Lessons Learnt the Hard Way

CGAP Working Group on Microinsurance
Good and Bad Practices
Case Study No. 6

ICMIF – January 2005

Good and Bad Practices in Microinsurance

This paper was commissioned by the "Good and Bad Practices in Microinsurance" project. Managed by the ILO's Social Finance Programme for the CGAP Working Group on Microinsurance, this project is jointly funded by SIDA, DFID, GTZ and the ILO. The major outputs of this project are:

1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website: www.microfinancegateway.org/section/resourcecenters/microinsurance

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Introduction

The CGAP Working Group on Microinsurance has commissioned the International Cooperative and Mutual Insurance Federation (ICMIF)[1] to document worst practices in microinsurance, from among its members and the insurance industry at large. How can one attempt a catalogue of things gone wrong in insurance companies? Best practices are much bandied about by businesses. Are worst practices a mere mirror-image of best practices, reversing right and wrong? Or are worst practices an extreme absence of best practices? Would it be meaningful to list worst practices without touching on how things should or could have been done best? Does fixing problems caused by a worst practice not call for a good measure of best practices? And are there not sometimes some seeds of disaster in a great decision made in the pursuit of excellence?

In answering these questions, this paper creates a framework of an insurer's vulnerabilities, with real-life examples of things going wrong sprinkled throughout. Essentially, the framework fits and joins together all the functions that make an insurer tick. To make sense of what went wrong and how and why exactly, each part of the framework describes the function and its proper handling (or best practice, if you wish). Devoid of the bad examples, the paper could therefore stand as a reference document, providing a rundown of the principles of insurance, and its functions, types, organisation, financial operation and control structure.

Appropriately, examples do not identify companies and people involved. The examples are drawn from actual insurers, in both developed and developing countries, and cannot strictly speaking be identified as microinsurers. Some are leading players in their markets. Typically the customers of developing insurers may not be the very poor, but they do take in people and market segments that may be described as insurance-poor.

Nevertheless, lessons learnt from the worst practices among this group of "regular" insurers should be of great relevance and use to microinsurers. It may be a surprise to many to learn that over 30 insurers in Europe have either gone into insolvency or required a "white knight" to save them in the last 10 years. This knowledge of failure has been collated by the European Commission and currently forms the bedrock of insurance regulation being worked on in Europe. Many of the reasons for failures are reflected in the examples shown below. A shock to the system a substantial insurer may be capable of absorbing could prove fatal to a small insurer. All the more reason microinsurers should realize that insurance is a risky business with its own strict discipline; fiddle with its fundamentals and you jeopardize your insurance programme's survival.

Insurance company failures are the result of a complex interaction of risks; they are not mono-causal but rather a mix of various causes and effects. Risks can be positively and

[1] ICMIF is an international association of insurers operating on the principles of the cooperative movement and democratic mutuality. Since it was founded in 1922, the Federation has steadily built up its membership from five European cooperative insurers to 141 organizations now in 67 countries, representing more than 300 insurance companies. The principal member services provided by ICMIF are reinsurance, development, market intelligence, investment, the biennial global conference, and training.

negatively correlated in often unexpected ways which can cause a domino effect where one risk leads to another which ultimately leads to failure. In the majority of cases management is the root cause of failure whether it is through incompetence, ignorance or malfeasance.

The cases chosen for this study are from the insurance market at large, with an emphasis on insurers most similar to microinsurers. Some of the facts have been modified to protect the identity of the organization. The cases span a wide range—from the basically amusing (a manager insisting at the commissioner's office that his company had indeed received the licence to do business, and discovering on his return to his office that what he had put on the wall was the elevator's licence), to the disastrous (a dishonest employee pocketing premiums for bogus long-tail policies that continued to chalk up claims for years after he was put behind bars).

Making the List

Company 1 started as an agency to serve the insurance needs of various affinity organisations[2] and businesses—agricultural, marketing and financial—in a developing country with a centralized economy and a state insurer. When the market was liberalized the agency was converted into an insurer owned and controlled by the affinity organizations. The company lasted barely five years.

Company 2 was set up as the first mutual society after a 50-year break in a country in transition where the insurance industry, before the Second World War, had followed the mutuality tradition. A principal sponsor is a farmers' organisation. A persistent challenge has been competition from stock companies selling products at lower prices, particularly to farmers. The company continues to exist—struggle?—with a perpetual shortage of capital.

Established in the mid-'70s, **Company 3** provided protection to middle- and low-income earners. Group life insurance showed early promise, but the company got into individual life insurance which is a significantly difference product. The company mistakenly thought it needed a vast network of branches spread across the country in order to distribute the product. It died a long, slow death in the '90s.

Company 4 is owned by many savings and credit cooperatives and their national federation. Together they have controlled—and run—this insurer for a dozen years. General managers have come and gone through a revolving door held by the board of directors, whose ambitious forays into unfamiliar lines of business have not failed to oblige—with stunning losses.

Company 5 is a mature and leading insurer in a developed market. Riding high in the late '80s, its senior management thought nothing of the executive in charge of diversification bringing in a well-regarded professional with a glowing resume from another organisation to introduce a new line of business. The recruit impressed colleagues with his professional knowledge, chalking up a good and profitable book of business. Before long his brilliance

[2] The term affinity organisation or group is used throughout this paper to refer to an association that is organised along cooperative or democratic principles, such as farmers' associations, savings and credit unions, housing cooperatives, trade unions and the like.

betrayed his true colours as a rogue trader, who had lined up his own pockets issuing policies that were not worth the paper they were (under)written on. A long tail of claims brought Company 5 to its knees. After a recovery that has taken years, the company stands upright again, buttressed by strong foundations in its affinity groups.

For 12 years, **Company 6** has been owned by and served a strong affinity group in a small country. A few years of operating beyond its means have brought it to a critical juncture, with the insurance regulator serving notice that it must increase its capital. Owner organisations have the money but appear unwilling to add to their shareholding in the company to help meet the minimum requirement. Would its reinsurers help with a restructuring of covers that would offset the capital shortfall? Or is there an insurer/investor overseas with a good eye for Company 6's potential in this promising market?

Company 7 primarily serves the agricultural and financial industries in a country destined to be the continent's model of development. The insurer took only a decade to stand out as a model insurer. But soon thereafter it took a turn for the worse with an ill-advised investment in real estate. An overseas financial injection in the company's equity rescued it from the brink of failure, but the accompanying programme of technical assistance did not sit well with its management and was plagued by a persistent lack of implementation until it ended five years later. New management has since declared Company 7 financially stable again, repatriated all foreign-owned shares and made an investment in prime property. With actuarial and claims reserves being adequate, outstanding premiums in check, and capital and retained earnings at the level required to back the influx of new business, Company 7 should gradually improve its position in the market.

With annual premiums just over $400,000, **Company 8** has remained a developing insurer for 31 years. Save for a brief moment in the sun in the mid-'80s when it enjoyed government support as well as patronage of the founding agricultural owners, the company has struggled to survive in the shadow of better-managed and better-governed insurers. It should not be doing badly, for the country and its markets are well-placed and suitably populated to appeal to international donors, attracting a regular inflow of assistance for the development of microfinancial services.

Company 9, founded by an affinity group in a region of the same country, it considers Company 8 an ill-conceived child of the government-imposed system. Genuine grassroots, however, have done little to let Company 9 grow out of its status of a mutual benefit association even after 34 years of operation despite having registered a life insurance subsidiary in 2003.

Putting It Together

The nine companies are numbered in the sequence in which they appear in the study. Their worst practices would have been of note simply recounted in nine chapters. However, the study is meant to satisfy more than curiosity and interest, so it has strung them in four chapters, along the thread of setting up, organising, operating and leading an insurance programme:

1. **How the insurer serves its purpose:** mission and objectives, and principles of insurance
2. **How the insurer is organised and managed:** core functions, marketing, collecting premiums, paying claims, and managing human resources
3. **How insurance works financially:** insurance accounting, investment, and reinsurance
4. **How the insurer is governed:** role and responsibilities of the board of directors

Each chapter begins with a list of **Pitfalls**, pointing to what it includes, and ends with **Signposts**, points that can help keep microinsurers on track. Here and there, boxes are inserted to bring home or detail some aspects of the text.

This paper can be summed up in the following way: it is better to learn from the mistakes of others than to simply repeat mistakes already made.

1. How the Insurer Serves its Purpose

Pitfalls

- **The mission is too idealistic, too visionary and too far removed from reality to be of practical value in guiding the organisation.** ***(Stick to the knitting)***
- **The mission has elements that serve the financial interests of sponsors and shareholders more than the insurer's purpose to serve its customers.** ***(Watch where the mission says the money goes)***
- **The mission guides the organisation to meet every need in the market, every which way.** ***(Have need, will meet)***

1.1 Stick to the Knitting

A business organisation is established for a purpose, defined in its **mission** and elaborated in its **objectives**. For an insurer set up by people-oriented organisations, the prime purpose is to meet the insurance needs of these organisations and their individual members. For a microinsurer, whether sponsored by a microfinance institution or not, the main purpose is to meet the protection needs of low-income households. And that should be its guiding light—not a grand design to achieve a pompous social objective (see Box 1).

Insurers, like other businesses, succeed if they stick to their knitting. As a manager trying one's best, one must keep one's eye on the ball and not get entangled in unplanned ventures. Yet a golden, get-rich-quick opportunity to expand the business can come along and make one forget that insurance is a long-term business and builds over time. One loses one's perspective and ignores the inner voice: "If it looks too good to be true, it probably is."

A microinsurer, doing a good job looking after its customers, could be tempted to take on customers with more lucrative businesses that are having difficulty for one reason or another insuring with regular insurers. The seemingly effortless hefty increase in premium income would certainly be nice, but would it spawn a much higher jump in claim payments at some point?

Such temptations commonly confront insurers, often on a much grander scale. One company decided to change its business mix by acquiring a reputable commercial company that was in financial difficulty and needed a capital injection. Despite qualified, experienced accountants and external auditors, the due diligence did not reveal the depth of the financial burden the acquisition placed on the acquiring company.

Box 1. Mission Statement Examples

A **mission statement** should call for a rifle, not a shotgun.

Good: Our mission is to provide relevant, competitive and high-quality insurance products and services that will make our targeted customers financially secure.

Bad: Our mission is to fulfil the social role of offering protection and safety to all sectors of the country's society.

Aside from this financial millstone around its neck, integration required much more time and effort than the acquiring company expected, putting great stress on its operations. Differences in corporate culture, computer systems, employee benefit programmes, competition for management posts and a host of other issues took years to resolve.

Expanding into new lines of business has been the undoing of many companies large and small, as the administrative differences and technical expertise required for each line of insurance are often underestimated. Yet there are successful organisations that have existed for more than two centuries concentrating on just two or three lines of insurance. Some companies begin with 10 to 15 lines of insurance and a staff of four or five with little or no experience, bent upon biting off more than they can chew. A lack of expertise and support services while introducing highly sophisticated and complicated products has put many an insurer on the road to ruin.

It must be said that acquiring or merging organizations rarely brings about the synergies and savings envisioned at the start of the process, but frequently leads to bitter in-fighting at every level, to the detriment of the insurers and their customers. So beware the "empire builder" style of manager.

1.2 Watch Where the Mission Says the Money Goes

Yet, sometimes an insurer's management can get caught in a web not entirely of its own weaving. The company's mission and objectives, a recipe for success, may contain a germ of terminal illness.

Drafting an organisation's mission and objectives looks easy—after all, it is usually just a handful of sentences that could be written and approved in a matter of hours. In fact, they should command the board and management's full attention and painstaking consideration of each element. If the board and management do not have the required expertise, they would be wise to hire a knowledgeable consultant to ensure that the organisation's strategic objectives are free of fatal flaws.

Once the mission statement is decided then it is essential to formulate a **business plan** to carry out that mission. This is where most businesses fail as the business plan is too optimistic and the reality often falls well short of the expectations. It is thus vital to run a number of financial scenarios to cover all eventualities. Current regulatory thinking focuses on over 500 scenarios for existing insurance companies in order for them to satisfy solvency

levels. Whilst this is not necessary in a microinsurance organization, it shows the importance and depth of analysis required from a business plan to carry out the mission statement

Take the case of **Company 1**—a developing insurer that is no more.

In 1976, an affinity group decided to establish an in-house insurance agency to look after the needs of its members. The agency mainly served as a convenient vehicle for the state-controlled national insurance company to tap into the captive market. By 1992, when the insurance market opened up, the agency had done well enough accumulating commission earnings and building expertise that it took the step up to become an insurer.

The insurance company began its new life with four key objectives. One of the objectives set by the board of directors was "to generate revenues which could then be utilized to develop and strengthen the affinity movement in (the country), by ploughing back surplus into its various activities and endeavours."

Later the general manager reported: "The image of the affinity group in my country was not very good, in the sense that it was initially so strongly related to the one-party state that existed. So what we're about to do is to paint a different image that we are there first and foremost to serve our members, and that indeed we are a commercial enterprise. And in general it is known that people don't look at insurance companies very positively. They normally think that people in insurance are crooks or they are there just to get quick money. So we've had to work towards building up a good image. I'm happy to say that in the short spell of time we've been operating—about four months—the response is positive."

The general manager went on to say: "I went out with the board members to the provinces and visited members to explain the services we were offering. We told them that the share capital was (the equivalent of) about $250,000, but they said 'We would like you to increase the share capital,' so it is now $1 million. We got a lot of support from the members; they were very, very willing to insure with us, and they look at the company as their own organisation."

Barely three years later, this "all in the family" feeling had turned sour. The company identified a reversal of fortunes as the main problem: the very organisations that had thought nothing of contributing a much-higher-than-requested share capital now wanted to siphon off money from the insurance company. "Most organisations that originally enjoyed heavy subsidies from the government," it said, "are now unable to operate viably, with serious consequences being passed to the insurance company."

The sponsors seemed to be saying: "Capital needs of the insurance company be damned. Let us fulfil that useful company objective—the one about ploughing back surplus into our own activities and endeavours."

While the board set upon bleeding the company dry, the general manager identified a new main challenge: "To market the company in a newly liberalized insurance market, particularly with regard to non-affinity customers."

1.3 Have Need, Will Meet

An original objective of Company 1 had indeed been "to improve the quality of services for the affinity movement, as existing covers had left small-scale farmers uninsured." The company enjoyed huge growth in the first couple of years of operation. Forty percent of its total premium came from its affinity group. Tied agents took new business and issued renewals from seven provincial offices.

But as the government began to withdraw support for the sector, the company, in what appeared to be a self-defeating change of direction, proclaimed that it was "embarking on programmes to introduce and tailor insurance packages to suit the varying needs of the insuring public, as it was necessitated by the government's Structural Adjustment Program (SAP) with its attendant social and economic problems."

What it meant was that the company would offer any product through any channel to anyone as long as there was a buck in it. Consider the new list of products, with scant mention of the primal agro line: "motor, marine, engineering, accident, fire, group life, mortgage protection and agro." There was no telling how, if at all, "custom-made packages of insurance coverage, meeting varying needs of individuals and businesses" complied with some, let alone all seven, principles of insurance (see Box 2).

A potential loss can be insured only if it has certain characteristics. The first of these is that the loss must occur by chance. A business and its activities cannot be insured if its failure or closure is certain—if the handwriting is on the wall, for example, as a consequence of the government's Structural Adjustment Program.

And then there is the seventh principle known as anti-selection. It refers to the tendency of persons with a greater-than-average likelihood of a loss to apply for or continue insurance protection. People in poor health or a hazardous occupation tend to seek life insurance. An insurer, while developing and offering a policy, needs to make sure that it does not only attract applicants likely to present claims. Company 1, knowing that the government's Structural Adjustment Program put the survival of many small businesses in question, went ahead and insured them anyway, thereby virtually ensuring a flood of claims in short order.

The new list of distribution channels also took in any that could be tried: "direct writing, exclusive agents, independent agents, brokers and direct mail." And so did promotion: "electronic media adverts, printed media, prospecting letters to potential customers, the company's own marketing executives and also associations, societies and unions."

A reinsurance underwriter who visited the company in its dying days reported, among other findings, the following:

- The company's flying start could have served as a good foundation for building the business, but through excessive board involvement and general mismanagement the money was either spent or premiums remained uncollected when claims came home to roost.

Box 2. Principles of Insurance

1. ***The loss must occur by chance.*** A loss is insurable only if it is caused by an unexpected event, and not caused intentionally by the person covered by insurance. For example, a property loss can be insured against the chance of fire, but the policy benefit is not payable if the fire is set deliberately. While death is certain, a person's life is insurable because the time of death is a matter of chance.
2. ***The loss must be definite.*** An insurable loss must be definite in terms of *time* and *amount*. The insurer must be able to determine *when* the benefit would be payable and *how much* it should be. A *contract of indemnity* sets a limit or maximum amount payable regardless of the size of the loss, and, used for insuring a car that is stolen for example, would pay the depreciated value of the car on the day it was stolen. A *valued contract*, used for a life insurance policy for $5,000, will pay that amount as the death benefit. (The amount is called the *face amount* or *face value* because it is mentioned on the face or first page of the policy.)
3. ***The loss must be significant.*** The loss of a pen or sunglasses would not cause financial hardship to anyone. These types of losses are not normally insured. The cost of providing such a small amount of insurance would be too high to make the protection economical.
4. ***The rate of loss must be predictable.*** The rate, or the number and timing of losses expected in a group of insureds during the term of coverage, determines the premium. The rate can be predicted by the use of: a) *probability*, of the relative frequency with which an event has occurred or is likely to occur; and b) the *law of large numbers*: the larger the sample, the more accurate the estimate or prediction.
5. ***The loss must not be catastrophic to the insurer.*** It should not be beyond the insurer's ability to honour claims. An insurer can avoid huge losses by means of reinsurance or a transfer of risk to other insurers.
6. ***There must be an insurable interest.*** The insured event must cause a genuine loss to the insured. A fire insurance policy on a particular building would not be sold to a person who does not own the building. For life insurance there must be family or financial ties: a) *Beneficiary's interest*. It is legally established that all persons have an insurable interest in their own lives; there is more to gain by living than by dying. An applicant/insured also has the legal right to designate as beneficiary any person or party desired. Family relationships create an insurable interest. b) *Financial interest*. An insurable interest is not presumed when the designated beneficiary is more distant than the insured's family by blood or marriage. In such a case a financial interest in the continued life of a person or safety of property must be demonstrated.
7. ***There must not be anti-selection or selection against the insurer.*** Insurance is based on a risk- pooling concept whereby funds from many policyholders are used to compensate the unfortunate few who are affected by a peril. For the risk-pooling mechanism to work, a policy should be designed to attract applicants who are unlikely to present claims. To avoid adverse selection, the risk should be spread among a large number of policyholders, and steps need to be taken to prevent the pool from being dominated by high-risk persons.

- The entire board went half way around the world on "study trips." Such extravagance was deemed necessary to keep the support of the board. Expensive company cars and lavish hospitality were also evident.
- There was a lack of focus in product design, marketing and distribution, with considerable chopping and changing to different methods and combinations. The share of business from the affinity group had fallen by 50%.
- After a protracted conflict with the chairman, the general manager resigned at the beginning of the year. An acting general manager was named and the marketing manager suspended.

A few months after this report, the company went into liquidation. It was essentially a reinsurance renewal report, and not as damning as it could have been. Yet its first two sentences on the company's financial performance were telling and pointed to what, despite other worst practices, was its Achilles heel: "The audited company accounts for the first period of operations (1 July 1992-31 March 1993) have now (in 1996) been prepared. These present a picture different from the management reports provided previously."

Poor and negligent accounting— certainly! But that is a thread of the story that belongs to another chapter.

Signposts

- **A number of reasons for an insurer's failure also apply to other businesses, but are still worth highlighting. They include: inadequate expertise and know-how, use of proceeds for personal gain, extravagant expenses, unreasonable delays in producing audited results, and trying to grow too quickly.**
- **Some failure factors are particular to the insurer's sponsoring organisation. For cooperatives or MFIs, these include seeing the insurance programme not as a service operated for the benefit of the customers, but as a source of revenue for the development of the sponsoring organisation itself.**
- **Complex products will invariably encounter uncontrollable claims costs and erratic cycles. A new insurance programme should begin operations with a limited number of services that are easy to manage and control.**
- **Insurance is a long-term business and builds over time. It is also technical and capital-intensive. For each line of insurance offered, adequate claims reserves need to be established and sufficient capital and surplus maintained in accordance with professional standards.**
- **As it expands, the insurance programme itself will require an increasing amount of capital. Before paying dividends, insurers should retain sufficient earnings to support future growth.**
- **If an opportunity looks too good to be true, it probably is.**

2. How the Insurer is Organised and Managed

Pitfalls

- **The corporate form chosen for the insurer—joint stock, mutual or other—stunts future growth.** ***(Look ahead when you put it together)***
- **Heavy infrastructure and overheads are not supported by the income stream.** ***(Put functions in place, but not everything everywhere)***
- **Distribution channels do not suit customers.** ***(Deliver what they want in a way that will reach them)***
- **Policyholder service is provided without an eye on the total picture and there is no appeals process in place for claimants.** ***(One person's gain could be at others' expense)***
- **Premium collection is tentative and a high proportion of amounts due remains outstanding.** ***(Premiums must precede coverage)***
- **Insurer falls to the temptation of raking in high premiums for riskier lines of insurance.** ***(Slow and steady does it)***
- **Employees are hired without proper background checks, and there are no checks and controls.** ***(Biggest asset, yes—but where has it been?)***

This next example is of an insurer in a transition country with an annual net premium income of $3.5 million, 27 staff members and no service centres other than the head office. In the same country, **Company 2** has a net premium income of $5.8 million, 210 employees plus 85 part-timers, and 23 regional offices with 32 sub-offices "for sales and loss adjusting." **Company 3**, in a developing country, had (the past tense is no mistake) a net premium income of $2.8 million, a staff of 705 plus 1,825 part-timers, and 58 service offices all over "for underwriting, claims settlement, premium collecting and marketing."

Even making allowances for the differences in products, market segments and geography, it is not hard to tell which insurer can look ahead to a stable future and which is likely to continue struggling, and why the third bit the dust. A basic, albeit rough, measure of productivity says it all: premium per employee. It is $129,629 for one and $19,661 for the other, and it was a mere $1,106 for the third. The one with the highest number of employees also, understandably, had the neck-breaking overhead burden of the highest number of service outlets.

To hold its own against all odds, an insurer—particularly a microinsurer—need not be mean, but it must be lean. And it can be that if its sponsors and managers know how a good operation is organised, how insurance works financially, and what to watch for once premiums begin rolling in.

2.1 Look Ahead When You Put It Together

The organisation of an insurance operation starts with a fundamental step, its legal set-up. The choice needs to be governed by not only what is available but, more importantly, what the insurer will need to do well in the years ahead if it is managed properly and continues to grow. There are basically two forms an insurer has to choose from when registering as a legal entity: **stock** and **mutual**.

A **stock company** is a business enterprise in which the capital is divided into small units permitting a number of investors to contribute varying amounts. Dividend payments are made out of profits in proportion to the number of shares stockholders own. The stock company developed because of the need for large capital by certain types of business.

A **mutual company** is a corporation without issued capital stock and owned by members who do business with it. Profits, after deductions for reserves, are held collectively for customer-owners in proportion to the business they did with the corporation. A mutual does not have shareholders to whom dividends need to be paid, but it may pay premium rebates to policyholders.

In some countries with a strong self-help and cooperative tradition, an insurance company or society can be incorporated as a **cooperative**. But in many countries, this is not an option. In some newly opening markets, such as China and Russia, insurance law does not even permit the mutual form—with the authorities relying on stock companies to bring in foreign investment.

The ownership structure reflects the main **difference between a mutual and a cooperative**. A mutual insurer must be owned by its policyholders, whereas a cooperative insurer can be owned by other cooperatives which are not required to be its policyholders (although they should support and patronize it as corporate policyholders). In other aspects such as marketing, community involvement, and staff participation and welfare, a mutual true to the spirit of mutuality **should** have the same ethos as a cooperative insurer.

There are numerous examples where cooperative and other types of apex organizations start insurance operations and establish them as stock companies. The reason for so doing may be legal (China, Russia), fiscal or merely for practical ownership reasons. They own the insurance companies' capital and exercise control on behalf of their members, while operating the company for the benefit of the policyholders.

For serving the poor, the most appropriate form of insurance operation depends on the circumstances.

If it is a microfinance institution (MFI) or a group of MFIs that would like to establish an insurance operation for customers, the stock form would be the way to go. In that case they would do well to follow the cooperative insurance model—owning the equity capital, exercising control and operating the insurer on behalf of and mainly for the benefit of their customers rather than their own benefit as shareholders. Stock insurance companies and mutuals adhering to cooperative principles have different roots in different countries, but share some characteristics:

- Democratic control, underpinned by education of the customer base and with policy-owners actively involved in setting policy through delegates and working groups.
- Limited return on equity capital.
- Affiliation of founding members and most policyholders to social, community or professional institutions.
- Promotion of loss prevention, health and safety to reduce the cost of insurance.
- Influence over the rest of the insurance industry and the government in the interest of policyholders.

If the insurer is to operate in an area where there is a solid and broad base of individuals interested in coming together to meet their own needs for microfinance, including insurance, the mutual form would be suitable—particularly if they already have an affinity or bond through membership in a professional or community group. The drawback of such a mutual may be that additional capital to support future growth is hard to get.

Company 2, the struggling insurer with a relatively large number of employees and offices in the country in transition, is a mutual. Its local sponsors now probably wish it were not a mutual. When it fell upon difficult times a few years ago—largely its own doing—it badly needed more capital to survive. The International Finance Corporation (IFC), which supports worthy enterprises in developing markets by taking minority equity positions, was invited to invest in the company. The IFC responded that the insurer's technical measures were not quite up to par, but even if they had been, it could not invest in a mutual because the exit strategy is too difficult due to the fact that there are no shares to sell (and the IFC is not permitted to invest using subordinated debt).

Over the past few years, business media have given much attention to pros and cons of the practice called demutualization—of mutuals becoming stock companies. Some of the points made would be of interest to those contemplating entry into microinsurance.

The insurance industry currently has a far greater number of stock companies than mutuals. In the United States, there are older and larger mutuals (as there are in a number of other big markets), but the number of demutualizations in the last 10 years has meant that the mutual market share has decreased. The trend towards demutualization does seem to have stabilized with no significant insurers demutualizing since 2001. Most newly formed insurers are, indeed, stock. One reason may be that in some markets mutuals are more difficult to form. To start a mutual in the state of New York, for example, there must be applications from at least 1,000 persons who have each bought at least $1,000 of life insurance and must have paid their first premiums. In other markets where microinsurers are more likely, the requirements for mutuals may be easier to meet.

In a mutual, policy-owners are, of course, also "owners" of the company, but the "ownership" value, other than the ongoing institutional value and benefits of mutuality, is minimal unless the company demutualizes and the market establishes its value, the so-called windfall.

To raise capital, mutuals sometimes can issue subordinated debt, but cannot get access to equity capital as stock companies, which can access the capital markets. Some organisations have managed to have their cake and eat it too—by creating an "upstream" holding company

as a mutual which controls operating companies providing insurance services that are stock and able to raise capital.

In an ideal world an insurer, irrelevant of its legal form should plan to build its own capital and reserves slowly and steadily by operating a profitable business model that grows within the boundaries of its own capital base. Introducing new capital automatically brings with it new risk that can overwhelm the competencies of management and board. That said, there is increasing pressure on capital from regulators brought on by increased solvency requirements, transparency and customer protection practices, which increases costs. Consequently, insurers today need more capital than ever before just to keep pace with regulatory reform.

2.2 Put Functions in Place—but Not Everything Everywhere

Company 3, the one with huge overheads that died before reaching maturity, wanted to be close to its customers spread across the country. So it put all the needed functions—underwriting, claims settlement, premium collecting and marketing—in each of its 58 service offices, without distinguishing between front-line and support services. Good for creating jobs, but temporary ones at best.

Insurers organise activities in different ways, typically by:

- **Function**. This is a division of labour by the type of work performed, or an aspect of operations that requires special technical knowledge. Box 3 summarises the major functional departments in an insurance company.
- **Product**. The work can also be organised according to the company's lines of insurance. For example, individual insurance and group insurance in a life company, or personal insurance and commercial insurance in a general insurance company.
- **Territory**. Field and branch operations of an insurance company are normally organised according to territory, and its major divisions are determined by geographic areas in which it operates.

A particular company may use any one of these systems or, quite likely, a combination of them. For example, a company could organise itself by product and then organise each product unit according to function. Or it could centralize most support services at the head office and have regional and branch offices focused on selling and servicing operations.

New insurers should adopt the form of organisation suited to their circumstances, markets and scope of operations. Microinsurers would do well to keep in mind a common recommendation of insurance specialists: in setting up and building an insurance programme, take one step at a time—according to and in response to business on hand. Experts suggest this having observed many promising insurance operations set up shop in their formative years as if the millionth customer was minutes away from knocking on the door, only to bite the dust a few years down the line when policy numbers as well as incoming dollars refuse to budge from tens of thousands at best.

Small or new insurance companies may operate with a handful of staff looking after a number of functions each. An emerging insurer can also outsource some of these functions to consultants, agents or support companies. For example, a small insurer cannot afford an in-house actuary, and is more likely to hire an actuarial consultant instead. The same situation may apply to IT services and investment management.

For microinsurance, where insurers are trying to manage large volumes of small policies, one of the biggest challenges is how to structure the sales and delivery systems to reach many people without heavy overhead costs. Here the cooperatives' structures and networks, or those of microfinance institutions, represent a significant advantage. Instead of creating a new delivery infrastructure, insurers sponsored by co-ops or MFIs can build on the financial transactions already taking place between its sponsors and their members. Company 3 did not have this luxury, and therefore felt obligated to create its own delivery system, which jacked up overhead costs to unsustainable levels.

Box 3. Basic Operations of an Insurer

A typical fully developed insurance operation might comprise the following departments:

Marketing and sales. This department normally conducts market research and works with other departments to develop new products and revise current ones to meet the customers' needs. It prepares advertising campaigns, designs promotional materials, and establishes and maintains distribution systems. It may be responsible for distribution and delivery of products and services to customers, or it may share that responsibility with a separate sales department. Sales targets are set for each year and agencies and branches are consulted on how best to achieve them. Branches carry out the programmes by appointing and training agents to represent the insurer, keeping them informed of new products and services, and following up on policy renewals.

Underwriting. To underwrite is to accept or reject the risk of insuring. This department studies market trends, past experience and statistics, and then formulates underwriting guidelines, such as risk and class limits and other controls. At the branch level, policies are underwritten according to those guidelines.

Loss prevention. General insurance (a.k.a. non-life or property-casualty) companies may have a technical services department with engineers and other specialists. They inspect and report on risks involving special hazards, assist in rating, and make loss prevention recommendations which benefit the insured and insurer.

Claims and policyholder service. This department is primarily responsible for servicing customers and managing their claims. Examiners review claims presented by policyholders or beneficiaries, verify the validity of claims, and authorize the payment of benefits. In a general insurance company, branch offices deal with claims up to a prearranged limit. Adjusters investigate, negotiate and settle these claims according to the provisions of the contract or policy.

Actuarial. This department is responsible for seeing that the company's operations are conducted on a mathematically sound basis. In conjunction with other departments, it designs and revises the insurance products. It establishes premium rates, determines future liabilities, and makes recommendations about the use of surplus. For general insurance, it predicts frequency and size of claims based on statistical records of previous losses and the probability of future losses. For life insurance, it researches mortality (the rate at which people whose lives are insured are expected to die at various ages) and morbidity (the percentage of deaths by specific diseases). And it establishes guidelines for selecting risks and determining the profitability of the company's products.

Investment. The investment department examines the financial marketplace, recommends investment strategies to the company's management and board, and manages the company's investments according to policies established by the board. Its staff buy and sell stocks, bonds, mortgages and real estate. They also act as advisers to the board when a merger or acquisition of another company is planned.

Accounting. The accounting department maintains records that show whether the company is being run in a profitable manner. Aside from the general accounting record, it prepares financial statements, controls receipts and disbursements, oversees the company's payroll, and works with the legal department to comply with regulations and tax laws.

Legal. The legal department makes sure that the company complies with relevant laws and with insurance regulations. It studies current and proposed legislation to determine its effects on the company's operations, advises the claims department when claims are disputed, and works with the accounting department in determining the company's tax liabilities. It represents the company or instructs outside lawyers in any litigation, and handles investment agreements. It also helps develop policy forms and other contracts used by the company.

Information systems. Also known as IT (information technology), this department develops and maintains the computer systems used by the company—for data and word processing and office automation. With increasing sophistication, IT's importance to the insurance industry has grown enormously. This department affects every part of the company. It helps other departments develop, buy and use computer systems and software needed to provide information, maintain records, and administer products. Information systems staff also maintain company records in computerized files, help prepare financial statements, and conduct analyses of various procedures and systems used in the company.

Human resources. Also called personnel, this department formulates company policy on hiring, training and dismissal of employees, determines levels of compensation, and ensures compliance with employment laws. It also administers employee benefit plans, such as group life insurance, group health coverage and employee pensions.

Office services. This unit is responsible for the premises, equipment, stationery and supplies, printing of all forms and policies, services, secretarial help and other administrative functions. It may be a part of the human resources department or an overall corporate services division.

2.3 Deliver What They Want in a Way that Will Reach Them

As in the choice of products and offices, excessive **distribution channels** can qualify as a worst practice, especially if the insurer forgets its target market in the process. Company 1, formed to serve an affinity group, neglected to focus on its existing distribution channel—the affinity group—to reach its target customer. Granted, management had an uneasy relationship with affinity leaders on its board, and the amounts of premiums from the affinity group were small.

Yet, a look back confirms what may not have been obvious at the time—that it is much easier and safer to work hard at removing difficulties from what is at hand than to jump into uncharted waters and take a stab at instant growth. In sum, delivery channels need to be effective ways of reaching the intended target market.

For example, one insurance company operating a pilot project to reach microentrepreneurs failed to show much for its efforts over the experiment's first year. It downsized some of its products to match the needs of this mobile and fickle market, but used a cadre of regular agents to distribute the products. Most of the targeted customers, essentially owner-operators of portable businesses, shunned the agents even when tracked down—if for no other reason than to avoid being identified for licensing, registration and tax purposes.

A microinsurer needs to put considerable effort into educating its potential customers and raising their awareness of insurance. Information about how insurance can improve their lot can help overcome their natural suspicion of insurance and insurance salespersons. And what better way of accomplishing this than employing processes, procedures and people they are familiar with, they can trust and speak their own language?

Successful cooperative insurers, in Canada and Singapore for example, have used recruits from local communities and outlets of sponsoring organisations as "insurance advisers" to reach and educate customers.

One insurer owned by credit unions and farmers' groups used a network of voluntary advisers based in each credit union to promote products and provide advice to members on insurance matters. A few times a year the district office of the insurer would hold a get-together for advisers to bring them up to date on plans and services and to honour them for their contribution. The other insurer, sponsored by the trade union movement, had a similar network of trade union and community officials who promoted insurance services part-time.

A study in the Philippines found that many MFIs had developed their own informal in-house insurance systems. Products ranged from very basic life insurance for loan protection to maternity, hospitalization and death aid. Some were compulsory (loan protection), others voluntary. Premiums were generally added to the loan amount or deducted from the loan proceeds. Amounts collected were put in a reserve in a bank account from which claims were paid (and which generated substantial interest to the MFIs). One MFI in the study served hawkers and peddlers successfully by using a few of its clients as agents to ride around on bicycles for collections and disbursements.

In Africa, an insurer used local churches for weekly payment of premiums as add-ons to Sunday collections from low-income customers. These poor, insured even against AIDS in an innovative group policy where the unit is the family not an individual, may not have a business or home address but they do go to church every Sunday—with the added incentive of having their premium coupon book stamped as proof of payment to keep the insurance policy in force.

Where a company has put its needs and convenience first—rather than the customer's—trouble has followed. Along with other self-inflicted wounds, Company 1's post mortem revealed a lack of focus on distribution strategy: "The company has decided that the branch office network is not functioning satisfactorily and one office has been closed. Management is testing the possibility of changing its distribution channels by recruiting agents. Contacts with brokers are being encouraged, even though most brokers use one insurer only. A major change can be expected next year with more business coming from intermediaries."

With its branch office network in need of review, downsizing and repair, the company instead experimented with agent recruitment, hoping for a quick fix to the loss of business. But this served only to widen and deepen the hole it was in, and it hastened the day of reckoning

2.4 One Person's Gain Could Be at Others' Expense

In smaller companies, functions that big insurers organise and manage in separate departments—policyholder service, administration, claims and even some of the accounting—may be combined in one unit. The objective is to ensure that policyholders are served well whatever their need, whether it is to change an address or beneficiary, pay the premium or report a claim.

Prompt and efficient **customer service** will help the company to maintain a high level of customer satisfaction and retain and increase its market share. Poor service is cancerous, particularly if caused by a pervasive attitude among employees that they are doing the customer a favour. The fact is that the customer, by doing business with the company, does its employees a favour and helps secure their jobs. This is perhaps more important in insurance than other service industries since policyholders are often loathe to pay their premiums and quick to find reasons to terminate their coverage. Consequently, insurers must put in place a **claims appeals process** involving efficient and effective channels through which claimants can question their settlements.

A novel approach being undertaken by an innovative insurer, which microinsurers may consider adapting, is to get customers to tell them their problems and then offer solutions. Customers who have a complaint can expect someone to follow it up quickly, knowledgeably and personally. Mature company **customer care officers** (CCOs), eager to find out why anyone is unhappy with the service they are receiving, will immediately get down to work to identify key points for follow-up action as soon as customers have explained their problem.

How does the system work? Operating from their homes, the CCOs are part-time workers in their mid-40s and over, who may have retired, been retrenched, or perhaps prefer this kind of a job because of family commitments. Once informed about an unhappy customer, one of these experienced CCOs will be assigned the job of finding out more about the nature of the complaint. The CCOs have more time and patience than time-pressed company staff to listen to the complaints and get to the heart of the problem. Moreover, because of their backgrounds and communication skills, they are able to better empathise with the customers.

Once the CCOs have understood the problems and the issues involved, they can then pass on the information to be followed up by the full-time staff from relevant departments in the company. In addition, CCOs can also help identify other customer issues that need to be tackled, so helping to further improve service quality.

The company that implemented the system reported that 85 percent of those with complaints saw no need to call again to voice their unhappiness—a significant improvement on previous claims experiences.

The customer is king, and the customer is always right, and so on. But not when one customer's interests go against others'—which explains why good insurers never forget to say "fair" among other adjectives describing their service.

One such insurer publishes in its company magazine letters from its satisfied claimants praising employees who investigated, negotiated and settled the claim. Reading such letters some cynical managers remark that these kudos are from policyholders who were overcompensated for their losses. Distrusting of the claimants' motive as this comment may be, it points to the need to watch over all policyholders' interests while minding a few who suffer and report a loss. Each policyholder has contributed to the pool of premium income out of which the losses of a few are paid. If a few claimants are allowed to take advantage of the system—through a special favour from an employee or by reporting a fraudulent claim—their ill-gotten gain is everyone else's loss.

2.5 Premiums Must Precede Coverage

Special treatment and rule bending also need to be controlled at **premium collection** time. A key component of an insurance programme is to ensure that premiums are paid on time for the coverage to become effective. While that may seem obvious, in practice the premium collection system among emerging insurers is often lacking or ineffective. It is easy to disregard the fact that insurance is based on receiving a premium in advance in exchange for accepting a risk. Too often, managers pay scant attention to premium collection, resulting in outstanding (that is, unpaid) premiums that exceed 50 percent of their written premiums.

Point this out and one might hear: "It is not so bad since any outstanding amount of premium is deducted from the claim amount." This, however, is not insurance. These insurers are unofficially in the credit business. But it is impossible to collect premiums once the policy period has expired (and no claims have occurred on the policy), which forces the insurer to write off premiums as bad debts. What does an insurer do if the policyholder comes in a few days after he has a claim and pays the premium? Is the claim covered? Deducting the overdue premium from claims payments is essentially the same thing and just as stupid. Companies should be absolutely clear to separate credit and insurance services.

To overcome this issue, one insurer has an arrangement with its affinity group, the credit unions, that they will provide interest-free loans to their members to allow them to purchase an insurance policy. This deal makes it possible for low-income members to afford insurance, by spreading the payments throughout the year, and it boosts sales. But what does the credit union get out of it? Why would it give interest-free loans? The insurer provides it with a sales commission that is greater than the interest that it would earn on the loan. This division of responsibilities allows each party to do what it does best: the credit union assumes the credit risk and the insurer the insurance risk.

At the very least, if the premium is outstanding, coverage should be denied. But far better, microinsurers should do whatever possible to not allow the matter to come to that. The low-income market is tentative toward insurance at best. A lapsed policy could amount to a loss far greater than just one premium payment, and no possible effort should be spared to prevent such lapses. If the policy lapses and then the beneficiary tries to make a claim, there will be huge public relations problems even if the claim is denied for legitimate reasons, because it

will just reinforce the community's view that insurers are quick to take one's money and very slow to pay it back, if they pay it back at all.

A good, even essential, starting point is an effective premium collection system. Failing to establish such a system deprives the company of cash necessary to pay salaries, other expenses and claims. And it also limits investment returns needed to fuel the company's growth.

A justification sometimes cited for unpaid and overdue premiums is the local consumer protection law, which may give a purchaser 30, 60 or even 90 days to seal a deal. Yet some insurance terms, particularly for protecting a car or home for only a specified period, may be as short as 180 days and should not belong in the category of "permanent" purchases to which such laws may apply. For life insurance, there are indeed laws to protect prospective policyholders' right to change their minds about buying insurance, allowing them a couple of weeks or more to think things over. But money must change hands before the coverage becomes effective.

Carrying a huge load of delinquent policyholders and outstanding premiums is certainly a bad practice. The worst case, however, had to be Company 1. As the country's economy took a nosedive and its affinity group went into sharp decline, paying insurance premiums became the least of their concerns. The company then struck a deal with its corporate policyholders—it would accept their buildings and other property in lieu of premiums and continue the insurance protection. It hoped that in time it would sell the property and clear the huge debtor balance, which was shown in the balance sheet as an asset and amounted to well over 50 percent of the earned premium. The plan went sour as the property market also collapsed. When it rains it pours. The company's days were numbered.

It was yet another reminder that one should not fiddle with insurance fundamentals. The barter Company 1 had tried belonged to simpler times and places that are either no more or fast disappearing. Then, life revolved around an extended family and the risk of loss was spread among family members. In small communities and villages, a group of families may still practise mutual aid by pledging to bear losses jointly. Such sharing of loss may also be common among farmers and traders in rural areas.

But in present-day commercial and even agricultural communities, the needs of individuals, families and groups have become more complex, and so has the spreading of risk to provide security. Insurance has evolved into a profession. It is a system with set rules to protect property and life against loss or harm in specified events. Each element of the system must be in place and be managed according to specified standards and norms. Only then can it deliver what is expected. And only then can it work financially.

Whatever the product and the distribution channel, underpinning everything is that essential initial transaction. Protection is given only in return for a payment, or premium, proportionate to the risk involved. If no money changes hands—for instance, the policyholder has a claim and says, "Now you can deduct my premium from the claim payment you owe me"—what transpires can hardly be called insurance. Hedging, perhaps, or gambling—but not insurance. In fact, the most severe adverse selection problem is if only policyholders with claims pay their premiums!

2.6 Slow and Steady Does It

Dominic D'Alessandro, Chief Executive Officer of Manulife Financial Corp, singled out by his peers as one of Canada's most respected corporate leaders, says his own experience proves that the boring tortoise is a safer bet than the flashy hare. "You have the opportunity to do all sorts of things if you do the basics right," he explains. "People forget that. They want to get the home run right away."

Business produced by the sales force and other distribution channels comes to the main office in the form of insurance applications. The underwriting department then examines the application, assesses the risk, determines the premium and issues the policy. How well this process of risk selection is handled—some applications may indeed be rejected—has a direct bearing on the amount and frequency of losses later claimed and, down the line, on the insurer's profitability.

As applications flow in and underwriters issue policies in a steady stream, managers see the small sums or premiums adding up. This is the time for the board and management to be content with a slow but unmistakable build-up of premium volume. It is natural to be tempted with the thought, "Wouldn't it be nice to every now and then have a substantial application in for a huge face amount that would jack up the premium income ten-fold in one shot!"

A tidy sum for a big insurance policy would indeed be nice—but in all likelihood it would not be money in the bank. An insurance policy is essentially a written pledge to pay, in return for a small premium, a much larger amount in the event of a future loss. The higher the premium, the greater the risk of a major claim materializing. Therefore care is needed not only in evaluating individual risks, but also in selecting the kind and classes of risks to accept. An insurer should only bite what it can chew.

Take the case of **Company 4**. It operated to serve the country's federation of savings and credit cooperatives and their many members. About three-quarters of its net premium income of $3 million comes in the form of group cover, like protecting the loans and savings of individual members.

The federation as the majority shareholder described its *raison d'être* this way: "We feel the need to have our own insurance company in order to continue, increase and diversify insurance services to our affiliated cooperatives and also to project to the local market."

This strategic objective gave the board the rationale it needed early on to take what it thought was a small step with a big pay-off: **bonds and fidelity insurance**. In other financial markets, a bond is a security that obligates the issuer to pay interest at specified intervals and to repay the principal amount of the loan at maturity; but in insurance, it is a form of suretyship. Bonds of various types guarantee a payment or a reimbursement for financial losses resulting from dishonesty, failure to perform and other acts. One type of bond is fidelity insurance, which protects policyholders for losses that they incur as a result of fraudulent acts by specified individuals—it usually insures a business for losses caused by the dishonest employees.

Company 4's step into these lines turned out to be a giant leap into trouble, for bonds are dangerous classes of business that many mature insurers will not touch. Losses were just crying out to happen and did not disappoint. Before long, the chief cashier (later incarcerated) of a credit and savings cooperative defrauded his employers of nearly a quarter of a million dollars by falsifying cheques. An additional $165,000 in cash was missing. The policy limit was $200,000, and there was reinsurance. This is how the numbers settled from the insurer's perspective:

Gross loss	$402,735
Insured loss	200,000
Policy deductible	5,000
Adjustment expenses	2,638
Net loss	197,638
Retained loss	49,410
Loss to quota share treaty	49,410
Loss to surplus treaty	98,819

So this fraud essentially cost the credit union just over $200K, Company 4 just under $50K, with two reinsurers picking up $50K and $100K respectively.

Around the same time, a performance bond involving a major development project came home to roost. A contracted organisation that was part of a joint venture failed to deliver and this non-performance basically gave the insurer two options: execute the bond or subrogate with the aim of completing the project. The limit of the bond was $1 million, with the insurer's retention $75,000 and the reinsurance cessions—quota share, surplus and facultative—assuming the balance of $925,000. (See Chapter 3 for an explanation of reinsurance covers and treaties quoted in this example.)

Without reinsurance, the two losses combined would have wiped out the company. Still, the retained loss of about $125,000 hit the company hard and left it shaking. The company also faced the prospect of challenging renewal negotiations with its reinsurers.

Company 4 is still mired in board-management conflicts (having gone through three general managers in three years), and it will appear again in Chapter 4 "How the insurer is governed."

2.7 Biggest Asset, Yes—But Where has It Been?

In the financial sector, credit unions have not had a monopoly on some employees behaving badly. Even their insurance companies, which pay the fidelity insurance claims and should be on guard against employee dishonesty, have fallen victim to fraud.

There is no shortage of organisations boasting that their employees their biggest asset. Some of the same organisations have seen their biggest asset turning into their biggest liability. If some employees are bent on taking a wrong turn, there is little the organisation can do other than vigilance to catch them before an infraction. People fall prey to temptation. Managers have their hands full keeping the straight staff in line, practising the art and science of human resource management as best they can muster. Little wonder that once in a while a good egg left untended would go rotten.

However, there is something an organisation can do to safeguard its financial assets before a new employee is recruited: do not hire staff without a **background review** to ascertain where they have been and what they have been up to.

Company 5 learned this the hard way. The company had decided to commence underwriting an additional commercial insurance line in what at that time was a buoyant property market. It hired an underwriter from another insurance company who appeared to have a proven track record in that class of business.

As often happens in competitive markets, rates for this class of business softened significantly, which meant that significant discounts were offered to attract new business. The new underwriter had an extensive professional background and was soon able to produce what seemed to be good book of business with profitable results. Perhaps because of the specialist nature of this product, he was allowed to operate with minimal supervision and when audited it turned out that on numerous occasions, he had exceeded and disregarded the underwriting guidelines that had been set by management. However, it later became apparent that another more sinister reason for his success was kickbacks that were being offered by potential clients and the "commission" that the underwriter himself was retaining.

This might have remained undetected for many years, but the crash in the property market in the late '80s caused a considerable worsening of the results of commercial credit business. Then the extent of Company 5's potential liabilities started to emerge, but it was not until many years later that these were quantified—they added up to hundreds of millions of dollars.

Regardless of the position, when the applicant has a poor credit rating, past employment difficulties or worse (such as a criminal record), the reputation and financial well-being of the company are placed unnecessarily at risk. In some places, meaningful background checks are difficult or impossible. Managers may have to go with whatever information is available and rely on their gut feeling. Then they should at least establish adequate limits and controls, and monitor staff performance to ensure that these limits and controls are followed.

Controls are only as good as the system for checking to see that the established rules are followed. Company 5's star underwriter acted outside the underwriting guidelines and solicited under-the-table transactions. Could occasional supervision of his performance in the field and a closer look at his book of business have prevented the horrendous loss? Of course, though it is more obvious in hindsight than at the time, when the sky seemed to be the limit to his ready success.

In microinsurance, underwriting is much simpler and such infractions much harder. But as cash changes hands, there is temptation and the need to fight it. In any business where an employee or a representative receives cash, it needs to be properly safeguarded, accounted for, documented and deposited. Under no circumstances should disbursements be made from cash receipts (for example, for purchases or to cash personal cheques for employees). Wherever possible, duties such as collecting cash, maintaining documentation, preparing deposits, and reconciling records should be separated among different individuals. If

separation of duties is not possible, compensating controls such as strict individual accountability and thorough management supervision and review are required.

Vladimir Ilyich Lenin said, "Trust is good, control better." Trust with control would be even better. Company 5 would certainly agree. It is of course almost impossible to be safeguarded against rogue traders, but lessons to be learnt are to ensure:

- that an unsavoury character is not hired after an incomplete background check;
- that an underwriter does not exceed established limits of the company's exposure;
- that pricing and underwriting rules are followed; and
- that for a new line of insurance, sufficient technical expertise and systems are in place.

Two notes of caution:

- Once guidelines are established, a manager should not overrule staff following the guidelines. This opens the door for staff to decide for themselves which rules to follow and when.
- The lack of availability of background information need not lead a manager to hire only family and friends. One may indeed know them well, but would there be the proper distance for good business interaction, let alone controls?

Signposts

To provide cost-effective service to a low-income clientele, a new insurer needs to:

- **Adopt a suitable institutional structure for organising an insurance business—suitable for today *and* tomorrow, for insurance is a long-term business**
- **Keep administrative costs low by outsourcing some functional responsibilities and leveraging existing infrastructure for distribution**
- **Use a distribution system that is familiar and comfortable to the customers**
- **Provide good claims service that responds quickly and fairly, and includes a formal appeals process**
- **Set up an effective premium collection system to minimise or prevent lapses**
- **Only provide insurance coverage to policyholders that are current with their premiums**
- **Avoid entangling insurance and credit risks**
- **Remain committed to building business gradually**
- **Select employees carefully**
- **Establish systems to ensure that controls and guidelines are properly followed**

3. How Insurance Works Financially

Pitfalls

- **Things are going well. Keep growing premiums regardless of the insurer's capital levels.** ***(In insurance, a rainy day is any day)***
- **All that money sitting as reserves for the future! Is it not better used now?** ***(How the numbers add up—and go down)***
- **Short-term investment of the premiums has such a modest return. Could the MFI sponsoring the insurer not provide a better return investing the funds in its own loan portfolio?** ***(Money on hand is not there to play with)***
- **These regulations! What a bureaucratic nightmare! Surely, going around some of them is not going to hurt.** ***(Watching the telltale signs)***
- **Capital and surplus are below the legal minimum for business on hand. Reinsurance can fill the capacity gap.** ***(Passing the buck can work—but it has a cost)***
- **The insurer wants its sponsor-shareholders to come up with more capital and continue propping up the business—as if they did not have plans of their own.** ***(The handwriting on the wall. WIIFM?)***

Company 6 has some 30,000 policyholders and writes about $20 million of premiums (90% car insurance and 10% home). It has capital and surplus of $2.7 million. Its loss ratio and expense ratio are below industry averages. Is there anything wrong?

In any other business enterprise, bringing in $20 million a year and having $2.7 million set aside would paint a pretty picture. Not so in insurance. The insurance regulator has told Company 6 that it is technically insolvent and he has given it a deadline to raise its capital to at least $7 million. To understand why, one must first go over the fundamentals.

3.1 In Insurance, a Rainy Day is Any Day

It goes without saying that when an industrial or manufacturing concern is established, it will not succeed without machinery or a roof on the building. Even with this infrastructure, success depends on the product being produced at a reasonable cost and on the market seeing the product as good value for money.

Once these standards are met, profits follow. Dividends can be paid and additional financing obtained for expansion or other purposes. The value of shareholders' equity is enhanced and everyone is happy.

Few of these suppositions work for an insurance company. An insurance policy is nothing more than a promise written on a piece of paper—a promise to pay a certain amount of

money should a certain event occur. To continue to sell promises requires that people who suffer losses get paid fairly and quickly, that the public has confidence in the insurer.

How much capital is required to sustain such an institution? In no other industry is a product sold before its "manufactured" cost is known. Clearly, this difference calls for a requirement for a safety margin in the insurance industry's capital structure—and that is why insurance is highly regulated in all markets of the world.

In most markets, insurance regulators allow competition, but monitor and control the pricing of the product, in various ways and to varying degrees. Often there are political connotations and considerations, particularly for motor insurance. But the focus of insurance regulation is on **adequate solvency margins**. The last thing a regulator wants is an insolvent insurer. Besides assuring the public that the insurer will be there to pay claims when needed, the solvency requirements give investors added confidence.

Generally, regulators require that an insurance company have at least one-third of the amount of its net business volume in capital and retained earnings. This means that if an insurance company has 3 million dollars in capital and retained earnings, it cannot write net premiums of more than 9 million dollars. This capital/premium ratio can also be 1 to 2 rather than 1 to 3 if the regulator judges the product mix to pose a greater risk to the company.

This capital requirement applies specifically to general insurance and short-term life-based insurance. Life companies with long-term policies as their core business have their own specific requirements and regulatory tests.

To enable the company to provide a good return on investment through an increase in business and market share, shareholders must ensure that their invested share capital is adequate for the long term.

If an insurer cannot comply with the capital requirements, the options for regulators are limited. They may require it to significantly reduce the volume of business written, so that it is in line with actual capital. But this takes courage because, to maintain acceptable expense ratios, the board would have to make a corresponding reduction in expenses, which likely requires layoffs. The regulator may order the company to be wound up and to cease writing new business altogether—with much uncertainty as to whether there will be any capital left at the end. Or, the regulator can require that capital be replenished to statutory levels.

3.2 How the Numbers Add Up—and Go Down

Insurance provides people with protection against financial loss, whether it is the loss of an asset such as a car or home, or the loss of income due to the disability or death of the breadwinner, or the cost of health care. The insurer must be confident of having enough money in premiums and investments to meet the demand for benefits claimed as well as the various expenses of doing business.

The **premium**, the sum of money paid by to the insurer to provide a specific coverage, is based on the probability of losses determined from past experience.

Underwriting profit (or loss) is the amount left over (or owing) after paying **claims costs**, **operating expenses** and **reinsurance premiums**. Operating expenses are all the costs involved in issuing insurance policies and operating the business, including the cost of sales, marketing, promotion, policyholder services, office maintenance, staff salaries, and taxes. Reinsurance premiums represent the cost of reinsuring risks with a reinsurer.

An insurer needs to watch the **loss ratio** (percent of net earned premiums used up for claims) and **expense ratio** (percent of net earned premiums spent on operating expenses).

Insurance premiums are paid in advance. A company however "earns" the premium only as fast as time elapses. Yesterday's premium is earned. The portion that covers tomorrow and beyond is **unearned premium**. **Earned premium** is the proportion of the total premium for which the time period has expired.

Net written premium is the premium income received by the insurer, less premiums paid for reinsurance. **Net earned premiums**, simply put, would be the earned part of net written premiums.

Main Entries in Company 3's Statement of Income (loss) for 1997

	USD 000s
Gross written premium	2,947
Reinsurance premium	6
Net written premium	2,941
Unearned premium	50
Net earned premium	2,891
Claims paid	2,162
Added to claims reserves	314
Claims costs	2,476
Operating expenses	945
Underwriting profit (loss)	(530)
Investment income	451
Pre-tax profit (loss)	(79)
Key indicators	
Loss ratio (2,476 / 2,891)	85.6%
Expense ratio (945 / 2,891)	32.6%
Combined ratio	118.2%
Underwriting loss (530 / 2,891)	18.2%
Decrease in retained earnings ($)	79

If claims costs took 70 cents of each premium dollar and operating expenses another 25 cents, the insurer would have an underwriting profit of 5 cents on each dollar or 5%. The **combined ratio** (of claims and operating expenses) may exceed premiums, but it is strongly advisable to maintain a combined ratio of less than 100. If the same insurer had paid out 80 instead of 70 cents of each premium dollar in claims, its combined ratio would have been 105, representing a 5% underwriting loss. Warren Buffet, the world's second richest man, owns several large insurance and reinsurance companies through his Berkshire Hathaway group. All his insurance companies must produce an underwriting profit as their primary objective. This is because all investments returns go direct to the holding company, Berkshire Hathaway. He is a wise man so follow his wise maxims.

Premiums, while held, normally generate **investment income** which, added to premium income, may produce an **operating profit** (or loss, if not enough to cover claims and operating costs). For example, if the insurer had invested available funds wisely to earn *a return equivalent to 6% of earned premiums*, it would have offset the underwriting loss and made an operating profit of 1%. (The *actual return on investment* in this case would depend on the amount invested, which in turn is dependent on the amount of assets it can invest, and

would probably have to be much higher than 6%, particularly if the insurer was short of capital and surplus on hand.)

An insurer sets aside **unearned premiums** covering the portion of premium for the policy period remaining at the time of financial reporting. The **claims (or loss) reserve** is the amount set aside by the insurer for reported claims that have not yet been settled, plus claims that have been Incurred But Not Reported (known as the **IBNR reserve**). Over the long term, an insurer's profitability depends on how well it has reserved for unsettled claims. Every year there is the desire to show a profit so it is tempting to under-reserve.

Before a **net profit or loss** is determined, the insurer has to pay taxes to the government and what remains is the after-tax profit. This is added to **retained earnings** or **surplus**. The board may decide to pay part or all of the after-tax profit as **dividends to shareholders**. (Dividend payments thus do not reduce the operating profit; they reduce the retained earnings of the company.) Most of the **surplus** needs to be retained to enable the operation to accept a growing amount of business.

Insurance profitability thus depends on a number of factors. In the first instance the premiums collected need to be (or should be) higher than the costs of acquisition, of management expenses, and incurred claims. Beyond that the key is investment income which is interest and dividend income earned on the invested assets of the company.

3.3 Money on Hand is not There to Play with

Insurance is often referred to as the lubricant of the economy. By providing protection against risk and loss it helps keep the economic engine functioning, maintaining its ability to generate wealth and provide jobs. Insurance facilitates the growth of agriculture, industry and commerce. It also gives individuals and families economic security, enabling them to contribute to society as productive citizens.

Insurance does this by accumulating small sums from a large number of policyholders, and holding collected premiums for the benefit of those who suffer a loss. In the process, where there is a developed financial market, the amount available is invested and put to use as capital for a variety of enterprises and ventures.

But it takes money to make money. An insurance company can get into business only if it has the required capital, enough to incur start-up costs and to stay in business for the first few years when it is likely to operate at a loss.

The Cooperative and Microfinance Difference

If the initial capital comes from outside a community, city or country, the insurer is likely to invest its funds elsewhere and expatriate any operating profits. However, if the needed capital is provided by local popularly based organisations, the community can benefit in three ways: 1) reduced vulnerability to risks; 2) an increase in local investments; and 3) the retention of profits by the community. Of these three, the potential of investments to produce wealth and raise living standards is often overlooked.

The ability to mobilize domestic sources to generate capital and to invest in the local economy and their own communities is the hallmark of cooperative and mutual insurers. They are an effective way to organise insurance programmes to reach and serve low-income people.

These and other microinsurers are also able to mobilize capital that otherwise would not be in the formal economy. More so than others, low-income people are prone to saving their earnings in cash. As owner-customers and stakeholders of a well-run and customer-focused microinsurance programme, they can put their cash savings to good use. All the more reason that their insurer should do a good job of managing and investing their funds.

Investment Guidelines

In fact, to safeguard the public interest, regulators make sure that all insurers licensed to do business follow a set of prescribed investment guidelines. The regulators' guidelines, although they vary from country to country, have at least one thing in common: they are different for general insurance and life insurance.

General insurance. With claims costs rising and severe weather patterns in the wake of climate changes causing increasingly heavy losses and frequent catastrophes, profitability of a general insurance company has depended more and more on how good a job its managers do investing the funds available. More often than not, the combined ratio exceeds 100 and earning a good return on investment to offset the underwriting loss becomes critical. Some of investment income is generated from the amount of premiums available for investment (with other returns coming from the investment of reserves and capital). As a large part of the premium income is expected to be paid out in claims within the same year, guidelines require secure instruments to minimize risk and produce a reasonable but sure return. Investment in real estate is limited to a small portion of the portfolio. Because of the short-term nature of the products, general insurers should not take investment income into account in calculating premium rates.

Life insurance. Generally, investment income is more significant for a life insurer than a general insurer. Most pure life policies are in force for a long time before any claims become payable, indeed sometimes they are never claimed on, and the premium received is invested to earn additional income. The money is invested in government and corporate bonds, real estate, mortgages, and corporate shares. Interest and other investment returns enable the insurer to charge lower premium rates than would be possible considering mortality rates alone. The longer a policy's duration, the greater the effect of investment income on premium rates. Investment income may have little effect on the cost of a policy for only one year, but compound interest and other earnings have a substantial effect on the cost of policies in force for long terms.

It should be noted that many life insurance products are actually savings products with an element of life insurance. These products are fixed in length and return an investment element to the policyholder on maturity. For these life products the "claim" or maturity is a certainty. The benefit of these products for policyholders is that they share in the investment performance of the insurers and the benefit to the insurer is that it builds capital and reserves

very quickly with very little downside risk. Pension business often falls into this category as well but usually does not carry a life insurance risk.

Informal microinsurers such as MFIs adding insurance services to their core business would do well to keep in mind the rationale behind investment guidelines. Most lines of insurance at the micro level are short-term (including group life), and insurance funds need to be invested in line with requirements for general insurance. Those guidelines would certainly exclude the MFIs' own loan portfolios; to siphon insurance funds off for their own use would be tantamount to killing the goose before it has laid the golden egg.

This commingling of insurance premiums and the loan portfolio creates a clear conflict of interest. Premiums paid by policyholders are strictly for the purpose of providing protection and need to be invested in whatever securities or instruments best match with the ultimate liabilities that will arise in the form of claims. Channelling these funds through a loan portfolio—with its own financial requirements, restrictions, obligations and risks—can compromise the insurance operation's ability to meet its fiduciary responsibility in paying claims when they become due.

Although the regulators' guidelines reduce the risk of investment losses, each may suggest a range such as percentages of portfolio for various instruments within which the insurer can make choices and decisions. And that is where things can go wrong.

The Case of Company 7

Company 7 served as a model of development in its first 10 years. An established western insurer had provided technical assistance and even supplied the services of a qualified actuary to review and endorse financial statements. Towards the end of the '80s, as the managing director approached retirement, he recommended to the board that the company invest in a choice parcel of land in a prestigious neighbourhood and make plans for a commercial property development. The price was the hefty equivalent of a million dollars, and short-term instruments in the market at the time were earning a decent 15 percent interest that was projected to keep climbing. But the board went along and approved the investment in real estate. Another quarter of a million dollars was earmarked for the managing director to hire a property development company to start working on architectural drawings and blue prints.

Around the same time the company's results began to suffer. There were disagreements with the guiding company's actuary on reporting and treatment of a number of items in the financial statements, exacerbated by the locally acceptable practice of producing one set of numbers in the printed annual report for shareholders and the public, and a different set of numbers for the report submitted to the regulator. The consulting actuary refused to endorse the current statements and the guiding company terminated its agreement with the insurer.

Soon thereafter, the managing director, following a protracted political struggle with the board, finally retired.

It did not take long for the new managing director to realise that the insurer would soon lose its licence because of a severe capital shortage. A group of overseas insurers raised a solidarity fund of a million and a half dollars to help the struggling insurer meet capital

requirements and maintain its licence. The financial assistance was coupled with technical assistance from two consultants with a wealth of experience in insurance management.

The insurer's management found the consultants' advice hard to take. In particular, it never quite accepted the need to maintain solvency margins by not writing premiums more than three times the amount of capital and surplus at hand. The concept of unearned premiums was also hard for the board to understand. The preference to deal with money on hand as just that may have had something to do with treating insurance as any other business. Then there was the huge amount of outstanding premiums, which the management preferred to carry as an asset instead of writing it off as bad debt.

After four years the assistance agreement was terminated. Another managing director, with a marketing bent, came on the scene to turn the company around. Company 7 eventually bought back the shares held by the overseas insurers, increased its premium volume three times and is basking in success again. It just moved into a new headquarters in a prestigious part of the capital city—part of a commercial complex it owns.

The now retired consultants acknowledge the marketing success of the new management. They continue to maintain, however, that Company 7 while becoming bigger also needs to become financially stronger—the amount of capital and retained earnings has stayed static and is now supporting four times the premium volume which is currently accepted by the country's regulators. In their opinion:

- Company 7 has invested heavily in a new building, perhaps because in this particular country there is not much choice for investment. Most countries place a limit on what can be invested in real estate as a percentage of an insurer's assets. A new headquarters in a prestigious area is good for marketing and branding. Such an investment also needs to help meet long-term financial objectives of the company, which in turn need to be pursued with short-term plans.
- The company needs to set an objective to *always* have capital/retained earnings at least equal to one third of its net written premiums. It should not pay any dividends if doing so would leave it with insufficient surplus to transfer to reserves.
- Company 7 seems to have adjusted its policy of "doing things differently"—such as having its own sales representatives—and is competing with well-financed companies by doing exactly what those insurers are doing, e.g., using the general agency system.
- The company has a good handle on the need for adequate claims reserves for motor insurance. The problem general insurers often face is the lack of underwriting (policy) and inadequate premiums, so that the more business they write the more money they lose.
- The company has in the past written off a large amount every year in uncollected premiums to tidy up the balance sheet.
- As in many other cases there should be training sessions for the board in the financial intricacies of insurance.

3.4 Watching the Tell-tale Signs

Several tests are used to measure the financial status of an insurer. In Canada, the Office of the Superintendent of Financial Institutions (OSFI) uses 15 financial tests or ratios for general insurance companies and 12 tests for life insurers which, when applied to their financial statements, act as early warning indicators of possible problems. Of these, five key tests are described below, with the regulator's benchmark, expressed as a "usual range."

1. Change in capital and surplus. Capital, the amount put up by sponsors of an insurer, and surplus or retained earnings, the amount left over after meeting all expenses and obligations at the end of a period of operations, together show the insurer's financial strength and ability to accept risks. A change in capital and surplus is the ultimate measure of improvement or deterioration in a company's financial position during the year. Any significant decrease or substantial increase may be cause for concern. It may reflect changes not only in profitability but also any additions to or deletions from reserves required by regulatory authorities. An unusual big increase would be of concern because it might be due to a transfer of funds from one of the statutory reserves to capital and surplus to meet the required minimum level. Regulator's usual range: -10% to +50%

2. Ratio of liquid assets to liabilities. This ratio is the percentage of total liabilities that is covered by liquid assets. Generally, liquidity is less important for a life insurer than non-life or general insurer because of the longer term policies. But both insurers face the potential of immediate cash outflows. For life insurers, for example, there could be a sudden demand for policy loans or cash surrenders, or a sudden spurt of new business involving considerable sales and issuing expense. In reviewing the distribution of the insurer's assets, it is important to consider matching liabilities and potential cash outflows as well as the ability of the insurer to withstand such outflows without undue deterioration of the asset portfolio. No industry exceptional values or a usual range is suggested.

The term "marketable securities" is often used to differentiate invested assets that are almost like cash, that is stocks and bonds which are actively traded, from less liquid investment categories such as real estate and private placements with severe redemption restrictions. While the latter may have a place in large portfolios, they usually represent a relatively small percentage of the total and are not considered in any cash flow projections. The other caution about stocks and bonds is that while they may be quite liquid, care must be used to ensure that there is not a need to cash them out at some low point in their market cycle.

As an example, Company 7's investment in a new building might heighten its profile and strengthen its image as a substantial financial institution, but in the event the business falters, the investment in that building may not be readily liquidated, thus precipitating a cash flow crisis. Similarly, a heavy investment in equities followed by a downturn in the market could have the same effect if the assets are sold at a substantial loss to meet today's cash flow requirements.

3. Change in gross premiums. A major increase in gross premiums written (total premium collected) may indicate an abrupt entry into new lines or new territories. This might indicate that the insurer is increasing its writings in an attempt to increase cash inflow to meet current loss payments. A major increase in net writings, relative to gross writings, would indicate an

increase in the company's retention for its own account. Consideration should probably be given to a company's liquidity position when a large increase in either net or gross writings occurs. Of course, any sharp decrease in gross or net writings might indicate deterioration in the company's market position. Regulator's usual range: -33% to +33%

4. Net risk ratio. This is the ratio of capital and surplus to net premiums written (gross premiums minus the amount paid over to reinsurers for reinsurance protection). It indicates the adequacy of a company's capital and surplus, relative to its net writings, to absorb above-average losses. The higher the ratio, the more risk the company bears in relation to the capital and surplus available to absorb losses. The value for the total of all federally registered Canadian general insurance companies in recent years has been between 2 and 2.5. In the regulator's experience most companies cannot maintain a net risk ratio of more than about 3 for an extended period of time, without running into difficulties. Regulator's usual range: up to 3.0

5. Gross risk ratio. This ratio, of capital and surplus to gross written premiums, indicates the reliance of the insurer on reinsurance. Once the figure exceeds about two times the net risk ratio, more than usual attention should be paid to reinsurance arrangements, and in particular to the documentation in place about the arrangements. The value for the total of all federally registered Canadian general insurance companies in recent years has varied between three and four. One needs to keep in mind that this ratio varies dramatically for lines of business written by each insurer. Heavy reinsurance is more appropriate and likely for expensive "long-tailed" or extended exposure on personal injury claims than for collision or homeowner business which is usually settled very quickly. The exception to this is the separate and distinct earthquake or other catastrophe coverage which is heavily reinsured. Regulator's usual range: up to 7.0

Taking the Pulse of Company 6

Company 6's capital and retained earnings decreased in fiscal 2003 from $3.7 million to $2.7 million, showing that its operating results fell short and it had to use 27% of capital and retained earnings to meet its obligations.

The ratio of liquid assets to liabilities dropped from 19.8% to 15.3%. This ratio provides an indication as to whether there would be sufficient liquid assets to meet liabilities over a short period of time if were to become necessary. As with most of the tests, it is important to consider the trend of results, as well as the actual results themselves. The range regulators usually consider is up to 105%.

While cash decreased, outstanding or unpaid premiums went up by 12.9%. They now stand at a hefty 40.7% of the earned premium, again far to high for any insurer who should be targeting unpaid premiums of around 8% of earned premiums.

Gross premiums went up by 9.8%—not a huge increase but definitely of concern in view of the reduction in capital and retained earnings. The company is indeed trying to bring in more money to offset the cash shortage. But it is a safe bet that outstanding premiums will go up even more—unless it makes a special effort to curb the practice.

The company's net risk ratio is 4.04, above the regulatory minimum of 3.

The gross risk ratio is 6.6, well above the usual range for the industry and approaching the regulator's maximum allowable 7. To offset the shortage of capital, the company has had to rely on reinsurance for surplus relief in a big way, ceding nearly half of its written premium to reinsurers. Obviously, more attention needs to be paid to reinsurance arrangements.

3.5 Passing the Buck Can Work, but it has a Cost

Just as an individual buys insurance because his or her resources are insufficient to bear a heavy loss, so an insurance company buys reinsurance to protect its financial position and spread the risk. While individuals insure the whole of a risk, an insurance company will reinsure only part because the company is in the business of accepting a large number of risks and averaging the losses; it expects to tolerate losses up to a previously agreed level and beyond that needs reinsurance (see Box 4).

Nevertheless, the same maxim applies: the losses of the few are paid by the contributions of the many. Reinsurance helps to spread the risk further, sometimes even beyond the geographical boundaries of the original risk. There are various reasons why an insurance company will buy reinsurance:

Protection against serious claims. Reinsurance protects the insurer against claims on large risks. However, serious claims can also arise out of small insurance policies. A single event such as a storm can give rise to claims on many individual policies, accumulating to a large amount beyond the insurer's capacity. Reinsurance protects against such catastrophes, often spreading the risk beyond national boundaries.

Stabilizing claims experience. An insurance company, particularly a small one with few policies, can have claims experience over a period of time which differs greatly from what it expected. Reinsurance helps the insurer to stabilize the level of such losses by passing the responsibility for payments over a certain amount to the reinsurer. This enables the insurer to make more accurate budgets and reserves. There is a reinsurance premium to be paid, but it is a definite annual cost and allows the insurer to reduce the fluctuation in claims costs.

Additional capacity. An insurance company limits the amount that it accepts on individual risks according to what it can afford to lose. This amount will depend on the capital and surplus of the company and its premium income. For example, if an insurer has capital and surplus of $50,000 and its annual premium income is $150,000, it is at the statutory maximum of the premium level it can maintain (remember the net risk ratio). It cannot afford to take on any more business. However, an affinity group shows interest in insuring its members with it—an attractive addition to the book of business. If it were to restrict itself to accepting only those risks that were within its current limit, it would be at a competitive disadvantage. It could not accept the larger risks which might be offered to it, and it could not move with confidence into new classes of business. Therefore the company buys reinsurance. It reinsures the amounts above those it can safely retain for itself. This allows the company to expand its portfolio and grow at a reasonable pace.

Box 4. A Reinsurance Primer

Forms of reinsurance. All reinsurance can be classified into two types: proportional and non-proportional.

Proportional. In this type the reinsurer accepts a fixed share of the original risks accepted by the insurer. The reinsurer receives an agreed proportion of the original premium and pays the same proportion of all losses. There are two main forms of proportional reinsurance: quota share and surplus. Under **quota share,** a fixed share of all risks accepted by the insurer is ceded to the reinsurer. For example, the insurer could retain 20% of all risks and cede the remaining 80%, to a maximum of say $100,000, to the reinsurer. Premiums as well as claims would then be shared in the same proportion. Under a **surplus** agreement the insurer has more choice, only ceding to the reinsurer amounts which are surplus to its own retention. The agreement specifies the retention and the surplus is expressed as a number of lines (or the number of times the retention). For example, the retention of the insurer is agreed at $10,000 and the reinsurer agrees to accept 20 lines or $200,000 as the maximum amount which can be ceded.

Non-proportional. In this type the reinsurer, in return for an agreed premium, accepts liability for all losses in excess of the agreed amount up to a limit. The two main forms of non-proportional reinsurance are: excess of loss and stop loss. Under **excess of loss** the reinsurer agrees to pay any losses on individual policies in excess of a figure agreed with the insurer, up to a certain agreed amount. In a **stop loss** cover the reinsurer agrees to make a payment if the aggregate or total amount of losses of the insurer in any one year exceeds a predetermined amount or proportion of premium. For example, an insurer may wish protection on a specific line of business for all losses incurred in excess of 95% of earned premiums up to 120%.

Methods of placing reinsurance. There are various methods of placing these forms of reinsurance.

Facultative. This was the first method to be used and means that the arrangement is optional. The ceding insurer is not bound to offer the risk and the reinsurer is not bound to accept it. Each risk must be offered individually to the reinsurer to underwrite.

Treaty. This method has developed in view of the uncertainty and expense of the facultative approach. The treaty is an agreement between the insurer and one or more reinsurers whereby the insurer agrees to cede and the reinsurer agrees to accept all risks within the terms of the treaty. This enables the insurer to obtain automatic reinsurance coverage. Treaties have become the main method of reinsuring business.

Facultative obligatory. This arrangement is half way between facultative and treaty. The reinsurer agrees to accept all risks offered but the insurer is not obliged to offer all risks. This cover is used when there are several large risks to be reinsured and the sums insured exceed the normal treaty arrangements of the insurer.

Reinsurance pool. This can be arranged by a number of separate companies, with the pool managed by one of the companies or by a separate organisation. The companies agree to cede certain risks or treaties to the pool which then is shared among member companies.

Looking at Company 6's figures, one sees it was overly dependent on reinsurance as a direct consequence of poor solvency. It has needed quota share reinsurance for some six years. Says the reinsurer: "The quota share treaty has only survived so long out of necessity. It should have been a short-term solution to the lack of capital and capacity, but poor motor results have caused the surplus to erode and new capital has not generally been forthcoming. Without quota share reinsurance these last 6 years (all other things being equal) the company would surely have gone out of business."

If its shareholders raise their equity capital to the standard minimum—at least a third of the net premiums and at least a fifth of the gross premiums written—it could rearrange its reinsurance programme at an annual cost savings of some $450,000.

3.6 The Handwriting on the Wall

Without the needed capital injection, Company 6 has few options. A deadline the regulator gave the company to increase its capital by the end of the last fiscal year was not met. Presentations and representations were made to existing shareholders to strengthen their equity positions, without any money coming forward.

Reinsurers, though, were willing to review their terms and covers—a sign of confidence in the current management. The management change a year ago put Company 6 on the right path operationally.

Well, almost. Its loss ratio has come down from 87% to 64%, and so has the expense ratio, from 30% to 22%. Outstanding premiums, however, have gone the wrong way—a potential looming crisis that requires focus and attention.

What else could it have done better? In hindsight, Company 6 expanded too fast in the formative years, far beyond its capital base. It went for an infrastructure and staffing that would have been adequate for a much larger company. There was some under pricing of its products and poor risk selection. Claims were also under-reserved.

Company 6 is correcting the shortcoming of earlier years. But the solvency shortfall is much harder to overcome. A quick fix to lack of capital comes in the form of a bitter pill that can turn out to be poisonous: reduce the premium volume to the correct level by raising prices so much above the market rates that about a fifth of the customers desert the company in one policy period and go to its competitors.

It would be much less risky to ask existing shareholders to put more money into the company. If only they would!

3.7 WIIFM (What's In It For Me?)

Company 6's shareholder-owners are all successful organizations, with combined assets of several hundred million dollars. The needed injection in their insurance company would amount to one half of one percent of their assets. But are they jumping at the opportunity to invest more in the company? Hardly. On the contrary, questions on their minds are: "Why

should we? The company hasn't made a profit in four years. What will we get if we invest in the company? Can we at least be guaranteed a reasonable return?"

Fair questions. They all have to do with WIIFM or "What's in it for me?"

WIIFM, in particular, underpins the very first question: "Why should we invest in our insurance company?" The answer is simpler than they think. Though the company has been without a net profit for four years, it does have a lot of embedded value. If they do not come forward and help the company turn the corner and save its potential for their own use later, other investors in the market will want to take it over from them, and at a price of their own choosing. So the real question to ask is: "Isn't it better that we keep this business for and among ourselves?"

And what can the insurance company promise as returns on this investment? Nothing, until there's more capital.

The first priority, of course, is to ensure that the company is managed appropriately—with a budget that reflects adequate and realistic pricing, expenses, loss projections and reserves, and investment returns.

All signs are that this is done. But the management's hands are tied without additional capital to back the business coming in. Once shareholders contribute more funds, there will be profitability and retained profits, along with a reasonable expectation that a return can be paid on the capital and free reserves. But until that is done, expecting a guaranteed return from the insurance company is like expecting a factory to produce profits when it has no machinery.

Yes, capital is the machinery of insurance. Shareholders, each of whom is represented on Company 6's board of directors, should realize that. The board seems as powerless to produce the desired results as shareholders appear disinterested. It does not seem to matter to them or the board that they are overlooking their responsibility to their own insurance company, which raises important questions of corporate governance, the topic for the next chapter.

Signposts

- **Financial planning and management need to be in line with fundamental practical factors and prevailing regulations.**
- **Insurers must have the ability to live up to these factors at start-up, and to manage any changes in these factors as time goes on. Not all changes can be foreseen, but a new insurer's potential to survive changing scenarios should be weighed and necessary allowances made.**
- **Insurance is not a cash-flow business. Reserves play a crucial role in maintaining the financial health of the organisation.**

- **Investment guidelines are prescribed to protect the insurer and its policyholders; these should be followed, not flouted.**
- **An insurer bears risk and writes business to a manageable level, arranging for a cost-effective reinsurance programme to cushion the impact of huge losses, disasters and calamities. That way it is able to share with other insurers risks which are too great for it to carry on its own.**
- **The insurer is not a source of revenue for the development of its sponsoring organisation(s).**
- **As it expands, the insurance operation will require an increasing amount of capital and surplus (retained earnings) to support its own growth.**

4. How the Insurer is Governed

Pitfalls

- **Govern…manage…is there a difference, and what is corporate governance anyway?** ***(Down to the basics)***
- **Board members are there to direct, not to get involved in operational matters.** ***(Nourishing the grass roots)***
- **The board's wish is the manager's command.** ***(Draw the line and stay clear)***
- **Being on the board is not a day job. No need to get worked up about it.** ***(Don'ts to avoid)***
- **Cooperate by all means – but why give an inch.** ***(Easier said than done)***

4.1 Down to the Basics

When one thinks of corporate governance, Enron, WorldCom and Parmalat come to mind. They certainly helped raise awareness of the need to not only manage, but also govern a business well. A lot of attention has since been paid to what corporate governance is and how it can be enhanced. Reflection and debate have unearthed a number of fundamentals that can help businesses avert disasters.

These basics, in their simplest form, would also apply to the level of microfinance and microinsurance. But at that level, any enhancement of corporate governance begins with an understanding of an even more basic element: the difference between managing and governing.

Look up their meaning and one begins to see the distinction: **manage** (administer, conduct affairs of, implement), and **govern** (direct, rule, oversee). To come to grips with this distinction is to know how the role of the board of directors differs from the role of management.[3] A good relationship between management and the board, underpinned by a clear understanding of, and respect for, how their responsibilities differ, leads to good corporate governance (see Boxes 5 and 6). A muddled relationship, marked by frequent forays into each other's territory, produces conflicts undermining management as well as governance. Checks and balances tend to vanish and, where integrity lacks, collusion follows. Result: Enron, WorldCom and Parmalat.

[3] The board of directors is called the supervisory board in countries where the law requires two boards of directors; the second, the management board, is what elsewhere is known as the senior management group.

Box 5. What is Corporate Governance?

Corporate governance is the system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation—such as the board, managers, shareholders and other stakeholders—and spells out the rules and procedures for making decisions on corporate affairs. By doing this, it also provides the structure through which the company objectives are set, and the means of attaining those objectives and monitoring performance.

- Organisation for Economic Cooperation and Development (OECD)

The importance of the board-management relationship is recognized in The World Bank's definition and view of **governance**: "the mechanisms in which suppliers of capital are assured adequate return on investment." If these mechanisms do not produce an adequate return on investment, more capital will not flow to the company and it will not grow to its potential. (This appears to be at the core of Company 6's crisis.) A strong relationship between the board and management counteracts the main impediment to the company's success in delivering an adequate return on capital: lack of agreement or misconception about the business's objectives and purpose and often about the business itself. It promotes what the Asian Development Bank identifies as the four pillars of governance:

1. **Accountability**, or the capacity to call officials to account for their actions.
2. **Transparency**, entailing low-cost access to relevant and material information.
3. **Predictability**, resulting primarily from laws and regulations that are clear, known in advance and uniformly and effectively enforced.
4. **Participation**, needed to obtain reliable information and to serve as reality check and watchdog for both government and corporate action.

4.2 Nourishing the Grass Roots

Development experts who have helped establish popularly-based insurance programmes in a number of countries over the years identify **leadership training** as a key factor. This is a euphemism for two "needs for improvement" items that they find among many organisers and elected officials of grassroots financial services: a) technical understanding and b) grasp of a board member's responsibilities.

Save for those elected or selected by virtue of education and experience in financial services, board members of popularly-based organisations are grounded in how other businesses are managed and run. They display leadership too, but it is driven by a populist cause or belief more so than an in-depth knowledge of financial services.

Box 6. Code of Best Practice: The Cadbury Report

The Committee on the Financial Aspects of Corporate Governance was set in May 1991 by the Financial Reporting Council, the London Stock Exchange, and the accountancy profession to address the financial aspects of corporate governance. The Cadbury Report is widely recognized as having laid the foundation for corporate governance. Its main recommendations are as follows:

1. The Board of Directors

- Meet regularly and retain full and effective control over the company and management
- Division of responsibilities at the head of the company
- Where Chairman and CEO are one, essential that there be a strong and independent element on the board
- Include non-executive directors

2. Non-Executive Directors

- Should bring independent judgement to bear on issues of strategy, performance, resources, appointments and standards of conduct
- Independent of management and free from any business or other relationships with the company
- Appointed for specified terms; reappointment not automatic
- Fees should reflect the time committed to the company
- Selected through a formal process acted on by the board as a whole

3. Executive Directors

- Contracts not to exceed three years without shareholders' approval
- Should have full and clear disclosure of directors' total emoluments (pay, pension contributions, stock options)
- Executive directors' pay subject to the recommendations of a remuneration committee made up wholly or mainly of non-executive directors

4. Reporting and Controls

- Board's duty to present a balanced and understandable assessment of the company's position
- Ensure an objective and professional relationship with the auditors
- Establish an audit committee of at least three non-executive directors with written terms of reference
- Explain their responsibility for preparing accounts next to a statement by the auditors
- Report on the effectiveness of the company's system of internal control
- Report that the business is a going concern

Advocates of microinsurance are prone to pointing out the need to conquer the poor's suspicion of insurance through education and awareness, and the need to upgrade managers' capabilities. But they seldom cite the greater need to train board members in the discipline of insurance and in the art of being a good corporate director.

Earlier chapters have said enough about the basics of insurance. To know what a board member is supposed to do, a good starting point is to look at the "job description" one insurance organisation uses.

4.3 Draw the Line and Stay Clear

The role of the board of directors (or the supervisory board) is to oversee the insurer's operations and management. The central purpose is to act on behalf of the shareholders/sponsors of the company, in the interest of the users of its services, and to direct the organisation's activities to attain its corporate objectives. To ensure focus, checks and balances, the board delegates key tasks—such as audit, investment and executive matters—to its dedicated **committees**.

The responsibility for managing and looking after the day-to-day affairs and implementing policies of the company rests with the executive management (or the board of executive directors). Where the lines between supportive and overseeing responsibilities and managing responsibilities are blurred, serious problems and debilitating conflicts arise.

The board's specific responsibilities are:

- to establish and review the aims and long-term objectives of the organisation;
- with the recommendation and participation of management, to develop policies whose implementation will establish the basic character and direction of the organisation;
- to ensure the development, review, approval and evaluation of the corporate planning process;
- to maintain the continuity of a viable organisation that delivers needed products and services to members and policyholders, and is managed in their best interests;
- to ensure adequate representation to and involvement of sponsors and other appropriate organisations;
- to oversee the management's role in ensuring compliance with the governing statutes and by-laws;
- to delegate specific aspects of decision-making to board committees; and
- to ensure the continuity of management.

The worst practices among insurers that involved the board of directors and its conflicts or collusion with management over various matters yield a number of don'ts other insurers can heed and avoid.

4.4 Don'ts to Avoid

Influencing decisions on investments and capital. The board should approve an investment policy appropriate to the size of the company and in accordance with local laws. It is vital that the investment guidelines are enforced and adhered to, and that the board has access to

external independent investment advice before making strategic investment decisions. Directors should never forget the rule that "return is tied to risk." There are too many examples where capital was lost or the return on capital severely limited. When a board approves or even directs investments in speculative ventures such as currency, undeveloped land, buildings, shaky subsidiaries or a weak parent organisation, it risks the capital and continued operation of the insurer. Too often, a close look at ill-advised investments reveals a conflict of interests on behalf of board members.

Not having the proper mix of skills and expertise on the board. Invariably the effectiveness of a board depends on the mix of individual directors, their experiences, risk appetite, causes and agendas. The chair and the chief executive should jointly ensure that officials nominated to the board have expertise that would complement rather than duplicate other directors.

Neglecting audit. After Enron, it was not the role of external auditors alone that came under the spotlight. Internal auditors also got mobilized. The Institute of Internal Auditors, for example, has been focusing on how its members can better help meet corporate governance standards. Insurers in their formative years may not be able to afford an internal audit unit, but it would serve their boards well to direct management to assign that responsibility to a suitable staff member who can then work closely with the board's audit committee. Credit unions have a time-honoured structure to ensure democratic control through their boards and committees, and other popularly-based financial service providers would do well to adapt it.

Making light of their legal obligations and liabilities. Not all board members may be aware that their position entails legal responsibilities and obligations to govern, that they may be held liable for misusing or neglecting their legal duties, and that they have to declare a conflict of interest if they stand to benefit financially directly or indirectly from any decisions or actions. In particular, board members are expected to attend meetings regularly and review reports and correspondence provided. The chair should ensure that management distributes agendas and operational reports ahead of time to directors to help make their meetings productive.

Becoming involved in personnel matters that are the responsibility of management. The board should approve personnel policies and then permit the manager to carry out those policies without interference. Examples abound of directors putting forward their friends and relatives for choice positions in the insurance company. The same employees later have no difficulty getting a board member to become an advocate for their complaints, which undermines the authority of the manager and has a negative effect on morale.

Occasionally, the board neglects its responsibilities to the manager. After hiring a qualified person, the board should not forget the manager's performance evaluation and, if results warrant it, to increase the compensation. In one case the manager, although successful, received neither recognition nor a pay increase. He left the company. Some years later, a new board rehired this manager with a much higher compensation and an improved contract.

The board is responsible for hiring *and* firing the manager. In one case, a manager noticed that several of his board members improperly submitted duplicate expenses for a donor-sponsored study trip. The manger broached the matter at a full board meeting. Being right

does not always work out. The manager was forced to resign. The matter would have been better left to the external auditor or the audit committee of the board.

Lesson for directors: someone somewhere actually goes over an expense report. Lesson for a general manager: remember who the boss is.

4.5 Easier Said than Done

In addition to dos and don'ts that apply to any insurer, governance of cooperative insurers has involved a specific challenge peculiar to the cooperative movement. When you see the short list of principles that govern the cooperative movement, the easiest to follow appears to be the one about "cooperation among cooperatives." In practice, however, it has turned out to be the most difficult.

In countries where cooperative insurance companies have succeeded in growing, much is owed to the fertile ground of a more or less captive segment of the market that sponsoring cooperative organisations from different business sectors—agriculture, finance and credit, fisheries, housing, retail and marketing, etc.—have provided by coming together to jointly own and control their own insurer.

Even in the best of cases, however, exemplary "cooperation among cooperatives" is not all-encompassing, but confined to natural partners within subgroups—with the subgroups coexisting side by side in a perpetual *entente cordiale*. Organisations in the agricultural cooperative sector, for example, may sponsor one cooperative insurer—and those in the consumer and workers' cooperative sector may support another insurer. In developed markets, both or several such insurers may do well. But in countries with weaker economies, where different cooperative business sectors are individually not strong and self-sustaining, separate insurers may not be sustainable.

A case in point involves **Company 8** and **Company 9** in a country which, unlike most, does not even have one apex body serving as an umbrella for cooperative bodies in various sectors. Such is the lack of "cooperation among cooperatives" that six apexes exist. Two of these apexes separately gave birth to Company 8 and Company 9. Company 8, with roots in the agricultural sector, has been an insurer from the beginning. Low on resources but high on cooperative spirit, Company 9 could be set up only as a mutual benefits association (MBA), skirting the minimum capital requirement for an insurer.

(Some jurisdictions allow a mutual benefit association to provide basic "pre-insurance" benefits to its membership. An MBA means a corporation, society, or association that has no capital stock, which issues certificates of membership providing for payment of benefits in case of sickness, disability or death of its members. It accumulates funds by the collection of fees or dues from its members, at either stated or irregular intervals, with which to discharge its liabilities on its membership certificates and with which to pay the administrative expenses.)

In at least two other countries where cooperative insurers were set up jointly supported by their movements around the same time—one in Asia and the other in Latin America—the insurers have since grown to be among leaders in their markets. Company 9 is still mainly a

mutual benefits association, though it has lately licensed and registered a life insurance subsidiary. Company 8, save for a brief golden interlude, continues to languish. Both insurance operations can best be described as "touch and go."

Based on international experiences of bringing cooperative organisations and sectors together, a project to unify Company 8 and Company 9 was undertaken. Five years of discussions and negotiations produced no movement, and the project had to abandon the desirable thought that Company 8 and Company 9 stood a better chance of surviving together, if not growing, in a changing market.

A year later, an established insurer from a developed market (call it Company A) picked up the pieces and started negotiating a joint venture with Company 8 and Company 9. After nearly two years of productive meetings to develop a business plan, which even had the blessings of the insurance regulator, a Saturday was set aside for the signing ceremony. At 4 o'clock in the afternoon of the Friday before, a fax arrived for the chief executive of Company A from the chairman of Company 8, saying that his board of directors had changed its mind and could not go ahead with the proposed joint venture.

No formal reason for this abrupt end of a long, and what seemed to be constructive process was given. The general view was that the negotiations stalled because the board members would not be as involved in the organization going forward as they had been in the past.

Signposts

- **Corporate governance ensures the integrity of corporations, financial institutions and markets, building public and investor confidence.**
- **Good governance starts with knowing what it is to manage and what it is to govern.**
- **To govern a microinsurer effectively, one must devote time to gain an understanding of insurance and take the director's responsibilities and obligations seriously.**
- **The board of directors is ultimately accountable for the company's success. And success means producing results for sponsors, shareholders and users of services—so the insurer is not left short of the capital and surplus required to maintain its financial strength.**
- **There are things better left to management to decide and follow through.**
- **If going it alone is rough and there is no easy way out of the rut, a joint venture or partnership may be a good option.**