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MicroInsurance in Uganda:

A Case Study of an Example of the Partner-Agent Model of MicroInsurance Provision

AIG/FINCA Uganda – Group Personal Accident Insurance

Report written by Michael J. McCord

Research conducted by Michael J. McCord, Leonard Mutesasira, Peter Mukwana, and Alex Sekiranda

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Michael J. McCord

INTRODUCTION:

Most people experience financial stresses that are potentially disastrous. This is especially true for the poor in developing countries. Much microfinance activity, including that which incorporates savings programs, has been done in an effort to relieve some of these stresses and help people to secure, and even improve, the status of their families. As a result, many poor people in developing countries have experienced improved household incomes. They also see the benefits of saving money, as well as maintaining a healthy credit relationship, to protect against future crises.

It has become clear that savings, though critical, only address the relatively simple life cycle events and minor emergencies. The issues of health care financing, deaths, and property loss, for example, often require a greater level of support so that the involved family does not slide back down the slippery slope of poverty.

For this reason, there has been much discussion about the provision of insurance products to the poor in order to address the needs arising from such events. Indeed, several organizations have created programs to provide insurance products, utilizing any of four general models of insurance provision. These models include:

1. The Partner-Agent Model
2. The Full-service Model
3. The Mutual Model
4. The Provider Model

This series of case studies is designed to review some of the products of the more prominent organizations offering insurance products to the poor and to review their product development and implementation of these models.

Objectives: This study seeks to review the Partner-Agent model supporting the relationships between FINCA Uganda and AIG.[1] It is intended to provide a practical understanding of the mechanisms of the model, as well as the satisfaction level of the partners and the market. It should also provide a better understanding of the practicalities of the model and help to identify its benefits and problems, thus aiding in the identification of further potential applications.

Additionally, this paper will review the process by which the individual product was developed, tested, and implemented to provide better understanding of the process itself and to identify issues in the product cycle.

Methodology: This study of the AIG/FINCA Uganda relationship was conducted through a field visit during the periods 26 – 30 June and 10 – 14 July, 2000. The consultant conducted interviews and document reviews with both partners (AIG and FINCA), while Participatory Rapid Appraisal (PRA) and focus group discussions were conducted with clients, former clients, and non-clients by a team from ***MicroSave*** and ACDI/VOCA.

1 The author wishes to thank the management, personnel, and clients of AIG and FINCA Uganda for their time and candor during the research of this case study. Most of the information reported in this paper derives from discussions with them and their internal documents, which they kindly shared with the author. Additional historical information is included directly from the author who served as Chief Executive Officer of FINCA Uganda from April 1995 to February 2000.

Detailed accounting and claims records, as well as other relevant documentation, were reviewed to provide the base data for analysis. The PRA and focus group discussions were conducted in order to gain an understanding of the perspective of the market.

A review of findings was provided to management of AIG and FINCA, and discussed during the visit.

I. CONTEXT:

I.A: MACROECONOMIC & LEGAL ENVIRONMENT

The macroeconomic environment of Uganda is illustrated in Table I.A.1, below.

Table I.A.1: Uganda Country Basics[2]
(1998 unless noted and US$ where relevant)

GDP (US$ Billions)	6.6
Population (millions)	21
Surface Area ('000 Km^2)	241
GDP/Capita (US$)	310
GDP Growth Rate (1997-8)	5.7%
GDP per Capita Rank (of 206)	180
Population per Km^2	105
Inflation (1999/2000)	10%
Exchange Rate (2000)(Uganda Schillings per US$1)[3]	1,500
PPP GDP per Capita	1,072
PPP GDP per Capita Rank (of 206 countries)	180
Infant Mortality (per 1000 live births) 1970/1998	109/101
Under Five Mortality (per thousand) 1970/1998	185/170
Maternal Mortality (per 100,000 live births)	510
Access to safe water (% of population) (1996)	34
Health Expenditure as % of GDP (public/private/total)	1.8/2.9/4.7
Health Expenditure per capita (US$)	14

[2] 2000 World Development Indicators, World Bank, Washington, D.C. 2000. pp. 12, 16, and 92.
[3] This exchange rate will be used in all calculations of current figures in this paper.

I.B: INSTITUTIONAL SUMMARY

Table I.B.1: Relevant Institutions:

	AIG (12/99)[4]	FINCA Uganda (1/00)[5]
Corporate Type:	Insurance Company	Microfinance Institution
Legal Structure	Regulated Insurance Company	Company Limited By Guarantee and NGO
Core Products	Non-life Insurance products	Credit (savings are not managed by FINCA Uganda)
Start of operations	<1990	1992
Total Assets (US$ Millions)	3.30	1.84
Number of Clients (thousands)	N/A	20
Number of staff	14	94

I.C: PRODUCT DESCRIPTION

Table I.C.1: Product Description Table:

	Group Personal Accident Policy[6]
Target Market (client type):	FINCA Uganda Borrowers and their families
Target Market (geographic):	Throughout FINCA Uganda's Market
Intended client benefits	✓ Coverage for group guaranteed loan ✓ Death benefit to family ✓ Client ability to care for children after death
Product coverage	✓ Death by illness – loan cover ✓ Death by accident (client) – loan cover plus US$800 ✓ Death by accident (husband) - US$400 ✓ Death by accident (each "dependent" up to 4) - US$200 ✓ Disability (client) – loan cover
Limitations	N/A
Exclusions	Death specifically noted as due to AIDS
Eligibility Requirements (and renewal terms):	✓ Must be FINCA borrower ✓ Eligible at the start of each loan cycle ✓ Previously, when voluntary, required 100% of group to purchase insurance (to minimize administrative burden on FINCA) ✓ Currently mandatory of all groups
Pricing (premiums)	✓ Clients pay 1% of loan principal to FINCA (fee imbedded in loan interest rate) ✓ FINCA pays 0.5% of borrowed loan principal to AIG ✓ Covers client, husband, and up to four pre-identified dependents
Pricing (co-payments)	N/A
Other	N/A

[4] AIG Uganda Limited, Directors' Report and Financial Statements for the year ended 31 December 1999.
[5] FINCA Uganda unpublished internal documents for January 2000
[6] From the AIG/FINCA client policy

II. MARKET RESEARCH

II.A: MARKET DEFINITION/SEGMENTATION

II.A.1: AIG:

In Uganda, AIG's traditional market has been mid-to-large-sized companies and wealthier individuals to which they provide non-life insurance products. The top three non-life insurance products offered by AIG are Fire (21% of gross premiums written in 1999), Energy (13%), and Group Personal Accident (7%).[7] They also cover the primary insurance needs of FINCA Uganda (GPA, liability, money, fidelity, all risks).

The FINCA Uganda (FU) client market was conceptually far from AIG's traditional market due to income levels and the level and types of their business activities. AIG has been actively looking to expand its market share in Uganda, though had not yet broadened its focus to the lower end market.

When FU came to them to propose insuring FU's clients, FU provided ideas for a simple mechanism to allow AIG easy access to this lower end market. FU had already done some of the preliminary work in identifying the demand, because they perceived that they would need to sell the idea to the potential insurer.

II.A.2: FINCA Uganda

In 1995, FU management recognized that some of its clients were dying with outstanding loans (although the volume of client deaths was relatively low). When a client died, their accumulated savings were used to repay the loan, and the group-guarantee mechanism was activated to complete the payments, if necessary, which was often the case. Thus, surviving clients were losing both their friend and their money.

In several instances, this caused a destabilization of the groups resulting in repayment problems. Concurrent with this, FU staff reported difficulties for families dealing with the sudden loss of a member, especially the mother (since virtually all FU clients are women).

FU management considered that an insurance product might assist in mitigating these issues among its clients and their families. Management also considered that such a product might help them to differentiate themselves from anticipated competition (even though they expected competitors to quickly copy any new product they offered which provided benefits to the institution).

II.B. MARKET RESEARCH

II.B.1: AIG

AIG accepted the very basic market research that FU management provided. Very little market research was actually conducted in preparation for this product since AIG deemed the cost of research to be significantly greater than the potential claims loss. They viewed themselves as protected from significant loss due to several factors.

- ⇨ They saw this as one policy (NOT a new product) within their Group Personal Accident portfolio
- ⇨ They recognized that short insuring cycles and their ability to cancel the policy after a cycle concentrated risk to a short period
- ⇨ They had far more than sufficient reserves to cover any possible problem (without significantly impacting the company)

Effectively the "research" for AIG, is the analysis done on a monthly basis of the activity related to the policy. This is a regular part of operational controls for AIG. Thus, the cost of research is essentially the same as the cost of researching any new policy.

[7] AIG Uganda Limited, Directors' Report and Financial Statements for the year ended 31 December 1999.

II.B.2: FINCA Uganda:

No formal market research was conducted. To research the potential demand for life insurance for clients, the senior manager conducted informal discussions with client groups. The results showed that clients were interested in protecting themselves from the financial burdens related to the death of other group members. They also expressed a desire for their families to benefit in such a way that their children could be cared for in the event of their death. No cost issues were discussed at that time beyond the fact that there would be a cost.

There was virtually no cost to this "research" as these discussions with clients were not the result of special trips but were conducted during regular account monitoring and/or supervisory visits.

II.C: COMPETITIVE ANALYSIS

II.C.1: AIG

No other insurers were providing any significant insurance products to the "micro" market in Uganda. This is likely due to the lack of an efficient conduit to get to this market coupled with an, at that time, underserved upper level market which more closely matched their traditional market niche.[8]

II.C.2: FINCA Uganda

Although there have been active traditional life insurance programs and mutual aid groups amongst clients, no other MFIs had offered any formal insurance to their clients at the time the AIG/FU product was developed or implemented.[9] This was likely the result of the nascent stage of the microfinance industry in Uganda. Most MFIs were still trying to get started and were addressing the development and provision of their basic core products, which did not include insurance.

[8] AIG staff has revealed that two other local insurers have developed products for this market and are about to begin marketing them. Additionally, AIG itself has recently begun providing insurance products through two other MFIs.

[9] Indeed, many FU groups maintained, and continue to maintain, a pool of funds from weekly contributions intended to provide assistance in case of death or other calamity.

III. PRODUCT DESIGN

III.A. PROTOTYPE DEVELOPMENT AND TESTING

There was no prototype or concept testing of the group personal accident policy. FU management simply discussed the concept with several FU client groups who received the concept favorably. The product was originally designed with the following features:

Table III.A.1: Elements of the Concept Generated by FU:

Terms, conditions and coverage:	Reasons:
Voluntary offering	Wanted clients to understand the product (this occurs best when the product is "sold" to a client). Also wanted the institution to understand the real demand for such a product (the best way to understand this is when people reach into their pockets and give you hard-earned money).
Required all members of a client group to participate	Minimized administrative burden and adverse selection
Covered the death of clients with √ Loan payment √ Payment to family	Wanted to provide continued benefit to the family for the transition after client's death, and to cover group losses
Claims payment provided within two weeks	So the family and group would realize benefits when they were needed
Four month insurance cycles	To match the loan cycles and provide a marketing benefit (if clients wanted the insurance they would have to borrow)
Collection of premium payments at loan disbursements	1. Loan disbursements mark the start of the four month cycle 2. Wanted to actually collect funds from clients so that they recognized the product as separate from the loan payment
A single monthly payment from FU to the insurer to cover all new and renewal groups for the month	Minimize administrative burden
Provide only FU pre-existing forms as documentation for the monthly payment	Minimize administrative burden
Pricing simply calculated by clients and staff (1% of loan principal borrowed)	For ease of transaction and understanding since all clients were already paying a 1% affiliation fee payable to FINCA International.

This concept was accepted by AIG with the following adjustment:

Table III.A.2: Alterations in Group Personal Accident Policy for FU

Concept:	Alteration:	Reasons for Alterations:
Cover the death of clients with loan payment and payment to family	Cover: a. Loan P&I in case of illness death b. Loan P&I plus about $800 for accidental death c. Loan P&I in case of total disability d. Loan P&I for period of partial disability e. Hospitalization in case of accident up to about $66	AIG did not have a license to issue Life policies, so the policy fell under their Group Personal Accident product. They adjusted the coverage to match the FINCA market needs.

Agreement on the structure of this product came quickly in discussions between FU management, and senior staff from AIG.

Table III.A.3: Primary objectives of concerned parties of the Group Personal Accident Policy:

AIG:	FINCA Uganda:
Reach new market (particularly the micro market)	Improve client retention
Generate Profits	Improve morale among groups whose members die
	Develop competitive advantage over anticipated competition
	Develop a product that helps clients to ease their family's transition without her

III.B. DELIVERY CHANNELS AND PARTNERSHIPS

One of the hurdles of extending an important product like insurance to a new market is finding an efficient delivery channel. This is particularly true for products offered to the very poor.

Some MFIs have an efficient delivery channel to the very poor and a desire to offer quality insurance products to their clients, but do not have the expertise and reserves to develop and manage an insurance product. Insurers have the product and the reserves, but do not have an efficient delivery channel to this sector. These respective assets and needs are what make a partnership between MFIs and insurers so potentially perfect.

FU management created logistical mechanisms through which they thought a group personal accident or life insurance program could work. They also collected basic data on client death rates and a summary of FU growth plans. This information was used to try to entice insurers to collaborate with FU to provide the desired life insurance. Two insurers (including AIG, at first) rejected FU management's idea.

When a new Managing Director for AIG Uganda arrived, the idea was introduced to him and, after a review by his underwriting team, he agreed to the plan with some alterations (see Table 3.A.2 above). Although there was little hard data to assess the insurance proposal, AIG decided that the price and terms were reasonable enough to test, especially since the product fit directly into their group personal accident line.[10] They could not, however, offer a term life insurance product, as had been originally envisaged, because they did not carry a Life Product license from the insurance commissioner[11]. Thus, the death coverage was limited due to the need to fit within the regulatory environment.

An important lesson here is that even though AIG did not have specific information on the new market, they were able to use broader market information coupled with a desire to enter a new market. Additionally, their product development costs were minimized since they were simply testing a variety of an existing product (as opposed to the MFI that would have had to create a new unit to accommodate the new business). Thus, development costs for a formal sector insurer can be nearly nil, while they could have been significant to the MFI.[12]

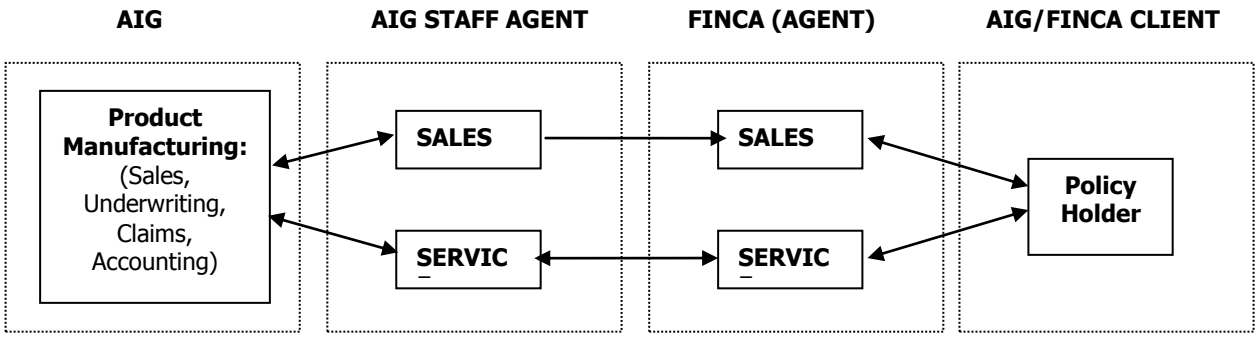
[10] This is one important benefit of working with an insurance company. They have ability to test a market that they think could be profitable, and they have the resources to learn a lesson and absorb unexpected losses.

[11] In Uganda, as in many countries, the insurance industry is split into two areas by the regulators: "Life" and ""Non-Life" business. In Uganda, in order to obtain a license to sell either of these lines, a company is required to hold at least Ushs1billion (about US$670,000). So far, AIG has not identified enough of a "Life" market in Uganda to warrant such an investment.

[12] This paper does not address the low risk (though common) MFI Loan Insurance which only covers the client's loan on death. This relatively simple product mainly benefits the MFI. What are addressed here are programs whereby clients and/or beneficiaries are provided significant claims payments (beyond loan repayment) on death.

The allocation of tasks was structured to intentionally minimize the TOTAL time involved in the sale and service of the product to the common clients. Because AIG retains the risk, they make the final decision on the pricing and product structure, and they handle all claims. FU, because it has people in the field with the clients each week, does the basic marketing and coordination of claims and acts as the pass-through for information to and from the clients. Transactional documents between the companies are simply documents that were already being produced by FU for other purposes. AIG agreed to accept this, recognizing the major reduction in administration for both parties.

Diagram III.B.1: AIG/FINCA Uganda Group Personal Accident Insurance



Once the basics were agreed to, AIG's agent provided training sessions to FU staff during their regular weekly meetings and the product was launched. The breakdown of activities for the Group Personal Accident Policy is shown in Diagram III.B.1.[13]

III.C: COSTING AND PRICING

No model was used for pricing the Group Personal Accident product. The price suggested by FU was deemed acceptable by AIG after a basic review of the projected costs and product uptake.

AIG based costing on a projection of claims based on the history provided by FU, as well as a review of the actuarial statistics for Uganda. Costing components included an estimate for the overhead (10% of premium price) as well as agent commission (20% of premium price), and an expected base level return (at least 30% of premium price), all based on the cost structure of their common Group Personal Accident line. Because of the anticipated volume of this product, at least in the early stages, no additional reserves were deemed necessary.

After AIG calculated the anticipated loss rate based on the projections from FU and its own actuarial data, the pricing for the product was calculated. However, this resulted in a flat price for the product. In order to pass the price on to the clients in a manner reflective of variable risk, it was decided to tie the price to the loan portfolio, since that is the source of the variability of coverage. Thus, insurance was priced as a once-per-cycle cost to the client of 1.0% of the principal borrowed. Although interest payable was also covered by the insurance, this was not directly factored into the price.

[13] It is important to recognize that for AIG, the activity represents one policy and their operations treat it as such. From a staffing and accounting perspective, this is simply one policy and AIG activities related to it are similar to those of all other large accounts. AIG management asserts that this policy, though not the most valuable, is within the top five policies of the office in terms of premium value.

The initial price proved more than sufficient and was, in 1999, reduced by half, while coverage was increased. This is discussed further below.

IV. PILOT TESTING

No formal pilot test was conducted for this product.

Because both FU and AIG expected relatively low initial uptake of the Group Personal Accident product, in the beginning the product was offered to all clients on a direct rollout basis. At the point of market introduction, FU had about 2,400 clients in 78 groups. It was expected that about 25% would purchase the product in the initial stages. Thus, the expectation was a mere 20 groups, or about 620 clients, for the first 6-9 months as clients tried out the product.

FU had seen that the impact of a client's death on groups was negative and occasionally led to client/group attrition, issues with group savings and internal repayment problems. Total group savings tended to drop because group savings were used to pay for the deceased's loan. As a reaction to this, internal payments tended to drop, and the level of the group savings recovered slowly because surviving clients wanted to minimize the potential for similar future losses. Often this was the first experience clients had with the implementation of the group guarantee (their money being taken to cover another client). This left them questioning the "protection" that they thought their savings were afforded within the group, resulted in a reluctance to continue saving, and sometimes in client attrition.

Although the Group Personal Accident Policy was intended to mitigate these problems, FU did not develop any formal (written, quantifiable, chronologically based, monitorable) objectives. No base line data was formally tabulated. No indicators were developed. No protocol was prepared. No effective monitoring was conducted.

At AIG, as mentioned above, this was not a new product, but was simply one additional policy among many. Their unwritten objective was to make profits within their expected range, and to offer a product to the lower markets without the incumbent issues of working with poor people (such as labor intensity, low nominal margins, strong marketing efforts). By virtue of their working with FINCA, they dramatically reduced the market entry issues. In terms of the profitability objective, they planned to review, and then did review, the account on a quarterly basis, assessing premiums against claims and operational costs to ensure that their profit was within the acceptable range for the Group Personal Accident product.

No adjustments to the product were made initially (for three years) based on very positive results for AIG results (between 30 and 50% annual returns), and the fact that FU was not tracking the product adequately.

V: ROLL OUT / IMPLEMENTATION

The AIG Group Personal Accident product was not formally tested but was rolled out for all to access as they wished.

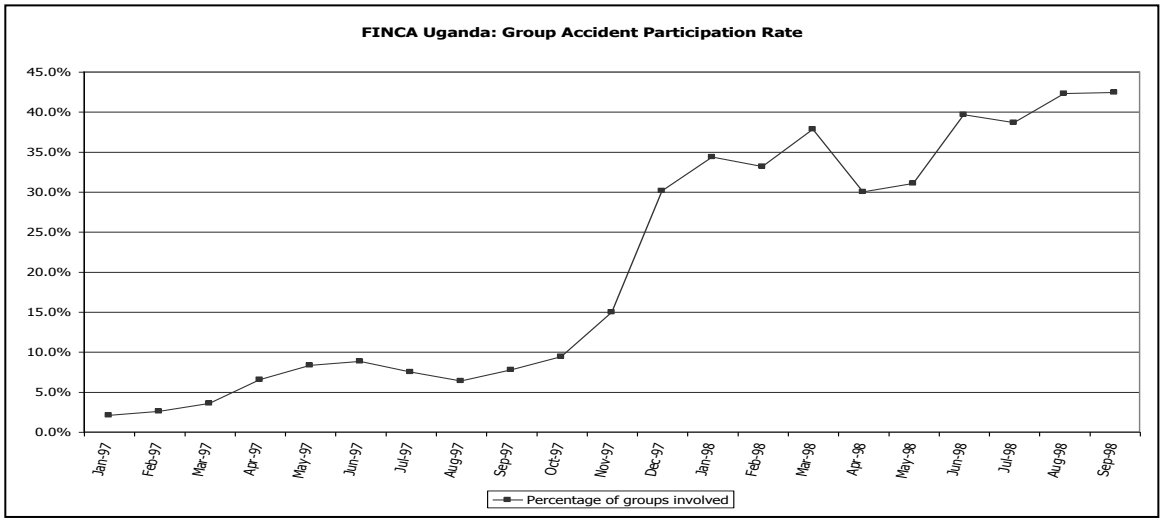
Management and credit officers were trained on the insurance product by both senior management and the AIG staff agent, so that they understood the product and the general concept of insurance in order to adequately inform clients. An agent from AIG came several times to the FU offices, and met staff in the field, to help explain the product. Management sent informational letters to client groups. Credit officers used those letters as a basis for informing clients, and their training as the basis for addressing client questions. In rollout, several issues arose, documented in Table V.1.

Table V.1: Issues of Rollout

Issues:	Corrective action:
Requiring all clients in a client group to purchase the product seriously limited ability to generate client groups	100% rule was not relaxed because of the extreme administrative burden that would have been added in accounting for individuals within groups rather than groups themselves. It was thought that once the "demonstration effect" was experienced this problem would be reduced (though never eliminated).
Staff were very reluctant to offer the insurance product. The field staff, including the field director, had seen poor claims payments by state insurers and believed that the AIG plan was a fraud. At the start of this product offering, insurance products had a poor image in Uganda.	Many staff trainings were held to promote understanding, but it really did not improve until several clients died and their claims were paid (i.e., the demonstration effect).
There was significant confusion by the staff because the information from management and that from the AIG staff agent was different.	More frequent discussions were held between the agent and management
It was recognized quickly that field workers were not sales oriented. This was seen as not only limiting the insurance program but the whole of FU's activities, since an organization with anticipated rapid growth needs people who can sell all its products.	A sales training team was contracted to provide sales training to all the FU staff on the range of FU activities. This four-day course (with adaptations) has been run annually at FU.
No commission was offered to the field staff for selling the product.	ORIGINALLY, FU agreed to take no commission as an inducement to AIG. It was expected that after the initial 6-9 months, there would be a strong uptake of the product and once AIG saw tangible returns there would be a renegotiation in the commission to FU. FU thus had no product related money to pay commissions from and thus rejected the request, but the issue still surfaces occasionally.
Clients wanted more than life insurance.	The strong demand for additional insurance products helped incite FU management's effort to identify health insurers.

Actual utilization of the product as a percentage of total client groups over time is indicated in Table V.2 below. From this table it is clear that uptake was very slow until the end of the first year. By March 1997 it had become clear to management that its credit officers were not sales oriented and had very limited sales and marketing skills. This was highly disturbing to management, not so much because of the insurance products, but because of management's very aggressive growth projections for their credit product. If the field staff had limited marketing skills, this would likely impact on the projections by slowing actual growth of the core business (credit).

Table V.2: Participation Rate



Management's response was to hire a team of marketing trainers[14] to conduct a four-day training program on the basics of marketing, with specific applications to the work of the credit officers. The lead trainer spent several days of preparation in the field talking with clients and staff to gain the insight to make the training highly relevant for the MFI credit officers.[15] The impact of the training, held in late June 1997 and followed up internally over the next three months, is dramatic with regards to the insurance product, (as seen from graph in Table V.2).[16]

The training was also instrumental in helping to propel client volumes and portfolio values of the credit product, which strengthened the institution as a whole. Additionally, work was done to get the credit director to understand the benefits of microinsurance, and there were several paid claims during that period which assisted with the demonstration effect.

In June 1999, FU Management met with AIG staff to reassess the relationship. Although this was dramatically overdue (it was the first such formal assessment meeting since the introduction of the product), it was actually called because of other institutional issues.

FU traditionally collected cash fee payments at the point of cash disbursement to clients (at inauguration or recapitalization of a new group, the beginning of a four-month loan cycle). These included: 1% FINCA International affiliation fee, a stationary fee covering client and group documents and amounting to about 0.5% (both levied on all groups), and 1% for insurance (from the participating groups). These were collected in cash and the management and security of these funds was developing into a serious administrative burden. As a result, FU decided to merge all fees into an increase in the loan interest rate (from 3% flat per month to 4% flat per month) to eliminate the transactions in cash, while maintaining the inflow to cover these expenses.

This created a problem for the voluntary aspect of the insurance provision. To maintain simple accounting, FU was averse to offering multiple interest rates (with and without insurance) because of MIS system

[14] This team was managed by the Marketing Professor at the MBA program at Makarere University in Kampala, and the team comprised senior level faculty and some students from that program.

[15] Recognizing the lack of staff marketing ability was a significant turning point for FU. As a result, other important activities during regular meetings are focused on marketing issues, the four-day training program has been repeated each year, and the lead trainer has been elected to the board of directors because FU now sees marketing as critically important to its future success. This was all the result of a recognition that the lack of marketing skills adversely affected the offering of the insurance product, but helped to identify critical deficiencies within the institution that were subsequently addressed.

[16] Note that because of the four-month cycles, any change takes four months to fully implement.

limitations, and did not want to take the fees directly from the loan principal (i.e. amount disbursed = loan principal – fees) due to issues of operations and client understanding. Thus, it was deemed that the product either be dropped or made mandatory to all in order to satisfy the efficiency objectives of the company.

It was decided, without client consultation, to make the product mandatory, but in order to do this FU management was not willing to pay a full 1% premium (per four-month loan cycle) as the clients had done. Additionally, an initial objective of FU was that after insuring the "easy" products to a level of comfort, the product line would expand to products that covered a greater amount of client risk.

At the June 1999 meeting, FU management requested a reduction in price to 0.5% of the principal borrowed (per four month loan cycle) and an expansion of the product line to include fire/theft coverage for clients. Fire/theft coverage was rejected by AIG because controlling moral hazard and outright fraud was deemed too difficult in the Ugandan context. Next, FU requested Group Personal Accident coverage for family members of the FU clients. After much discussion and recalculation by AIG, changes in the basic product and price were accepted, as was an additional change to the monthly premium payment procedure designed to reduce again the administrative burden of the product.[17] Table V.3 outlines changes in the product features (in US$):

Table V.3: Changes in Group Personal Accident Product Features, June 1999

Feature:	AIG/FU Original Product	AIG/FU Enhanced
Client illness death coverage	Loan P&I	Loan P&I
Client accidental death coverage	Loan P&I plus $800	Loan P&I plus $800
Client permanent disability coverage	Loan P&I	Loan P&I
Client temporary disability coverage	Loan P&I during period of disablement	N/A
Client hospitalization from accident coverage	Up to $66	N/A
Husband accidental death coverage	N/A	$400
Up to four dependents accidental death coverage	N/A	$200 (each)
Insurance term	4 months	4 months
Method of payment	Cash at start of cycle	In weekly interest payment
Cost to client (client to FINCA)	1% loan principal disbursed	1% loan principal disbursed
Cost to FU (FINCA to AIG)	1% Loan principal disbursed	0.5% Loan principal disbursed
Voluntary/mandatory Coverage	Voluntary (by group)	Mandatory

Thus, coverage for husband and dependents was added, and hospitalization (from accident) and temporary disability were eliminated.[18]

When the interest rate adjustment was made, it was explained to clients that all fees remained but were simply rolled into one for transactional ease. Clients who understand the policy continue to believe that they are paying 1% of their loan principle per loan cycle for the insurance. FU pays 0.5% of the loan principle per loan cycle to AIG. Thus, theoretically FU is now earning a 50% commission on the premiums clients believe they are paying for the insurance.

[17] FU clients were insured as part of a group policy with AIG. This means that although FU collected client premiums at the beginning of each four-month loan cycle for the coverage, FU was paying a monthly premium for the group policy to AIG.
[18] The temporary disability and hospitalization were offered by AIG to match their group accident policies, however, these were not marketed significantly to FU clients because of the high risk of fraud in these products.

In fact, many clients no longer understand the policy due to the change from a voluntary to a mandatory product and the resultant reduction in the dissemination of information about the product to clients. This has resulted in clients interpreting the rate increase as simply an increase in the cost of borrowing, which can itself lead to client attrition (when other credit organizations offer a lower rate of interest). This is discussed fully in the next section.

VI: INSTITUTIONAL IMPACT

VI.A: HUMAN RESOURCES

AIG experienced very little impact on human resources since the FU Group Personal Accident product was one of several large GPA policies. The only issues were related to internal communications and claims volume.

The greatest issue expressed by AIG relative to human resources was that the volume of claims was increasing as FU grew. AIG suggests that they experience more activity on this account than on others of equal size. The FU account is AIG Uganda's fifth largest policy (by gross premiums). Other GPA policies in this range experience about five claims per year, while the FU policy experiences about 45 per year. However, the FU claims values are significantly less than those of the other policies.

Outside the claims area, there is no direct correlation between product growth and any significant additional staffing needs by AIG, since this product is structured as a single policy with monthly premium payments paid by FU on behalf of FU clients.[19]

The internal communications issues involved AIG Senior Management and the Claims Department. At the start of the negotiations for this product, it was agreed that because FU was trying to mitigate the shocks to its client's households, and since FU, management would provide full documentation, claims were to be paid within one week. Unfortunately, these original meetings did not include members of the Claims Department, and internally the agreement was not adequately conveyed. This led to a basic average of 52 days, and a median average of 21 days, from documentation receipt to disbursement of the claim by AIG.[20] This disbursement problem continued because neither FU nor the AIG staff agent were adequately tracking the claims.

A second, significant communications issue involves communicating the policy to the clients, as will be more fully explained below. Part of this problem results from weak product management from the AIG staff agent assigned to the FINCA Uganda client's account. When the agent does not follow up on claims as per the agreement, claims are delayed and clients become disgruntled with both AIG and FINCA.

FU human resources were impacted very moderately. There were several training sessions in the beginning that took place during regular credit officer meetings. Later, a small session was added to the induction-training program for new credit officers. Discussions with clients about the product are minimal and occur during regular meetings. The group or the client herself collects all documentation relating to the death. They convey the documentation to their credit officer. Finally, the FU Finance Director receives the claim documents and submits them to AIG.[21]

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[19] During this period, AIG Uganda experienced very significant growth. Gross premiums written went from Ushs 1.175 Billion (US$1.1 million - at Ushs1030 to US$1) in 1996 to Ushs5.604 Billion (US$3.7 million - at Ushs1500 to US$1) in 1999. This growth yielded an increase in market share from 3.98% (number 7) to 16.78% (number 3) in 1996 and 1999, respectively. (Uganda Insurance Commission annual report for 1999)

[20] Data collected and analyzed by the author from internal documents at AIG.

[21] The finance director states that he spends no more than 5 minutes on each claim and there were 47 claims submitted in 1999, with a projected 60 for 2000.

The FU accounts department prepares premium payments. No invoice is sent by AIG (since they do not know the value of disbursements for the month). They utilize a report that they regularly submitted to FINCA International (confirming the affiliation fee payment based on loans disbursed) to calculate the monthly AIG premium payment and document the basis for the premium payment. FU then cuts a check to AIG. The time required is less than that for most other bill payments since the documentation used is already being produced for other purposes. There has been no effort at confirmation of the payment amounts by AIG.

The activity of credit officers in relation to the AIG product has dwindled to virtually nothing since the product was converted from voluntary to mandatory. Although this improves FU's financial position (even less labor requirement coupled with a 0.5% of loan principal "commission") it actually follows a problematic course that is common for mandatory products.

It is clear that most clients no longer understand the product that they are buying. Part of the reasoning behind initially starting as a voluntary product (even though a mandatory product would make the insurer happier, and actually reduce administration further for the MFI) is because FU management wanted to make sure that people were really "buying" the product. It forced staff to understand it and sell it and this had significant ancillary benefits to the company. It also helped clients to know what they are buying rather than simply being forced to accept one product (insurance) in their quest for another (credit).

The reduction/elimination of providing information on this product to clients is illustrated in at least two examples. The first is that after the change was made in June 1999, management sent out staff to conduct a Participatory Rapid Appraisal (PRA) assessment of the communication of the price alteration to clients. After conducting several PRA sessions, the staff found that most clients were seriously confused about the components of the GPA policy.

The second example comes from the report of one of the PRA specialists who conducted several PRA sessions in July 2000 about the AIG/FU product. He concluded that:

> The clients' understanding of the Product is far below the expected level. The groups visited have been in the scheme for over a year now – a period reasonable enough for one to know . . . who pays the Premium, [the] Term of the Policy, Coverage, and Procedures involved in having a claim processed and paid. The responses captured in the . . . Field Reports clearly indicate that clients are walking on a quagmire of confusion.[22]

Of eight groups of clients visited for PRA sessions, five were neutral or negative about the policy stating that they did not understand it. Those groups who understood the policy, and especially those who had positive experiences of claims, were very positive about the policy. Clearly, not enough is being done to educate clients now that this is a mandatory product.

The limited transfer of knowledge is the result of a common, but regrettable, response by staff to a mandatory product. Here we see the direct expense of this product reduced and the risk pool increased due to the shifting to a mandatory product. However, clients become disgruntled when they do not understand what they are paying for, and this can lead to significant indirect costs such as dropouts and image problems.

The intention of making the product mandatory was to minimize the administrative burden on the product thus keeping the costs very low. This has been achieved. However, it is clear from the review that the

[22] From an internal memo to the author from Peter Mukwana of ACDI/VOCA Uganda.

administrative activities have been reduced too far, and that there is need, especially on the part of the AIG staff agent (not FU), to manage this account more actively in terms of:

- √ Follow-up training to credit officers
- √ Provision of language-specific marketing documents for final clients
- √ Improved processing of claims
- √ Occasional confirmation of premium payments

By far the most difficult aspect of this product was getting the staff to understand the concept of insurance, and have confidence that the product would actually benefit clients. According to the AIG staff agent, the credit director at the time of product inception was against the product from the start because she had no confidence in AIG, and thought the clients would be cheated. When the claims were paid and the demonstration effect was felt, she began to alter her opinion, but significant damage was done already relative to the confidence of the staff.

VI.B: OPERATIONS AND SYSTEMS

AIG already had systems and procedures to manage this product since it was one policy within an existing product. In small ways, they adapted the product to the specific needs of FU, especially with regards to paperwork, the promise to accept FU's confirmation of death, and to process claims within 7 days. This required their staff to be aware of the agreements and had essentially no cost impact.

For FU, the operational and systems issues were minimal, as intended according to FU's three primary requirements for introducing an insurance product.[23]

At the introduction of the program, a memo explaining the product to all staff was developed and distributed. This memo included information on the basic coverage and terms of the policy as well as a "Frequently Asked Questions" section to help staff understand the product and respond better to clients. This was adjusted several times as the product was implemented and lessons were learned. The "final" version of the memo was inserted directly into the overall FU Operations Manual.

With the original product, the primary administrative requirement for FU was in the collection of the premiums from the groups that chose to purchase the policies. Premiums were collected at the inauguration or recapitalization meetings along with the affiliation and stationary fees. The premiums were returned to the FU branch offices by credit supervisors, and conveyed to branch secretaries for processing. The secretaries made the accounting entries, and the branch managers (or their designee) made the deposit to the bank. Transaction information went to the head office accounts department who kept track of the groups that paid during the month, and then made the payment at the end of each month.

Claims followed the same path, except that there was no banking involved. Ultimately everything was to flow from the field through the head office so all could be controlled. This was the agreed transactional path and FU/AIG partnership policy.

Lax compliance with agreed policies created serious problems and added to delays in beneficiary receipt of claims payments which, in turn, reinforced client and staff skepticism of insurance products. For example, after the policy had been in operation for a year, and after the FU head offices were moved from Jinja to Kampala, the Jinja branch office began to make claims and premium payments directly to the AIG branch office in Jinja (in contradiction to the policy). AIG made all claims payments to the head offices of FU, as

[23] These were: (1) it had to be a product deemed valuable to clients; (2) it had to carry virtually no risk to FU; and (3) the administrative burden had to be minimal.

per the original agreement and policy, but because the FU Jinja office had dealt directly with AIG Jinja office in terms of submitting premiums and claims, the FU head office in Kampala had no record of filed claims for those being paid.

All of these issues were considered when FU management reevaluated the product and made the decision to make the product mandatory for all groups. Making the insurance mandatory eliminated all transactional work in the field and the branch offices, and minimized the effort required at the head office. Additionally, it helped the insurer to spread out their risk pool and minimize adverse selection, which was a factor while the product was voluntary.[24]

There was no adjustment to any computerized systems as a result of the product.

VI.C: FEEDBACK MECHANISMS

Product use information was not identified, collected, or analyzed, and no formal analysis systems were devised by FU. AIG conducted a monthly and then quarterly review of the profitability of the product but did not assess uptake or client satisfaction.

After the product was made mandatory, it became very clear through anecdotal reports that clients did not understand the product or the alteration in the pricing. This was causing disaffection among the clients and became a concern for FU management.

This led to conducting a PRA exercise in which FU/PRA Trained staff held sessions with clients to identify issues. The PRA report showed significant communication problems between FU and its clients. Before this, FU had used Focus Groups to obtain feedback from clients (though none specifically related to the insurance products). Although useful information came from these PRA and focus group exercises, there was limited application of the lessons learned from them.

Other than these, the only feedback mechanisms used were anecdotal, based on informal credit officer assessments. These were often complaints and based on what one individual or group had to say, and thus not necessarily representative.

AIG has limited interest in creating formal feedback mechanisms. This is because the PGA policy is an AIG product and the most meaningful feedback for them is continued and growing initial and renewal premiums. The AIG staff agent does meet directly with some clients to gain product feedback, but AIG's primary interest is pleasing the overall policyholder, FU.

Having no formal feedback mechanisms for this product saves on the administrative costs and management time. At the same time, FU has made this a mandatory product and has a responsibility to clients to gather feedback to ensure that the product meets client's needs and expectations. This should be done as efficiently as possible to minimize the additional labor burden. Earnings currently coming to FU from this product could theoretically pay for this activity.[25]

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[24] As noted above, over 60% of the groups that had taken the policy did so for only one cycle.

[25] As mentioned earlier, for the first three years this product was offered as voluntary to client FU groups. The product was priced at 1% of the loan principal borrowed for each cycle. In addition to this, clients paid a 3% per month interest on the borrowed money, as well as another 1% of principal to FINCA International per loan cycle, and about 0.5% for stationary per loan cycle. When FU converted to a mandatory insurance program, the three fees were collapsed into a single interest cost of 4% per month. It was explained to clients that these fees all remained but were simply rolled into one for transactional ease. Clients continue to believe that they are paying 1% of their loan principle per loan cycle for the insurance. FU is paying 0.5% of the loan principle per loan cycle to AIG. Thus, theoretically FU is now earning 50% of the premiums clients believe they are paying for the insurance as a commission This is not to say that if the insurance product were eliminated, FU would alter its interest rate, or to say that 1% of the loan principal per loan cycle is an appropriate price for this insurance.

VI.D: MARKETING

This product was initially marketed through credit officers during their regular weekly meetings with client groups. Typically, this would occur towards the end of a loan cycle in preparation for the start of the next loan cycle. Credit officers were not paid a commission for insurance sales. They learned about the product in their induction training and participated in annual credit officer marketing training sessions (not specifically related to insurance).

Marketing of the group accident policy was very weak. As seen in Table V.2: Participation, uptake was very slow initially and only reached about 42% (little more than half the projected uptake of 75%). There are several reasons for this:

- Limited confidence in the product, exacerbated by:
  a. Low confidence level of Ugandans towards insurance companies
  b. Vocal skepticism expressed by the credit director – the credit officers' boss.
- Lack of incentives, financial or otherwise, for the credit officers
- Core business pressures – credit officers were pushed to greater performance (more clients, more groups, greater loan volume, improved loan portfolio quality) and the ancillary insurance product proved little benefit to them.
- 100% group participation requirement. This stopped many interested groups because one or two members did not want to purchase the product.

At one point, a new credit director required credit officers to note on the loan application report whether or not a group was purchasing the insurance. If the group was not buying it, credit officers were required to note the reasons. This showed some level of administrative pressure to sell the product.

As this product shifted to mandatory, it is clear that marketing by the credit officers virtually stopped. As mentioned above, it is highly unfortunate and inappropriate to stop marketing simply because a product is forced on clients.

VII: RESULTS

VII.A: FINANCIAL AND OPERATIONAL RESULTS

The objectives of FU, and results through the time of the consultant's visit, are as follows:

Table VII.A.1: FU Objectives for Group Personal Accident Policy

Original Objectives:	Results:
Improve client retention	There is no evidence of a direct link between the insurance product and client retention.
Improve morale among groups whose members die	Anecdotally, morale improved in several insured groups where their claim was submitted and paid quickly, and when the payment was correct per the policy.
Develop competitive advantage over anticipated competition	As expressed above, there has been a significant problem in getting people to understand insurance as a product, and pooling as a strategy. This has limited the value of the insurance as a competitive advantage. Those who do understand insurance (most often those who have been in groups that have benefited from the policy) state that it is an important product for them and one that holds them to FU. Many others report that they do not understand the insurance and that explanations have been weak and therefore they see this as an additional cost for an ambiguous product.
Develop a product that helps clients to ease their family's transition without them	Virtually no follow-up has been done on the utilization of the claims payments by beneficiaries. The product is structured to provide control by the client even after death. Whether or not client strategies in identifying beneficiaries actually satisfy their prior objectives is unknown.

It is important to recognize that although it is appropriate to collect data to ensure a product is "successful," this was not a primary product line for either AIG or FU. For AIG it was one policy among many similar policies. For FU, it was completely ancillary to core products, and thus FU's evaluation of the product became of secondary or even tertiary importance and thus did not receive heavy management input during a time when management was strongly focused on the growth and expansion of the core products.

AIG objectives and results through the time of the consultant's visit are outlined in Table VII.A.2.

Table VII.A.2: AIG Objectives for the FU Group Personal Accident Policy

Original Objectives:	Results:
Reach new market (particularly the micro market)	Through its relationship with FU, AIG is satisfied that it has clearly reached a new, and very large potential market. The product is adapted for this market and the adaptations make the product more appropriate for both the intended market niche, and the partner. AIG had expected to reach 40,000 FU clients based on original projections from FU management. Their current outreach is just over 20,000.
Generate profits	As noted below in Table VII.A.3, AIG has generated profits from this product even when it was expanded to include additional family members.

AIG management considers itself to have achieved its objectives, though they would like to service additional clients in this market. This has led them to sign an agreement with another MFI, and they are currently in negotiations with two others to expand this product offering beyond FU.

Financial estimates for AIG/FU GPA products are presented in Table VII.A.3:[26]

[26] Analysis of the AIG annual report shows that the estimations for the expense ratios of the GPA account conform to activity for 1998 at 30% of gross premiums written.

Table VII.A.3: Financial Information on AIG/FU GPA Insurance[27]

Financial Information on AIG / FINCA Uganda GPA Insurance (In US$ where appropriate)								
				Expense Ratio		Estimated Profits:		
Fiscal Year	Premiums collected:	Claims losses:	Loss Ratio:	Administrative costs:	Commissions:	Ratio:	US$:	Exch rate
1997	2,908	209	7.2%	10%	20%	62.8%	1,826	1,050
1998	21,739	1,515	7.0%	10%	20%	63.0%	13,702	1,300
1999	30,000	3,784	12.6%	10%	20%	57.4%	17,216	1,460
2000	33,760	12,241	36.3%	10%	20%	33.7%	11,391	1,800

The financial results show that this account has been highly profitable for AIG, especially in the earlier, more rudimentary structure. In June 1999, the basic policy was expanded to family members and the price paid to AIG was cut from 1% of principal borrowed per loan cycle to 0.5% of principal borrowed per loan cycle. The results of this adjustment are visible in the drop from a consistent 63% return in 1997 and 1998, to 57% in 1999, and then 34% in 2000. AIG management indicated that acceptable ratios for any GPA policy are a loss ratio of ≤40% and a profit ratio of ≥ 30%. Though close to these limits, this account still falls within the acceptable range given the regular calculation used by AIG management.[28]

Have AIG objectives been met? AIG staff believe the product has helped to develop a more positive attitude in the public towards insurance. They believe that part of their corporate growth is related to this product. The positive marketing they are getting is noted as not just from the clients themselves, but also from beneficiaries. For example, AIG is always mentioned at the funerals of covered clients and this provides a large audience that sees a positive impact from insurance. The agent says he has gained several up-market clients from this kind of promotion.

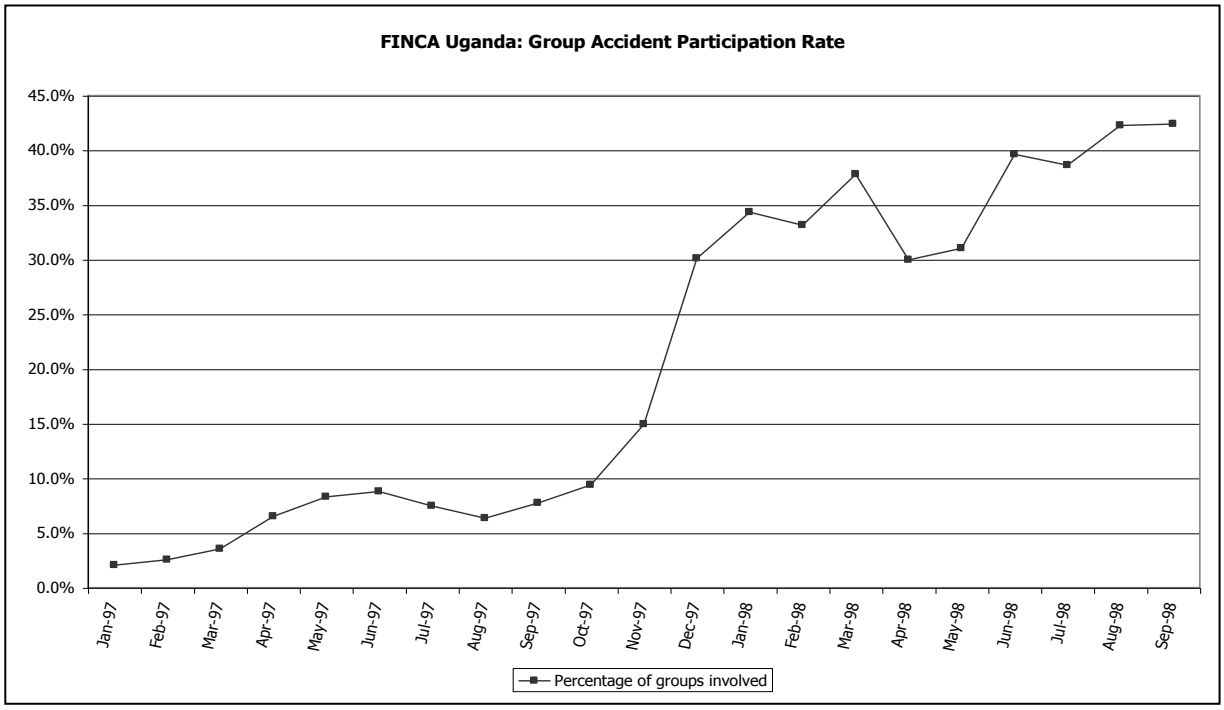
As a testament to their belief in the benefit of this product to their product line, AIG is actively marketing this product among other MFIs.

As for the clients, their satisfaction with this product is most important. Such satisfaction can be assessed through Participatory Rapid Appraisal (PRA) or focus groups. These tools are utilized in the discussion below as well as some analysis of the factors contributing to satisfaction or dissatisfaction.

Table VII.A.4 provides details of the purchase rates for the GPA policy covering the period January 1997 through September 1998. Data for the period October 1998 and May 1999 was not available in a compatible format, and from June 1999 through present, the utilization rate was 100% due the mandatory nature of the product.

[27] The source of this data is internal documents from AIG and calculations made by the author.
[28] The profit levels discussed in this paper relate to underwriting profit only. No interest income either direct or by proxy is included in this calculation.

Table VII.A.4: FU Group Accident Participation Rate



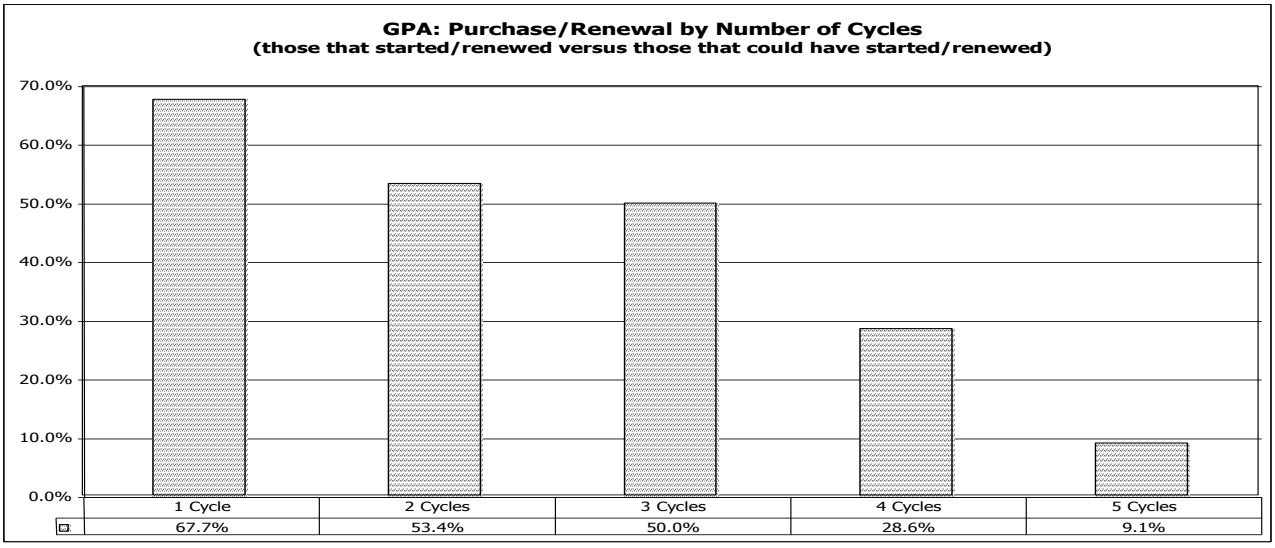
The percentage of client groups that bought the policy versus the total FU groups (see Table VII.A.4) allows the neutralization of FU growth for analysis purposes. This shows slow growth through August 1997, then a dramatic increase after July 1997, partly attributable to the dramatic growth of FU but also partly the result of both intensified marketing training efforts and the "demonstration effect" evident after the payment of claims. This increased interest occurred even with the dampening effect of the requirement of 100% of member participation within groups and thus understates the interest of individuals within groups (many of whom did not join simply because they cannot get 100% participation among their members).

However, even given this membership constraint, the projection had been for a participation rate of 75%. The difference between projected and actual participation is likely related to problems of communication discussed above. The lower than expected participation is also probably a result of the negative demonstration effect relating to late claims payments. In the case of this product, 32% of claims are paid between 90 and 182 days after the death, and fully 25% are paid over six months after death. This delay for groups with a 4-month loan cycle is highly detrimental to renewals and the favorable image of insurance that AIG and FU are trying to foster.

Table VII.A.5 looks at renewals as well as initial utilization. Once a client has purchased a product, one of the best indicators of satisfaction is repurchase or renewal (with regards to a voluntary purchase system). Over 65% of all FU groups have purchased the GPA policy at least once. After that, close to 50% of those that could renew their policies did so for the second and third cycles. Then renewals declined to about 30% for four cycles and 10% for five (no groups could have renewed for a sixth cycle). This reflects several issues:

- A clear difficulty with clients understanding and accepting the pooling effect.
- A potential moral hazard problem (with groups only insuring when they see one of their members is near death)
- Service and marketing / communications issues

Table VII.A.5: Purchase/Renewal Rate by Number of Cycles



An important factor in client satisfaction is customer service. From the client's perspective, with a life insurance product the service involves three things:

- Knowledge transfer regarding the product
- Ease of premium payment
- Claims processing

As will be discussed below, there are several serious problems with product communications.

There are virtually no problems with the payment mechanism. When it was a voluntary program, the payment mechanism for the GPA product was rather simple since clients had the option to save for it through their regular FU savings activities, use separate funds, or use loan proceeds. Now it is even easier, since payment is effectively made through their weekly interest payments.

Clients (or their beneficiaries) have experienced several problems with the processing of claims. The original agreement with AIG was that claims would be paid within one week of receipt of complete claims documents at the AIG head offices. It was assumed that claims would be made rapidly, within one to two weeks of the insurable event, and thus the whole process would be concluded within a month of the event. Table VII.A.6 provides detailed information about the claims duration. It shows minimum and maximum periods, and the arithmatic mean, median, and mode for the periods related to claims payments. Because there are several significant outliers in the data, the median and the mode are offered to provide a more reasonable perspective on the data.

As can be seen from Table VII.A.6, the period from death to claim is much longer than was anticipated. For all accounts, the average claim period is 80 days, with a median of 69. Accidental death claims, probobly because they provide a much larger benefit, are claimed almost two weeks sooner than the average for all claims, and claims for medical coverage and disability take almost three weeks more than the average, probably because of the smaller amounts and the additional data that must be provided.

Table VII.A.6: Client Death to Claims Period Data[29]

	Minimum	Maximum	Arithmetic Mean[30]	Median[31]	Mode[32]
Days from death to claim at AIG – All claims	18	284	80	69	45
Days from death to claim at AIG – Accidental death claims only	25	223	68	64	68
Days from death to claim at AIG – Medical and Disability claims only	37	241	109	104	N/A
Days from death to claim at AIG – Claims pending (8 total with 7 accidental death and 1 medical/disability claim)	20	228	86	63	N/A

The claims process was to be conducted by the clients with minimal assistance from the credit officer. The requirements to make a claim are as follows (from the guidelines FU conveys to the clients):

> "The procedures for claims will be as follows,
> 1. The group should inform their credit officer immediately of the death of a client, or client's husband or child/dependant.
> 2. The credit officer collects the following information from the group;
>   a) Death certificate stating cause of death and signed by a Medical Official
>   b) The client's passbook (only in the case of death of the client)
>   c) The beneficiary/insured family members form
>   d) A copy of the cash book (loan payment page)
>   e) A copy of the loan agreement and the signed request
>   f) A letter of request by the group confirming the death and signed by the executives
> 3. The credit officer is to provide a statement to management confirming that the above points are correct.
>
> The above must be submitted to FINCA Uganda management as soon as possible after the death. FINCA Uganda will provide a cheque covering the specified amount to the group in case of death of a client or to the client in case of death of the husband or the child/dependant but only after receiving payment from the Insurance Company."[33]

There are essentially three steps to claims:

1) The clients collect required data and pass them to the credit officer.
2) The credit officer reviews the documents, confirms death through simple summary note, and passes the packet to management.
3) FU management reviews the documents and submits to AIG.

Occasionally there are difficulties getting the death certificate. FU and AIG do allow that a note can be written by the relevant local counselor (the most local level of elected official) confirming the death, in place of the death certificate. These officials often create delays as a means of generating "fee income" for themselves.

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[29] Data for these tables was tabulated directly from AIG source documents by the author.
[30] The arithmetic mean is the basic average (sum of values/number of values) of all the values in a range or selection. This can be skewed by significantly different outlying numbers, as is the case here.
[31] The median is the middle number when all numbers in a range or selection are arrayed from lowest to highest.
[32] The mode is the number that appears most frequently in a range or selection of numbers. Thus if no number appears more than any other the result is "N/A".
[33] FINCA Uganda memo to clients and staff dated 21 June 1999.

FU management also delays the claim. It is clear from reviewing the claims documents and the dates of receipt at AIG, that FU management has been batch processing these claims. Thus, some claims have sat at the FU head offices for a month or more. Finally, credit officers occasionally delay the claim by submitting incomplete documentation from the clients.

Once the claim gets to AIG, the agreement had been that AIG would process and pay the claims within one week. As can be seen in Table VII.A.7, the average claim payments come almost two months after submission, but the median shows most claims being paid within three weeks. However, claims due to accidental death have taken significantly longer – more than three months on average, with a median of more than two months. The pending claims, all but one of which were for accidental deaths, have been held for over four months on average with a three-month median (and these claims were still pending at the close of the visit).

Table VII.A.7: Claims to Payment Period

	Minimum	Maximum	Arithmetic Mean	Median	Mode
Days from claim to payment by AIG – All claims	7	330	52	21	21
Days from claim to payment by AIG – Accidental death claims only	7	274	98	62	9
Days from claim to payment by AIG – Medical and disability claims only	7	340	68	18	9
Days from claim to payment at AIG – Claims pending (8 total with 7 accidental death and 1 medical claim/disability claim)	14	409	130	89	14
Amounts claimed for loan repayment – all claims (current US$)	5	257	74	60	51

Clearly, AIG is being more "careful" with the claims on accidental deaths likely because these are the ones with the highest benefit amounts (on average US$ 215 versus US$ 75 for all claims, including the accidental deaths).

At least 5 accidental death claims were not paid as accidental deaths per the policy. Only the loan balances were paid. This was because FU management excluded the additional benefit from their cover letter, only requesting the loan amount due, even though the cases were clearly accidental deaths. When AIG claims-staff were queried on this they reported that even though they could see the claim request was wrong and should have included an additional sum, they could not pay more than the claim. This confusion between the two organizations cost several families their rightful benefits.

The amounts borrowed by clients who subsequently died during an insured cycle (presented in Table VII.A.8) averaged just under US$133, versus an average loan disbursed for the first six months of Fiscal Year 2000 of US$ 130. This suggests an even distribution of dying clients, and a moderation of moral hazard.

Table VII.A.8: Borrowed Loan P&I (current US$):

	Minimum	Maximum	Arithmetic Mean	Median	Mode
Borrowed Loan principal and interest – All claims	37	448	132	110	75
Borrowed Loan principal and interest – Accidental death claims only	39	448	141	85	75
Borrowed Loan principal and interest – Medical and disability claims only	57	224	113	112	75
Amounts claimed other than loan repayment – all claims	5	800	215	200	200
Age of Deceased/injured – all claims	4	65	37	38	24
Age of deceased by accident	4	60	27	21	4
Age of injured claimants	23	46	34	32	N/A

Because FU has groups with self-selected membership, there is a serious risk that members might invite their very ill friends to join the group before they die, thus taking a loan and not having to repay it without any detriment to the group. If this were a problem, one would expect to see many deaths of people in their first cycle with FU, and one would expect to see a greater proportion of the loan paid by the insurance company.

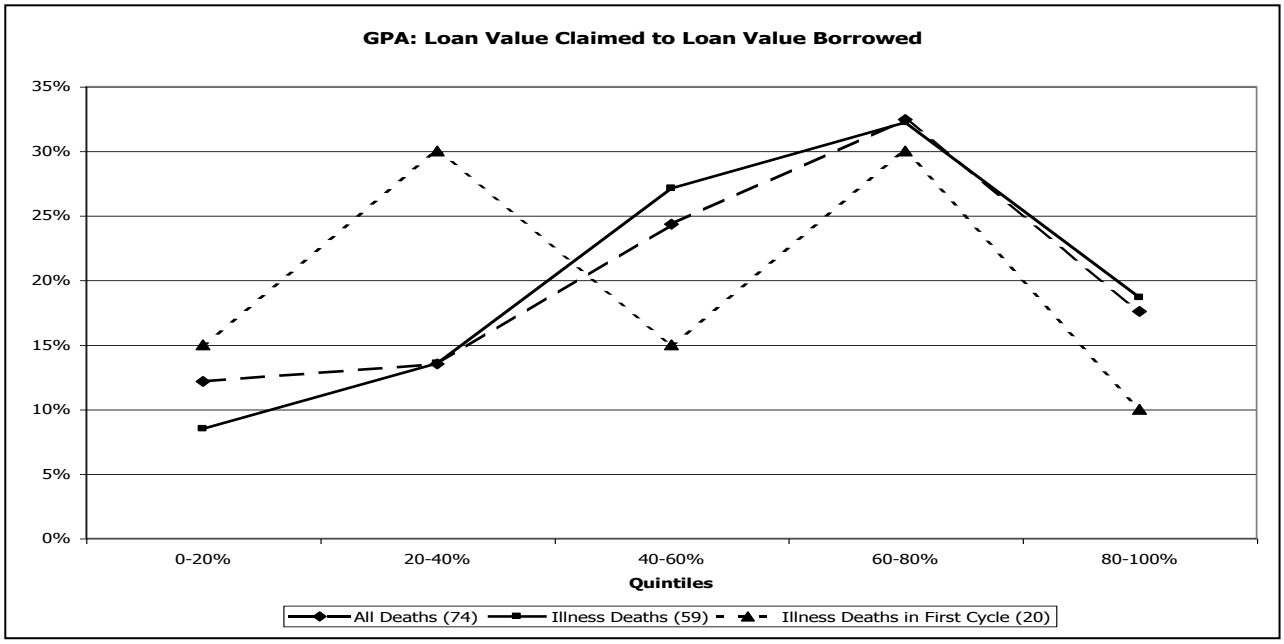
Table VII.A.9: Causes of Death

Total number of claims against the policy (where the cycle of the client could be determined)		89
Number of deaths by illness for clients in their first cycle		20
Cause of death of those dying during their first cycle:	Respiratory Issues	6
	Cardiac Arrest	3
	Meningitis / Encephalitis	3
	Dehydration, abortion, tetanus, malaria, tuberculosis (one occurrence each)	5
	Not Available	3
Number of deaths by accident or disability by accident claims for clients in their first cycle		10

In fact, the evidence shows that with this policy, 22% of claims for deaths by illness were for clients in their first cycle with FU. This might suggest some level of adverse selection and moral hazard. Table VII.A.9 includes a list of the causes of death of those insured for which benefits were paid. Although many of these are likely to be sudden killers (cardiac arrest, meningitis and malaria, for example), several others could have been related to illnesses that were terminal (respiratory problems, for example, are common in AIDS victims). It might have been difficult to determine when the client might die and thus when they should not have been allowed to continue with FU and/or the insurance. AIDS, for example, is an illness that commonly debilitates over a long period. Many clients with AIDS have been successful FU clients for several cycles without any adverse impact on the program, or the group membership. Thus, it is legitimately difficult to tell a client that they cannot participate until it is clear that they can no longer work.

The claims distribution, shown in the Table VII.A.10, provides information about when the clients are dying in relation to their loan balances. If adverse selection were an issue, one would expect significantly more loans being claimed with maximum balances (thus in the 80-100% quintile). The chart shows a peak in the 60-80% range, though not significantly higher than the 40-60 day range. However it is clear that most claims are made when balances remaining are greater that 50%. With first cycle clients, the average is very close to 50%, which is where it should be given a “normal” selection.

Table VII.A.10: Loan Value Claimed to Loan Value Borrowed



This chart measures deaths that related to loan claims. 15 other claims were for other compensation only.

If clients are to find satisfaction in this product, the number of errors must be kept to a minimum. The numbers of clear errors are noted in Table VII.A.11. These include readily identified errors, such as when a client obviously died in an accident yet had only their loan balance covered. This table shows a very high level of errors dramatically benefiting the insurer. In fact, fifteen percent of all claims had significant errors and all but one benefited the insurer. If clients are adequately educated about the policy benefits, they must recognize that in these cases the policy is not providing coverage as advertised or contracted. This will surely bring down the interest of clients in this product and increase their distrust of insurance products (increasing trust had been an objective of AIG).

FU credit officers and clients have complained that accidental cases are not paid properly. The reason they were given was that it was due to rejection of the claim by AIG. It is clear from the documents that the problem actually derives from FU management and their claims procedures. FU management has simply been asking for the wrong amounts for clients, and the AIG claims manager has refused to correct the mistakes. FU management must improve their level of care in preparing their claims to the insurers on behalf of their clients. However, it is also clear that the AIG staff agent has not been adequately overseeing this account for the benefit of his client.

Table VII.A.11: Claims Errors

Number of clear claims errors of 89 that had enough data to determine correctness	13 (14.6%)
Number of accidental death claims where accident bonus was not paid out (of 18 accident claims)	6 (33.3%)
Number of claims duplicate paid (of 89 total claims with complete data)	1 (1.1%)
Total errors identified relating to 11 medical and disability claims	6 (54.5%)

Rejected claims are a key area for understanding both the level of fraud and the level of customer satisfaction with an insurance product. Data on rejected claims has not been tracked by either AIG or FU.

Another indication of client satisfaction with the product is client retention, a goal of FU. Because FU has offered this product exclusively among the MFIs one could surmise that an attraction to the product would keep clients borrowing from FU. In fact, there is no evidence to support the contention that this product has had any impact on improving client retention. This seems a result of several issues, including:

- ⇨ There is a lack of any analytical data having been collected by FU to understand the relationship between this product and client retention.
- ⇨ Poor quality marketing has continued, especially since this product was made mandatory. Clients do not understand the product well, and therefore it does not factor significantly in the clients continue/depart decision-making process.
- ⇨ In order to access the insurance product, and be a FU client, one must borrow from FU. Insurance and loan capital have completely different usage objectives (from the perspective of the individual) and are not related, since each are related to different events, needs, seasonality, and future perspective of each client. Because credit is relatively so much more expensive, and insurance and credit are linked, the need for credit drives the decision about the insurance.

VII.B: CLIENT PERSPECTIVES ON THE PRODUCT

Participatory Rapid Appraisals were conducted with clients to assess their impressions of the product, and were in no way intended to be an impact study. [34] The summary of these PRA visits showed that the clients' understanding of the product is far below the expected level.

The PRA work focused on the "Ps" of customer satisfaction. The results of the queries showed the following:

a. **Product:** In general the clients that are aware of the product and its benefits to them are very pleased with it, while those with limited or no understanding see no value in it, as would be expected. They did not indicate any desire for expanded coverage for death by illness or death by accident.
b. **Process:** Clients were pleased with how easy the process is, especially now that they do not have to make separate payments. Claims procedures are reasonable, though clients say they sometimes find it hard to get the legal proof of death. They complain that claims payments take an "unnecessarily" long period to clear.
c. **People:** Clients only interact with FU credit officers on this policy and offered appreciation for the "attitude" of FU staff, but questioned their knowledge and involvement in the scheme.
d. **Policies:** Clients expressed satisfaction with the number of people in their families covered and the levels of coverage, though they would prefer an *even* death-by-accident coverage for each member as opposed to the *tiered structure* for husbands and children.
e. **Promotion/Communication/Feedback:** Promotion of the product was said to be ineffective due to a lack of follow-up information. There was a notice about the change to a compulsory product in mid-1999 but they report not hearing anything about it again. Given FU's rate of client turnover (reported by FU as averaging greater than 4% per month) coupled with its growth, this leaves most clients without significant information about this product for which they pay. Several issues, noted

[34] This activity was conducted by Peter Mukwana and Alex Ssekiranda of ACDI/VOCA Uganda who chose groups of clients to visit according to which groups were meeting on the dates and times the researchers were available in different areas of Uganda. The dates, times and regions were chosen at random, as were the groups that matched these three criteria. Thus, though the sample is not truly scientific, it is deemed reasonably representative. This assessment was in no way intended to be an impact study. The team held eight different sessions for eight groups out of the expected eighteen sessions. This was mainly due to the poor mobilization of the groups. The following groups were met: Kampala area; Agali Awamu Women's Group and Twekembe Women's Group; Jinja area: Njeru West Women's Group and Progressive Women's Group; Iganga area: Basooka na Ndala Women's Group, Muto Akula Women's Group, Lugolole Women's Group and Munaku Kaama Women's Group

below, reflect this problem. Clients offered that a limitation on the policy is that it does not encourage feedback from them.

Those clients who understand the product appear to appreciate it. However, the communications to clients are clearly very weak. Other information derived from the PRA sessions includes:

- ⇨ In relating the terms of the product, almost every group made significant errors in describing the coverage.
- ⇨ Several of the groups reporting having made claims that were significantly delayed. In one group a client said: "we lost a member in our group called Kakaire Tapenesi who suddenly died of shock when someone broke the news of her sister's death. Our efforts to lodge in a claim have been frustrated by FINCA." The lack of knowledge by FU staff not only hinders the message from getting out to clients, but even when clients know what to do, this deficiency hinders the claims also.
- ⇨ Of the eight groups visited, four of them indicated that they had little knowledge about the product. Still, except for one, they were able to answer the basic questions about the product with some significant errors. Also, of the eight, one said that they would be better off without the product, four responded neutrally when asked about the impact on them if the product was cancelled, and three stated that they would miss the product if it were eliminated from FU's product line.
- ⇨ The most repeated suggestions that clients offered were:
  - √ Provide more information about the product periodically
  - √ Reduce the death-to-payment time to less than one month
  - √ Expand to cover more fully death by illness for client and her family.

VII.C: CORPORATE CULTURE

The introduction of this product and the resulting marketing problems had a very strong impact on the corporate culture at FU.

On initially offering the GPA product FU management expected that in parts of Uganda the microfinance business would soon become very competitive, where MFIs would have to compete with one another for clients. The experience in selling the GPA policy – or, rather, in *not* selling it – helped management to recognize that its credit officers were not skilled in marketing or sales, consider a key skill required of MFI staff in a competitive market.

The recognition by management that the credit officers were not marketers spurred management into a strong response to uplift the marketing ability of the whole organization. It resulted in marketing training programs, and quarterly "State of FINCA Uganda" addresses, among other things, so that staff could see the results (or not) of their efforts, and recognize the relationship between their work and the results of the company. This also made management more professionally focused.

This product was also an early attempt to set FU apart from the growing competition. FU management wanted to create a culture of innovation and this was one of the efforts that exemplified that culture.

VII.D: PRODUCT DEVELOPMENT PROCESS

As seen above, there was little formal "product development process" with regards to the GPA policy. There was no protocol developed for it, little specific data was collected and analyzed along the way, it was introduced to all clients at once, and there was no real pilot testing.

Essentially, FU management devised the product concept, and AIG agreed to insure it. There was effectively very little time or funds spent by either party in this process.

Because the results were significantly less than anticipated, what was learned through this process was that a new product does require a more formal development, testing, and implementation structure.

VIII: SUMMARY OF LESSONS LEARNED

The research on the Partner-Agent model as illustrated in FU's relationship with AIG Uganda has revealed much interesting and enlightening information. In general, the Partner-Agent model allows for new product development in ways that reduces risk to the MFI, and offers innovative insurance products to MFI clients.

There is much to be learned from the experiences documented here. These are summarized below in bulleted points. A further summary can be found in the tables at the end of the document.

Table VIII.1 outlines the specific strategies used by both FU and AIG to reduce risk inherent in these insurance products.

Table VIII.2 summarizes the strengths, weaknesses, threats, and opportunities by stakeholder. This information can be utilized in product improvement, and in new product development by other MFIs and their partners.

- Developing and following a protocol for any new product is essential to the process of product development.
- Insurance and risk pooling are difficult concepts for staff to understand and feel confident with in order to sell it. Thus, training needs to be provided using several different techniques. Staff should be tested on these techniques, and have easy resources to refer to when addressing clients.
- Although there were clearly significant problems with the provision of these products, at least the financial risk fell to an institution other than the MFI. If FU found that the effort was too great, or that the product was not selling well, they could have simply cancelled their relationship with the partner organization without feeling the pain of a large product development cost, and without being trapped by donor requirements.
- The agent (FU) needs to be organized so that the clients are not cheated (missed accidental death benefits, late payments). When FU proved to be better prepared for negotiations in 1999 with AIG, they were able to come away with a significant improvement to the policy as well as a reduction in the premium cost.
- When negotiating between the partner and the agent, all major related departments should be involved. In this case, the Claims Department staff members were not part of the discussions and were not aware of the claims concessions made by AIG management to FU. This slowed the claims process.
- There should be regular (semi-annual?) meetings to assess the progress of the product and address any problems.
- Both Partner and Agent should have a focal person to address issues immediately. AIG has their agent, but he was clearly weak in managing this account.
- Premium prices must be structured to cover costs from the start. Increases in the price are difficult for clients to accept, while reductions are highly palatable.

Table VIII.1: Managing Insurance Risks: The Strategies used in the AIG/FU Provision of Group Personal Accident Insurance

Risk:	General Strategy[35]:	Specific Strategy:
Moral Hazard	A. Cause-of-Loss Exclusions	Separate coverage schedule for illness versus accidental death
		Specific exclusion for death by AIDS
		Separate coverage for family members since their relationship with FINCA is secondary
	B. Claims Procedures:	Require proof of death documented by doctor or local councilor (local government authority)
		Require note from credit officer who works with group
		Paper trail required to prove client membership and premium "payment"
		Require written pre-identification of family members
	C. Co-Payments/Deductibles/Claims caps	Covers proven loan P&I due at death
		Fixed payment amounts for accidental death
	D. Fixed Lifecycle of Product	Insurance cycle matches loan cycle
		Insurance cycle is only four months
	E. Using Established Social groups	Only available to borrowing clients of FINCA Uganda
Adverse Selection	A. Waiting Periods	No waiting periods are required
	B. Mandatory Insurance	Currently product is mandatory for all clients
		When the product was voluntary, 100% of the group (averaging over 30 members) had to purchase the policy
Cost Escalation	A. Fixed payments on claims	Accidental death claims pre-set
	B. Frequent assessment of cost risk	Price varies with the risk as 1% of loan principal borrowed
Fraud and Abuse	A. Claims confirmation	AIG has agent to confirm death and collect relevant documents

[35] General strategies are taken from Brown, Warren and Craig Churchill. Providing Insurance to Low Income. Part 1 – A Primer on Insurance Principles and Products. Microfinance Best Practices project, DAI, Bethesda, MD, 2000.

Table VIII.2: Strengths, Weaknesses, Threats, and Opportunities by Stakeholder

AIG - FINCA Uganda Group Personal Accident Policy		
STRENGTHS of the program with regards to each stakeholder		
Insurer	**MFI**	**Clients**
All MFI clients covered, reducing potential adverse selection	All clients covered, thus administration is simple, and all groups are protected from loss due to member death	All clients covered, thus death of a borrower is no longer a financial burden on the group regarding the loan.
Professional controls through underwriting and claims management	Administrative burden is minimal though MFI does pay monthly premium. MFI presents and (should) track claims	Clients now have financial assistance in case of accidental death of family members, thus reducing the financial shock when these events incur.
Profitable Product - <70% operations and claims costs to gross premiums paid.	MFI has taken a strong stance in developing new products for its market.	Clients can assign benefits to people other than their husbands, thus maintaining a level of control over the disposition of their children.
Insurer reaches previously inaccessible markets.	Rather than add a product with differing complexities, MFI has chosen to access the product from a more appropriate vendor.	Clients expect that their claims have more clout when they are submitted by MFI (though this could be the case, this MFI has been weak in protecting the client's claim rights)
Insurer has tested the product using the MFI partner and now has a stronger product and better understanding of the market by which it is seeking to attract other MFIs	MFI absorbs no risk to its cash flow of capital base due to this product	
>$650,000 in capital reserves which cover approximately 50% of liabilities	Some clients perceive this product as a critical element to the MFI program, thus this provides some competitive advantage to the MFI.	
Insurer has been willing to test new products in, and new mechanisms for reaching, this market.		
Insurer has been responsive to the MFI management in the design of products appropriate for this market.		

Table VIII.2, Continued

AIG - FINCA Uganda Group Personal Accident Policy		
WEAKNESSES of the program with regards to each stake holder		
Insurer	**MFI**	**Clients**
No license for full life insurance coverage thus restricting available products.	Assessment of the product with regards to company objectives was not done	Clients or beneficiaries delay in submitting claims forms after insurable event.
Poor insurer internal communications (underwriting, marketing and claims) leading to misunderstandings of the product features.	Adequate pilot testing process was not followed and data was not adequately tracked by the MFI	
Delayed payment of claims (average 52 days from submission to payment) leading to client mistrust.	Poor communications (between MFI and insurer) due to a lack of effective communications focal point at each institution.	
Claims department requirements were different than agreed, requiring unreasonable documents given the status of the clients.	Poor communication to clients with materials in English, and limited MFI staff understanding of the product, have yielded very limited benefit recognition by many clients.	
There was no control mechanism in place for insurer to confirm accuracy of premium amounts paid	Product was pushed by senior management but not fully accepted by other management staff.	
Insurer's agent was very weak in maintaining proper communications, training staff, and monitoring claims.	MFI delay in submission of claims with field staff not pushing for claims, and management submitting claims in batch form and often erroneously.	
Once the first core family grouping purchases insurance, others can be added one at a time for a fee. At this point, there is a strong risk of adverse selection.	MFI claims submissions often excluded accident benefit thus resulting in a lost claim to the client's beneficiary, and creating product discontent.	
	Clients report MFI staff unsure of scheme details	
	Very little client participation in the design of the product.	
	Weak controls when product was voluntary and field staff were collecting premiums in cash. (Has been eliminated)	
	With mandatory insurance the MFI has less opportunity to assess the perceived benefit to the clients.	
	With a mandatory product MFI has greatly reduced its marketing of the product, leading to misunderstandings by clients	

Table VIII.2, Continued

AIG – FINCA Uganda Group Personal Accident Policy		
THREATS of the program with regards to each stake holder		
Insurer	**MFI**	**Clients**
In expanding product to other family members loss ratio has significantly increased, and will require close review.	MFI will lose its competitive advantage in this product (if in fact they had one) once the insurer has secured other MFI arrangements.	A rising loss ratio will lead insurer to reassess the product coverage.
Client disenchantment with claims process is undermining advances this product has made in improving public perceptions about insurance.	Client disenchantment with claims process is undermining advances this product has made in improving public perceptions about insurance.	The MFI may decide that the product does not meet its objectives and cancel the product.
		The clients are at risk in relying on the MFI to properly submit their claims.

Table VIII.2, Continued

OPPORTUNITIES of the program with regards to each stake holder		
Insurer	**MFI**	**Clients**
Insurer now has experience in this market and with this model of product delivery. This will facilitate expansion to other MFIs.	MFI can leverage the lessons and experience gained over the years with this insurer into additional products to suit other client needs.	Clients can advocate through MFI for specific additional products.
The experience gained in working with this MFI will assist the insurer in deciding to develop new products for this market.		