

OVC-RELEVANT HEALTH MICROINSURANCE

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About the Technical Guidance Brief Series

This Technical Guidance Brief series was commissioned by ASPIRES, through FHI 360, to explore the state of the practice of microinsurance, with an emphasis on orphans and vulnerable children (OVC) households

The *Evidence Base Report on Microinsurance for Orphans and Vulnerable Children* identified a number of knowledge gaps in the literature that have formed the basis for a series of four technical guidance briefs (TGBs), covering:

- The role of microinsurance in the social protection space;
- The role of public-private partnerships (PPPs) and how government subsidies for orphans and vulnerable children can be leveraged in the microinsurance space;
- The existing state of health microinsurance and how health microinsurance can target orphans and vulnerable children; and
- The potential to link microinsurance benefits to education in order to meet a key need of orphans and vulnerable children

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Introduction

This brief aims to provide an overview of health microinsurance (HMI) and how it can play a role in protecting vulnerable children, by looking at examples around the world and lessons learned. It reviews how microinsurance fits into the broader social protection toolbox and frames the discussion around health insurance for orphans and vulnerable children (OVC).¹ It then provides an overview of specific types of OVC-relevant HMI, some of the challenges in providing this insurance, and other product design considerations.



MICROINSURANCE: A ROLE TO PLAY

As outlined in the first technical guidance brief,² microinsurance is just one among a variety of social protection tools relevant to orphans and vulnerable children. The attraction of microinsurance lies in the fact that it leverages the market mechanism to extend protection to people often missed by other government-led initiatives and provides benefits that compliment other social protection tools.

Microinsurance is especially useful in financing healthcare for vulnerable populations and is a tool to be considered for implementation in conjunction with other healthcare financing programs. In most instances, there will be a mix of healthcare provision through public, private and donor-funded facilities, and blended models where governments, donors and the private sector work together. Healthcare funding varies between being fully government sponsored (i.e., national health insurance

schemes), relying on private funding (i.e., patients leverage private health insurance or pay for service out of pocket), donor funding, or a combination of the above. Health insurance can be provided through national schemes (typically co-funded through government or donor-funding), by commercial insurers or through mutual, or community-based schemes.

As this brief will make clear, HMI cannot be the only solution to financing and facilitating healthcare for low-income individuals and vulnerable populations. Instead, it must be viewed as one potential piece of a larger solution supporting OVC protection.



FRAMING THE DISCUSSION

The health-linked challenges faced by orphans and vulnerable children are multifaceted. To frame this guidance brief, it is first key to highlight the strong link between HIV and orphans and vulnerable children. While many different health and economic factors play a role in increasing the vulnerability of children, HIV has been a leading cause of orphans in the developing world over the past 25 years.³ Even when the HIV epidemic wanes, the economic impact on orphans and vulnerable children will remain for decades.⁴ Thus, when speaking about the role of microinsurance, specifically HMI, in the protection of orphans and vulnerable children, one must always bear in mind the impact of HIV—as an illness which can undermine an individual’s productivity and shorten one’s lifespan, as well as a force which places additional economic challenges on families and communities, thereby further increasing vulnerability among children and adolescents.

Secondly, it is useful to distinguish between those orphans and vulnerable children that are affected because they are living with HIV and

those that are affected because someone they depend on is living with HIV. This distinction is important since the challenges faced by the two groups are different, yet both ultimately impact the welfare of orphans and vulnerable children. Given its unique design to cater to the needs of vulnerable groups, HMI has a potential role to play in both instances.

In the case of orphans and vulnerable children infected with HIV, access to treatment for the disease, notably anti-retroviral treatment (ART), as well as treatment for associated infections like tuberculosis, pneumonia and cancer is of critical importance. Effective access to care can prolong the lifespan, increase educational and economic opportunities for the children, and improve welfare.^{5,6}

In the case of caregivers affected by HIV, the family may slip into a poverty spiral,⁷ whereby the caregiver cannot afford to cover their own healthcare and thus becomes more ill. Eventually, the caregiver can become incapacitated or die, in each case unable to provide for the family, particularly the children, any longer. Furthermore, healthcare costs for the impacted individual can divert household resources from childcare, nutrition, or primary healthcare for children. In such cases, not only do children face an increased threat of poverty due to a lost source of income, but studies have also shown an increased risk of becoming infected with HIV themselves.⁸

Thus, in outlining the role of HMI, it is appropriate to recognize that beneficial outcomes for orphans and vulnerable children can flow through health insurance products either targeted at the children themselves or at their family members or caregivers. This lens is applied in the remainder of this guidance brief.

Relevant HMI Products for Orphans and Vulnerable Children

This section discusses some of the considerations around the various product benefits relevant to orphans and vulnerable children and their caregivers.

Table 1 illustrates the different types of benefits that health-linked insurance products can provide to these groups, namely financing the cost of care, providing ancillary benefits and facilitating access to other insurance products.

COVERING THE COST OF CARE

Due to a number of challenges that will be discussed later in this brief, traditional HMI products which cover the cost of care, either in part or in full, are not easy for policymakers to operate.⁹ Nevertheless, experience has shown that such products can increase access to valuable healthcare services.^{10,11,12}

Table 1. Benefits of HMI by Target Population

		Targeted Population	
		Orphans and Vulnerable Children	Caregivers
Benefits of HMI	Financing of Care	Government- or private-led health insurance products that provide in-patient or out-patient coverage for care	
	Ancillary Benefits	Cash payouts triggered by time in hospital or other health events, but not linked to cost-of-care	Cash payouts triggered by time in hospital or other health events, but not linked to cost-of-care Income protection insurance
	Increased eligibility for other insurance	For certain income protection and life insurance products, access to vital healthcare is a pre-requisite to make one eligible for coverage. As health microinsurance can facilitate access to healthcare, it can thus facilitate access to these other insurance products.	

Table 1: Benefits linked to health microinsurance products

In-patient benefits are more insurable, as they are low-frequency and high-severity events. OVC populations may especially benefit from in-patient microinsurance because AIDS is

characterized by occasional opportunistic infections that require in-patient care for full recovery. Because patients tend to only be hospitalized for severe health situations that happen infrequently, coverage for in-patient benefits is more easily insurable (as opposed to the high frequency, low cost nature of out-patient care). For this reason, insurance premiums for in-patient-only care are 2-3 times more affordable than those combining in- and out-patient care.¹³

Nevertheless, products which provide out-patient care arguably offer greater value to insurance clients, especially HIV-positive patients. HIV-positive patients require access to chronic medication like ARVs and more regular blood work and check-ups to remain healthy. Simply providing in-patient cover will not allow for appropriate treatment to ensure that the virus does not degenerate into greater health problems. Providing out-patient benefits along with in-patient benefits can also increase the sustainability of the insurance scheme.¹⁴ Studies have shown that when patients have access to out-patient care, this can ultimately lead to fewer in-patient claims.¹⁵

In addition to insurance that provides treatment, it is also important to consider preventative measures. The potential for preventative care is highlighted in the case of BRAC, the world's largest non-governmental development organization, which runs an essential care health program that aims to provide primary healthcare to millions of low-income individuals in Bangladesh.¹⁶ BRAC applies a frontline approach to treat and provide information on basic ailments in order to create a "health empowered" community.^{17,18} There may be additional opportunities to provide information specific to HIV that could help prevent infection among orphans and vulnerable children and their caregivers.

Furthermore, as shown in the RSBY case in the above box, HMI schemes may elect to include HIV counseling and advice to all persons joining, to enable them to more effectively protect themselves from the disease.¹⁹



PROVIDING ANCILLARY HEALTH BENEFITS

In addition to direct cost of care benefits, health insurance products that help cover related costs also can prove beneficial to orphans and vulnerable children. One notable example of this type of product is a hospital cash plan product.²⁶ Under this type of product, should a covered person be hospitalized, he or she would receive a fixed cash payout per day in the hospital. This money can then be used to cover ancillary expenses like lost income, transportation to healthcare facilities and non-covered medication. These products tend to be simpler to administer compared to more traditional health insurance products which cover in-patient or out-patient benefits. This, in turn, makes them much more affordable for the low-income market. On the other hand, these products are more open to fraud, which can increase costs. They also offer potentially less value to the client, as the benefits only kick in upon a specified event like hospitalization, and still do not provide for cost of care. Nevertheless, a recent study in South Africa did find that these products, while not able to cover costs associated with private healthcare facilities, can help patients who access care at subsidized state facilities to cope with ancillary expenses and income loss when hospitalized.²⁷

Beyond hospital cash plan products, health microinsurance products can replace income and provide payouts to caregivers and family members in the event of a diagnosis with a specific disease, such as HIV. Such insurance products do not pay out upon hospitalization, but instead upon a specified condition or

Case Study: RSBY in India

Rashtriya Swasthya Bima Yojana (RSBY) is a health microinsurance program launched by the Government of India in 2008, in collaboration with a number of private sector players and donors. The program aims to extend health services to Indians below the poverty line. As of April 2014, a total of 37.1 million households were enrolled. Through government subsidization, RSBY beneficiaries pay a nominal fee of INR 30 (US\$0.50).²⁰ The primary cover offered by RSBY includes in-patient benefits up to INR 30,000 (US\$500) per household at over 12,000 public and private hospitals across India.²¹ HIV was initially excluded from cover, but the exclusion was removed in 2009²² and RSBY currently allows for counseling services for HIV patients as well.²³ Some out-of-pocket expenses are still incurred by patients who need to be hospitalized.

In 2011, RSBY began a pilot process whereby benefits were extended to include out-patient services (for an additional premium, cover was extended to ten visits to a doctor per year as well as the required drugs and follow up visits).²⁴ Initial findings on the feasibility of defined benefit out-patient cover for the RSBY scheme was positive, although results of the pilot indicate underutilization of out-patient benefits, this could be in part due to the lack of private primary care facilities included in the pilot.²⁵

diagnosis (called critical illness or dread disease cover) or a person being declared unfit to work (called income protection in the case of temporary incapacity). While many of these will not cover clients who already have HIV before purchase, there are products available which provide cover for lost income due to future HIV infection.²⁸



FACILITATING ACCESS TO OTHER INSURANCE

Health insurance can also be leveraged in conjunction with other insurance products in order to achieve the goal of protecting orphans and vulnerable children from the impact of HIV. For example, while many life insurance

products may exclude those with HIV, others allow coverage if the covered persons have access to vital healthcare like ARVs. One innovative product in this regard is AllLife, a life insurance product offered to HIV positive persons in South Africa.²⁹ As a part of this product, patients are compelled to conduct CD4 count blood tests every six months, and, should their immunity drop below a certain level, to start treatment in order to continue benefiting from the full life insurance benefit under the policy. Linking health preservation measures with life cover in this way allows the HIV-positive caregivers of children to stay healthier for longer while also providing protection in the event of death of the caregiver. Although AllLife does not pay for the medical costs associated with the tests or treatment, HMI could assume this role in other instances.

The logic behind the approach of AllLife can also be extended to other forms of insurance. In another example from South Africa, the credit life insurance provided by furniture retailer group Ellerines covers HIV-related treatment, including ART, for exposure to HIV as long as the patient is still repaying the debt incurred by a credit purchase.³⁰

Addressing the challenges of health microinsurance

HMI is undoubtedly one of the most challenging types of insurance to offer and has struggled in many cases to achieve sustainability. The discussion below presents a number of challenges highlighted in literature and research on HMI,³¹ specifically focusing on HIV- and OVC-linked microinsurance, while also outlining some potential solutions to these challenges.



CHALLENGE #1: HIGH COST OF CHRONIC CARE FOR HIV-POSITIVE PATIENTS

As mentioned previously, health risks are most insurable when they are low frequency, high severity events. The chronic nature of HIV, however, makes it a high frequency event³² and a challenge to insure. Thus, one could find many examples of HMI products which exclude coverage for HIV-positive patients. One notable example is the National Health Insurance Fund (NHIF) in Ghana, which applies exclusion for persons living with HIV.³³ This is not an isolated case, as many other HMI do the same.^{34,35,36} Other schemes, such as the RSBY example referred to above, will cover HIV related care only when it results in hospitalization,³⁷ an approach that often only provides benefits once it is too late and results in higher-cost events later on.

For those HMI products which do not have exclusions for HIV-positive patients, controlling costs can be an issue. The high cost of ARVs³⁸ may drive up the premiums of HMI schemes,³⁹ ultimately making them inaccessible to their typical target market⁴⁰ and even threatening their stability.⁴¹



Solution: Economies of scale, falling ART prices, and government partnerships

Cost concerns associated with ART can be readily addressed by taking advantage of the size of the scheme (in patient numbers) and using strategic partnerships and volume discounts.⁴² This, coupled with the falling price of ARVs globally⁴³ may allow larger microinsurance schemes to provide HIV coverage cost effectively. In the case of smaller, community based health insurance schemes, these may still take advantage of the benefits associated with larger organizations

through strategic partnerships.⁴⁴ Finally, many governments (including those of South Africa⁴⁵ and Brazil⁴⁶) are providing HIV testing and treatment free of charge, a benefit which can be leveraged by private insurers in order to bolster their ability to include HIV-positive patients in their HMI products. Beyond this, the high cost burden of ART may be minimized when the state carries some of the responsibility for the health insurance premium.⁴⁷



CHALLENGE #2: FRAGMENTED RISK POOLS AND ADVERSE SELECTION

Some level of cross-subsidization is needed between the healthy and sick to ensure viability, and thus HMI schemes need to ensure a broad and diverse pool of clients. Adverse selection,⁴⁸ whereby patients opt into insurance products only when they have an immediate need, undermines sustainability. The risk of adverse selection is exasperated in HIV inclusive programs,⁴⁹ as individuals with immediate healthcare needs are more likely to join a program than those without.



Solution: Social solidarity via compulsion or preventing exclusions

In order to avoid fragmented risk pools, insurance products must either draw on some sort of compulsion (as in the case of universal healthcare initiatives) or the prevention of price discrimination based on individual circumstances. These types of initiatives operate on a “social solidarity” principle which encourages cross-subsidization between various groups. Without price discrimination, however, cross-subsidies may lead to adverse selection, whereby only the ill would elect to enroll for cover, pushing up the costs for all. One key example is the South African Medical Schemes Act⁵⁰ that entrenches the need for

social solidarity in private schemes by disallowing price discrimination based on individual circumstances and removing barriers to pre-existing conditions. However, there is currently no compulsion. Along with a variety of other factors, this has meant that South African medical schemes are generally too expensive to focus on the poor.



Solution: Targeting family units and groups

Traditional methods for dealing with adverse selection, such as the use of waiting periods,⁵¹ may not be appropriate for HIV due to the protracted nature as well as the incurability of the disease. Targeting specific units or groups, however, may play a role in addressing adverse selection.⁵²

Making the insured unit an entire family, for example, will reduce adverse selection since healthy members will join the scheme together with any ill members, ensuring some level of cross-subsidization (unless the whole family is affected by HIV).⁵³

Another manner for addressing adverse selection is to make membership in an HMI scheme compulsory among a certain group, meaning that the healthy would be obliged to obtain insurance along with the unhealthy individuals. The National Health Insurance Fund in Ghana⁵⁴ is one such example. Although it currently excludes HIV positive individuals, the program is unique in that it mandates contributions from all workers in the country, and provides free membership for vulnerable groups such as the severely impoverished as well as children. Other examples come from MFIs which provide mandatory coverage for all borrowers.⁵⁵ In such cases, from the HMI perspective, the problem of adverse selection would be minimized.



CHALLENGE #3: MORAL HAZARD AND FRAUD

It is important to acknowledge the risk of moral hazard in insurance products, whereby clients or providers take additional risks and/or engage in unnecessary behavior,^{56 57} which leads to an overutilization of the services that are covered under the insurance product. Similarly, fraud in microinsurance can take many forms, ranging from non-insured patients posing as insured ones to healthcare providers claiming fraudulently in order to cover non-insured procedures. In some instances, healthcare providers may even claim for services that were not rendered or may provide unnecessary treatment.⁵⁸

One would not expect moral hazard or fraud to necessarily be any higher for schemes providing HIV care or targeting orphans and vulnerable children as opposed to other health insurance products. Nevertheless, specific product design considerations around these issues are important.



Solution: Removing co-payments for certain HIV-linked treatments

One of the most popular coping mechanisms for moral hazard is the co-payment system.^{59,60} While this may curb the problem of overutilization, it may also prove very exclusionary for the most vulnerable social groups⁶¹ such as HIV patients. Removing co-payments on ART medication and other HIV-linked treatments would be beneficial, while also not compromising on the risk of moral hazard since these are not treatments those without HIV would seek.



Photo: Child patient in GhanaSource: avso.org



Solution: Linking to specific provider networks

Correctly designing provider networks may help reduce the burden of moral hazard as well as fraud. This may be done through vertical integration between the institution financing the care and that providing the care (though regulation typically requires insurers to do only insurance business), or by incorporating effective monitoring, control and pricing structures into the agreement between the insurer and the provider. For example, insurers may specify that certain types of treatments require pre-authorization. In such a case, the scope for fraud as well as moral hazard may be reduced.

Furthermore, in order to ensure the sustainability and affordability of an HMI product, it may be important to limit the choice of service provider as well as the type of provider that the insured may consult.⁶² However, care must be taken to ensure that excessive limitations on provider choice do not present barriers to orphans and vulnerable children affected by HIV. Longer travel times and greater transportation costs to reach approved medical professionals may deter orphans and vulnerable children from seeking care.



CHALLENGE #4: EXTENDING COVERAGE TO MINORS

Vulnerable populations such as children and orphans are particularly hard to reach when it comes to healthcare coverage.⁶³ In cases where a caregiver is present, they are often faced with choices between which member of their family to insure⁶⁴ given affordability constraints, with women and particularly girls being neglected in favor of men and boys.⁶⁵ In the case where a caregiver is not present, children may suffer particularly due to the typical inability of minors to contract. In South Africa alone, this precludes 150,000 children currently living as part of child headed households from purchasing insurance on their own.⁶⁶



Solution: Family cover

One potential remedy is to expand the definition of the insured unit to the entire household. In such a case, children that form part of the household may be included regardless of whether legal or blood ties exist to the head of the household. This way, there is no trade-off between the insurance of a girl or boy child, or between an adult, orphan or vulnerable child.⁶⁷ Children who have no living relatives and have not been legally adopted are also not excluded.

Given the role women play as caregivers,⁶⁸ it may be worthwhile investigating the option that women are the primary policyholder through which the rest of the family can access insurance.⁶⁹ While these packages are generally more expensive, it is possible to mitigate these increased expenses by targeting a larger population. Of particular note is the case of SEWA in India, where women were explicitly targeted and offered programs that would insure their entire family,⁷⁰ highlighting the impact that insurance targeted at female

caregivers can have on orphans and vulnerable children. In order to help mitigate the costs associated with adding additional beneficiaries, governments or NGOs may elect to cover the premiums associated with orphans and vulnerable children as well as their caregivers.⁷¹



Solution: Targeting children via broader programs

Several strategies have been employed to target care and social protection to children, even if they are not the contracting party. Schools and orphanages can provide knowledge of and access to vulnerable children, while mobile network operators can be harnessed to disseminate public service announcements to their mobile users as a method of communicating with vulnerable populations and broadcasting opportunities for social protection.^{71 72} Under these potential models, governments, private organizations, or mobile network operators fund the premiums to provide valuable cover to the groups.



CHALLENGE #5: PREMIUM COLLECTION

The nature of premium collection will depend first and foremost on the funding model. In the cases where orphans and vulnerable children are added at no additional charge and automatically become beneficiaries to a scheme, no premium collection vis-à-vis this group is required,⁷² however registration may still be necessary.⁷³ Should the state or an NGO decide to provide cover through another vehicle, such as an established insurance firm, premium collection will take place from the government or NGO while registration of the individual or family with the firm will still be required.⁷⁴ From the perspective of the orphans and vulnerable children or their caregivers, these two options do not differ much.

In the case where orphans and vulnerable children or their caregivers are required to pay or co-pay the insurance premium, premium collection will be more challenging, as poor and vulnerable populations typically have low bank account penetration and irregular incomes. However, several innovative options exist.



Solution: Links to mobile and retail payment channels

The most convenient approach might be the use of mobile phones for payment. Microinsurance distributed through mobile phones has seen significant growth in recent years.⁷⁵ In these cases, premiums may be paid by drawing on mobile phone credits or facilitated via a mobile money platform. Mobile money premiums have also been found to be up to 98 percent cheaper than premium collection via banks.⁷⁸ This reduction can be further increased if agents are excluded from the model and payments are made directly by the insured.⁷⁶ Furthermore, where prepaid credit or mobile money is used to fund the insurance premium, the insured individual may elect to pay over the course of the month, with small daily deductions being made.⁷⁷ This reduces the risk that the poor may find themselves without cover due to the irregularity and volatility of their income.

Where this channel is not available, payment options may be made available through retailers or vendors that the poor frequent on a regular basis, where point-of-sale technology might be used for the collection of premiums.⁷⁸ In such instances, persistency of payments may still be a challenge. Insurers have found that using the mobile phone as a communication tool, by sending policyholders SMS reminders to go and make a premium payment, may increase persistency.⁷⁹



CHALLENGE #6: PAYMENTS TO HEALTHCARE PROVIDERS

Nearly all HMI schemes that cover cost-of-care must deal with the challenge of how to reimburse healthcare providers for their services.⁸⁰ The various reimbursement models for HMI include fee-for-service,⁸¹ capitation (the provision of a fixed sum of money for each individual to be covered),⁸² and case-based payment systems.⁸³



Solution: Caution with capitation

All of these systems have their own advantages and disadvantages, but from the perspective of HIV treatment, the capitation model of payment is particularly challenging, since it provides a disincentive for the treatment of individuals with expensive ailments, including those with HIV, with the potential to lead to substandard care. At the same time, no one reimbursement model can be touted as the best, with the positives and drawbacks of each needing to be considered based on the individual HMI product.

Conclusion

The poor carry a disproportionate burden of disease⁸⁴ while facing some of the most severe supply side constraints to healthcare access.⁸⁵ Furthermore, the challenges of funding healthcare places additional strain both on groups like orphans and vulnerable children and their caregivers.

It is with this in mind that health microinsurance should be considered as one potential tool to help address issues of healthcare access and financing. Coverage for financing the cost of care, provision of ancillary benefits, and increased eligibility for other useful insurance products like life coverage are all potential arguments for HMI.

Nevertheless, as this brief has shown, HMI, specifically for orphans and caregivers, comes with a broad set of challenges. The chronic nature of HIV can be difficult to insure. Sustainability can be undermined by fragmented risk pools, adverse selection, moral hazard, and fraud. Product design features like premium collection methods and provider reimbursement can make or break a product. And finding ways to target orphans and vulnerable children can be limited by affordability and contracting restrictions.

Despite these barriers, potential solutions do exist, and a growing number of examples of success in HMI are presenting themselves.

Ultimately, one of the key conclusions must be that HMI for orphans and vulnerable children must be viewed only as one piece of the solution to improved care. Creating links to existing social protection channels and health programs and forming partnerships with government for both subsidized premiums and care will often be vital to ensuring the viability of HMI programs seeking to reach orphans and vulnerable children.⁸⁶

Notes

Note: Complete bibliographic information is provided only on first citation to the source. Subsequent citations only include a “Name (year)” reference.

- ¹ For the purpose of this study, the *Evidence Base Report* identified orphans and vulnerable children as children under the age of 18 who have lost one or both parents to HIV, and/or have at least one chronically ill parent, and/or live in a household headed by a chronically ill individual (including child-headed households), and/or are themselves living with HIV. This definition is narrower than the one provided by PEPFAR, as it includes children who are directly affected by HIV but excludes those who live in areas of high HIV prevalence but do not have HIV directly in their home environment. For PEPFAR’s current definition, please see: PEPFAR (2012). *Guidance for Orphans and Vulnerable Children Programming*. Washington, DC: U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Available at: <http://www.pepfar.gov/documents/organization/195702.pdf>
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