Microinsurance Metrics

from the Microinsurance Network and LeapFrog Investments

The list of IRIS metrics below represent those that align with the Microinsurance Network Social and Financial Performance Indicators, with market-based feedback provided by LeapFrog Investments through their FIIRM framework.

Microinsurance Network Indicator	IRIS Metric	Metric Definition	Calculation	Usage Guidance
Incurred Claims Ratio *= Gross Incurred Claims / Gross Earned Premium*	Incurred Claims Ratio	Percent of gross incurred claims during the reporting period relative to the gross earned premium during the same reporting period.	= Gross Incurred Claims (FP2460) / Gross Earned Premium (PI2025)	The metric can be used to interpret the value of products to the insured. As an example a 70 percent incurred claims ratio means that for every $100 of premium earned in a given accounting period, $70 is paid back in the form of benefits (claims). Organizations should note that incurred claims ratios cannot be compared across different product types or at different stages of a product's life cycle. For more detail on the ratio and for guidance on interpretation, see the Microinsurance Network's Social Performance Indicators for Microinsurance, p. 16 (http://www.microfact.org/social-performance/).
	Gross Incurred Claims	Value of the organization's gross incurred claims at the end of the reporting period. Incurred claims are those where the insured event has happened, and for which the insurer may be liable if a claim is made. An insurer is usually not aware of all incurred claims at a particular point in time or for a current accounting period.	= Benefits paid during the reporting period + (Total reserves at the beginning of the reporting period - Total reserves at the end of the reporting period)	This metric should include all gross paid claims during the period plus a reasonable estimate of unpaid liabilities. Unpaid liabilities can be calculated by summing the change in reserves, including the incurred but not reported claims reserve, course of settlement reserve and accrued liabilities reserve. This metric is an input into the Incurred Claims Ratio (FP2460), which helps assess the value of an insurance product per premium payment. For more information, see the Incurred Claims Ratio (FP2460).
	Gross Earned Premium	Value of gross earned premiums collected by the organization as of the end of the reporting period without any deductions such as commissions and other expenses.	= Gross written premium + (Unearned premium at the beginning of the reporting period - Unearned premium at the end of the reporting period)	This metric measures the premium income in the period minus change in unearned premium reserve.
Renewal Ratio *=Number of renewals / Number of potential renewals*	Renewal Ratio	Percent of policies that stay enrolled after their coverage term expires, during the reporting period.	=Number of Renewals (PI3212) / Number of Potential Renewals (PI3069)	As an example, a 90 percent renewal ratio means that for very 100 insured, 90 renew while 10 do not. For more detail on the ratio and for guidance on interpretation, see the Microinsurance Network's Social Performance Indicators for Microinsurance, p. 18 (http://www.microfact.org/social-performance/).
	Number of Renewals	Number of policies that are renewed after the coverage term expired, during the reporting period.		This metric should include the number of policies that have expired in the previous reporting period and are renewed during the current reporting period.
	Number of Potential Renewals	Number of policies that could have been renewed during the reporting period. This number excludes policies that became ineligible due to clients' old age, death, or due to other reasons which results in ineligibility during the reporting period. Organizations should footnote specific criteria resulting in ineligibility.		
Promptness of Claims Settlement *Schedule of claims settlement*	Promptness of Claims Settlement	Average number of days elapsed between when an insured incident occurred and when the beneficiary received the payment or claim denial, for all claims settled (or rejected) during the reporting period. Organizations should note that acceptable timing can vary by geography, and should footnote the details of claims settlement using a schedule to reflect the detailed timeline breakouts of claims settlement. See usage guidance for further information.	= Sum of the number of days between the date of the claims settlement payment or denial and the date of the insured incidents / Total number of claims settled during the reporting period	Organizations should note that this metric is calculated using the average of dates from when an insured incident occurs through the date that the beneficiary receives payment or claim denial. Organizations should footnote a schedule outlining the number of claims settled within specified durations and are encouraged to use the breakouts recommended by the Microinsurance Network. The Microinsurance Network recommends that organizations report the number of claims settled within 7 days, 8-30 days, 31-90 days and more than 90 days. Where applicable, organizations should alter the duration buckets to reflect regional norms. It is not always possible to know how long it takes for a payment to reach a beneficiary (i.e. the benefit received date). In these cases, organizations should estimate using the date in which the claim was paid and footnote these assumptions. For more detail on the ratio, the recommended footnote schedule, and for guidance on interpretation, see the Microinsurance Network's Social Performance Indicators for Microinsurance, p. 19 (http://www.microfact.org/social-performance/).

Microinsurance Network Indicator	IRIS Metric	Metric Definition	Calculation	Usage Guidance
	Promptness of Claims Submission	Average number of days elapsed between when an insured incident occurred and when the beneficiary submits a complete claim, for all claims settled during the reporting period.	= Sum of the number of days between complete claims submission and the date of the insured incidents / Total number of claims settled during the reporting period	Organizations should note that this metric is calculated using the average of dates from when an insured incident occurs through the date that the claim is submitted by the beneficiary. Organizations can use the raw data relevant to this metric when calculating Promptness of Claims Settlement (PI9897). For more detail on the Promptness of Claims Settlement and for guidance on interpretation, see the Microinsurance Network's Social Performance Indicators for Microinsurance, p. 19 (http://www.microfact.org/social-performance/).
	Promptness of Claims Processing	Average number of days elapsed between when a beneficiary submits a completed claim and when the beneficiary received the payment or claim denial, for all claims settled during the reporting period.	= Sum of the number of days between claims settlement and the date of complete claims submission / Total number of claims settled during the reporting period	Organizations should note that this metric is calculated using the average of dates from when a claim is submitted through the date that the beneficiary receives payment or claim denial. Organizations can use the raw data relevant to this metric when calculating Promptness of Claims Settlement (PI9897).
Claims Rejection Ratio *=Number of claims rejected / Number of claims in the sample*	Claims Rejection Ratio	Percent of claims rejected by the organization during the reporting period relative to the total claims submitted to the organization during the reporting period.	= Number of Claims Rejected (PI3383) during the reporting period / Number of Claims Submitted (PI8018) during the reporting period	The metric can be used to examine the proportion of claims that were disqualified for benefit payment (rejected), for whatever reason. As an example a 10 percent claims rejection ratio means that for every 100 claims reported, 90 result in a benefit payment while the other 10 are denied. For more detail on the ratio and for guidance on interpretation, see the Microinsurance Network's Social Performance Indicators for Microinsurance, p. 25 (http://www.microfact.org/social-performance/).
	Claims Rejected	Number of claims that were submitted to the organization but rejected during the reporting period.		This metric should capture the number of claims that has been disqualified for benefit payment (rejected), for whatever reason. Examples of reasons for which claims might be rejected include: claims submitted for events that are not covered, claims submitted before the waiting period has lapsed, the insured is no longer covered due to expiration of the coverage period or by attaining maximum, etc. eligible age.
	Claims Submitted	Number of claims submitted to the organization during the reporting period.		The metric should include all claims that were submitted to the organization regardless of if they were eventually rejected or not.
Complaints Ratio *= Number of complaints registered / Total Number of clients*	Complaints Ratio	Percent of complaints registered by clients of the reporting organization relative to the total number of clients during the reporting period.	= Number of Complaints Registered (PI2197) / Client Individuals: Total (PI4060)	The metric assumes that the provider has a complaint tracking mechanism in place. Complaints should be recorded and tracked as part of a redress system. While there are different modes for processing complaints, this metric captures all modes for client recourse. For more detail on the ratio and for guidance on interpretation for organizations providing microinsurance, see the Microinsurance Network's Social Performance Indicators for Microinsurance, p. 27 (http://www.microfact.org/social-performance/).
	Number of Complaints Registered	The number of complaints registered by clients of the reporting organization during the reporting period.		This metric is intended to capture the number of unique complains made by microinsurance clients of the reporting organization. The metric assumes that the provider has a complaint tracking mechanism as part of a redress system.
	Client Individuals: Total	Number of unique individuals who were clients of the organization during the reporting period.		This metric is intended to capture the number of unique clients who were recipients of the organization's products or services during the reporting period. It is not a measure of foot traffic. It is also not intended to capture the number of consumer transactions. For example a customer who makes two purchases during a period should only be counted once. Organizations wishing to report on total client transactions should refer to Client Transactions (PI5184). For healthcare providers, this refers to patients.

Microinsurance Network Indicator	IRIS Metric	Metric Definition	Calculation	Usage Guidance
Percentage of insured below the poverty line *= Number of clients below defined poverty line / Total number of clients* *Note that the listed IRIS Metric captures Client Individuals below the "low income" poverty threshold line, however there are other IRIS Metrics, such as Client Individuals: Minority/Previously Excluded (PI4237) that capture other client demographic information organizations may wish to track.*	Client Individuals: Low Income	Number of unique low-income individuals who were clients of the organization during the reporting period.		This metric is intended to capture the number of unique low income clients who were recipients of the organization's products or services during the reporting period. It is not a measure of foot traffic. It is also not intended to capture the number of consumer transactions. For example a customer who makes two purchases during a period should only be counted once. Organizations wishing to report on total client transactions should refer to Client Transactions (PI5184). For healthcare providers, this refers to patients. The population classified as low income includes all those who fall below a fixed threshold, and is inclusive of those classified as poor or very poor. Due to the complexities of assessing the poverty level of clients, organizations will likely have to use specific assessment tools to report on this accurately. See the glossary definition for additional information on commonly used tools to help determine the absolute poverty level of individuals and households. Organizations that rely on assumptions to report against this metric should footnote any assumptions used in the calculation process. For example, organizations that sell solar lanterns via a series of local network distributors might estimate the number of client individuals reached by the number of units sold. Details on how and why these assumptions were made should be footnoted. This metric is meant to capture the unique number of specific individuals serviced. Organizations should not use any household multipliers when
	Client Individuals: Total	Number of unique individuals who were clients of the organization during the reporting period.		This metric is intended to capture the number of unique clients who were recipients of the organization's products or services during the reporting period. It is not a measure of foot traffic. It is also not intended to capture the number of consumer transactions. For example a customer who makes two purchases during a period should only be counted once. Organizations wishing to report on total client transactions should refer to Client Transactions (PI5184). For healthcare providers, this refers to patients. Organizations that rely on assumptions to report against this metric should footnote any assumptions used in the calculation process. For example, organizations that sell solar lanterns via a series of local network distributors might estimate the number of client individuals reached by the number of units sold. Details on how and why these assumptions were made should be footnoted. This metric is meant to capture the unique number of specific individuals serviced. Organizations should not use any household multipliers when reporting against this number. If organizations consider the entire household to be the customer/client they can report against Client Households: Total (PI7954) and its associated submetircs.
Percentage of female insured *= Number of women clients / Total number of clients*	Client Individuals: Female	Number of unique women who were clients of the organization during the reporting period.		This metric is intended to capture the number of unique female clients who were recipients of the organization's products or services during the reporting period. It is not a measure of foot traffic. It is also not intended to capture the number of consumer transactions. For example a customer who makes two purchases during a period should only be counted once. Organizations wishing to report on total client transactions should refer to Client Transactions (PI5184). For healthcare providers, this refers to patients. Organizations that rely on assumptions to report against this metric should footnote any assumptions used in the calculation process. For example, organizations that sell solar lanterns via a series of local network distributors might estimate the number of client individuals reached by the number of units sold. Details on how and why these assumptions were made should be footnoted. This metric is meant to capture the unique number of specific individuals serviced. Organizations should not use any household multipliers when reporting against this number. If organizations consider the entire household to be the customer/client they can report against Client Households: Total (PI7954) and its associated submetircs.

Microinsurance Network Indicator	IRIS Metric	Metric Definition	Calculation	Usage Guidance
	Client Individuals: Total	Number of unique individuals who were clients of the organization during the reporting period.		This metric is intended to capture the number of unique clients who were recipients of the organization's products or services during the reporting period. It is not a measure of foot traffic. It is also not intended to capture the number of consumer transactions. For example a customer who makes two purchases during a period should only be counted once. Organizations wishing to report on total client transactions should refer to Client Transactions (PI5184). For healthcare providers, this refers to patients. Organizations that rely on assumptions to report against this metric should footnote any assumptions used in the calculation process. For example, organizations that sell solar lanterns via a series of local network distributors might estimate the number of client individuals reached by the number of units sold. Details on how and why these assumptions were made should be footnoted. This metric is meant to capture the unique number of specific individuals serviced. Organizations should not use any household multipliers when reporting against this number. If organizations consider the entire household to be the customer/client they can report against Client Households: Total (PI7954) and its associated submetircs.
Incurred Expense Ratio *= Incurred Expenses / Gross Earned Premium*	Total Expenses	Value of all operating expenditures incurred by the organization during the reporting period.		For insurance providers, this metric exclude claims payments.
	Gross Earned Premium	Value of gross earned premiums collected by the organization as of the end of the reporting period without any deductions such as commissions and other expenses.	= Gross written premium + (Unearned premium at the beginning of the reporting period - Unearned premium at the end of the reporting period)	This metric measures the premium income in the period minus change in unearned premium reserve.
Net Income Ratio *= Net Income / Gross Earned Premium*	Net Income	Value of the organization's net profit, calculated as total income minus total expenses during the reporting period.		
	Gross Earned Premium	Value of gross earned premiums collected by the organization as of the end of the reporting period without any deductions such as commissions and other expenses.	= Gross written premium + (Unearned premium at the beginning of the reporting period - Unearned premium at the end of the reporting period)	This metric measures the premium income in the period minus change in unearned premium reserve.
Growth Ratio *=(Number of insured n – Number of insured n-1) / Number of insured n-1*	Client Individuals: Active	Number of unique individuals who were active clients of the organization as of the end of the reporting period. Organizations should footnote the description of the type of clients included in the calculation.		This metric is intended to capture the number of unique clients who were unique active users of the organization's products or services as of the end of the reporting period. Organizations wishing to report on total client transactions should refer to Client Transactions (PI5184). Organizations wishing to report against the number of unique clients during the course of the reporting period can report on the Client Individual metrics. For healthcare providers, this refers to patients. For financial institutions (including microfinance institutions) this would include the number of individuals who currently have an outstanding loan balance with the organization. For those financial institutions offering deposit products, this would include the number of individuals who have an active deposit account with the organization. For those financial institutions offering insurance products, this would include those with an active insurance policy. In all cases, the number should be based on the number of individuals rather than the number of groups or number of active policies/accounts. Organizations that rely on assumptions to report against this metric should footnote any assumptions used in the calculation process. For example, organizations that sell solar lanterns via a series of local network distributors might estimate the number of client individuals reached by the number of units sold. Details on how and why these assumptions were made should be footnoted. This metric is meant to capture the unique number of specific individuals serviced. Organizations should not use any household multipliers when reporting against this number. If organizations consider the entire household to be the customer/client they can report against Client Households: Total

Microinsurance Network Indicator	IRIS Metric	Metric Definition	Calculation	Usage Guidance
Solvency Ratio *= Admitted Assets / Liabilities*	Solvency Ratio	Ratio of an organization's admitted assets to admitted liabilities, per an organization's statutory accounts, as of the end of the reporting period.	= Admitted assets / Total Liabilities (FP1996)	Organizations should note that this metric does not refer to Solvency I or II rules, but rather seeks to address the financial strength of the insurance programme (as a 'cover ratio' would address for international insurers). Admitted assets are defined by the Insurance Information Institute, as applicable in the United States, as "assets that can be easily sold in the event of liquidation or borrowed against, and receivables for which payment can be reasonable anticipated". In the absence of regulatory definitions of admitted assets, organizations should include higher quality assets that can be easily liquidated. For more detail on the ratio and for guidance on interpretation, see the Microinsurance Network's Performance Indicators for Microinsurance (2nd Edition), p. 49 (http://www.microfact.org/social-performance/).
	Total Liabilities	Value of organization's liabilities at the end of the reporting period.		
Liquidity Ratio *= Available cash or cash equivalents / Short-term payables*	Current Assets	Value, at the end of the reporting period, of the organization's assets that are reasonably expected to be converted into cash within one year in the normal course of business.		Current assets can include cash, accounts receivable, inventory, marketable securities, prepaid expenses and other liquid assets that can be readily converted to cash.
	Current Liabilities	Value, at the end of the reporting period, of all liabilities that are expected to be settled within one year in the normal course of business.		Current liabilities include accounts payable, lines of credit, or other short term debts.