"Developing partnerships to insure the world's poor"

Community Health Plan
("CHeaP" - Kisumu, Kenya)

Notes from a visit 1st and 2nd July 2002

(Research conducted for ***MicroSave***)

Michael J. McCord
Senior Technical Advisor, ***MicroSave***
Director, The MicroInsurance Centre

Sylvia Osinde
Consultant

9 December 2002
Version 2.1

INTRODUCTION AND BACKGROUND

The Community Health Plan (CHeaP) is a project of the microfinance organisation CENT[1]. Based in Kisumu, Kenya, their focus is providing financial (and other) services to the rural communities in Nyanza Province. CENT in turn is a project of the "Comprehensive Course on Franciscan Mission Charism" (CCFMC), a mission of Catholic nuns. The CCFMC runs a multi-product development initiative that includes several projects, among them:

- an orphans health project (sponsoring forty families with Kshs 10,000 (US$ 125[2]) per year per family)
- HIV prevention and behavioural change
- a system of Community Banks (as part of the CENT network)
- Training programs (in sewing and other practical skills) for orphaned girls
- Nutrition programs
- A neem tree project
- The construction of boreholes to provide clean water
- Income generating projects
- Provision of subsidised bed nets
- Community based health care services
- The newly introduced health care financing project

CENT commenced operations in 1999 and uses a mutual community banking methodology (where members "own" and manage the community bank with technical assistance from CENT) in the provision of its financial services. By June 2002, CENT was working with forty-five community banks (CBs), and a total of 3,174 members. CB members have access to savings and credit services offered by the CB.

With a rural focus, most CBs are located in areas with very low-income levels, and a high rate of disease. There is a particularly high incidence of malaria and typhoid among people in the Nyanza Province in general, where both are endemic. Rates of malnutrition are high as are those for child mortality. Additionally, there is said to be a very high rate of HIV/AIDS in the region, with a local physician noting that about 40% of the local sexually active population are infected with the virus[3]. This prevalence of AIDS leaves a dramatic population of orphans with few means of support or adequate care.

As a result of this environment, CENT has felt pressured to introduce a health insurance product to help people cope with the many health issues in their lives. This led to the development of the Community Health Plan (CHeaP). The project is still in its very early stages. Though they are selling policies, covered members are still in the waiting period before gaining access to care, and many of the basic systems that we had come to expect were not in place.[4]

CHeaP is using a savings-based mechanism for premium collections, and some CENT clients are already making payments to the scheme while others are saving for the premiums. CHeaP reported a very enthusiastic response from its clients – leading to expectations of 100% uptake by existing CB members. This will take some time to generate since the initial offering is fraught with inefficiencies and disorganisation (as will be discussed below). Stated demand is

[1] CENT, the name of their microfinance operation, simply refers to their motto 'Save a cent a day.' Initially their objective was to encourage poor people to save through putting aside at least a cent a day (one Kenyan shilling is referred to as a "cent"). According to management, they had conducted research and found out that a cent was the minimum that even the poorest family could put aside daily.

[2] At the time of the visit, the exchange rate was Kshs80 to US$1.

[3] DFID reports, at http://www.dfid.gov.uk/AboutDFID/files/hpd/pdf/hpd_kenyastory.pdf that this rate is 20-30% of the sexually active. Likely contributors to the AIDS prevalence include the practice of wife inheritance, and the location of Kisumu, Nyanza's main urban centre as a resting point for vehicles transporting goods to the central African interior.

[4] We arrived at CHeaP with the understanding that they had provided significant health care financing operations for more than three years and had more than three thousand families covered. Even though advance clarification of these numbers reported for the health program were sought and confirmed, it turned out that these were numbers for the CENT finance program. However, there appear to be important lessons to learn from the development of this product. These will be presented in this paper.

excessively high because clients perceive dramatic savings through membership in this program. However, the structures (controls, pricing, and procedures) are such that in its current state this program will be unable to provide care for more than a few months.

THE COMMUNITY HEALTH PLAN PRODUCT:

The health care plan was developed in response to the very serious health and economic conditions in Nyanza Province, by the local Catholic Mission, with a very strong mission to serve the community. The mission of CHeaP is "To provide [an] affordable health care insurance program to [the] majority of people earning less than a dollar per day." The mission is entirely social, and the product was developed completely with the objective of satisfying local needs without looking at the need for institution building to manage and maintain the product. In fact, CCFMC management themselves point out that their staff have no knowledge of insurance or its requirements. It was with this background that the product has been developed. The key details of the product are noted below.

The Cheap Community Health Plan product details:

PRODUCT	
Eligibility Criteria	▪ A potential CHeaP member must be a Community Bank member (not necessarily a borrower since this coverage is not tied to loans). CB membership requires membership in a sub-group of 10-20 members, and an equity payment of Kshs 300 (US$3.75). CB membership opens eligibility to all CENT programs including savings, credit, and insurance. ▪ There is no requirement that a certain percentage of the group must join. ▪ Members are free to choose whom if any in the family may be insured. ▪ There are no eligibility issues related to current or historical health conditions.
Coverage	▪ Out-patient cover only (including consultation, diagnostic tests, and medications)[5]
Duration of Cover	▪ Open ended for as long as primary insured continues to be a member of the CB, and continues to make the required premiums. After one month of non-payment the covered family is technically terminated, however there was no mechanism in place to control utilisation at the hospitals. ▪ Though members can choose their payment frequency, all payments must be paid by the end of the month before coverage. However, given current systems, this is unlikely to be enforceable.
Exclusions	▪ In-patient care is excluded ▪ Chronic treatment of HIV/AIDS is excluded, although acute care requiring outpatient services is covered. ▪ Any care before the end of the three-month waiting period after the first payment.
Limitations	▪ Kshs 5,000 (US$ 62.50) annual limit per insured. (Though all systems are manual and it will be very difficult to determine in a timely manner when the limit had been reached.) ▪ Member must have made insurance payments covering at least three months before access.
Mode of Delivery	▪ Premium collection is through the CB where the premiums are

[5] In discussions with Community Bank clients, there was an understanding that the program actually does provide for inpatient care. Further discussions with CHeaP management confirmed the in-patient exclusion.

	collected by the CB manager and held aside for collection when they are visited by CHeaP or CENT staff. ▪ Outpatient services are provided through ten catholic mission hospitals spread throughout the district.
PRICING	
Premium	▪ Kshs 1 (US$0.0125) per day per insured member of a household. Kshs 360 per person per year (US$4.50). "Save a cent and it makes sense" is the marketing tag line.
Method of payment	▪ Members may choose the frequency of their premium payments as long as each month's payments are completed before the end of the month before care is to be provided. ▪ Payment is made to the CB cashier, and held by the CB manager
Other	▪ Members must provide photos of each family member for the identification cards. ▪ Identification cards for each insured are provided at no charge by CHeaP. The Kshs 70 (US$0.90) cost for each individual member's card is to be borne by CHeaP. ▪ No co-payments are charged. Insured are free to use the outpatient services at will. ▪ There are no deductibles
PLACE	
	▪ Ten Catholic mission hospitals spread throughout the market area, in or near most market centres. ▪ The peri-urban CCFMC hospital visited was clean, and had short lines for outpatient care.
PROCESS	
Enrolment/Renewal	▪ Client group pay Kshs 300 (US$ 3.75) to join the CB ▪ Individual group members then pay Kshs 300 to join CB. This provides the individuals within the group with access to savings, credit, insurance, and other planned services. ▪ Each individual member choosing insurance must make at least three months of premium payments during an initial waiting period (implemented as a control against adverse selection) before access to care starts. ▪ Members are required to complete a detailed application form (that was substantially copied from one of the national health management organisations) ▪ CHeaP receives photographs of each family member covered and ID cards are prepared for each family member ▪ ID cards of family members remain valid for as long as the principal policy holder continues to make premium payments
Receipt of Treatment (details of the process are provided in Appendix 3)	▪ Members may obtain care at any of the ten hospitals in the CHeaP network. ▪ Patient presents ID card to nurse at hospital registration desk and receives a treatment form, completes basic details. Membership is confirmed solely by the presentation of the scheme ID card. ▪ Patient carries the treatment form to the consulting physician who indicates the diagnosis, recommended course of treatment, and requirements of tests or medications on the treatment form (Patient carries around treatment form to each stop within hospital) ▪ Patient takes the form to the lab, then back to the doctor, and finally to the pharmacy where drugs are dispensed.

	▪ Pharmacist retains the form (if it is the last stop), and sends it to cashier. ▪ The patient returns home without any expenditure other than transport. ▪ In case of admission, fees are to be paid directly by the insured and are non-reimbursable.
PHYSICAL EVIDENCE	
	▪ Detailed application form (in draft) ▪ Photo ID card for each person covered (in draft) ▪ Treatment form (in draft)
PEOPLE	
	▪ The manager of their CB who handles local marketing, premium collection, and questions ▪ The field officer who works with the CB manager, and may train the members on the insurance product during marketing efforts. ▪ The hospital nurses and doctors who appear professional and provide clinical treatments
PROMOTION	
	▪ Word of mouth by CB Manager to members ▪ Presentations by field officers during the promotion of the whole CENT program and its benefits. ▪ Information on the insurance scheme included with CENT brochures ▪ Tagline: "Save a cent, and it makes sense."

Prevention:
CHeaP and CENT are a part of the CCFMC (Comprehensive Course on Franciscan Mission Charism) group of projects in Kisumu district. Other projects of the CCFMC include an HIV prevention and behaviour change project, and a community based health care project. These projects' activities include education on community-based healthcare for people with AIDS within the community, and on general hygiene.

Nyanza province, which encompasses Kisumu District, is said to have a very high HIV/AIDS prevalence rate. This clearly creates a strong risk to the insurance project, but the efforts of the HIV P&BC, and the CBHC projects could assist in mitigating some of the insurance losses, at least over time. However, at present, there is no linkage between these projects and the insurance project.

Physicians, and CHeaP's own research, note that malaria is by far the most diagnosed illness in the region. This will likely also be a prominent cost driver for the CHeaP insurance product. CCFMC also runs a bed net project that could help reduce experience levels of the insurance product if the nets were distributed to, and properly used by, insured members.

Management noted that there would be an effort to coordinate these projects in the future.

INSTITUTIONAL STRUCTURE:
Currently, CHeaP is managed as a financial product of CENT, which has its own Board of Directors, and an accountant. The project manager for CENT also manages the CHeaP project and reports to the Director of the CCFMC. Most of the activity of CHeaP is conducted directly through the staff of CENT and the management of the CBs. Cent's five field officers market and oversee all the community banks and their products (savings, credit, and insurance). These field officers report to the CHeaP/CENT project manager.

Management is beginning to recognize however that CHeaP is much more complex than their basic savings and credit products, and thus they have plans to put in place a separate institutional structure for CHeaP. At that point, CHeaP would cease to be simply a CB product, and would become a program with its own marketing and support staff.

Ultimately the Director of the CCFMC makes the key decisions. This is appropriate because this is where the risk lies. If the project performs poorly, it is the CCFMC that will need to identify funding to cover the shortfalls. At one point, the director was asked why she thought so many people would immediately join CHeaP. She responded without hesitating that people trust the CCFMC. Thus, not only does CCFMC risk funds, they risk their very credibility with this insurance program that the director notes they know very little about.

CCFMC embraces a very strong focus on providing assistance to the "poor" in their market. In response to this, almost all of CCFMC's projects are run as charities. In particular, CCFMC runs their orphan health project on a charity basis. Operations of this program are funded completely from donors under the understanding that the orphans would get no healthcare without this support, because they "would not be able to afford care themselves." This focus and approach is laudable, however, it is questionable if such an organisation should also introduce an insurance type product that requires strict adherence to policies, the generation of a surplus, maintenance of reserves, and specialised skill to identify and manage risks. With the same management for the charity program and the business-focused program, there are likely to be significant problems.

Health Scheme Operations:
Currently, the structure is such that scheme's operations are very closely integrated with those of the savings and credit operation. Marketing and premium collection for the product is done through the CBs. Health care is provided at the catholic mission hospitals. Members have the freedom to go to any one of ten approved service providers. CHeaP will rely on hospital staff for all procedures that relate to registration and control of service, as well as billing.

As earlier mentioned, the scheme is in its very initial stages. CB clients have the expectation that they will be able to begin to access healthcare at the beginning of September 2002. Through August 2002, only a very small fraction of the CB members have begun to make the required premium payments. This has primarily been a result of the lack of systems for receipting and tracking of these payments.

The program operates under very limited controls against adverse selection, moral hazard, fraud and over utilization. At the time of the visit, there were no formal plans to enhance any of these controls. However, subsequent to the visit, management decided to put the project on hold until they were better able to develop a product that would both aid the market and the minimise the risk to the institution.

The organisation has followed a very weak product development process. The concept came from observing the needs of the community and an institutional desire to help them. Some very basic demand side work was done to assess interest in the general provision of financial products, of which health care financing was one of several components. The product was designed with little knowledge of proper insurance procedures, and then was announced to the membership and rolled out. Among the issues that have resulted from this process:

Issue:	Result:
Training has been very limited	Clients have been left with a significantly distorted view of the product and its coverage.

Transactional documents are not available	Even after collecting premiums for almost three months before the visit, there was no application form available, and there are no receipts for people to confirm their payments
Hospitals have not been trained on processing patients with this new program	There are likely to be errors in claims procedures
No procedures or policies are documented	This exacerbates the confusion since people cannot get clarification on processes.
The projections had errors that dramatically altered the likely outcome of the program	The correction of one error in the calculation of likely claims changed a very favourable projection of net earnings into a dramatic loss. Many decisions were based in the projection of surplus generation that was erroneous.
No objectives were quantified	There would be no way to legitimately assess progress
Controls are very weak	An immediate total rollout will likely increases losses as management learns lessons over a broad market.
Pricing was conceptual rather than based on financial considerations	The price is so low that several potential clients reported that they would not buy the product because CHeaP could not possibly cover everyone at that price. Others noted that they know CHeaP will have to pay much more than their premium.
There is a weak structure of accountability	The premium funds may pass through several hands before a formal accounting increasing the risk of fraud.

A proper product development process may have assisted them in refining the product in such a way that many of these issues could have been addressed before the institution risked full rollout.

Accounting:
Accounting processes at CHeaP are completely manual and require both record keeping and initial safekeeping of premiums by the CB manager (a control risk). Claims from the hospitals will also be passed through the CB managers. Structures for confirming claims have not been developed and the expectation is to simply pay the invoices as they are received. There is no capacity to confirm clinical treatments, and there are no medication limits (except for the maximum per year claim value). Their accounting processes have not yet been fully tested but clearly show several important weaknesses in terms of controls and information management.

Aside from tracking cash flows and claims versus premiums, management did not seem to have a clear idea of what information to collect, or which key ratios to monitor. There is a need to significantly strengthen the management accounting function of the program and for management to have a better understanding of what information to track, and how it should be tracked.

The pricing exercise for CHeaP started with a survey of what their potential members earned on an average day, and what they could afford to pay for health care cover. From this they found that earnings averaged 80 Kshs (US$1) per day, and then determined that these households could afford to pay one Kenya schilling (US$ 0.0125) per day per person towards health care costs. This was deemed especially appropriate since it nicely led to what became their marketing

tag line: "Save a cent, and it makes sense." It was inferred that the ability to use this tag line actually drove the finalising of the price as one cent.

Marketing

Initially, the CENT manager marketed the product to CB management, their members, and potential members. This was done during regular management visits to the CBs. The marketing has now passed to the CB managers. Training of these managers was very limited, and tools for marketing and management of the product (brochures, posters, even receipts for the acceptance of premiums, and policy information) have not been provided. Procedures and policies documents are also lacking.

Marketing through the bank managers has the potential to reduce administrative costs for the program. However, it would have to be backed up with thorough training for the bank managers and the development of a clear and standardized marketing approach.

The community bank managers report that there has been a very enthusiastic response from their members. However, it is apparent from focus group discussions that this response is based on several key factors that members are considering in their decision-making process. These are:

1. The erroneous understanding that the insurance will cover in-patient care as well as outpatient.
2. That with a very large percentage of the adult population said to be HIV positive, coupled with a lack of HIV testing facilities in the region, each person is aware that they could very well be carrying the HIV virus and therefore stand to benefit well in excess of their contributions.
3. Recognising the high rates of illness in the region and the cost of health care, people have a very high likelihood of using far more in benefits than the cost of the premium.

At this point, the interest is therefore based on misunderstanding the product, and poor pricing. This is a very dangerous combination.

Marketing efforts seem to consist primarily of educating potential clients about the benefits of risk pooling. Communication about the product has been very vague since the product definition itself has been a bit fluid. The product, as currently marketed, has very limited controls. There are no limits to types of illnesses covered or drugs utilized, neither are there co payments. The management now realizes that this initial product cannot be sustainably delivered and plans to revisit the pricing and possibly the coverage as well. Future marketing efforts that communicate these changes are likely to result in added confusion, and a decline of interest in the product.

In most places, among the most important sources of health care financing are family and friends (whether through gifts or loans). In the Kisumu area, within a country that is known for its "harambe" spirit (collective funding for important events), this source has all but dried up. It was explained by several people (including the Director of CCFMC, and the physician at Saint Anne's Hospital) that the AIDS problem has reached such proportions that anyone who is sick at all, regardless of the cause, is assumed to suffer from AIDS. Because they see AIDS as incurable, they refuse to help fund any medical treatment for friends or relatives, arguing that the money will simply be wasted. Thus, in the region around Kisumu people are happy to contribute money for a funeral, but will not help pay for someone to get well. This leaves people dying in the villages because they cannot generate funds for treatment.[6] It also leaves the hospitals,

[6] We were also informed that it is prestigious for people to die in a hospital, rather than in the village, so families sometimes use their last funds to get someone into the hospital simply to die there.

especially outside the urban areas, operating far from capacity since so few people are able to afford to come for treatment.

Overall:
The program is newly operational and comparable financial information is not yet available. Management had not yet developed a structure for monitoring the progress of the scheme, beyond tracking the numbers of members. Management is currently looking at tracking claims versus premiums as well as cash flows. Systems for tracking these and other key performance indicators have not been put in place yet, and since it is a manual system, timely and accurate accumulation and reporting of transactions from distant CBs and providers will likely prove a significant challenge.

CHeaP had developed a set of projections that it used to make several key decisions. During the visit, it was found that there were calculation errors and problems with some of the assumptions. These were corrected and adjusted and a revised set of projections was produced. The revised set of projections retained the current premium to show how it would affect the projections based on more realistic projections. In addition, the rate of growth was retained until CHeaP adjusts the premium, the coverage, the cost structure, or some combination of each. Such adjustment will be necessary, and will result in adjusted growth projections.

Some projected ratios calculated during the visit based on the initial projections and then on the adjusted projections, include:

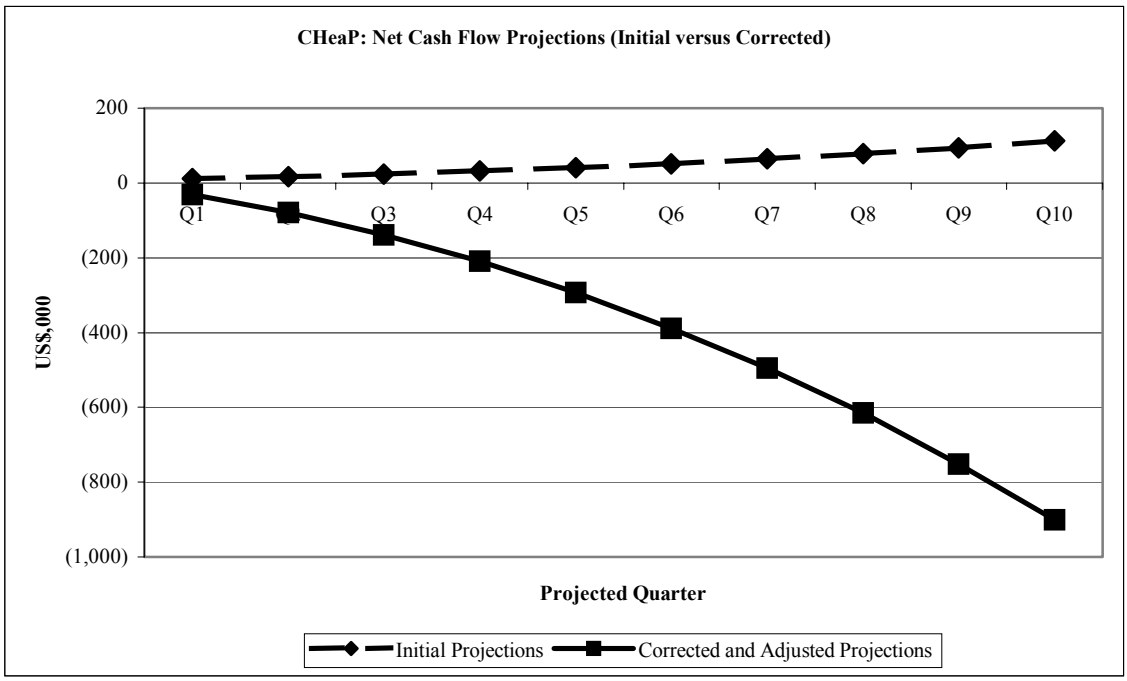
Indicator:	**Initial Projections** (for quarters 7-10):	**Adjusted Projections** (for quarters 7-10):
Admin to Premiums:	54%	42%
Claims to Premiums:	17%	280%
Total outflows to total inflows	27%	318%
Change in premiums written (year 1 to year 2):	+91%	+91%
Member utilisation:		
▪ Number of outpatient visits per person per year	0.6	4.2
▪ Average cost per outpatient visit (US$)	1.25	3.00
Reserves to claims (assumes no loss of reserves in Q1-10):	180%	13%

The most significant differences relate to the utilisation where the number of visits projected initially was clearly to low, and the cost, even based on negotiated fees, was too low.[7] Clearly given the present mix of product components and premiums, the premiums are too low (to cover this package of products and operations) by a factor of over three times. CHeaP noted that they would halt movement on the product until they re-evaluate their mix of premium, cover, and administration.

[7] CHeaP negotiated with the hospitals to obtain consultations for Kshs 30 (US$0.38) versus the regular charge of Kshs 100 (US$1.25), and they agreed to cap medication costs to Kshs 100 per visit versus a broad range of fees. Diagnostic charges were not negotiable.

Likelihood of Sustainability:

Although the program is still in its infancy it is clear to all that continuing with their rollout process with the product in its current state would lead to almost certain disaster for CCFMC. A graph of the net inflows/outflows projected for the program's first ten quarters and based on both initial and corrected/adjusted figures is provided below.



Clearly, the adjusted line shows that this is not a sustainable product given its current components.

CHeaP is faced with several risks/challenges whereby unless the control structure is significantly altered immediately, will compromise its ability to operate for more than a few months. Some of these challenges include:

- The likelihood that actual demand will be significantly less than what has been projected: There is a high theoretical demand for the product however this is based on a misunderstanding of the product components by the intended market.[8]
- Difficulty in avoiding adverse selection: In a population with a very high HIV/AIDS prevalence it will be difficult to avoid adverse selection without extensive controls which are not present in the current product.
- Pricing: Even discounting the risk of high claims due to HIV/AIDS, the product is priced so low that clients we spoke to saw this as a huge benefit to them where they state that their claims will easily exceed the premium amount. When asked how the rest of her bills will be paid, one insured client gleefully noted "it will have to be paid by CHeaP". As is appropriate, there was an attempt to price the product to match the community's income levels. This should be one component in a complicated mix that makes up a professionally derived price. However, CHeaP management did not have the skills or background to adequately assess the full range of components that are integral parts of the pricing formulation. Some of the other components include adequate reserves, realistic estimates of utilisation, operating costs, and others.

[8] Institutions are commonly optimistic about the demand for particular services, especially when they have not conducted adequate demand side research. As an example, in one community bank with 556 members we were told that all members wanted to join. From this CB only ten families had actually registered and paid. Part of the problem is certainly the lack of formal documents. However, it is also highly likely that effective demand is not in fact 100%.

- Lack of reserves: Although they must take responsibility for underwriting any losses, neither CENT nor CCMFC are in a position to do so. The only reserves for this program that the organisation holds are the three months of premium payments paid before the insured receive access to care. A family of five will pay a premium of Kshs450 (US$5.63) during the first three months. One case of typhoid in the family (which was noted as common in Kisumu) would cost Kshs330 (US$4.13).[9]

Pricing is not the only issue in this case. It is important when working with this market to balance the premium, with coverage, demand, operating efficiencies, and the need for reserves.

It is reasonably clear that CENT and CCMFC have developed a product concept, and skipped the other product development steps to move directly to rollout. Many of the problems that are evident would likely have been seen through prototype and pilot testing.

MANAGEMENT AND GOVERNANCE

CHeaP enjoys very strong strategic level support. The CCFMC Director is very enthusiastic about the product and strongly champions it. However, CHeaP, as a health care financing program, has an ownership and management structure that is likely to be difficult in balancing the objectives of the Sisters, and that requirements of an insurance product. Ownership is by the Catholic Church whose charity driven philosophy conflicts with some of the fundamental principles governing the operation of a successful insurance business. Both the CCFMC Director and other key management staff recognize the need for intervention to address health issues in the communities in which they operate. However, management lacks knowledge of, and experience with, insurance. CHeaP is therefore an urgent response to a demand without clear consideration of the implications of that response. Management lacks a clear understanding of the controls and procedures required to safeguard institutional viability.

The CCMFC Director noted that their most valuable asset is that people in the region trust them. The reputational risk to the organisation of this insurance product is significant and real. It was suggested during the visit that CHeaP stop all new client intakes, and reassess their ability to offer such a product. Management subsequently agreed, and is reassessing the product.

PARTNERSHIPS

CHeaP's key partners are the Catholic diocese hospitals within the program's area of operations. There already exists a relationship between CHeaP and the providers since CHeaP is part of a wider framework of interventions by CCMFC that includes the approved hospitals.

The partners exhibit a sense of heightened obligation to help CHeaP get established since they are all part of a common and larger institution – the Catholic Church. The sense of obligation that partners have towards CHeaP is an advantage in a sense since CHeaP has used this to negotiate a cap of Kshs100 (US$1.25) for all drugs, and Kshs30 (US$0.38) for consultations. While this might not be sustainable for the partners over time, it helps CHeaP mitigate the effects of adverse selection and poor pricing by significantly lowering the cost of treatment. The hospitals are interested because they are operating far below capacity and see low paying customers as better than empty waiting rooms (although the drug subsidy is likely top prove rather painful over time).

Because CHeaP is a product of CENT, there is not effectively a partnership arrangement at this time. There was discussion of separating these organisations and creating a partnership relationship. The costs of the offering the CHeaP product have not been tracked by CENT.

[9] The component cost of outpatient typhoid care is: consultation at Kshs30 (US$0.38), typhoid test (the "widow's test") at Kshs200 (US$2.50), and norfloxicine as the curative drug capped at Kshs100 (US$1.25)

There is a partnership role with the Community Banks that are separate institutions from CENT, though overseen by them.

Details of partner expectations and roles within this relationship are provided below.

	PROVIDERS	Community Banks
Objectives and expectations	▪ Utilisation of drugs that are close to expiry ▪ Ability of the community to access quality healthcare ▪ Shifting payment modes from cash and individual credit, to institutional credit.	▪ A product to add value to members ▪ Improved member health ▪ Member retention ▪ Increased membership
Relationship	▪ Initially positive since both provider and CHeaP are part of a larger network of CCFMC projects ▪ Still largely untested	▪ Initially positive, though CBs do not identify CHeaP as separate from CENT since the management is the same.
Roles within the relationship		
Partner role	▪ Provision of healthcare for CHeaP ▪ Accurate and timely invoicing ▪ Management of control system	▪ Marketing to clients ▪ Collection of premiums though CBs ▪ Recordkeeping ▪ Member ID preparation
CHeaP role	▪ Administration of the health insurance scheme ▪ Timely payment of invoices ▪ Training relevant hospital staff on the policies and procedures of CHeaP ▪ Providing timely data to providers about lapsed and cancelled policies, as well as procedural changes.	▪ Training of CB managers to market product ▪ Management of premiums and claims ▪ Providing a training guide for training members about the CHeaP product ▪ Overseeing an adequate regimen of controls.
Capacity demands	▪ Minimal for those outside Kisumu where providers are significantly under-utilised ▪ In Kisumu itself the situation is completely different where the CCFMC hospitals are said to be already beyond capacity	▪ The frequency and irregularity of premium payments makes this a rather complicated task, and there appears to be no formal tracking mechanism being provided to the CB managers to control these operations. ▪ Training is clearly required on policies and procedures as noted by one of the CB managers. ▪ Tools to manage the program are lacking

CLIENT EXPECTATIONS WITH REGARD TO THE PRODUCT

CHeaP's members have not yet had opportunity to have access to healthcare since those that have paid premiums are still within the waiting period. However, there seems to be significant misunderstanding between their expectations and the program's intentions. Clients expect in- and out-patient cover, and are purchasing the product with this expectation. However, the program only intends to offer outpatient care.

The clients who participated in this study indicated that some of them would not have joined if CHeaP's coverage were only for outpatient care. It was evident that for most of the clients, their interest in the product arose from the uncertainty about their sero status given the percentage of HIV positive people in the region. Though even with the limitation, many of the clients expect to benefit well in excess of their contributions.

Members seemed to be comfortable with the idea of risk pooling because they perceived themselves as being at risk, and clearly saw themselves directly benefiting. More savvy potential members were concerned with risk pooling because they were convinced that everyone will use more than the premium amounts.

The clients who participated in the focus group discussion explained that they avoided going to hospital because they can't afford it. When they go to hospital now – which is rarely – they negotiate with the doctor for cheaper alternative medication or for a less comprehensive prescription regimen in order to be able to afford the treatment. They anticipate that their level of utilisation of the hospitals' services will increase significantly once they are insured because then they will not have to spend any additional money to receive treatment. Most of these clients live within walking distance from the hospital (since the community bank is located on the grounds of the hospital) and will clearly increase utilisation.

Those in focus groups also indicated that they expected to receive more comprehensive medication and that the doctor would prescribe the appropriate treatment for them once they became insured since he/she would then be aware that they had no concerns about the cost of the treatment. Because the fees for consultations have been fixed and those for drugs have been capped, this is unlikely to influence CHeaP. Additionally, members are unlikely to experience additional services from the hospital since they will represent directly unreimbursable expenses for hospitals that are already experiencing budget constraints.

Where members may see additional services is in the area of testing since there is no agreement to cap or fix the cost of diagnostic testing. There will be an incentive on the part of the hospitals to conduct "extra" testing. Also, due to ease of access – currently short wait times, outpatient facilities near the community bank, no co-payment requirement, and a prevalence of disease – there are likely to be numerous visits.

RISK MANAGEMENT

CHeaP has implemented very limited controls for this product. Some potential serious problems with this lack of controls include:

- Clients have the freedom to decide on whom and how many individuals to insure from their household. This exacerbates the potential for adverse selection.
- The program does not have in place systems to track which members' payments are current, and therefore members who have not paid for a period could still receive service.
- Many of the members live within walking distance of the hospital and in the absence of a co-payment; members could get into the habit of coming to hospital for frivolous reasons.
- The program has in place a treatment limit of Kshs 5000 (US$ 62.50) per year, however without a proper MIS to track usage across the different service providers, insured clients can very easily exceed this limit.
- CHeaP has very limited reserves to cover any financial problems

In general, the program has inadequate controls and a very high exposure to risk from fraud, adverse selection, and moral hazard. Details of their strategies to mitigate risk are provided in

Appendix 1: Managing Insurance Risks: Strategies used by CHeaP in its Community Health Plan.

Risks to Partners:
The hospitals with which the insurance program works are exposed to a high level of risk resulting from the lack of improper risk management within CHeaP. In the event that claims exceed premiums over a period of several months, it is likely that the hospitals will be put under pressure by CCFMC to continue to provide treatment to insured clients without a realistic expectation of payment, especially since the hospitals and CHeaP are under the same ownership. Right from the start, the providers will absorb the risk resulting from CHeaP's pricing structure. Hospitals have already agreed to drop their consultation fee from Kshs 100 (US$1.25) to Kshs 30 (US$0.38) for insured clients. CHeaP has also negotiated a standard medication fee of Kshs 100 with the providers regardless of the type of medication. Again, the hospitals are absorbing the extra cost of care.

Discussions with clients indicated that many community members were joining the CBs in order to have access to the health insurance product. If there is truth in this, then CENT could end up with large CBs with few borrowers and savers. In addition, it is unlikely that CHeaP will sustain its operation –even in the long-term – and this would reflect on CENT as well.

SWOT ANALYSIS
A detailed SWOT analysis is provided in Appendix 2: SWOT Analysis

LESSONS LEARNED
Operations:
- The fact that an MFI can effectively administer a credit product does not qualify the same institution to deliver a health insurance product. When they recognised the deficiencies of their health care financing product, management decided to halt the introduction of the product. In structuring the product, they used their knowledge of microfinance, and this proved seriously insufficient.
- There must be protection of the MFIs capital. CHeaP became concerned when they realised how quickly their MFI capital could be depleted covering health care financing claims.
- Institutions need to follow the full product development process and not just rollout with a concept. CHeaP management experienced the problem of skipping the testing stages, and noted that they will pilot test when and if they are ready with a newly designed product.
- It is admirable to want to assist the community. However, as CHeaP has learned, you can only really help if your product and the operations that support it are well designed to the benefit of both the community and the institution. Without proper controls, such a product puts an institution at serious reputational and financial risk.
- Without formal product documentation, it is difficult to control the message of the product and the policies and procedures the staff follow in managing the product. CHeaP found clients, community bank staff, and hospital staff confused about the operation and details of the product.

Marketing:
- While health insurance product marketing to community groups seems to generate significant levels of interest, this often does not translate into actual purchases for various reasons. CHeaP reports an enthusiastic response to their initial marketing efforts. However only a very small proportion of their community bank clients have actually began to make premium contributions. This is partly because systems are not fully in place, partly because some potential clients do not believe that the product can work, and partly because of

natural new product purchasing behaviours. Thus, projections must reflect a more gradual uptake.

- A standardised approach to marketing may have been a better approach for CHeaP. The current system has led to significant confusion about the product coverage, and would like result in credibility problems as people tried to use services and were then told of the limitations of treatment.

Accounts:

- Pricing must be conducted based on realistic expectations of loss experience, operational costs, reserves, and surplus. Otherwise, it is almost inevitable that the institution will be forced to go back to clients with an increased premium. CHeaP based their pricing on social objectives only without clearly understanding the cost structure of an insurance product.
- Before a product is offered, the institution must clearly understand the flow of payments, and provide for proper transactional documentation. CHeaP had no documentation to guide the collection process, and provided no receipts to maintain cash controls.

Partners:

- All partners in an insuring relationship stand to absorb some risk. The underwriter, who in the case is CENT, the MFI, holds the ultimate financial risk. However, other partners experience reputational risk, whereby if the product fails, their reputation is damaged, as is the case with CCFMC. The hospitals in this instance also take on significant credit risk in that they will rely on CHeaP to pay the treatment bills in arrears (at least thirty days, but more likely sixty days in arrears). If Cheap has poorly calculated its premiums, or experiences inefficient operations, than the hospital may be at a loss for collection of those treatment costs.
- Because of the risk to the partners, they should make sure that the insurer is credible as a means of reducing their own risk. One of the key issues that made CCFMC halt the rollout of this product was the recognition of the strong potential to suffer reputational damage because of the problems with the CHeaP program.

Appendix 1: Managing Insurance Risks: Strategies used by CHeaP in its Community Health Plan

Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	▪ Clients can choose from up to ten service providers. These providers were selected because they are activities of the same religious order. This has enhanced the ability to negotiate pricing.
	Claims limits	▪ Patients can use up to Kshs5,000 (US$62.50) per year (but there is currently no mechanism to track the individual member utilization
	Co-Payments	▪ None
	Loss review	▪ None
	Exclusion	▪ Chronic care of HIV/AIDS, acute outpatient care is covered
		▪ In-patient care
	Waiting periods	▪ From the date of application acceptance, 3 months of continuous premium payments for any care
	Proof of event	▪ The invoice from the hospital, nothing from the patient
	Client identification	▪ Use of ID card by all insured
		▪ Confirmation of identification is left to hospital staff
	Pre-approval of treatment	▪ Not required
	Expense verification	▪ Use of treatment sheet detailing charges for expense verification. This is sent to CHeaP with the monthly invoice
	Deductibles	▪ None
	Initial exams	▪ None required
	Use of pre-existing groups	▪ All primary members must belong to a group, though some are formed to enter the community bank.
	Prerequisites to care	▪ None
	Membership from existing groups only	▪ Must belong to a community bank sub-group
Adverse Selection	Whole family membership required	▪ Selection of family members is by primary member's choice. The primary member must be a community bank member, and then any "family member" may be placed on the cover.
	Required membership within groups	▪ 60% requirement from within each sub-group, though this has been completely ignored
	Defined risk pools	▪ No distinction between risk types
	Waiting periods	▪ 3 months from application

Risk:	General Strategy:	Specific Strategy:
	Tying insurance to other products	▪ Require membership in a community bank (which requires some savings), but CHeaP members are not required to link with any product
	Periodic cost evaluation	▪ Likely to occur by default due to a severe mismatch between projected costs and premiums. No plans for formal evaluations otherwise.
Cost escalation	Preset pricing agreements with providers	▪ Agreement exists with hospitals to charge a fixed fee of Kshs 30 (US$0.38) for consultation and capped fee of Kshs 100 (US$1.25) for medication. No agreements on diagnostic tests
	Preset drugs list	▪ None, though the drug must be available at the designated hospital because no external pharmacies are part of this plan.
	Price cap on drugs	▪ Maximum cost per single medication was negotiated at Kshs100 (US$1.25)
	Negotiated fixed price on consultations	▪ Regular price is Kshs 100 (US$1.25), but this was negotiated to a fixed Kshs 30 (US$0.38)
	Co-payments	▪ None
Fraud and Abuse	Computerised ID systems	▪ IDs in place but no systems in place to ensure verification that patient cover is current, and all systems are manual
	Coverage limits	▪ Kshs 5,000 (US$62.50) per person per year limit, though it is hard to see how this will be enforced given current systems
	Efficient termination on non-payment	▪ There is no mechanism in place yet to effectively notify the hospital when a covered individual is terminated from the program. At present, the plan is to simply reject payment for those who are no longer covered. However, this leaves the risk to the hospitals that must rely on CHeaP to inform them of terminations.
	Physical identification	▪ ID card. Confirmation of identity is left to the hospital staff.

Appendix 2: SWOT Analysis

CHeaP Community Health Plan: Institutional SWOT Analysis			
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
	PRODUCT		
Responds to a clear community need	Product components and controls were designed poorly	Though rolled out, few members have begun paying premiums so halting the product will have a limited negative impact	Place of delivery very convenient to most clients, but this is likely to result in high utilisation, especially with the lack of co-payment requirements
Providers are well respected in the area	Coverage does not match market objective (outpatient only versus comprehensive care)	From the brief activity so far, management has learned significant lessons that will help them going forward	Serious misunderstanding of the product features will lead to discouraged members
	A product development process was not followed	They have the ability to go back to the product development process and work out the steps that were missed	Hospital staff do not understand the operations of the product and its requirements of them
	OPERATIONS		
Low administrative costs because they are taking advantage of the efficiencies of the community bank system	There is a lack of formal structures, systems, and controls to support delivery of product	The community bank network provides an efficient mechanism for product outreach	CHeaP maintains very limited reserves to protect against even slight fiscal jolts.
	There is a lack of knowledge or experience of insurance operations within the management, and limited means of gaining that knowledge	The close relationship with the hospitals enhances the ability to address operational issues among the partners	There is a likelihood of a large variance between projected and actual demand especially once changes are made to initial product concept to make it more institutionally viable
	MARKETING		
Stated emphasis is on training the market to understand insurance (though there has resulted significant confusion in the market)	A standardized marketing approach has not been developed so several messages are getting to the market	Potentially large market	Within the market the product concept is still very hazy,
With better training they can effectively use CENT staff who have the trust of their members	There is no formal marketing plan, and "Marketing" staff require improved training and tangible guidelines	Willingness of community bank leaders within communities to market the product	The market is confused about the product and the misunderstandings will lead to dissatisfaction

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
	ACCOUNTING		
Basic bookkeeping is done is the field	Weak management accounting function, no tracking of key ratios (limited knowledge of what the key ratios should be)		Lack of a proper and realistic basis for projections
	The pricing process does not consider all necessary components, and formal costing is non-existent		Corrected projections forecast a severe cash flow problem if there is no intervention
	RISK MANAGEMENT		
Some key risk mitigation measures have been included (however they are not necessarily followed)	Many common controls have not been implemented, and some controls mentioned are not likely to be adhered to given weak operational systems.	They can learn from lessons others have learned through reviewing the growing pool of microinsurance literature.	Risk levels are likely to be larger than estimated for all parties
	They have no way at this time of adequately assessing their risk	They have halted to rollout of the product and thus have the opportunity to introduce appropriate controls.	Partners did not conduct due diligence to minimise their own risk in this relationship

Appendix 3: Patient Flow at Hospital: