴ This is inferred from the fact that the claims audit showed that 35 per cent of all claims costs came from six corporate schemes and that a significant amount of these claims originated with the service providers that were responsible for 52 per cent of all claims costs in 2008 - supported by the fact that these service providers had often been included in the service network as a result of pressure from the very same corporate schemes. See discussion in the section of claims experience.

³⁵ Explained in footnote 36.

6. > SERVICE PROVIDER MANAGEMENT

The pre-payment of premiums for health insurance transfers the risk of incurring treatment cost to the insurer. This creates a triangular relationship between the insurer, the service provider, and the patient, with potentially conflicting incentives that must be aligned to ensure sustainability. The World Health Organisation estimated in 2008 that approximately 7 per cent of all global healthcare expenditure is lost to fraud or error - a staggering US\$ 41.5 billion in 2008³⁶. One of the best ways to avoid this loss is to employ an integrated approach that controls as many of the links in the healthcare value chain as possible.

Service provider network setup

MIL used the services of MHL to manage the delivery of cost-effective healthcare services to its policyholders. MHL maintained a large network of contracted healthcare service providers, comprising over 150 clinics and hospitals offering both outpatient and inpatient services across Uganda. MHL employed a comprehensive range of mechanisms to manage this service provider network and to maintain a balance between the different stakeholder interests:

PROVIDER SELECTION

Providers were selected to service specific policy benefits. This allowed the premiums, fee structure, and service levels to be matched. This initially meant that a Social Basic policyholder could only obtain services from a limited number of providers that were selected specifically to service Social Basic policies, and so on for each premium level. Choice of service network was therefore linked to premiums and benefits. Providers were also selected only after a process of evaluation of the quality of their physical infrastructure and the competence of their personnel. Sometimes a provider that did not meet all the criteria was contracted because it was the only healthcare facility in a particular town. Due to pressure from a few large corporate clients³⁷ MHL was sometimes forced to relax its selection criteria. This was the origin of many of the later difficulties with service providers. Providers were later allowed to provide treatment to policyholders from a number of different products with different benefit options and limits. This often allowed service providers to provide treatment for conditions that were not covered (costly diagnostics, chronic conditions, non-formulary drugs) supposedly by mistake, which MIL was expected to pay for. This caused claim rejections and sometimes conflict.

HELP DESKS

MHL installed help desks (sometimes referred to as “check-in” desks) at all the major service provider facilities. Each help desk was staffed by a qualified nurse and equipped with a computer terminal which was linked to MHL through a GSM (mobile phone) link. This allowed policyholders to be verified prior to treatment. It was also meant to speed up claims processing. However, help desks were not designed to prevent unnecessary treatment³⁸ procedures or frequently recurring visits by some patients. In some cases doctors allowed patients to bypass the help desks completely, causing claim rejections and slowing down claims processing.

THERAPEUTIC COMMITTEE

MHL established a committee of prominent local medical practitioners and specialists, including some of the owners of prominent clinics. The rationale for the therapeutic committee was to ensure visible objectivity in setting treatment protocols and a drug formulary and to act as a forum for dialogue between MHL and the medical profession on a doctor-to-doctor basis. When relations with some service providers deteriorated, the therapeutic committee unfortunately became a lobby group for the interests of a small group of providers. This undermined its role of independent oversight.

Figure 7: Microcare help desk



Microcare help desk

³⁶ <http://www.who.int/bulletin/volumes/89/12/11-021211/en/index.html>

³⁷ Pressure from corporate clients to include a specific clinic was often due to the fact that such a clinic was owned by a family member of a senior manager of the company/NGO who could make the appointment of MIL conditional on the inclusion of such a clinic.

³⁸ As new clinical technology was introduced into Uganda it became fashionable to undergo diagnostic procedures such as MRI scans or an echocardiogram at high cost and without clinical indication.

PROVIDER CONTRACTS

Each network provider was formally contracted and contracts contained specific provisions about service fees, drug prices, excluded benefits, and the process for submitting claims. The claims management system required compliance with these provisions and was designed to reject claims which did not comply with these provisions (which then required manual evaluation and sign-off).

MANAGED CARE

MHL employed a team of medical staff that provided managed care services consisting of the following:

- Pre-authorisation - Policyholders were required to obtain pre-authorisation for all in-hospital admissions. This allowed MHL to monitor in-hospital treatment and the length of in-hospital confinement.
- Hospital visits - Pre-authorisations enabled MHL to maintain a caring relationship with patients, who were visited on a daily basis while in hospital (except for admissions outside Kampala, which were monitored by phone). This also served to verify claims.
- Preventative care - Each new policyholder in the community schemes received mosquito nets and a plastic can with water purification tablets to prevent malaria and waterborne diseases. Health education sessions were conducted regularly to share information about issues such as malaria prevention, safe water and good sanitation, prevention and treatment of worms, nutrition, safe motherhood and childcare, healthy living, immunization of children, and HIV/AIDS.

Figure 8: Example of identity card



IDENTIFY CARDS

Photo identity smart card technology was used by Microcare for identification of all members. To reduce cost, complete families were recorded on a single card by placing family members' pictures on the reverse of the main member's card and recording their data on the card chip as well. This allowed MHL to ensure that patients were covered when they came for treatment. In practice the smart card technology could not be accessed or updated outside of the main centres.

In most instances these measures were successful and laid the foundation for the good relationship between Microcare and the majority of providers in the network that continued into 2009³⁹. However, the increase in claims costs which occurred in 2008 showed that these measures were not always successful in preventing over claiming and over servicing.

³⁹ Louise Memorial Medical Centre provided the following endorsement of Microcare in a letter dated April 22, 2009: "The Management of Louise Memorial Medical Centre wishes to inform you that Louise Memorial Medical Centre was and still is one of the Microcare service providers. We have worked with Microcare for approximately 4 years and have had no problems in our partnership."

Kololo Hospital (Kampala) Limited provided the following endorsement of Microcare in a letter dated June 4, 2009: "We have been in close business relations with the Microcare group for the past 5 years and highly recommend them to you."

Namulundu Medical Centre (Kajjansi-Entebbe Road) provided the following endorsement in a letter dated June 2, 2009: "We are glad to inform you that we have been providing medical services to Microcare clients' members and their families since 2002 (6 years plus). Their contribution to our business and the community in terms of quality health services is significant. We highly recommend Microcare to you and we look forward to partnering with Microcare."

These are only a few of the many endorsements, in addition to the numerous personal recommendations, which Microcare received on an ongoing basis from its service providers.

Lessons:

- When different benefit structures are serviced by the same medical providers, benefit creep (i.e. excluded benefits treated “by mistake”) and disputes over rejected claims frequently occur. Controlling claim costs is far easier when policies that offer low-cost benefits are serviced by a separate group of service providers on a single-fee schedule.
- The fact that MIL’s contracted network was allowed to grow to more than 150 service providers made it more difficult to maintain the level of service provider compliance which had existed in the early years. Compliance with agreed terms and conditions is easier to maintain with a more manageable number of service providers.
- Bodies, such as MIL’s Therapeutic Committee, used to provide independent oversight of treatment protocols and quality should consist of respected healthcare professionals who are not part of the provider network. This will eliminate the potential for conflicts of interest.
- Aligning the interests of providers, patients, and the insurer through incentives and risk sharing may be a more effective way to control claim costs than elaborate control mechanisms alone.

Service provider disputes

As a result of the in-depth claims audit, referred to earlier, MIL introduced additional controls, such as pre-authorisation of high-cost diagnostic tests, and revised its products and pricing. MIL also notified certain service providers that it planned to reverse some payments previously made. This caused a strong reaction and some of the affected service providers started refusing services to key MIL clients. In one instance a senior officer of a major corporate client held back payment of the annual renewal premium to put pressure on MIL to settle all disputed payments to a clinic that was owned by her sister.

Based on information provided by these service providers an article appeared in the Observer Newspaper on the 17th December 2008, titled “Private hospitals in financial mess”, which blamed non-payment by Microcare for financial difficulties of service providers⁴⁰. This negative publicity was timed to impact on the January 2009 policy renewals and to undermine MIL’s credibility as an insurer. It is no coincidence that five of these service providers⁴¹ had started to operate as HMOs and were actively trying to persuade MIL’s key clients to move their business to these institutions.

In March 2009 a group of eight service providers⁴² launched an application for a winding-up order⁴³ against Microcare in the High Court. This action impacted on Microcare’s relationships with the whole service provider network and placed a damper on new and renewal business. The winding-up application was also clearly timed to coincide with the renewal of insurance licenses for 2009 and to undermine MIL’s credibility with the regulator. In an article by Barbara Among in the New Vision newspaper on the 27th March 2009 under the headline, “Microcare in financial crisis”⁴⁴, it was stated that Microcare could not pay its debts and that MIL’s insurance license had been revoked. It was also prominently stated that the International Health Network⁴⁵, Kadic Health Foundation (Kadic Hospital) and Case Medicare (Case Medical Centre) were HMO’s that were providing pre-paid healthcare products.

The negative publicity caused by the application for the winding-up order resulted in a loss of trust in MIL, which caused a significant loss of business. It also created panic among many of MIL’s creditors, including the contracted service providers. MIL was forced to settle outstanding debts much sooner than normal, whilst debtors became difficult to collect from. This caused serious cash flow difficulties for MIL that impacted negatively on its solvency margin.

⁴⁰ http://www.observer.ug/index.php?option=com_content&view=article&id=1879:private-hospitals-in-financial-mess

⁴¹ Case Medical Centre, Kadic Hospital, International Health Network, St Catherine’s Clinic & Paragon Hospital (Zikusooka, 2008). Some of these have since been licensed in terms of the Insurance Amendment Act of 2011.

⁴² Paragon Hospital, SAS Clinic, Victoria Medical Centre, Case Medical Centre, Pan Dental Surgery, St Catherine’s Clinic & Bugolobi Nursing Home. St Catherine’s later withdrew from this action.

⁴³ Section 71 of the Insurance Act of Uganda, Cap213 provided for “Winding up” of an insurer under certain conditions. The application for the winding-up order was withdrawn with legal costs of both sides to be paid by the plaintiffs by Order of the High Court of Uganda (No 344 of 2009) issued on the 2nd September 2009.

⁴⁴ <http://www.newvision.co.ug/D/8/13/676117>

⁴⁵ Led by Kampala Medical Chambers Clinic and Majanja Memorial Hospital and to which the Victoria Medical Centre was affiliated.

Subsequent newspaper articles started to express alternative views on Microcare⁴⁶, but this could not repair the damage that had been done. Microcare was also able to show that the winding-up application had no foundation and had simply been designed to create negative publicity. However, as a result of the slow process of obtaining a court hearing in Uganda, this was only finalised in September 2009, by which time MIL's business had been irreparably damaged.

As a result of the backlog in claims processing (discussed earlier) and the cash flow crisis, payments to all of Microcare's contracted service providers were delayed, causing many of them to withdraw from providing treatment to MIL's policyholders. This caused further difficulties in MIL's ability to retain and secure new business.

Lessons:

- When a dominant health insurer's control mechanisms start to impact on excessive claim behaviour, providers may be left without significant alternative revenue channels (e.g. because in this case MIL had become the dominant health insurer and purchaser of healthcare services). As a result providers may resist by withholding treatment to policyholders of the insurer and by taking actions to undermine the insurer⁴⁷. It may be possible for the insurer to balance this risk by controlling key elements in the healthcare supply chain, such as opening its own clinic/s.
- The conflict of interest that develops when a healthcare service provider starts to compete with the insurer in offering pre-paid products should be discouraged. Insurers should try to secure agreement with the service provider that it will not compete in this way. Where suitable providers cannot be contracted it may be necessary for the insurer to establish its own clinics to avoid the risk that such conflicts of interest represent when these providers are included in the insurer's service network.
- In many emerging markets it may be difficult to enforce contractual terms and conditions and to defend against vicarious actions due to long delays in obtaining a court hearing. Often the best protection may be obtained by building strong local partnerships.

⁴⁶ Dishonesty is killing medical insurance (The Observer, 20th April 2009), Competitors plot to kill Microcare (The Observer, 27th April 2009), The insurance sector needs closer attention (The Observer, 28th May 2009)

⁴⁷ Pan World Insurance was the previous health insurer to go out of business in Uganda under circumstances that were remarkably similar to those experienced by Microcare.

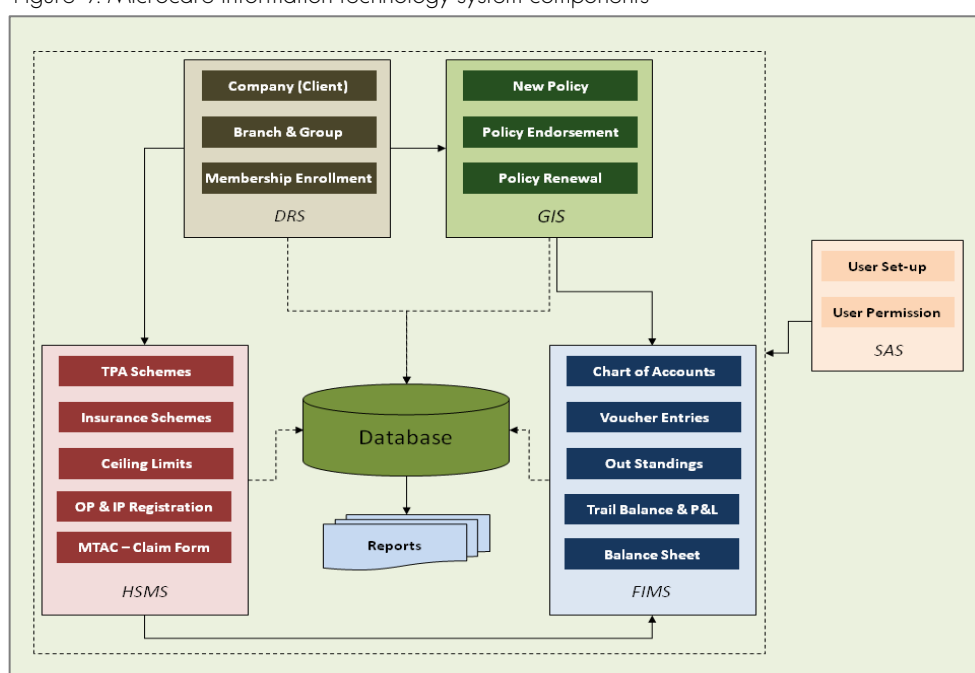
7. > INFORMATION TECHNOLOGY

Microinsurance is developed in an environment where people have access to a variety of tools to cope with risk. Credit, savings, informal risk sharing agreements and self-insurance strategies also offer (partial) protection against risks and are seen as substitutes for insurance. It is of the utmost importance to understand the added value of insurance in comparison with other risk management services, so as to position microinsurance products correctly.

Health insurance claims administration involves very high volumes of transaction processing which can only be done efficiently within an automated rules-based system⁴⁸. By mid 2008 Microcare covered over 70,000 lives, generating approximately 800,000 claim item verifications per year⁴⁹. The pressure of high-volume claims administration is one of the biggest contributors to high management cost for health insurers because of the ease with which manual claims processing can be manipulated (e.g. by submitting multiple claims for the same treatment event).

One of Microcare's strengths was its healthcare and claims management software system that was developed from experience of a hospital environment and by combining the expertise and experience of a medical doctor and an IT specialist. It managed the process of delivering a specified range of medical services to a large group of people on a centralised data base. This system consisted of components that were each designed to deal with different operational challenges within the health insurance/TPA environment, as illustrated by Figure 9. In 2008 the Microcare healthcare and claims management software was valued⁵⁰ by Meys Consult, consulting engineers and valuers, at UGX 10,133,990,000 (approximately US\$ 5.5 million) in order to determine a fair market value when the software was bought by MIL to comply with the UIC's instructions to completely separate MHL and MIL.

Figure 9: Microcare information technology system components



Source: Francis Somerwell presentation 2009

⁴⁸ Rules-based systems trigger actions or reach decisions based on combinations of conditions and/or events encountered. Rules may be defined by business-level policymakers to reflect regulatory requirements, domain-specific best practices, enterprise business policies or process-control tasks. In Microcare's case it provided for automated claims vetting based on prescribed clinical treatment protocols and terms and conditions and fees as agreed to in service provider contracts. This was designed to allow fast processing of compliant claims before involving medical staff in vetting claims which did not get past the automated stage.

⁴⁹ In considering the claims volume it is important to bear in mind that Uganda does not have any of the usual devices that are found in most developed societies, such as national identity numbers, standard diagnostic codes (e.g. ICD10), standard agreements on pricing for medical services and drugs. Therefore all coding still had to be done manually and each provider had a separate fee schedule which was entered into the claims management system. Nevertheless, once data was entered all claim item verifications could be done within the automated rules-based system. This created efficiencies that allowed Microcare to save costs by having a significantly smaller team of people processing claims with far greater accuracy. However, it was dependent on compliance with the agreed protocols by all the stakeholders.

⁵⁰ For the purpose of transferring full ownership of the source code and intellectual property rights.

One of the mechanisms to facilitate claims management was the help desk at provider facilities, which facilitated checking-in patients and tracking treatment through connected terminals. This created a fast track to verify client identity and process claims at the point of treatment. It ensured that a large number of claims did not require further steps for data input and verification. The smart card technology used for patient identity verification ensured that Microcare membership identity cards could not be used by friends and neighbours.

A rules-based and automated system such as this, however, cannot function properly without consistent compliance of service providers with the agreed treatment protocols⁵¹ and pricing – deviations required manual interventions which slowed down the process of claim payments and weakened controls⁵². As a result of the subsequent high levels of non-compliance by service providers which arose in 2008, mechanisms had to be created to bypass the system-based controls to allow these claims to be processed manually rather than being returned to service providers as complete rejections.

The Health Schemes Management System (HSMS) used for claims management was designed to track claims and produce reports based on the date when treatment was provided, for example to list all patients treated for malaria in a particular month. This meant that the claims for any given period remained “open” until all the claims which had occurred within that period were submitted and processed and an accurate claims position could be determined. This usually took about three months, allowing time for up-country service providers to submit all claims, after which the system was “closed” for that period. While the claims period remained “open”, the amount of claims paid and outstanding for the period in question kept being adjusted as new claims were received and processed. This created difficulties for financial management (in FIMS) since real time details of claims paid and outstanding could not be determined until the system was “closed”. Therefore, the true financial position at month end could not be established at the end of that month. This had a critical impact as it delayed management’s ability to respond to important developments in the business and to provide accurate month-end financial balances⁵³.

Claim payment transactions were processed in the Financial Information Management System (FIMS) based on information from HSMS. The HSMS system only recorded details of approved claims, but not rejections or partial rejections. As a result it was very difficult to reconcile the claims reflected in the healthcare system (HSMS) with claims reflected in the financial system (FIMS).

Apart from the ability to process large volumes of claims, an insurance administration system must be able to provide regular reports that will allow management to compare actual performance against projections – specifically as it relates to premium determination and other performance indicators⁵⁴. Whilst Microcare’s healthcare and claims management software system could provide very detailed reports on healthcare treatment and claims behaviour, it was unable to provide critical reports needed for effective financial management of the insurance company, such as expressing different categories of expenses as a unit cost portion of the annual premium.

Management was aware of these issues and work was in fact being done to upgrade the system and fix these shortcomings, but unfortunately the non-renewal of MIL’s insurance license prevented it from being completed.

Lessons:

- Rules will not always be followed by all and technology will not necessarily work all the time. Therefore, even in a rules-based automated setting, provision must be made for dealing with exceptions so that they can be dealt with in such a way that neither controls nor relationships suffer.

51 Provider contracts stipulated clinical treatment protocols based on the Uganda Standard Treatment Guidelines, combined with updated best practice guidelines advised by the Therapeutic Standards Committee from which system-based parameters were also determined.

52 Medical claims management requires a multitude of checks (e.g. is the person covered, correlation between diagnosis and treatment, was clinical protocol followed in prescribing medication, was the dosage and the price charged within the service contract) and is much more difficult to do accurately with a manual process, which can also be more easily manipulated for fraudulent purposes.

53 e.g. this caused delays in the top-up of TPA funds and caused the late submission of bordereaux which affected relations with reinsurers.

54 See Wipf and Garand (2010) for an in-depth discussion on the issue of performance management.

- The absence of accurate and timely financial reporting prevents effective tracking of the causes and interventions in claim trends and means that statutory and other reports cannot be provided within stipulated deadlines. This shortcoming undermines the credibility of the organisation and may have a negative impact on relationships with key partners (such as clients, service providers, and reinsurers) and the regulator.
- Claims management systems that cannot automatically post claim payment transactions to the general ledger will cause reconciliation problems.

8. > CORPORATE GOVERNANCE

Corporate governance refers to the system by which a corporation is directed and controlled and the structure by which it pursues its objectives within the context of the social, regulatory and market environment. The actions of management, their decisions, and their strategies are monitored against this backdrop. Good governance should ensure the alignment of the interests of all the stakeholders in the corporation, including owners, clients, creditors, and employees.

This case study considers two aspects of governance – financial and non-financial governance.

Financial governance

In a study of Microcare, conducted by Microsave in June 2002 (McCord and Osinde, 2002), Michael McCord stated the following:

- “Proper accounting is not currently being conducted. For example, at the time of the June 2002 visit, books of accounts were completed only through 12/31/01, little to no accounting analysis was being conducted, and a rudimentary cash flow analysis process had just been instituted (by the health scheme operations manager). This is a serious impediment to proper management of this business.”
- “Cash flow was a serious problem for Microcare resulting from slow payments from other obligated entities. Payments to providers are averaging ninety days from the end of the month of service. We were unable to identify the period between invoice receipt and payment because there was no documentation on this.”

Clearly there were issues with financial management within Microcare right from the beginning. The stakeholders in Microcare were never able to create a dynamic and robust financial management unit within the Microcare companies. This is surprising given the initial involvement of institutions such as DfID and Aon. Nevertheless, Microcare continued to suffer from inadequate financial management, which played a critical role in the eventual difficulties which resulted in the withdrawal of MIL's insurance license.

This deficiency created difficulties such as:

- Unreliable reconciliations of TPA accounts that undermined confidence in Microcare's custodial role when managing employer funds and caused delays in top-up of employer accounts. This resulted in Microcare having to bear the cash flow burden of TPA accounts which had not been topped up;
- Lack of financial controls resulted in employers/policyholders not being invoiced for new members who joined after the annual inception/renewal date of schemes. This resulted in claims costs which were not offset by premiums received.
- Delays in the production of accurate financial statements compromised management decision making and undermined credibility with potential investors.
- System-generated trial balances were questioned by external accountants and caused difficulties for audit purposes.

These issues were highlighted in the management letter by the auditors in 2007 which specifically highlighted the need for better internal control systems and the risk that rapid growth posed for solvency. The issue of internal controls was also highlighted as follows by the auditors appointed in 2009 by the UIC⁵⁵ to review MIL's business: “The company's gross insurance receipts have crossed US\$ 6 billion and the company still operates with only the Financial Controller reviewing the overall affairs of the company without a formal internal audit department.”

After the December 2008 newspaper article referred to earlier, service providers became concerned when claim payments were delayed and threatened to terminate services to MIL policyholders. At the same time, claims processing was delayed as a result of the increase in claims volumes and restructured claims processes (discussed earlier). This forced MIL to pay advances to providers pending processing of outstanding claims and reconciliations of accounts. In the normal business cycle, which generated a steady stream of new claims, advances could subsequently be offset against new claims where necessary. However, when service providers started terminating services, this became impossible. In the turmoil of the developing crisis some of these advances could not be matched to actual claims.

55 Seijaaka, Kawaase & Co, Certified Public Accountants.

Non-financial governance

After the buy-out of investors by Dr Noble in 2005, the owners were also part of the executive management. The Board of Directors included both executive and non-executive directors. The non-executive directors were respected business owners within Uganda and were not dominated by the executives. Sejjiaakaa, Kawaase & Co reported that all the company officers within MIL were adequately qualified.

A number of non-financial issues were highlighted by the company auditors since 2007 and subsequently by Sejjiaakaa Kawaase & Co. These are briefly covered below:

- The filing system required improvement. The MIL auditors, in the management letter pertaining to the 2007 audit, observed that the filing system was “pathetic”. They recommended that action should be taken to strengthen the system of filing, particularly in respect of statutory records like Income Tax returns, audited financial statements, and other statutory reports. However, it seems that this recommendation was ignored.
- Management reports contained incorrect information as a result of incorrect accounting records, some of which related to problems with the way in which claims were finalised (as discussed earlier).
- Internal financial controls were found to be inadequate.
- After the restructure of the way in which MIL’s business was organised it became possible for membership identity cards to be issued without authorised sign-off after confirming that premiums had been received. Whether this actually happened is uncertain, but the fact that it became possible was a breakdown in controls that could potentially have had a very negative impact.

Shortcomings in corporate governance contributed to the problems which MIL experienced and made it difficult to demonstrate that MIL’s business practices were beyond reproach – particularly when it became involved in a dispute with the UIC.

Lessons:

- Shortcomings in corporate governance invariably precede problems in the business and stakeholders should ensure that business is conducted according to best practice guidelines at all times.
- Specialised software programmes can make a significant contribution to the competitive position of an organisation when this is developed as a result of in-depth specialist knowledge and experience. However, developing bespoke components for applications outside of the area of specialisation should be avoided, particularly when good systems that can do the job can be bought off the shelf. Had Microcare simply made use of a good commercial accounting and financial management application in conjunction with its own claims management systems, the financial reporting may have been far better and many of its problems may have been avoided.
- The inability to track key performance indicators (Wipf and Garand, 2010) undermined MIL’s ability to predict solvency requirements more accurately and prevented a more dynamic pricing strategy from being implemented in response to the deteriorating claims experience.
- Payments of advances should have been recorded in such a way that they can subsequently be easily allocated to actual claims for treatment already provided. Ad hoc payments which occur outside the established procedures should, however, be avoided completely.

9. > UGANDA INSURANCE COMMISSION

The Uganda Insurance Commission⁵⁶ (UIC) was responsible for the supervision and regulation of the insurance sector. The insurance regulatory framework in Uganda distinguished between life and non-life business but provided no separate demarcation for health insurance - which received no explicit mention within the regulatory regime⁵⁷. It is interesting that law makers had recognised the need for separate legislation for motor vehicle and marine insurance, but until 2011 made no provision for the specific issues that only relate to health insurance⁵⁸.

Microcare was the only specialist health insurer that chose to comply⁵⁹ with the law as it was. It is therefore ironic that instead of working with Microcare to find better ways to deal with the unique challenges of health insurance, the Acting Commissioner, who took office in 2008, chose to follow a more rigid approach to the interpretation of the Insurance Act than her predecessor - e.g. the issue of related party (or "inter-company") transactions.

As a result of vaguely-worded provisions in the Insurance Act, the members of the Technical Committee⁶⁰ of the UIC included the General Manager of The Jubilee Insurance Company of Uganda (who also served as chairperson) and the owner/CEO of a brokerage that had close ties to Paragon Hospital. This situation clearly created a conflict of interest. When insurers were asked to submit information, such as strategic plans, they became suspicious that the office of the UIC was being abused for unfair competition (see Observer article in Annex C).

When the Acting Commissioner took office, the UIC started to focus heavily on MIL and during the course of 2008 it conducted two separate inspections. Solvency became a point of contention when the UIC refused to recognise the healthcare and claims management software (which MIL had acquired from MHL) as an asset for the determination of solvency.

MIL argued that this software was an integral part of its business that had been purchased for this purpose, and could also in the future be sold or leased out. It pointed out that according to the International Accounting Standard (IAS 38) an intangible asset can be capitalised when it has an independently observable existence and a cost that can be assigned to it⁶¹. According to MIL this position was also supported by the Financial Accounting Standards Board (FASB) and Generally Accepted Accounting Practice (GAAP)⁶² positions. MIL also argued that the Solvency II framework directed that, "Valuation standards for supervisory purposes should be compatible with international accounting developments, to the extent possible, so as to limit the administrative burden on insurance or reinsurance undertakings."⁶³

The UIC was also reminded that in any event MIL was very close to a large scale recapitalisation by bringing in new investors, after which the valuation of the software system would become irrelevant for the determination of solvency⁶⁴.

⁵⁶ It became the Insurance Regulatory Authority (IRA) in terms of the Insurance Amendment Act of 2011.

⁵⁷ This situation was only addressed in 2011 with the Insurance Amendment Act of 2011.

⁵⁸ Such as the large numbers of small claims that accumulate and the challenges of managing healthcare service delivery together with patient confidentiality, the need for managed care interventions and other unique issues such as the fact that unlike motor vehicle insurance where claims can be delayed indefinitely, in health insurance the patient may die if treatment is withheld.

⁵⁹ Other regulated insurers combined health insurance with other more dominant classes of general insurance and the HMOs simply refused to comply with the Insurance Act and were not challenged by the UIC.

⁶⁰ The committee of the UIC that decides whether an insurer's license application will be approved or declined and was responsible for recommending the preferred candidate for the post of Commissioner of Insurance for appointment by the UIC Board.

⁶¹ International accounting standards first addressed accounting for intangibles in a thorough way with IAS 38, which was promulgated after a rather long and contentious gestation period that included the issuance of two Exposure Drafts. IAS 38 is a comprehensive standard which superseded an earlier standard dealing solely with research and development expenditures. It established recognition criteria, measurement bases, and disclosure requirements for intangible assets.

⁶² Paragraph thirty-nine of FAS 141 addresses the recognition of intangible assets:

"An intangible asset shall be recognized as an asset apart from goodwill if it arises from contractual or other legal rights (regardless of whether those rights are transferable or separable from the acquired entity or from other rights and obligations). If an intangible asset does not arise from contractual or other legal rights, it shall be recognized as an asset apart from goodwill only if it is separable, that is, it is capable of being separated or divided from the acquired entity and sold, transferred, licensed, rented, or exchanged (regardless of whether there is an intent to do so)."

⁶³ Solvency II draft framework Directive: Introductory note 28, 100707.

⁶⁴ The UIC had previously been introduced to the prospective investors and shown a letter of intent in this regard.

However, the valuation of the software was not the only issue⁶⁵ on which MIL disagreed with the UIC and no agreement was reached. In the event of a disagreement between an insurer and the UIC, regulation 32 provided for the appointment of a competent person to carry out a new and independent inspection and MIL asked the UIC to make such an appointment. The UIC refused and, in spite of these ongoing discussions, proceeded, in March 2009 to publish the list of companies for whom insurance licenses had been renewed without including MIL. Against the backdrop of the recent media attention on the petition for a winding-up order, this caused significant concern among potential and existing clients at a time when a large proportion of MIL's business was due for renewal.

Regulation 9 stipulated that when the UIC intended to suspend or revoke an insurer's license, written notice of this intention should be given. This was not done and the non-publication of MIL's name in the list of renewed insurance licenses was seen by MIL as a breach of the law. Therefore MIL approached the High Court for relief.

On the 25th March 2009, the High Court ordered the UIC not to prevent MIL from transacting insurance business until the application for a judicial review over the solvency determination could be heard. This technically allowed MIL to continue doing insurance business. However, despite this interim order of the court, the UIC placed notices in the national press (in direct contravention of the court order) stating that MIL was not authorized to transact business as an insurer and that MIL was insolvent. This effectively ended MIL's ability to conduct normal insurance business, forcing it into run-off.⁶⁶

Sections 32(4), 33(5), and 50(4) of the Act and regulation 10 of the Regulations stipulated that in the event of an insurance license being revoked an insurer can appeal to the Minister, which was also done.⁶⁷ In a letter to the Chief Executive of the Uganda Insurance Association dated the 3rd April 2009 MIL explained its position and appealed for support from the Insurance Association. This plea received no reply or support.

This issue continued to drag on in the High Court until the 22nd October 2009 when the High Court finally determined that MIL should have appealed to the Minister before obtaining a court order. As a result the order of the 25th March 2009 was revoked. MIL was now no longer able to trade as an insurer pending an appeal to the Minister. However, by this time MIL was no longer in a position to continue with further actions.

As a result of the ongoing dispute between MIL and the UIC, the investors withdrew and a 5-year contract to provide health insurance to the Uganda People's Defence Force staff and dependants could not be implemented.

The regulatory environment was updated by the promulgation in September 2011 of the The Insurance Amendment Act, 2011 (Amendment Act), which introduced material changes to insurance regulation in Uganda and which, if it had been in place at the time, could have made a big difference to how Microcare's issues were addressed:

- This legislation compelled "health insurers and health membership insurers" (meaning HMOs) to be licensed under the Act and created a level playing field in respect of health insurance for the first time;
- It changed the structure of the regulatory authority and removed the opportunity for conflict of interest;
- It also introduced an Appeals Tribunal which has jurisdiction to make determinations on disputes between insurers and the UIC (now IRA).
- It also stipulates that the IRA "shall not decide any matter brought before it without giving the appellant an opportunity to be heard."

⁶⁵ There were also differences with regard to the value of premiums due (as a result of endorsements) and outstanding claims.

⁶⁶ An insurance company is in run-off if it has stopped writing new business and only manages existing policyholder liabilities until the end of the policy year of each remaining policy.

⁶⁷ This was reported in the New Vision newspaper of the 21st April 2009 under the headline, "Microcare appeals to the government"

Lessons:

“Those who govern, having much business on their hands, do not generally like to take the trouble of considering and carrying into execution new projects. The best public measures are therefore seldom adopted from previous wisdom, but forced by the occasion.”

- Benjamin Franklin

- In many ways, MIL paid a price for being the first regulated specialist health insurer in Uganda, as it was required to comply with a regulatory regime that was not designed for health insurance. The regulatory shortcomings demanded a flexible approach in supervision to allow room for experimentation. While such flexibility existed MIL was able to grow, but when it was removed MIL faced insurmountable problems. The lesson in this seems to be that in pioneering new approaches in insurance, stakeholders must work very closely with the regulator, ensuring continuity in their relationship and keeping detailed records of decisions by the regulator allowing a more flexible interpretation of regulations or accepted practices.
- MIL was constrained by its own governance shortcomings from more effectively presenting its case to the Acting Commissioner.

10. > SOLVENCY

It is commonly said that for low cost insurance to be successful it must achieve scale. The Law of Large Numbers postulates that the larger the group of units insured, the more accurate the predictions of loss will be, resulting in more accurate pricing. Scale also reduces the unit cost of administration, particularly when, as in MIL's case, processes are automated, so staff numbers do not increase proportionally to the number of policyholders. MIL therefore deployed strategies which aimed to reach significant policyholder numbers quickly and in this they were quite successful. However, growth in premiums requires additional reserves to be set aside, and in health insurance it is very difficult to increase reserves out of premiums.

Microcare's shareholders had recognised that continued growth would require additional capital investment and discussions with potential investors had been ongoing for more than a year. By the end of 2008 a Letter of Intent had been issued by investors, who were keen to buy an equity stake in Microcare. Finalisation of the recapitalisation was subject to a due diligence, which was in progress when the service providers applied for the winding-up order against Microcare. This investment would have recapitalised MIL to a level far above the solvency requirements with a view to the UPDF scheme (discussed in Section 4). Both the Uganda Investment Authority and the Acting Commissioner were aware of this potential investment.

The objectives of capital adequacy regulations should be to protect policyholders, establish capital requirements matched to the insurer's risks, avoid unnecessary complexity, reflect market developments, and avoid unnecessary overcapitalization. These objectives have led many countries to move towards Risk Based Supervision (as opposed to Rules Based Supervision) and to establish a principles-based approach (such as Solvency II⁶⁸) rather than applying the same system or ratios to all insurers or classes of business regardless of their characteristics. This approach also allows room for an insurer to convince regulators of its financial solidity using an individualized internal model. Had this approach been possible in the MIL case, the company may have been given sufficient time to finalise its re-capitalisation.

It can also be argued that forcing health insurers to comply with reserve requirements designed for property insurance can contribute to the failure of health insurers. This argument is discussed in some more detail in Annex D.

The consultants, Le Boeuf, Lamb, Greene & MacRae, that were appointed by the government of Uganda to evaluate the state of the insurance industry in 2005 recommended "that the Commission obtain the services of an actuary to determine whether the existing appropriate margins of solvency and reserve requirements that apply to insurance in Uganda are appropriate for HMOs" (Kearney et al., 2005). This recommendation should apply to all health insurance.

Lessons:

- Health insurance claims occur on an ongoing and high-frequency basis, and at a level that uses the full provision for treatment cost in each cover period. This makes it virtually impossible to set aside a portion of premium receipts in a good year to provide for a high claim experience in a bad year. Therefore, premium-based reserve requirements undermine the ability of health insurers to attain the scale required for less volatile claims experience. This makes it impossible for specialist health microinsurers to survive without external capital injections. It may therefore be time for an in-depth review of the basis for determining solvency for health microinsurers – even if this means a higher initial capital requirement as well as a higher margin of assets over liabilities to free up cash flow for paying claims.

68 The Solvency II Directive 2009/138/EC is an EU Directive that codifies and harmonises the EU insurance regulation. Primarily this concerns the amount of capital that EU insurance companies must hold to reduce the risk of insolvency.

11. > REINSURANCE

Reinsurance is a method that insurers use to “insure” the insurance risks that they undertake by transferring portions of their risk portfolios to other parties (reinsurers). This reduces the insurer’s risk that a large claim or a large number of claims threaten its ability to survive. The Act in section 2(m) defines “reinsurance business” as “a business of undertaking liability to pay money to insurers or reinsurers in respect of contractual liabilities in respect of insurance business incurred by insurers or reinsurers and includes retrocession.”

In Uganda it was a statutory requirement that at least 15 per cent of all reinsurance should be offered to two specified reinsurers – ZEP Re (10 per cent) and Africa Re (5 per cent).

From its establishment in 2005 up to May 2007, MIL made use of a basic Excess of Loss (XOL) cover, on which it never claimed. From May 2007 up to December 2008, a Quota Share (QS) Treaty cover was in place, which was arranged through J B Boda Reinsurance Brokers in India. MIL was only provided with a cover note, which subsequently proved inadequate to clarify misunderstanding about requirements such as the exact contents required in bordereaux and other issues⁶⁹.

The QS treaty involved five reinsurers, which included the two compulsory cessionaries, one of which (ZEP Re) was appointed as the lead reinsurer. The reinsurers agreed to a “follow the fortunes” arrangement. This meant that each reinsurer would share in the premiums and claims of MIL, subject to agreement by the primary reinsurer, ZEP Re – effectively giving one official total decision making power over all reinsurance decisions. The cover note stipulated that the policy wording would be agreed between MIL and ZEP Re, which, to the knowledge of the writer, never actually happened.

The relationship continued on a cordial basis while MIL was paying net reinsurance premiums (without any complaints about bordereaux or procedures). As discussed in Section 5, there was an increase in claims from the second quarter of 2008 which meant that for the first time MIL became the net beneficiary of the reinsurance treaty. At this point disagreements about procedures, policy conditions, and bordereaux structure arose for the first time and effectively caused the reinsurers to default on their QS treaty obligations for the 2008 underwriting year. This is still unresolved.

Other issues which gave rise to difficulties were:

- The lead reinsurer insisted on receiving claim records down to individual claim levels. This amounted to thousands of pages of electronic records. The reinsurers suspected MIL of trying to bury them in documentation and refused to accept that the typical paper-based claims register used in general insurance was impractical for health insurance.
- Even the fact that all claims were reconciled down to the actual payment record did not satisfy the ZEP Re representative, who eventually avoided MIL’s enquiries and suggestions of involving third parties in an attempt to resolve outstanding (largely undisclosed) issues.
- The long tail of health insurance claims caused many problems with regard to policy year and underwriting year⁷⁰.
- It was common practice throughout East Africa for policies to offer unlimited outpatient benefits, and these benefits had been included in the “follow the fortunes” arrangement without any of the reinsurers raising a concern. Nonetheless, this later became a contentious issue with the reinsurers.
- Due to the lack of healthcare infrastructure in Western Uganda, Hima Cement agreed to provide the physical infrastructure for the establishment of an on-site clinic to provide outpatient treatment for staff members and their families. MHL agreed to manage the clinic, and the cost of treatment was insured by MIL. This arrangement was discussed and cleared with the ZEP Re, ZEP Re had then accepted reinsurance premiums on this scheme, and it had

⁶⁹ The cover note failed to provide details of the requirements for records such as the premium register and the claims register. In MIL’s case these records were kept in an electronic format. The reinsurers subsequently insisted that a traditional book-based record should have been kept. In the early part of the quota share (QS) treaty claims were reflected on an accrual basis rather than a paid basis, which was never contested by the lead reinsurer until the second half of 2008. When MIL rectified this with a reconciliation of all policies from the inception of the QS treaty ZEP Re refused to accept the adjustments this required.

⁷⁰ Healthcare claims have a long tail, which means that treatment may have been received by a policyholder on November 25 of a policy year that started on December 1 of the previous year and fell in underwriting year one. This claim would most likely only be submitted to the insurer by end of January of the flowing year and be paid in March. Assuming that underwriting years on the reinsurance treaty starts on January 1 this results in a situation where the claim on a policy in underwriting year one may only be paid (and become a reinsurance claim) after the start of underwriting year three – even though it remains a claim against the reinsurance treaty of year one.

the lowest claims ratio (49 per cent) of all MIL's schemes. Nonetheless, claims on this scheme were refused due to the possibility of internal manipulation between MHL and MIL.

During the course of the interactions between MIL and representatives of ZEP Re and Africa Re it seemed that they did not have the same depth of understanding of health insurance as they had of property insurance – leading to misconceptions that caused them to challenge normal healthcare claims⁷¹. The reinsurers' unfamiliarity with health insurance resulted in an unhelpful approach to issues which should have been easy to resolve, such as whether the claims register was in electronic format or paper-based.

Quota share treaties require very detailed regular bordereaux, which are an administrative burden on both the insurer and the reinsurer. The challenge for health insurers is to control the ongoing burden of small outpatient claims, which are a bigger threat to their survival than the risk of the occasional hospital admission. This lends itself to an excess-of-loss reinsurance cover. Therefore MIL may not have been correctly guided to selecting a quota share arrangement.

Lessons:

- As a pioneer of health insurance in Uganda, MIL found itself in a situation where the mandatory reinsurers did not have sufficient experience in dealing with health microinsurance claims. However, had MIL followed through with its brokers to obtain a comprehensive reinsurance policy contract, many subsequent problems may have been avoided.
- The mandatory cession of reinsurance to established regional reinsurers removes market competition, and its continued application must be questioned. The mandatory cession regime removes any incentive for these reinsurers to develop new thinking and procedures, particularly with a view to low-cost mass market insurance.
- Creating templates for micro health reinsurance contracts and bordereaux could provide clarity up front and avoid the misunderstandings which plagued MIL.

⁷¹ See comments in footnote 74

12. > DISPUTE RESOLUTION

The Insurance Act contained no provisions for dispute resolution. The Uganda court system is slow, unreliable, and costly. Cases often get moved from one court jurisdiction to another on a whim, files get lost, and when plaintiffs fail to make an appearance the case is simply postponed.

Whereas the winding-up petition should have been dealt with on an urgent basis and resolved within a few days, it was allowed to drag on for nine months. In an industry that is based on trust, such a long delay in resolving a vicarious action that caused immense reputational damage turned a simple billing dispute into something fatal. This situation is not conducive for making long-term investments in health microinsurance.

The same applies to cases where policyholders get into a dispute with an insurer (or vice versa), or a dispute between an insurer and its reinsurers, or even a material disagreement between an insurer and the regulator⁷². These are issues that require speedy action and resolution to avoid a crisis of confidence in an insurer or indeed in the industry as a whole.

The MIL dispute with ZEP Re and Africa Re is a compelling example that demonstrates the difficulty in resolving disputes within a relationship between contracting parties with unequal power. The rules surrounding the reinsurers were established at a pan-African political level.⁷³ The reinsurers do not have an office in Uganda, and it is unclear which forum can be approached to resolve disputes with them.

Lessons:

- The introduction of a compulsory alternative dispute resolution mechanism may speed up the resolution of disputes. It could also allow the process of dispute resolution to take place without attracting media attention so that the process itself does not cause reputational damage to the insurer or the industry.
- Investors require a stable and secure environment before they will invest in the growth potential of the insurance industry and such investment is critical for achieving increased access to insurance by un-served communities.

⁷² The introduction of an Insurance Appeals Tribunal by the Amendment Act in 2011 to adjudicate disputes between with regulator provides recognition for the need that existed for more effective dispute resolution. Such a Tribunal could have resolved the interpretations in respect of solvency and created an opportunity for MIL to complete its process of recapitalisation.

⁷³ This therefore raises some questions that may need to be answered with a view to establishing a more customer-focused reinsurance regime:

Having had many years to become established players in the reinsurance market in Africa, does it still make sense for a compulsory reinsurance regime or should the market be opened to competition?

To maintain trust in the insurance instrument it is critical that disputes should be resolved quickly. This is something that has been shown internationally to be achieved much more effectively through out-of-court dispute resolution procedures.

13. > CONCLUSION

MIL provided low-cost insurance products to a previously un-served market. MHL provided the capabilities to manage all the medical disciplines and touch points related to health insurance – including claims management, managed care services, and management of the medical provider network. At the time, Uganda had just emerged from a long period of turbulence and healthcare infrastructure was inadequate. Pre-paid healthcare offered an opportunity to accumulate and channel resources so that poor people would get cashless access to healthcare services and service providers would benefit from more regular and dependable cash flows.

The economic benefits of a strong insurance market, through its effect on financial sector efficiency and depth, are identified within a study by Webb, Skipper, and Grace (2002). Using 16 years of data from 55 countries, this study finds that when higher levels of banking and insurance activity coexist, countries are more likely to have higher levels of economic growth. The finding is particularly noteworthy in that it shows that higher economic growth cannot be explained as well by the individual development of banking or insurance markets as it can by the joint development of these markets (Webb, Grace and Skipper, 2002).

MIL's success in growing gross premiums and penetration of previously un-served low-income groups could not be maintained as a result of a combination of factors with which it was unable to cope. This prevented the success with sales being translated into a sustainably profitable business in the long run. MIL's shareholders maintain that it was the target of service providers who thought that MIL was deriving a disproportionate share of the healthcare spending. However, MIL also left itself open to failure through weak financial management systems and shortcomings in its internal controls and reporting.

While it was in operation, Microcare in its various structures employed more than 100 people who were able to improve the lives of their families and added value to the communities in which they lived through outreach programmes, health education, and other activities. Over the course of 2007, until the withdrawal of its license, provider facilities in Uganda had benefited from MIL's purchasing activities to a total amount of approximately US\$ 10.9 million. Many of them used this revenue to expand their healthcare facilities and to improve the quality of healthcare. Some of these facilities were in the least developed areas of Uganda where doctor patient ratios had been 1:100,000.

According to the renamed Uganda Insurance Regulatory Authority's (IRA) 2011 Annual Report there were 32,726⁷⁴ people covered for health insurance by four insurers, none of whom provided only health insurance. Financial data for health insurance was still being reported under "miscellaneous accident", which also includes product liability, fidelity guarantee, livestock cover, cash in transit, professional indemnity, goods in transit, and business interruption. It is therefore impossible to determine the premium income or underwriting results in respect of health insurance alone. However, the miscellaneous accident grouping as a whole made an underwriting loss.

No institution has so far ventured back into the low-income sector, causing the IRA to remark in respect of health insurance that, "Currently, there are outpatient, hospitalisation and comprehensive policies. However there is a need for a more targeted benefit for the poor. Such models could provide defined lists of treatments. What is clear is that the majority of Ugandans need affordable products."

⁷⁴ Less than half of the number of lives covered by MIL in 2008 and less than MIL's low-income community business alone.

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ANNEX A: MICROCARE TIMELINE OF KEY EVENTS

May 2000	Microcare Limited established as non-profit company
Mar 2004	Microinsurance pre-feasibility study completed by Microinsurance Centre
May 2004	Microcare Health Limited (MHL) established as a for-profit HMO
Jul 2004	Aon's corporate TPA clients transferred to MHL
Dec 2004	Microcare Insurance Limited (MIL) established with Aon Uganda as technical advisors
May 2005	Microcare Insurance Limited (MIL) started trading
Jul 2006	Buyout of other shareholders by Gerry Noble and friends, and termination of partnership with AON
Jun 2008	Appraisal report and valuation of insurance management systems
Aug 2008	MoD advised all those who tendered that Microcare scored highest on the evaluation UIC challenged MIL's 2007 audited and published accounts and insisted on appointing its own specified auditors to review MIL's business at MIL's expense. MIL requested an independent review as per Regulation 32 of the Insurance Regulations
Oct 2008	UPDF invited MIL to negotiate final terms for providing cover for soldiers and families MIL submitted application for renewal of insurance license
Dec 2008	Quindiem Consulting Actuarial evaluation of claims history and trajectory for adjustment of business/premiums Observer article - "Private hospitals in financial mess" blaming Microcare for financial problems of service providers MIL Press release to contest Observer article
Jan 2009	Sejjaka, Kaawase & Co appointed by UIC to inspect MIL's business and review MIL financials for 2007 and 2008
Feb 2009	Letter of intent from interested investors Due diligence by investors and meetings with Uganda Investment Authority and UIC UIC rejected MIL's valuation of healthcare and claims management software system and challenged MIL's solvency MIL again requested independent inspection per Regulation 32 of the Insurance Regulations 2002 but UIC refused UIC Press release - Microcare not listed as licensed insurer
Mar 2009	Court granted order for MIL to continue business pending a judicial review MIL Press release - Continuing to trade legally A group of medical service providers launched a court application for winding up Microcare New Vision article - Microcare in financial crisis Application for winding-up order stayed pending a formal court hearing
Apr 2009	UIC placed half page advert in New Vision stating that Microcare was insolvent MIL appealed to Minister of Finance to allow independent inspection as per Regulation 32 New Vision article - Microcare appeals to government MIL letter to UIA explaining issues and asking support (following on from a meeting with management committee) Observer article - Competitors plot to wind up Microcare Observer article - Dishonesty is killing medical insurance
May 2009	Observer article - Medical insurance regulator colludes to kill Microcare Observer Editorial - The insurance sector needs closer attention
July 2009	On site inspection of claims by ZEP Re and Africa Re but no report provided and no follow-up
Sep 2009	Court ruling in favour of MIL by rejecting the winding-up petition and ordering claimants to pay legal costs of all parties
Oct 2009	Court ruling in favour of UIC that MIL did not follow correct procedure to obtain Reg 32 inspection UIC instructed MIL to stop trading Takeover by International Medical Group (which owns the Kampala International Hospital)

ANNEX B: BENEFITS

BENEFITS COVERED BY CORPORATE PLANS

Inpatient benefits

Inpatient overall annual benefit limits – US\$ 6,250, US\$ 3,125, and US\$ 625 per policy

Bed limits – US\$ 46.88, US\$ 31.25, and US\$ 12.50 per night

Surgery including physician's, surgeon's, consultant's, and anaesthetist's fees, and cost of prescribed medicines and dressings

Maternity benefits

X-rays, ECGs, CT scans, pathology, diagnostic tests, and procedures

Diagnostic consultations, specialist's and pathologist's fees

Chronic conditions (ulcers, diabetes, sickle cells, hypertension, asthma, etc) including drugs/medicine for one week

Radiotherapy and chemotherapy

Physiotherapy up to a limit of US\$ 125 per year

Excluded under Corporate Basic: Radiotherapy, chemotherapy and physiotherapy

Outpatient benefits

Outpatient benefit limits - Unlimited

Physician's, surgeon's, consultant's, and anaesthetist's fees

Cost of prescribed medicines and dressings

X-rays, ECGs, CT Scans, pathology, diagnostic tests, and procedures

Outpatient surgery

Emergency road ambulance within Uganda

Dental benefits: Benefit limits – US\$ 62.50, US\$ 62.50 and US\$ 31.25 per policy

Dental benefits: Annual check-ups, X-Rays, ordinary extractions, and fillings only – consultation, treatment, and anaesthetist's and operating theatre fees

Optical benefits: Optical consultations only

Enhanced benefits cover included chronic illnesses, pre-existing conditions and HIV/AIDS treatment as an optional extra

BENEFITS COVERED BY BOTH COMMUNITY PLANS

Inpatient benefits

In hospital overall annual benefit limits – US\$ 1,875 and US\$ 1,250 per family

Bed limits – US\$ 15.63 and US\$ 9.38 per night

Surgery including physician's, surgeon's, consultant's, and anaesthetist's fees, and cost of prescribed medicines and dressings

Maternity benefits

X-rays, ECGs, CT scans, pathology, diagnostic tests, and procedures

Diagnostic consultations, specialist's and pathologist's fees

Chronic conditions (ulcers, diabetes, sickle cells, hypertension, asthma, etc) including drugs/medicine for one week.

Excluded: Radiotherapy, chemotherapy and physiotherapy

Outpatient benefits

Outpatient benefit limits - Unlimited

Physician's, surgeon's, consultant's, and anaesthetist's fees

Cost of prescribed medicines and dressings

X-rays, ECGs, CT Scans, pathology, diagnostic tests, and procedures

Outpatient surgery

Hypertension up to US\$ 62.50 per family

Dental benefits: Benefit limit – US\$ 31.25 per person

Dental benefits: Extractions and fillings only – consultation, treatment, and anaesthetist's and operating theatre fees

Optical benefits: Optical consultations only

Basic Plus covered emergency road ambulance evacuation within Uganda up to a maximum of US\$ 46.88 per event.

ANNEX C: NEWSPAPER ARTICLE

Article in the Observer Newspaper under the heading "Insurance sector hit by influence peddling charges"

An anonymous letter addressed to the Minister of Finance accusing two board members of the Uganda Insurance Commission (UIC) of influence peddling and conflict of interest has thrown the entire industry in a state of panic.

So damaging are the issues raised against the Commission that an emergency executive meeting of the Uganda Insurance Association (UIA), the industry's umbrella organization, was hastily convened on September 5, 2008 to discuss the allegations that were feared would tear apart the industry. Association chairman Solomon Rubondo convened the meeting.

In calling for the emergency meeting, Rubondo said that as chairman, he was deeply concerned about the allegations "that painted an undignified picture of the commission" at the time when the search for the Chief Executive Officer of the commission was on and the licensing for the year 2009 is around the corner.

"The timing is crucial given the on-going search for a CEO, 2009 licensing around the corner, among other activities; which phase dictates that the commission as a regulatory body has an impeccable image and our representatives on the board enjoy our trust," Rubondo said in a circular to chief executives of all insurance companies after the meeting.

The anonymous letter, copied to the IGG, accuses Deepak Panday, the Chief Executive Officer at Jubilee Insurance and Irene Kego Oloya, of Padre Pio Insurance, of using their positions at the Commission to violate industry rules to benefit their companies. The two are representatives of the UIA on the UIC board. It also accuses the Commission in general of incompetence and flouting procedures of good corporate governance.

The letter, which went around through e-mail purportedly sent by one Brian Leach and dated September 1, originated from people who simply signed as "Concerned Members of the Insurance Fraternity." It pokes at Deepak Panday, alleging that he uses his position at the Commission to access confidential information on competitors such as their books of accounts. This, his accusers say, is against the rules.

"He is using his influence on the Insurance commission's Board to ensure Jubilee Insurance Company replaces ICEA (Insurance Company of East Africa) as the medical service provider for the Commission. He tendered in his bid long after the contracts committee had closed the tendering process."

Panday dismissed all the accusations against him and referred this reporter to Evelyn Nkalubo-Muwemba, the Commissioner of Insurance at the Uganda Insurance Commission. She, in turn, declined to discuss the matter in detail. She simply dismissed the accusations, saying these are "disgruntled people peddling lies."

The same letter takes a swipe at Irene Kego, alleging that her Padre-pio Insurance has failed to meet capital requirements for the second year running.

"When it was discovered that that she lacks the necessary capital, senior management at the Uganda Insurance Commission used a new method of assessing capital which greatly reduced her capital deficiency. Normally they would have closed the brokerage firm," the letter said.

Our sources at both the UIC and UIA say the letter indeed originated from a number of insurance companies that are not happy with "the way certain issues were managed in the insurance industry."

According to these sources, the UIA was particularly aware of "some of the concerns" raised in the anonymous letter and that explains why the association chairman hastily called an emergency executive committee meeting on September 5, 2008 to discuss the matter.

In the meeting, the officials concluded that the allegations in the letter were baseless.

"The Emergency Executive Committee sitting discussed the matter and unanimously resolved that the accusations were baseless," Rubondo's circular states.

There is little doubt however that the timing of its circulation has sent jitters within the insurance industry that is still trying to heal from the fight for the control of the multi-million dollar Common Market for Eastern and Southern Africa (COMESA) motor third party insurance scheme between the UIA and the National Insurance Corporation.

That standoff has already brewed insults and accusations between the warring parties. Further disgruntlement among the officials is expected to dampen confidence in the industry.

Then again, the insurance industry is one of the weakest financial institutions in the country and anything that taints the image of its management is expected to grab attention both from within and outside.

Ugandans continue to portray strong feelings of skepticism towards the insurance industry due to, among other things, delays in accessing their compensations in the event of calamity.

Such reports can only undermine public confidence in the industry.

Rubondo told The Weekly Observer that the matter cannot be pursued since there has not been any complaints to the association. Both the Ministry of Finance and the IGG's office are yet to react to the letter.

Source:

http://www.observer.ug/index.php?option=com_content&view=article&id=1131%3Ainsurance-sector-hit-by-influence-peddling-charges&Itemid=96

ANNEX D: THOUGHTS ON HEALTH MICROINSURANCE CAPITAL ADEQUACY (USING MIL AS AN EXAMPLE)

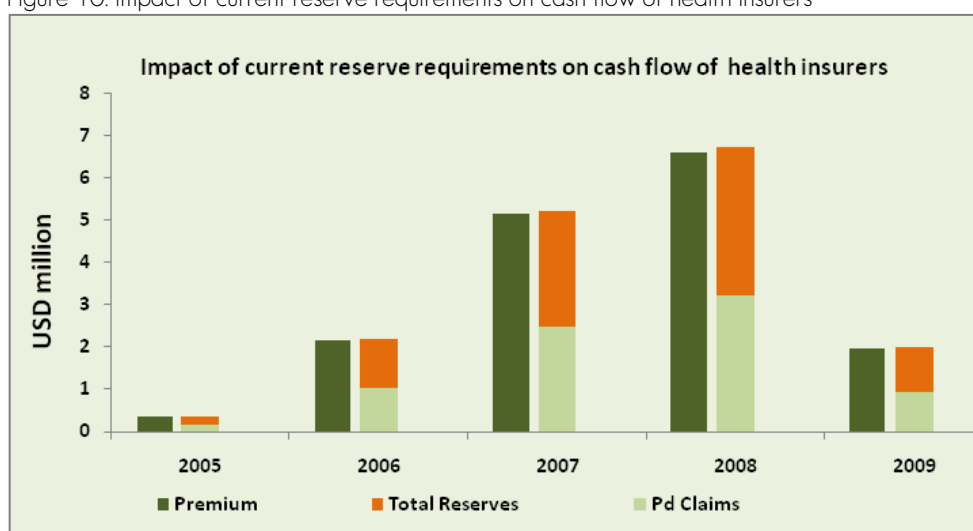
Box 2: Uganda Insurance Act Section 4/ (2)

Section 47 (2) of the Uganda Insurance Act determines that the insurer should maintain the following reserves:

- (a) Reserves for unexpected risks amounting to not less than 40 per cent of the total net premiums or such other amounts as the commissioner may decide;
- (b) Reserves for outstanding claims, a sum equal to the total estimated amount of all outstanding reported claims together with an additional amount of not less than 15 per cent of the total amount of outstanding reported claims, in respect of claims incurred but not reported at the end of the last preceding year; and
- (c) a contingency reserve, which shall not be less than 2 per cent of the gross premium income or 15 per cent of the net profits, whichever is the greater, or such other amounts as the commission may decide; and that reserve shall accumulate until it reaches the minimum paid-up capital or 50 per cent of the net premiums, whichever is the greater."

This approach causes pressure on cash flows which are required for claim payments. The effect is illustrated in Figure 10, which shows MIL premiums over the period, together with paid claims plus reserves. It assumes a claims ratio of 65 per cent and that all claims are reported but 30 per cent are outstanding and that no risk is transferred to reinsurance. As illustrated in the figure, this leaves insufficient cash flow to fully cover claims and nothing for management expenses.

Figure 10: Impact of current reserve requirements on cash flow of health insurers



Outpatient claims (OP)

Unlike property insurance, health insurance generates high volumes of ongoing small claims. In MIL's case the average claim cost for outpatient treatment never exceeded US\$ 15!

Claims also do not arise in line with the vesting of premiums. The full value of the benefit limit on a policy may be used in the first month of the cover term. For this reason all MIL policies contained a clause which limited premium refunds to cancellations within the first 6 months of the term, provided that no claims had been submitted. Where a premium refund became due Short Period Rates⁷⁵ were applied in order to recover initial costs incurred. This meant that premiums vested much more quickly and the assumption in the Act that unexpired risks (or risk in respect of "unearned premiums" or UPR) would on average be 40 per cent of premiums is incorrect, with serious implications for health insurer cash flows which are needed for claim payments.

Table 8 illustrates the cash flow difference created by the ongoing volume of small claims for outpatient insurance compared to one large claim that occurs in property insurance. This illustration only takes account of the impact of the way in which the UPR

⁷⁵ Applies a penalty on the refund of unearned premiums to account for administration and other costs incurred.

must be determined and ignores the other reserves which have to be provided in addition to this. It also assumes an even spread of claims with a slight increase during the wet seasons.

It is easy to see that a spike in claims cost at any time can easily cause cash flow to become negative. This demonstrates that sound cash flow may be more critical for health insurers than reserves based on premiums.

Table 8: Cash flow comparison between property and outpatient insurance

Portfolio life cycle (inception at 1 st July for all)		Property	Outpatient
Sum insured (SI)		20,000	2,000
Annual premium		400	80
# policies		50	250
Exposure (SI x # policies)		1,000,000	500,000
Total gross premium		20,000	20,000
Less management expenses		2,000	3,000
Risk premium		18,000	17,000
Pd claims	Jul	0	1,000
	Aug	0	1,000
	Sep*	0	1,500
	Oct*	0	1,500
	Nov*	0	1,500
	Dec	0	1,000
Total paid claims 1st period		0	7,500
Risk premium less paid claims		18,000	9,500
UPR @ 40% of gross premium		8,000	8,000
Cash balance end of 1 st period		10,000	1,500
Plus UPR b/f beginning 2 nd period		8,000	8,000
Cash available to pay claims		18,000	9,500
Pd claims	Jan	0	833
	Feb	10,000	833
	Mar*	0	1,333
	Apr*	0	1,333
	May*	0	1,333
	Jun	0	833
Total paid claims 2nd period		10,000	6,500
Cash surplus/-shortfall (before other statutory reserves)		8,000	3,000
Total claims		10,000	14,000
Loss ratio		50%	70%

Inpatient claims (IP)

The concern that IP admissions may threaten the survival of a health insurer in Uganda (or any other low-income segment of an emerging economy) is also misplaced. During 2008, when MIL experienced its worst claims ratios, the rate of hospitalisations was 11 per cent⁷⁶ (admissions/lives insured) and the average IP claim was US\$ 284. The highest IP claim was US\$ 1,449 and

⁷⁶ Under normal conditions an admission rate of 3 per cent is more likely.

there were only two claims above US\$ 1,000. The highest maximum IP benefit limit was US\$ 6,000 and very few of MIL's policyholders were in this higher benefit category. This experience was not unusual.

Studies in India have shown that OP benefits can sometimes generate up to 50 times more claims than IP benefits⁷⁷. A comparison of IP and OP claims for a low-income family in India also determined that over a period of 10 years their OP expenditure would average US\$ 22 per year with one IP incident of US\$ 100 every 9 years.⁷⁸

Conclusion

Volatility in claims experience can only be stabilised by achieving scale, but to achieve scale requires more capital, which cannot be funded from premiums. Health insurers without very deep pockets will therefore forever be prevented from reaching the scale required to stabilise claims experience and therefore from achieving sustainability. Through an insistence on maintaining reserves, which are arguably unnecessary and which compromise the cash flow needed to pay claims, the current approach to health insurer reserves may be counterproductive.

It may therefore be time for stakeholders in health insurance, together with regulators, to review the way in which sustainable capital adequacy for health insurance should be established.

⁷⁷ Pott, J.; Holtz, J. 2013. Value-Added Services in Health Microinsurance, Microinsurance Paper No. 19 (Geneva, International Labour Office)

⁷⁸ IBID

MICROINSURANCE INNOVATION FACILITY

Housed at the International Labour Organization's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with generous support from the [Bill & Melinda Gates Foundation](#) to learn and promote how to extend better insurance to the working poor. Additional funding has gratefully been received from [several donors](#), including the [Z Zurich Foundation](#) and [AusAID](#). See more at: www.ilo.org/microinsurance

