



# Securing the Silent

## Microinsurance in India

– *The Story So Far*

***MicroSave***  
*Market-led solutions for financial services*

***Compiled by -***

Premasis Mukherjee

Rosalind Piggot

Sunil Bhat

## A message from the director

India is and continues to be a largely credit led market as far as the low income segment is concerned. The absence of a range of financial services including savings, insurance and pension makes it very difficult for poor people to manage their finances and makes it almost impossible to manage risks. While some attempts were made to address the risk to life by offering life insurance to borrowers and to their spouses; the pioneering collaboration between insurance companies and microfinance institutions degenerated in at least a few cases and become more of an operational risk cover for MFIs. After the regulations were tightened by IRDA, the life insurance industry has been looking to develop other channels for distribution of microinsurance products which are viable and can achieve scale.

The health microinsurance space is even more challenging despite the fact that innumerable studies show that health related issues are perhaps the single biggest reason because of which low income people slide further into poverty. The government has launched the *Rashtriya Swasthya Bima Yojana* where the coverage has been impressive but issues around client education, service delivery and the sustainability of the exercise considering the claims ratio (well over a 100%) continue to cast doubts on the long term sustainability of schemes such as these. Overall, a lot more emphasis needs to be given on the design and delivery of insurance services to poor people. This report seeks to capture the state of microinsurance services in the country specifically for life and health and also traces the genesis of the sector. As part of the recommendation, the report lays out the steps that are needed to provide risk cover to poor household.

This report could not have been written without the invaluable insights and assistance from a number of experts. We would like to thank all the professionals from across the sector for sharing their time and views with us; **Dr. DVS Sastry**, and **Mr. Arman Oza, CEO, VimoSewa** deserve special mention for their guidance. Special thanks are due to the team managing the Microfinance India Summit for their support. Thanks are due to **Shri. Brij Mohan, Shri. Vipin Sharma and Smt. Radhika Agashe, colleagues at Access Development Services** for their constant encouragement.

We sincerely hope that the report will serve as a compendium for the industry and will welcome comments and suggestions which will improve the quality and presentation of the next edition.



Manoj K. Sharma  
Managing Director  
*MicroSave*

# Abbreviations

AABY	Aam Admi BimaYojana
ACCORD	Action for Community Organisation, Rehabilitation and Development
AP	Andhra Pradesh
BAIF	Bharatiya Agro Industries Foundation
BASIX	Bhartiya Samruddhi Investments and Consultancy Services
BC	Business Correspondent
BCNM	Business Correspondent Network Manager
BoP	Base of the Pyramid
BPL	Below the Poverty Line
CBHI	Community Based Health Insurer
CGHS	Central Government Health Scheme
DHAN	Development of Humane Action
ESAF	Evangelical Social Action Forum
ESIS	Employee State Insurance Scheme
FHLP	Family Health Plan Limited
GDP	Gross Domestic Product
GSGSKK	Gandhi Smaraka Grama Seva Kendram Karadka
IDBI	Industrial Development Bank of India
INR	Indian Rupee
HDFC	Housing Development and Finance Corporation
HSBC	Hong-Kong Shanghai Banking Corporation
IRDA	Insurance Regulatory and Development Authority
IT	Information Technology
JBY	Janashree BimaYojana
LIC	Life Insurance Corporation India
MFI	Microfinance Institution
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act

MIA	Micro Insurance Agent
MIS	Management Information System
NAV	Net Asset Value
NBFC	Non-Banking Financial Corporation
NGO	Non Government Organisation
NoP	Number of Policies
NSSO	National Sample Survey Organisation
OASIS	Organisation for Awareness of Integrated Social Security
PPP	Public Private Partnership
PREM	People's Rural Education Movement
RAY	Rajiv Arogyashree Yojana
RBI	Reserve Bank of India
RRDC	Regional Rural Development Centre
RSBY	Rashtriya Swasthya Bima Yojana
SBI	State Bank of India
SERP	Society for Elimination of Rural Poverty
SEWA	Self Employed Women's Association
SHADE	Self Help Association for Development and Empowerment
SHG	Self Help Group
SKAP	Sampoorna Kutumba Arogya Pathakam
SKDRDP	Shree Kshetra Dharmasthala Rural Development Project
SKS	Swayam Krishi Sangam
SPARC	Society for the Promotion of Area Resources
TN	Tamil Nadu
TPA	Third Party Administrator
ULIP	Unit Linked Insurance Plan
UNDP	United Nations Development Programme
USD	United States Dollar
VAY	Vajpayee Arogyashree Yojana
WHO	World Health Organisation



# Securing the Silent Life Microinsurance



*MicroSave - Market-led solution for financial services*

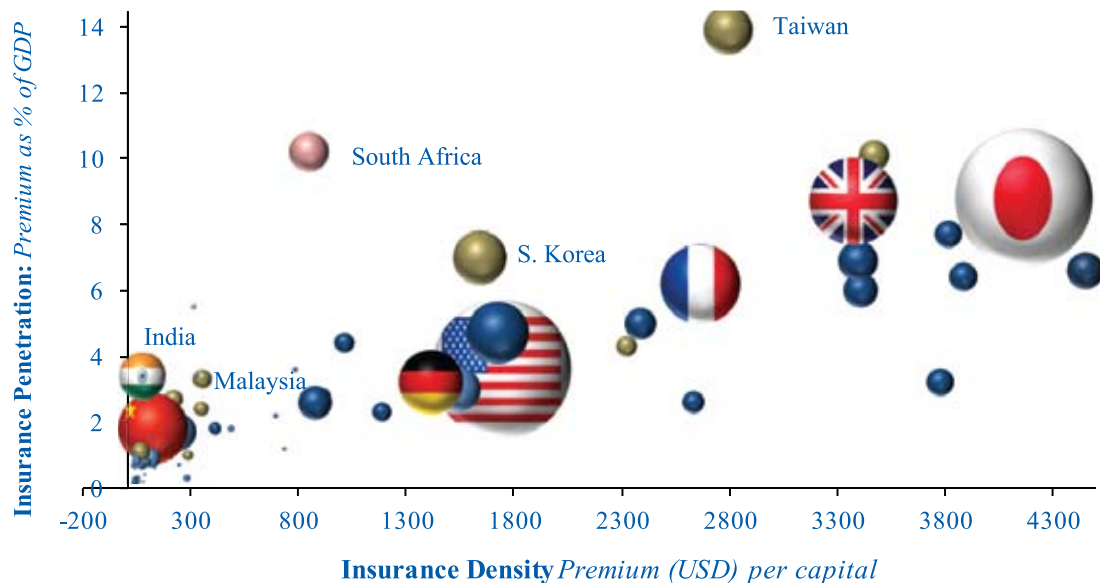
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## 1. Introduction: The Background and Snapshot

After 44 years of public sector dominance, the life insurance industry in India was liberalised in 1999-2000. Since then, the industry has witnessed rapid growth of 15-20% (Year on Year). From a mere INR348 billion in 2000-01, the industry grew to a size of INR2,893 billion (in 2011-12)<sup>1</sup>, where it constitutes 2.3% of the global life insurance market<sup>2</sup>. Though still quite behind the insurance penetration achieved in developed nations, the growth story of insurance (particularly life insurance) in India is overwhelming.

### India's Position in the Global Life Insurance Industry



*Source: Swiss Re Sigma, 2011 and MicroSave Analysis*

It is worthy to note that the inspiring growth of life insurance in India was mainly fuelled by urban high-end insurance business. 90%<sup>3</sup> of the Indian population and 88%<sup>4</sup> of the Indian workforce (the majority of which is the unorganised sector) are still excluded from any kind of insurance and pension cover. This fact underlines the overall scenario of financial exclusion of low income households in India. Only 27.1% of the lowest 40% earners have some form of a basic account in formal financial institutions in India<sup>5</sup>. While the penetration of financial services is sub-par, the potential of rural and low income market is beyond doubt. UNDP, in 2009, estimated that the potential size of the Indian microinsurance market is INR62-84 billion and the life microinsurance market of India has a potential of USD321-420 million<sup>6</sup>.

The sector experts, policy makers and regulators have always been worried about the dichotomy. The reason for under-penetration of life microinsurance, despite the proven need, lies in the

<sup>1</sup>In premium income

<sup>2</sup>Swiss Re Sigma Study 2011, March 2012

<sup>3</sup>Mare Socquetl, ILO/STEP, Microinsurance workshop, India, October 2005

<sup>4</sup>Pension reforms for unorganised sector, ADB, TA IND-4226, 2006

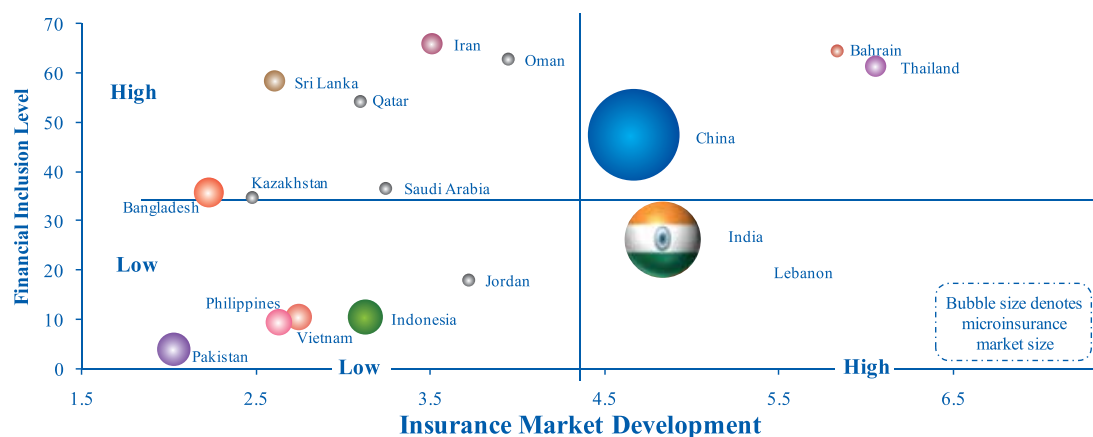
<sup>5</sup>World Bank financial inclusion database, 2012

<sup>6</sup>Potential and prospects of Microinsurance in India; UNDP Regional Centre of Human Development Unit, 2009



characteristics of the overall life insurance industry of India. Though India currently is thought to account for 60% of the all individuals covered by microinsurance worldwide<sup>7</sup>, the life microinsurance sector is very small as compared to the overall life insurance industry. Life microinsurance accounts for only 4.59% of the total lives covered, 7.6% of the total number of policies and 0.23% of premium collected by the life insurance industry of India<sup>8</sup>. It is no wonder that the life microinsurance industry is dominated by the trends exhibited by the conventional life insurance industry of India. It is imperative, therefore, to understand the trends and characteristics of the life insurance industry of India in order to understand the life microinsurance sector.

### Positioning of India among Asian Countries in Microinsurance Potential



*Source: World Bank; Swiss Re, 2011; MicroSave*

In this report, we discuss the trends of the life microinsurance sector in India with a level of detailing of the trends of the conventional life insurance industry. The following section (Section 2) of the report details the development and characteristics of the conventional life insurance industry and the trends it exhibited. This will help us understand the development of life microinsurance sector, detailed in Section 2. In the third and fourth section, we discuss the recent trends in the life insurance Sector (particularly micro life), which gives way to the futuristic commentary approached in section five.

### The life insurance industry has gone through a long development phase

The first insurance company in India was established in 1818. However, till 1912, nearly 176 insurance companies existed in India without any regulation or Act governing them. Life Insurance Act, 1912 and Insurance Act, 1938 were the only regulatory interventions in insurance pre-independence. After independence (in 1947), Indian Government nationalised the existing insurance companies and brought them under one life (Life Insurance Corporation of India) [in 1956] and four general public sector insurance companies [in 1972]. Life Insurance Corporation of India (LIC) was formed by merging 245 small scale

<sup>7</sup>[http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS\\_177356/lang--en/index.htm](http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_177356/lang--en/index.htm)  
<sup>8</sup>IRDA Annual Report, 2010-11

insurers and provident societies. Till 1993, through its network of 2,000 branches and more than 1 million commission agents, LIC reached to 60-70 million customers, conducted business worth INR900 billion and contributed 5.95% to the GDP. In 1993, insurance reform was conceived, however, it took another seven years for the government to liberalise the market, and allow private insurance companies to conduct life insurance business in India. In 1999, private insurers were allowed with a maximum of 26% Foreign Direct investment (FDI). In 2000, Insurance Regulatory and Development Authority (IRDA) was established as an independent regulator of the insurance industry. Since then 41 private companies have entered the market. Of these, 23 are life insurance companies.

Oriental Insurance  
Company established in 1818

Life Insurance Act, 1912  
and Insurance Act, 1938

Life insurance nationalisation,  
1956 and formation of LIC

Malhotra Committee recommends  
insurance reforms, 1993

IRDA established, 2000

23 private insurance companies  
with 24.19% FDI, 2011

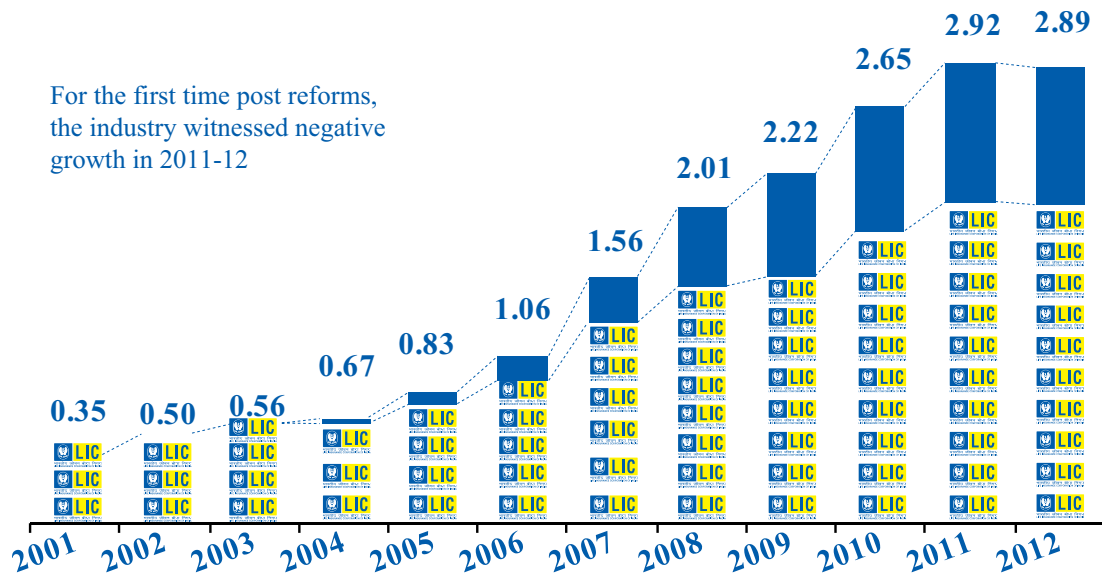
## 2. From 1999, Anatomy of the Life Insurance Industry has Changed

After nearly four decades of monopoly of the public insurer (Life Insurance Corporation of India), the life insurance industry was liberalised in 2000. Since then, 23 private life insurers have entered the market, with an equity of INR236.6 billion. Insurance Regulatory and Development Authority (IRDA) regulates the market.

The entry of private insurers has changed the life insurance industry of India substantially, fuelling the growth as well as changing the business dynamics of insurance. The reason for the change can be attributed to the ownership structure of private insurance companies. Most of the new private companies are a joint venture between international insurers and Indian banks. As on 2010, foreign insurers and Indian banks held 24% and 15% respectively of the equity in the Indian life insurance industry. Collaboration between international insurers and Indian banks brought the best of both worlds in terms of experience, channels and distribution networks, and performance benchmarks to compare Indian insurers with their global peers. The subsequent sections elaborate how attaining such benchmarks remained the theme of the industry in the last decade as well as in recent years.

## Growth of the Life Insurance Industry (in premium) Post Reforms (INR billion)

For the first time post reforms, the industry witnessed negative growth in 2011-12

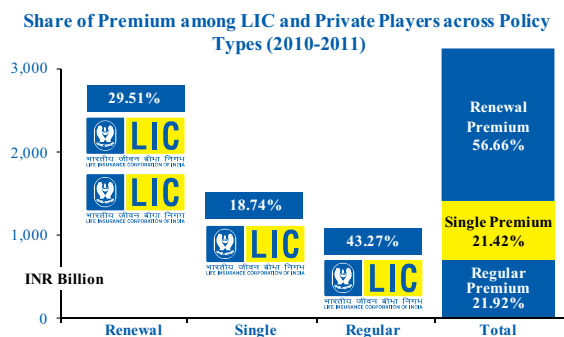


Source: IRDA Annual Reports; MicroSave Analysis

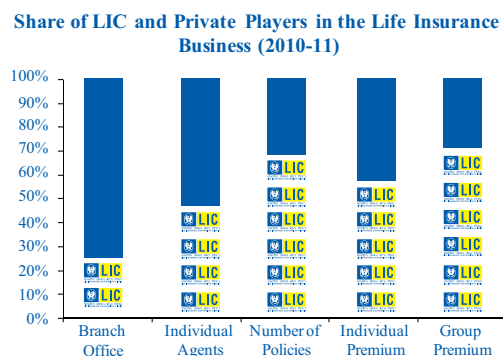
### 2.1. LIC, however, continues to dominate the market

With the entry of private players, LIC lost its monopoly in the life insurance industry. Market share of LIC has diminished from 99.46% in 2001-02 to 70.11% in 2011-12. However, LIC has an established business infrastructure in place and a strong brand due to its long history. The brand is strong even amongst the low income groups who inherently trust government institutions. Hence, despite the aggressive forays by private players, LIC could maintain its leading position in the market and overall, the industry collectively could grow the market. Hence, while on a percentage basis, LIC may have been able to come down in terms of market share, the company continues to lead the competition in premium (regular, single and renewal) collected as well as number of policies sold.

### 2.2. Private players, therefore, subscribed to alternative business models



Source: IRDA Annual Report 2010-2011



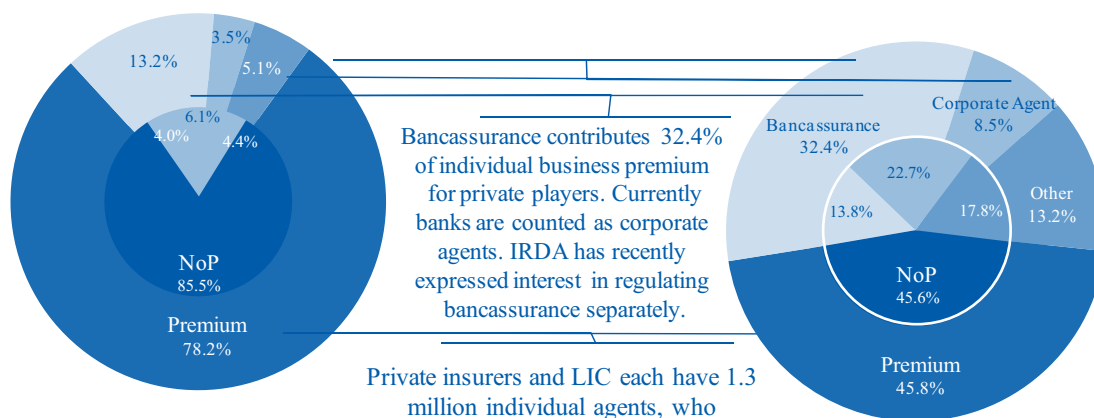
Source: IRDA Annual Report 2010-2011

In response, private insurers devised strategies to cope with the continued market leadership of LIC. To break LIC's dominance of the market, the private insurers, on one side rapidly enhanced their branch and agent network and on the other, subscribed to alternative business models.

### 2.2.1. Alternative channels emerged as a response to LIC's dominance in agency channel

Traditionally, life insurance policies in India were sold using individual commission agents (commonly known as Tied Agents). LIC still sources 87.38% of its policies and 95.49% of premium (including group policies) through individual agents<sup>9</sup>. In the initial days of reforms, private players too, followed the tied agency model and in the last decade, rapidly expanded their branch network. However, the growing branch network did not result in higher profits for them largely due to higher cost structures. Owing to strong bank partnership and a legacy of foreign insurers who are used to managing alternative channels in other countries, most private insurers diversified their distribution through bancassurance, corporate agents and direct selling channels.

There are 285 insurance brokers, who contribute 4.4% of private insurer business in terms of policies sold. In addition, 9.19% of private players' individual business is from direct selling. In group business (not shown here) direct selling contributes 79% to industry business, 2,165 corporate agents contribute 8.5% of new policies sold by private companies. Amid penalty to insurers for not adhering to corporate agent guidelines and over-paying, the celebrated Berkshire-Hathaway enters corporate agency market in India in 2012.




















Bancassurance contributes 32.4% of individual business premium for private players. Currently banks are counted as corporate agents. IRDA has recently expressed interest in regulating bancassurance separately.

Private insurers and LIC each have 1.3 million individual agents, who contribute 45.6% to the business of private insurers and 78% of premium of the industry. There is high agent turnover in the industry (148%), which increases cost for the insurer.

Though alternate channels contribute to a majority of business in private insurance companies, usage of alternate channels for distribution is not uniform across companies. While insurers having banks as a major partner (e.g. HDFC Life, SBI Life, IDBI Federal, Star Union DaiChi, Canara HSBC), have focused more on bancassurance channels, some companies (e.g. Birla Sunlife, Reliance, Bajaj Allianz and Future Generali) built their business models on corporate agents. Direct Selling is also a major channel for several insurers under both group and individual insurance business. Insurance brokers, who constitute 11-12% of global insurance market<sup>10</sup>, is another emerging channel. A careful study of the channels helps understand the diversity of business models of Indian insurers.

<sup>9</sup>2011-12 figures calculated from company disclosure of LIC

<sup>10</sup>Global Insurance Brokers and Agencies : Market Research Report, 2012; IBIS World

Year of Starting Business	2000-01	2001-02	2002-03	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Preferred Channel									
Individual Agent									
Bancassurance									
Corporate Agent									
Direct Selling									
Broker									

\*Overall, Reliance Life sells maximum number of policies and ICICI Prudential collects maximum premium from alternate channels

\*\* No insurance company started business in the year 2003-04

Source: IRDA Annual Report 2010-11, MicroSave Analysis

Bancassurance has been a particular focus of the industry owing to lower cost of policy administration under this channel. Banks, on their part, have also found this to be an opportune business for them. In fact, majority of equity restructuring of life insurers happened last year since banks entered into joint venture with insurers for a piece of the bancassurance business. However, industry experts are of the opinion that such aggressive bank infusion has cost implications for insurers, at least in short term. In 2012, Birla Sunlife, Aviva, MetLife and Max Life each have, paid nearly INR2.5 billion to INR5 billion to different banks, as advance commission to enter into such joint ventures and partnerships.

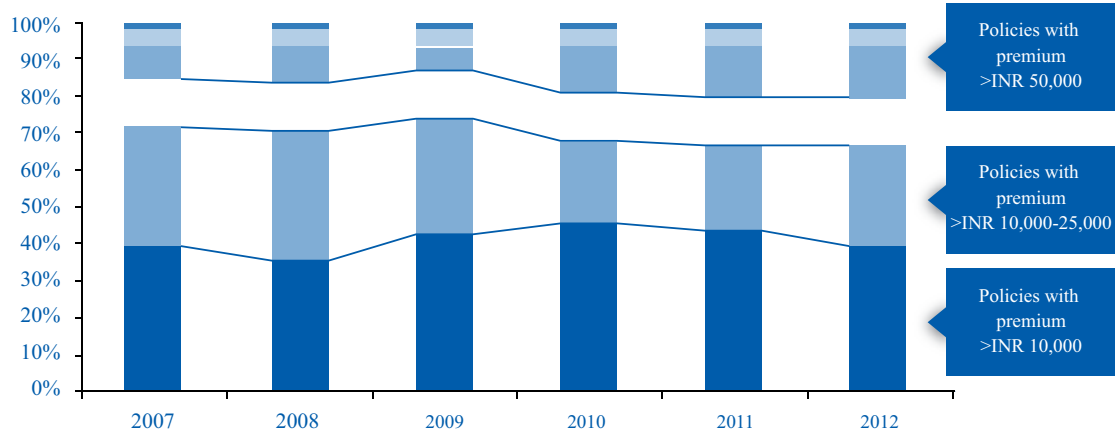
Bancassurance is the use of banks for selling insurance. Since, many of the private insurers are joint ventures of leading banks; bancassurance emerged as choicest channel for these companies.  Maximum Preference is by Canara HSBC, where 100% of the business is conducted through bancassurance.	IRDA allows companies having existing distribution network to work as Corporate Agents. This channel is preferred only by a limited number of companies, owing to stringent regulation.  Maximum Preference is by Future Generali, where 58% of NoP and 40% of Premium is collected through this channel.	Though limited, some private companies prefer to conduct business through insurance brokers.  Maximum Preference is by Shriram Life, where 30% of NoP and 28% of Premium is collected through this channel.	Direct Selling by call centre and online media is an emerging channel. Companies having expertise in call centre and online selling and those having limited agent network, prefer this channel for simple products.  Maximum Preference is by Aegon Religare, where 40% of NoP and 39% of Premium is collected through this channel.
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### 2.2.2. Private insurers adopted different product strategy as well

LIC's business mainly depends on low to medium ticket endowment life insurance products. On an average, policies having less than INR25,000 annual premium constitute 91% of LIC's



portfolio<sup>11</sup>. LIC's insurance business is also balanced amongst group and individual policies, with 60% premium coming from individual policies. Since private players have a limited agent and branch net work, they adopt product strategies that gives them an advantage over LIC.



While LIC dominates through low premium endowment based individual product, private players focused more on high premium, unit linked and group products.

### 2.2.2.1. *ULIP products were conceived by private insurers*

Life insurance has always been popular as a savings instrument in India. In 2000, 13.46%<sup>11</sup> of household financial savings was placed in life insurance. While LIC inculcated the culture of endowment products, the private players leveraged this savings culture by introducing Unit Linked Insurance Plans (ULIP<sup>12</sup>). In 2006-07, ULIPs accounted for a 70.3% of new business premium collection (individual policies) by the industry. In the same period, the industry also witnessed a high annual growth rate of 38% in premium. In short, the rapid growth of life insurance sector can significantly be attributed to the growth of ULIPs.

### 2.2.2.2. *Private players became adept in managing group life insurance business*

By the time private insurers entered the business, LIC already had a million strong agent network experienced in selling individual life insurance policies. There was no way private insurers could immediately acquire such expertise. Besides, cost of agent distribution was high for private insurers. While, they tried to compete with LIC on individual products through alternative distributions, many private insurers found group life insurance products as an effective segment to attain competitive growth. Over time, private insurers also became adept in selling group policies more efficiently than LIC.

The trends discussed so far have created the foundation for discussing the life microinsurance sector in India. In the forthcoming sections, we will elaborate the emergence of diverse business models in the life microinsurance sector and the role of LIC and private insurance companies. The reasons for

<sup>11</sup>Private pension plans: a policy perspective, Dr. Kumar, CII, 2005

<sup>12</sup>ULIPs are insurance plans, where some part of the money invested goes into the insurance cover and the remaining goes into different asset classes, viz. debt and equity. These are market linked and the value of investment varies daily based on the Net Asset Value (NAV) of the portfolio (selected by the client) of the investment.

positive bias amongst private players towards group microinsurance policies, issues in distribution, especially in rural areas, and the overall lack of interest in small ticket microinsurance products all has its genesis in the emergence and growth of insurance in the country.

Number of Lives Covered/Group Scheme

Premium/Group Scheme



LIC: 1,398 Industry Average: 2,720 Private: 9,352



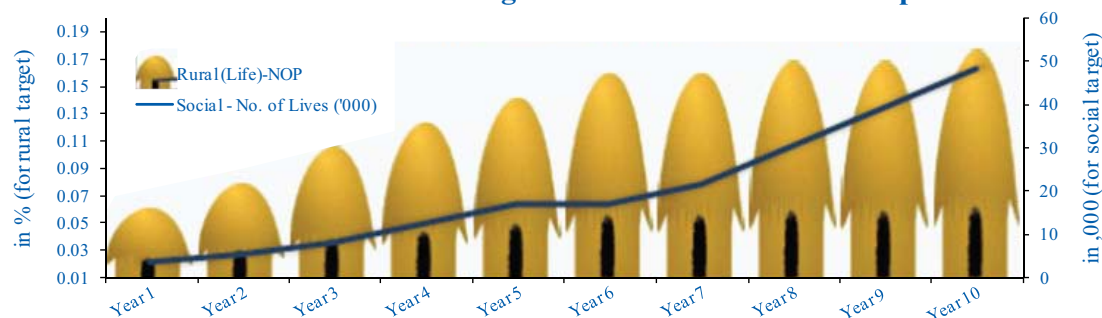
LIC: INR 13.42mn Industry Average: INR 14.11mn Private: INR 17.55mn

### 3. Micro Life Insurance Evolved as Derivative of Rural and Social Sector Regulation

During the nationalised insurance phase, market penetration of insurance in rural areas grew substantially. In 1993, approximately 48%<sup>13</sup> of LIC’s customers were from rural and semi-urban areas. When the sector was liberalised, the industry regulator was concerned about inclusive insurance growth and rural exposure for insurance companies. IRDA, therefore, mandated the insurance companies through rural and social sector obligation, 2002, to ensure that:

- A certain percentage of policies be sold in rural areas; and
- A certain number of lives are covered in the social sector.

Rural and Social Sector Obligation for Life Insurance Companies



Immediately after this regulation, almost all insurance companies designed products specifically to achieve these regulatory mandates. Prior to 2005, 12 insurance companies launched nearly forty two life microinsurance products<sup>14</sup>.

<sup>13</sup>“Privatisation of the Insurance Market in India: From the British Raj to Monopoly Raj to Swaraj”, TapanSinha, Centre for Insurance and Risk-Management, University of Nottingham ;2002

<sup>14</sup>ILO Special Study, “Insurance Products Provided by Insurance Companies to the Disadvantaged Groups in India”, 2005. Note: the report is as of 2005, before the Microinsurance Regulation; post regulation, most of these products have been discontinued and some new products are added under the new regulation.

### 3.1. IRDA wanted to unleash the microinsurance potential in India

The effect of Rural and Social Sector Obligation, 2002, was encouraging; however, IRDA wanted to unleash the potential of microinsurance beyond the exclusive business motive of attaining rural and social sector obligation.

Product Boundaries as per Microinsurance Regulation, 2005			
Type	Sum Assured (Rs. '000)	Term (Yrs.)	Age (Yrs.)
Term Life	5-50	5-15	18-60
Endowment	5-30	5-15	18-60
Health (individual)	5-30	1-7	Insurers' discretion
Health (family)	10-30	1-7	
Accident rider	10-50	5-15	18-60
Livestock/assets	5-30	1	NA
Accident (non-life)	10-30	1	5-70

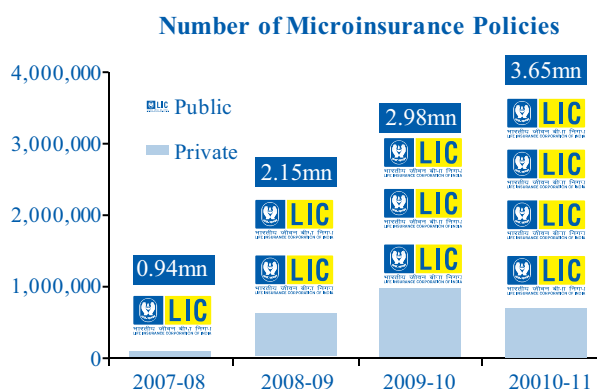
Driven by the rising insurance exclusion on one hand and optimism over the potential microinsurance market on the other, IRDA stipulated Microinsurance Regulation in 2005. Globally, this was a pioneering attempt on stipulating specific regulations for microinsurance.











The core of these regulations is -

- Stipulation of product boundaries in terms of minimum and maximum sum assured, the term of product, the allowable age group and the maximum commission to agents;
- SHGs, MFIs and NGOs were allowed to become Microinsurance Agents (MIA), a status that has simple agency clearance process and sustainable long term earning potential; and
- Fulfilment of both rural and social sector obligation through microinsurance products. Since the requirement for the social sector has always been relatively low, the regulations were especially critical in helping insurers reach rural targets.

### 3.2. The regulation prompted growth of the life microinsurance sector

A new wave of change came with the introduction of Microinsurance Regulation, 2005, as a result of which 14 life insurance companies registered 23 microinsurance products with IRDA. The registered microinsurance products have seen accelerated growth. According to the IRDA Annual Report, 2010-11, 3.65 million microinsurance policies were sold in India in the year 2010-11 covering the lives of 18.9 million people. The cumulative premium collected from microinsurance was INR2.86 million.



Launch of Microinsurance Products by Life insurers						
Launch Year >	Before 2005	2006	2007	2008	2009	2010
Individual Policy						
Group Policy						

Like in the conventional insurance industry, LIC leads the microinsurance sector, too. The trends and characteristics of the life microinsurance sector are a function of the conventional life insurance industry on one hand and the microinsurance regulation and rural-social sector obligation on the other.

### 3.3. But, private insurers perceived microinsurance as an obligatory necessity

IRDA assumed that the “rural and social sector obligation” would drive microinsurance innovation by insurance companies. However, as we have seen earlier, Indian insurers (particularly private insurers) focussed more on high value business and ULIPs, in order to achieve rapid growth and to cover their comparatively higher operating costs<sup>15</sup>. Insurance inclusion and entering the small premium market was the least of their priorities. Moreover, lack of experience in the rural and low-income segment meant that the insurers were not sure if the variable revenue and projected income/client numbers from microinsurance could justify the fixed cost of administration and distribution. Low ticket microinsurance products, therefore, failed to allure them. Most of the private insurers considered microinsurance more as an “obligatory necessity”, rather than a profitable product category. They adopted a “just achieve target” approach in microinsurance, so that they could achieve the mandatory numbers.

Thus, on the one side microinsurance became synonymous with rural insurance and at the same time it became positioned as a “necessary evil” for the insurers. The attached graph shows that even in 2010-11, microinsurance sales approximate only the rural sector obligation of the insurers. Life microinsurance, virtually a tool only to achieve the regulatory obligation, is often referred to by insurance companies as “compliance business”. Naturally, insurers do not want to make any extra effort towards selling and investing in such products.

<sup>15</sup>Operating expense of private insurers is 18 paise per rupee earned as premium, as compared to 8 paise/premium earned by LIC.

## Rural NoP vs. Rural Sector Obligation



Source: IRDA Annual Reports; Microsave Analysis

### 3.4. NGOs and MFIs became choicest conduit to push life microinsurance

In the absence of banking infrastructure reaching the rural and low income population, insurers could not depend on their low cost bancassurance channel for distributions of microinsurance products. Since agency recruitment required high investment (in training and licensing) from insurers; they expected high productivity (in terms of premium) from this channel, which could not be achieved from distribution of low ticket size microinsurance policies. Coupled with high agency management cost and value-based front-loaded commission regime (which makes agents interested only in high value business), it was (and still is) virtually impossible for private insurers to push life microinsurance through their agent channel.

Hence, there was no option available for distribution and limited incentive for insurers to go for voluntary life micro insurance. The search was on for a channel through which microinsurance could be pushed at a low cost and without much hassle. Fortunately for the insurers, this was the time when microfinance institutions (MFIs) were witnessing a boom phase and emerged as a natural choice for distribution of microinsurance in rural areas. Bank partners of private insurers had an existing relationship with MFIs (generally through credit for on-lending), for their priority sector portfolio. Besides, use of MFIs for rural sector targets was a tested choice for private insurers as they had worked with this channel to achieve obligatory targets from 2002 to 2005. The new regulation gave a fillip to this practice. Since the regulations allowed MFIs to be micro insurance agents through a partner-agent model, almost all insurers followed a similar model of life microinsurance and pushed life microinsurance through the microfinance channel. Currently 96% of the MIAs of the life insurers are NGO-MFIs<sup>16</sup>.

However, only 8 insurance companies have actually registered MIAs in last 5 years. Usage of MIAs has also reduced in recent years and some private players have even decreased their number of MIAs. In the next section, we will see that such reduction in MIA can be attributed to the advent of group life microinsurance products, which are sold directly to the MFIs, without making them an MIA.

<sup>16</sup>IRDA exposure draft on microinsurance, July,2012





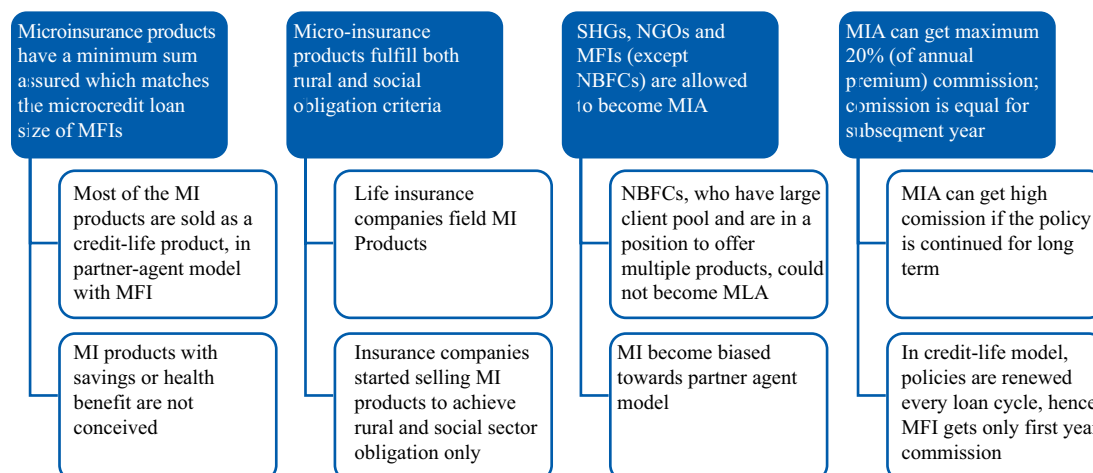
### 3.5. The regulation also promoted credit-life products

Apart from its bias towards the partner-agent model, the Microinsurance Regulation, 2005 had another aspect that helped the present day trends in the sector. The sum assured prescribed by the regulation is generally in consonance with the size of the loan extended by the MFIs to its clients (typically women and generally from the weaker sections of society). Thus on one hand, insurers approached MFIs for selling the life microinsurance products and on the other, they tried to do so in a hassle free, low cost way. MFIs on the other hand found a convenient way of covering some of the risk inherent in serving the low income sector. The foundation for credit-life products was all set.

Soon the credit-life model - where the MFI bundles the term life insurance with its loan – became an industry norm as far as life microinsurance was concerned. It was a marriage of convenience between the insurers and the MFIs, since:

- The insurance companies could attain the rural and social sector obligation by partnering with MFIs -an arrangement where they do not have to incur any additional cost of soliciting clients and creating a separate distribution channel; and
- MFIs could secure their loan portfolio against life risk as well as earn commission income for no additional responsibility and very little extra work.

#### Impact of Microinsurance Regulation on Industry



In such arrangements, however, the clients do not get any real benefit. They are covered only to the extent of the loan amount and mostly do not receive any maturity benefit or long-term risk cover. The premium is appropriated from them either as an “insurance charge” from the loan amount or is collected through a semi-voluntary mechanism<sup>17</sup>.

### 3.6. Product strategy for credit-life, however, varies across insurers

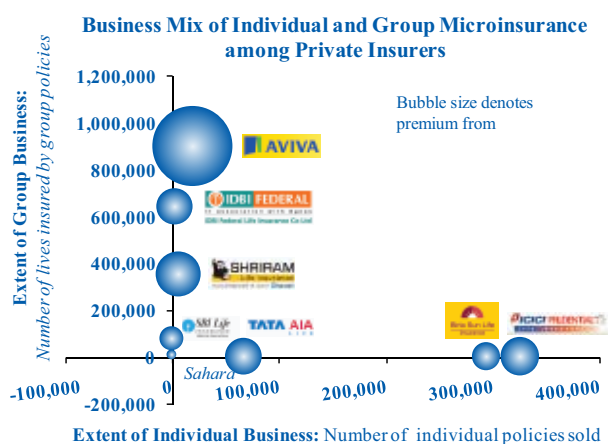
While credit-life is the predominant mode for distribution of microinsurance, product strategy may differ from insurer to insurer. Some prefer to sell individual term products, while others prefer group term products. It is interesting to see that the private insurers decidedly adopt either of these products and a product mix is typically not visible.

As the sector progressed, large MFIs realised that premium for group term products is much lower than the pay-out for individual term life products. Hence, MFIs, interested primarily in covering their portfolio at the lowest possible cost, took to group life as the preferred arrangement. They negotiated with insurers on the premium amount and the cost / profit share arrangements. Insurers with large MFIs as aggregator therefore started selling credit-life through group policies (e.g. Aviva has exclusive partnership with Basix, one of the largest MFIs in India).

Insurers having numerous small MFIs as partners, on the other hand, prefer the individual term insurance mode, since the MFIs capacity to negotiate is limited (owing to disproportionate magnitude of the two parties).

Though the sector largely mirrors the practices of the conventional insurance industry, adoption of individual and group product strategy in microinsurance is often different from their conventional business strategy. While most of the private players prefer the group microinsurance model, the predominance of one or the other is determined by the kind of MFIs they have been able to partner with.

LIC is the only company that maintains a balanced business mix between individual and group microinsurance policies. Only 53% of microinsurance premium of LIC comes from group products, while the rest is contributed by individual portfolio. We will shortly visit the unique microinsurance business model of LIC.



Source: IRDA Annual Report 2010 11; MicroSave Analysis

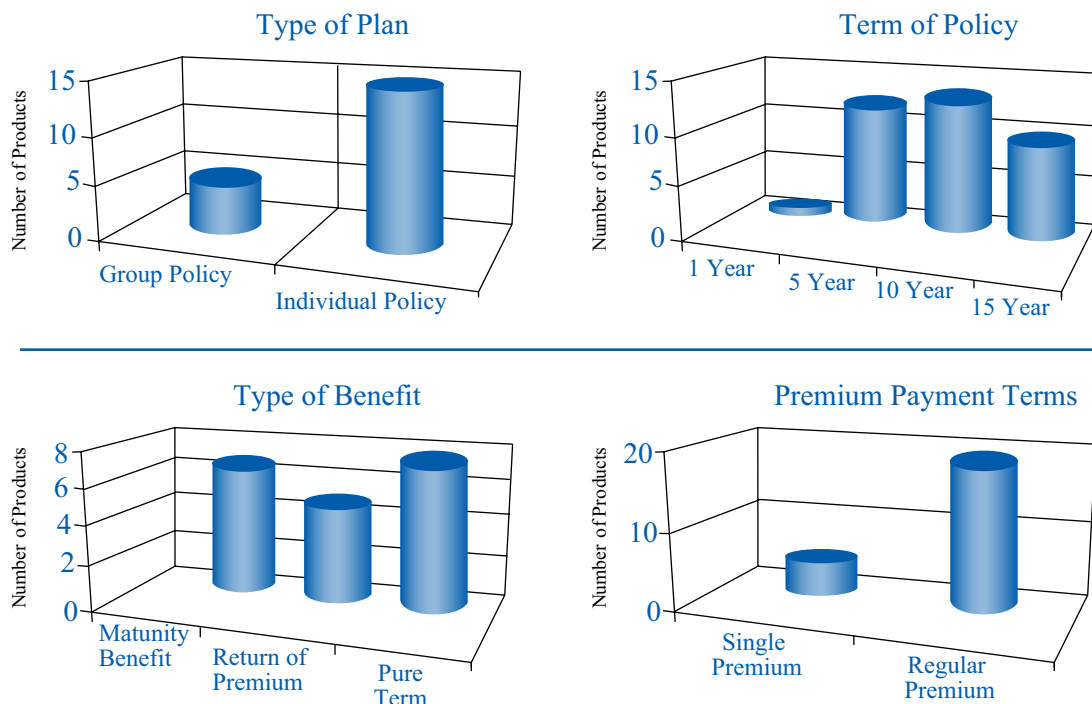
<sup>17</sup>Often, taking insurance is used as a condition for getting credit.

Product Strategy of Insurers on Non-micro and Microinsurance (2011-12)		
Non –micro policies		
	Group	Individual
Microinsurance	Group	
	Individual	

### 3.6.1. Registered “Microinsurance Products” are mostly individual term products

Most of the registered microinsurance products are individual term products well within the boundaries prescribed by the Microinsurance Regulation. The premium collection and underwriting of these policies, however, is done at a group level or the MFI level. In turn, the MFIs receive a commission of 20-40% on the first year premium of the policies. Though by design many of these policies have a term of more than a year, persistency of these products is negligible.

Specification\*of Registered Microinsurance Products<sup>18</sup>



<sup>18</sup>Calculated from brochures and websites of insurance companies

## Why individual microinsurance has low persistency?

Persistency is a common problem for the life insurance industry in India. However, the issues for low persistency in life microinsurance are unique. In the Microinsurance Regulation, 2005, commission for the MIA is limited at 20% of the annual premium. IRDA expected that “same commission every year” (as against the front-loaded commission culture of the industry) would motivate aggregators to ensure persistency. However, the regulation did not increase persistency in microinsurance products as:

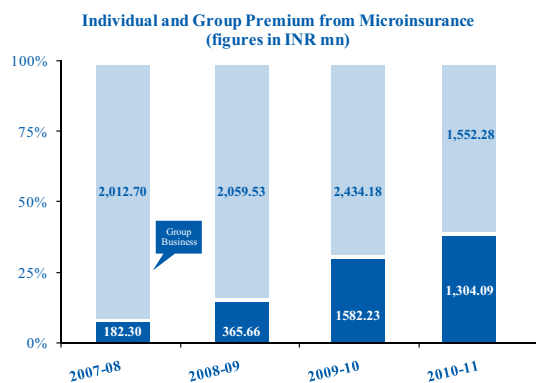
- Microinsurance products are bundled as credit-life products, which lapse after the loan term, which is typically one year for MFI loans, hence, there is a term mismatch if policies are sold as credit-life and have a tenure of more than a year;
- The insurance companies are eligible for rural and social sector obligation only on first year policies, so there is no incentive for the insurer to renew a microinsurance policy. Since the commission is equal for all years, the insurance company does not save on commission expenses, either.
- Since commission is similar year after year, MFIs/aggregators are indifferent towards the issue.

### *3.6.2. Group products are preferred by private insurers for microinsurance*

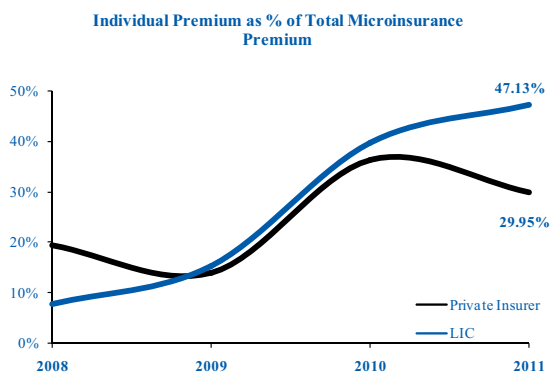
In 2010-11, private insurers collected 70% of their microinsurance premium through group policies. Apart from their general ability to manage group products efficiently, their preference of group microinsurance is driven by the facts that:

- Group term products are more suitable as compared to individual policies for credit-life, since premium can be negotiated and terms can be customised (for profit sharing, service level agreements etc.) according to the requirement of the MFIs and the insurance company; and
- Premium for group term products are almost 1/3rd of the premium for individual terms products with a similar sum assured. Such low premium provides MFIs (and rural banks) with an option to charge less from clients for insurance or make an additional margin on the microinsurance product.

Since LIC is not that adept in selling and managing group products, they are increasingly reducing focus on group microinsurance in favour of savings linked individual policies.



Source: IRDA Annual Reports; MicroSave Analysis



Source: IRDA Annual Reports; MicroSave Analysis

### 3.6.3. LIC leveraged its expertise through individual endowment microinsurance products

Being experienced in selling low premium individual products, LIC did not have to take the easy credit-life way to sell microinsurance. While it provided credit-life covers through group insurance products, for individual segment, LIC launched an endowment life microinsurance product named *Jeevan Madhur*. The product is sold through LIC's Microinsurance Agents (MIAs), who are primarily NGOs, SHGs and MFIs. To market the product, LIC adopts a community approach. The company adopts villages with *Jeevan Madhur* customers as *Madhur Bimagram* and provides a monetary incentive to the village for social development works<sup>19</sup>. *Jeevan Madhur* has broken the myth that standalone life microinsurance products cannot be delivered profitably. The product has also proven that savings linked life insurance has an established demand in the microinsurance segment as well. The product has grown at an impressive year-on-year rate of 48.67% and currently constitutes a major part of LIC's microinsurance business. With the help of this product, microinsurance constitutes 7.97% of overall New Business Premium income of LIC<sup>20</sup>.

It is worthy to note here that following LIC, some other companies also experimented with savings linked life microinsurance products in recent years. Max New York Life's (now Max Life) *Max Vijay*, ICICI Prudential's *Anmol Nivesh*, Bajaj Allianz's *Sarve Shakti Suraksha* and SBI Life's *Grameen Shakti* are some examples of savings linked microinsurance policies launched by private insurance companies. Bajaj Allianz and SBI Life have also been able to sell nearly 4 million savings linked (endowment) policies so far. ICICI Prudential's *Anmol Nivesh* was the first unit linked microinsurance policy, while *Max Vijay* had an innovative over-the-counter selling strategy through retailers and mom and pop stores. However, the growth of these two products were not encouraging, *Anmol Nivesh* was discontinued post regulatory changes in 2010 and *Max Vijay* reached only 90,000 policies, till April 2012. However, this indicates that even private insurers are trying to re-discover the life microinsurance sector and trying to find value beyond regulatory obligations.

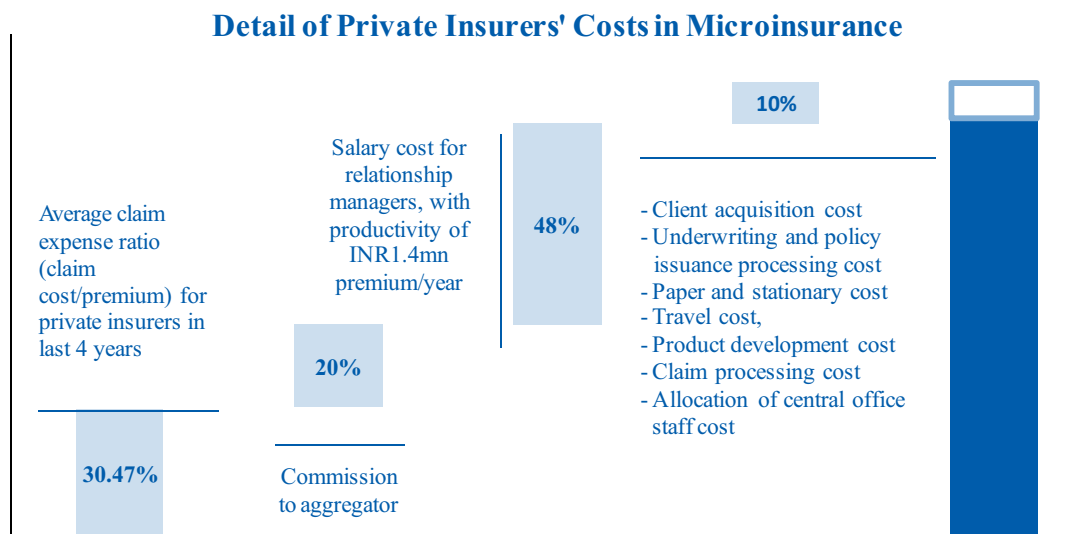
<sup>19</sup>For villages with more than 1,000 population and more than 300 policies, INR22,500 is given; while for villages with less than 1,000 population and more than 125 policies, Rs.10,000 is given as incentive.

<sup>20</sup>LIC Annual Report, 2010-11



### 3.7. Cost of selling microinsurance, however, remains a deterrent for private insurers

Though LIC's experience motivates private insurers, the dominant paradigm still remains the compulsory credit-life policies sold exclusively for the rural sector obligation. The reason why private insurers have limited enthusiasm for microinsurance is rooted in the fact that management of such policies is not sustainable for them. The fixed cost of aggregator acquisition, policy management and documentation is often more than the premium collected by the insurers.

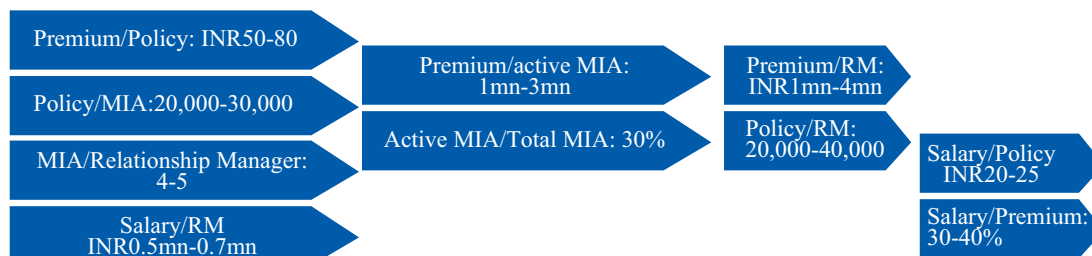


**Source:** MicroSave Analysis

Microinsurance, in most of the private insurers, is a separate department (or a division under its rural business department) divided into 3-4 zones, 8-9 regions and 10-15 relationship managers, each managing 4-5 Microinsurance Agent (MIA). Since the premium from their life microinsurance products is low, the staff productivity remains abysmally low to justify any business interest in this product segment.

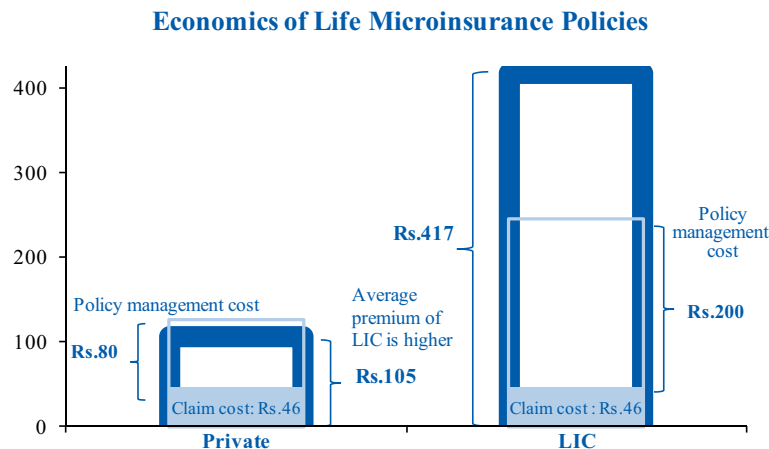
However, it is interesting to see that, in spite of having a similar cost structure, LIC manages microinsurance policies profitably. Since average premium of their savings linked insurance is high, they could take care of the fixed cost of operation far more effectively than the private players.

#### Productivity in microinsurance among private insurance



**Source:** MicroSave Analysis of market learns

So far, we have seen that LIC and private insurers have emerged as two distinct business blocks within the life as well as life microinsurance space. While LIC continues to drive business through endowment products sourced through agents, private insurers have innovated channels as well



Source: Company Disclosures; MicroSave Analysis

as developed new product strategies to compete. Though IRDA ensured emergence and development of life microinsurance, it is still hostage to the rural sector obligation. Very few private insurers have actually initiated beyond the convenient zone of compulsory selling of credit-life policies through the MFI partners. However, industry experts have observed that the life insurance industry in India is going through major changes that will alter the way business is conducted. In the next section, we discuss the changes brought upon the industry and how they can and will impact the microinsurance sector in India.

#### 4. ULIP Guideline and the Crisis of Life Insurance Industry

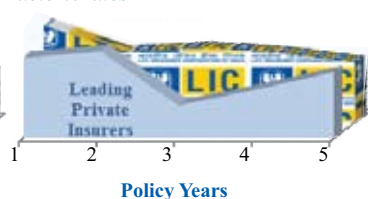
**As on 2008-09:**

While LIC'S persistency is gradual, private players' policy show decline after 3 years



**As on 2009-10:**

With focus of LIC'S shifting towards ULIPs, persistency ratio aisa deteriorates



**As on 2011-12**

Persistency of last two years' policies improve, while old policies continue to have low persistency



Profitability of life insurers depends on amortising the cost of policy acquisition over a long term. A healthy lapse ratio<sup>21</sup> therefore is a pre-requisite for sustainability of the industry. During 1956-1975, LIC operated at a lapse ratio of 6.83%<sup>22 23</sup>, which was the best among all its South Asian peers. However, the lapse ratio of the current life insurance industry stands close to 20%<sup>24</sup>. Private companies state their focus on ULIPs (which are not included in this ratio) as the reason for such poor lapse ratio. Year-on-year persistency ratio<sup>25</sup>, which includes ULIPs too,

<sup>21</sup>Lapse Ratio during the year = Lapses (including forfeitures) during the year/Arithmetic Mean of the business in force at the beginning and at the end of the year [This does not include ULIP policies, since by definition, ULIPs do not lapse, rather they are treated as "Premium awaited" if renewal is not paid].

<sup>22</sup>Calculated from "Nationalisation on Insurance in India"; Arjun Bhattacharya and O'Neil Rane; Table 9; <http://www.ccsindia.org/ccsindia/interns2003/chap32.pdf>

<sup>23</sup>IRDA Annual Report 2009

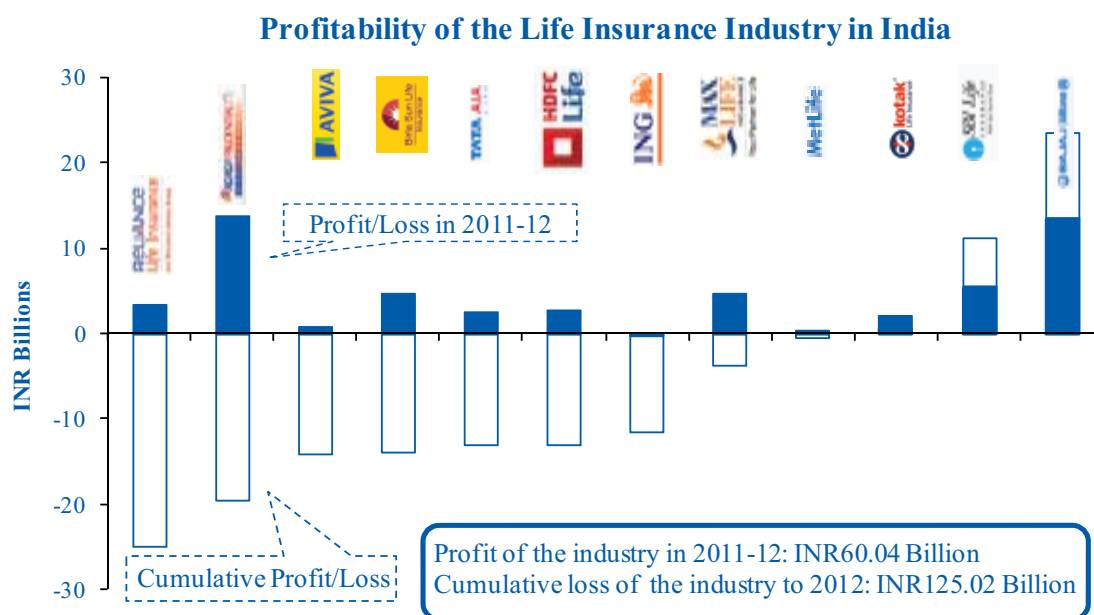
<sup>24</sup>Asia Insurance Review; Vol. III, issue 53

<sup>25</sup>Persistency ratio: the proportion of policies remaining in force at the end of the period out of the total policies in force at the beginning of the period. This indicator basically measures the magnitude of renewal or continuation of policies without lapse (in paying renewal premium) or surrender. It is a parameter indicating the customer satisfaction and quality of sales force

however, indicates that unlike LIC, the portfolio of private companies was mainly short-term, where most of the clients withdrew policies after 3rd or 5th year. This means, if private insurers sell 100 policies, only 3 remain in force post 5 years.

Industry observers are of the opinion that mis-selling of ULIPs is a major cause for such poor persistency. In India, majority of customers are not aware of the difference between ULIPs and mutual funds. Insurance agents often exploit this lack of financial literacy by asking clients to invest for only 3 years and withdraw money once the lock-in period (generally 3 years) or cover continuance period (generally 5 years) is over.

Such short-term focus and mis-selling is detrimental for both the insurers as well as the customers. Poor persistency ratio depletes the resource of the insurer, since they cannot realise the policy acquisition cost in 3-5 year. Since ULIPs are highly front-loaded in terms of charge (40-70% of premium in first year goes towards policy maintenance), the customer also does not get any real benefit when they withdraw. ULIPs, though, contributed towards the growth of the private life insurance industry, such growth could not be translated into profitability and sustainability for the private insurers. Until March 2010, the life insurance industry had an accumulated loss of over INR160 billion.



**Source:** Financial Statements of Insurance Companies; MicroSave Analysis

Even in the insurance industry which has a long term horizon, such losses are not acceptable. This troubled the investors in private insurance companies. During the 2008 global recession, most of the foreign investors of these companies started raising questions about profitability. As an immediate response, private insurers started reducing their costs and focusing more on high value ULIP sales. Meanwhile, IRDA received lots of complaints of mis-selling of ULIPs and was genuinely concerned about client protection aspects. To make matter worse, SEBI, the securities market regulator of India, came down heavily on life insurers stating that ULIP selling is not following the norms of the securities market. After a brief spat between IRDA and SEBI, IRDA in September 2010 formulated new and more stringent guidelines for ULIPs. The new guidelines include the following:

- The minimum “lock-in” period has been raised to 5 years from 3 years;
- ULIPs need to have mandatory insurance cover of a minimum guaranteed addition of 4.5% per year of the fund value;
- Insurance companies must issue fund statement on a half yearly basis to the clients;
- The charge on first year premium has been capped; and
- Maximum charge on surrender/discontinuation of the policy has been capped.

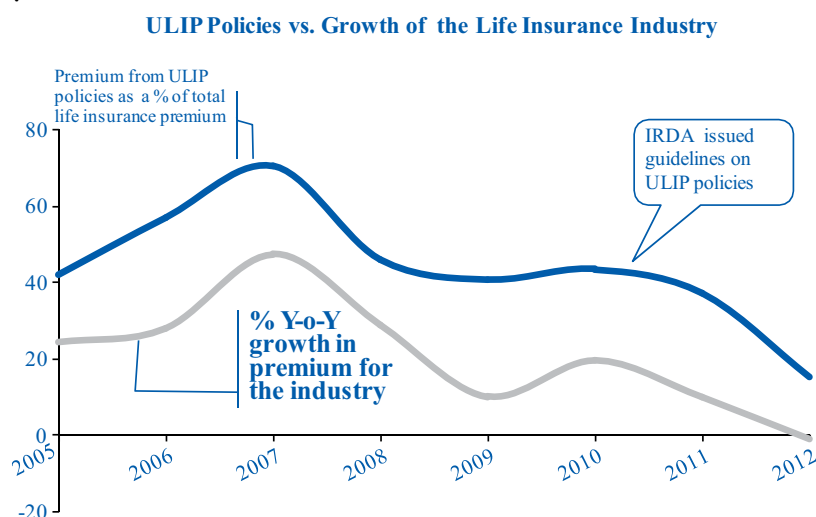
In addition, IRDA also mandated 50% persistency by the tied and corporate agency channel, for renewal of their license<sup>26</sup>. These guidelines have entirely changed the business mode of most of the private insurers. Many of their leading products had to be withdrawn and distribution re-trained on selling traditional insurance products.

Ridden by profitability expectation of investors on one hand and coping with stringent ULIP guidelines on the other, private insurers have witnessed turbulent times in the last two years. After more than a decade of double digit growth, life insurance industry of India has registered negative growth of 10.15% in First Year Premium<sup>27</sup> and 3% in overall premium in 2011-12. The negative growth has further continued in the first quarter of 2012-13, with private insurers<sup>27</sup> registering a cumulative negative growth of 7.8%.

#### 4.1. Insurers focused on traditional products, in spite of negative growth

It is a known fact that growth in the Indian life insurance industry came with the growth in ULIPs. After, the 2010 regulation, however, most of the private insurers have increased their focus on traditional insurance products. In 2011-12, only 15.35% of new business premium of life insurers was from ULIP products. During the same tenure, however, traditional products saw a growth of 32.06%<sup>28</sup>.

In the near future, a balanced portfolio mix of traditional and ULIP products might emerge in the life insurance industry. Until such time, however, insurers will remain wary of low premium microinsurance products, which would not add value to their recovery and growth agenda.



Source: IRDA Annual Reports; MicroSave Analysis

<sup>26</sup>Vide circular IRDA/CAD/GDL/AGN/016/02/2011 and IRDA/Life/GDL/GLD/217/09/2011

<sup>27</sup>IRDA Journal, May 2012

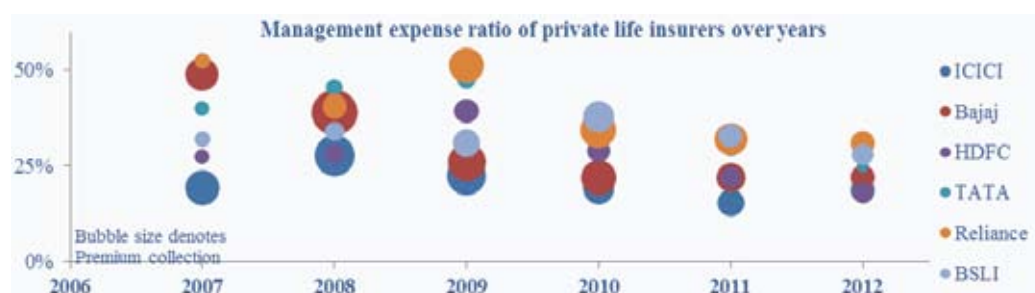
<sup>28</sup>Life Insurance Council of India quoted in Business Standard, July 13, 2012

## 4.2. Cost consciousness increased in the industry

Private insurers in India had a high cost distribution model, with target driven sales numbers often at a high fixed cost. Irrespective of the company size, the operational cost of some private insurers has been as high as 58% of the premium collected. To cope with the negative growth on one hand and to deliver on profitability demands of investors on the other, private insurance companies have cautiously reduced their distribution and management expenses in recent years. Expense ratios of most of the private insurers have converged towards creating an industry benchmark. Still, the management expenses of the private insurers stand at 21%, which is substantially higher than that of LIC at 14%<sup>29</sup>.

In 2011-12, 14 insurance companies have registered profit. However, apart from 5 companies (including LIC), all have accumulated losses from the earlier years. The cost reduction and channel diversification motive therefore will continue for some more time in the Indian life insurance industry.

Unfortunately for microinsurance, such increased cost consciousness and drive towards profitability has made insurers further dis-interested in microinsurance products; microinsurance is considered costlier than conventional products to distribute and manage. With the increased cost motive, we expect that the insurers will search for low cost medium to deliver microinsurance in the near future. Innovation in life microinsurance, therefore, probably has to wait for some more time to come.



*Source: Company Disclosures; MicroSave Analysis*

## 5. Search for Alternatives is a Challenge for Microinsurance

Life microinsurance sector in India is challenged by strategic incongruence among its value chain stakeholders. Building and positioning a portfolio of microinsurance products is still not a priority for either the insurer or their channel partners (mostly MFIs). Both the stakeholders are struggling to analyse whether microinsurance can be an independent revenue generator or provide value add over their existing services. Until now, insurers are in microinsurance business, even at the cost of cross-subsidising, since it enables them to achieve obligatory numbers.

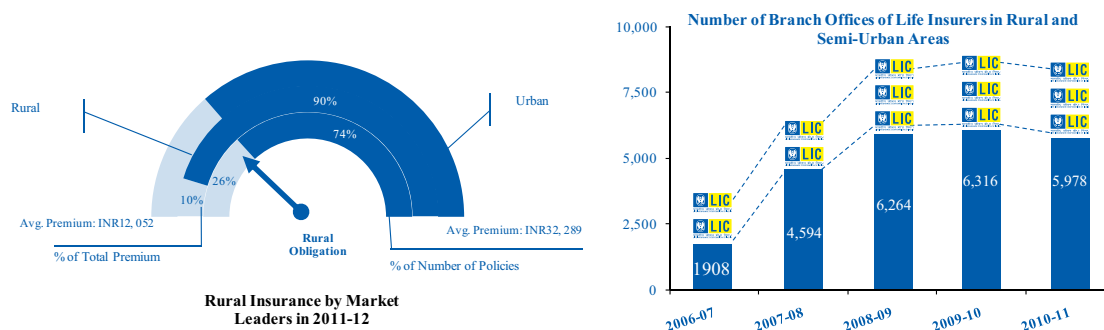
<sup>29</sup>Calculate from Disclosures of life insurance companies

However, such “business by force” always remains a half-hearted effort. Insurers will migrate from the sector as soon as a profitable alternative to microinsurance is found. In fact, many private insurers are already reducing their efforts towards the distribution of microinsurance policies. Though every life and general insurance company needs to fulfil their mandatory rural and social sector obligation, only 14 companies<sup>31</sup> (of a total of 47 companies)<sup>30</sup> have registered microinsurance products with IRDA. Of these, only 7 companies have actually sold microinsurance products in 2010-11<sup>31</sup>. Surely, private insurers do not depend on microinsurance alone to achieve the rural sector obligation, any more.

### 5.1. Conventional rural insurance replaces the privilege of microinsurance for obligatory business

In 2011-12, most of the market leaders have sold more rural policies than the mandatory requirement. The average premium of rural policies, however, indicates that these are high premium policies and not microinsurance products. Clearly, private insurers have started to focus on the rural affluent class against the low-income microinsurance segment.

Over the years, life insurance companies have increased their presence in rural areas through their branch network. From 65% in 2006-07, the proportion of rural and semi-urban branches increased to 73% in 2010-11. Of these, 45% are situated in rural areas (33% of the total branches). Once the dependence on microinsurance policies for the rural sector obligation dies, private insurers will no more be interested to sell costly microinsurance products. Unless product and channel innovations are able to demonstrate the viability of microinsurance, the life microinsurance sector will struggle to survive in the near future. At least, private insurers will have no incentive to dwell in this space.



## 6. Future of Microinsurance Lies in Innovation

Two major events shook the Indian financial markets last year. First, the insurance industry saw some serious turbulence with regulatory control on ULIPs and corporate agency guidelines. The industry, for the first time in a decade registered negative growth. Almost, all the private

<sup>30</sup>Excluding the re-insurer GIC Re

<sup>31</sup>Including LIC, all of them are life insurance companies



insurers, for the first time in their brief history, have reduced their branch network and have focused on cost optimisation. In parallel, some major investors left the insurance industry (including New York Life, ING, Bharti), some of the insurers have been restructured with the entry of banks into joint ventures (Met Life, AVIVA, Birla Sunlife), one of the insurers has been semi-acquired by another insurer (BhartiAxa) and some new investors entered (e.g. Japanese investors like Nippon and Mitsui Sumitomo) the industry. Such turbulence necessarily will re-shape the industry in favour of alternative approaches.

Secondly, in almost the same period, the microfinance sector, once portrayed as poster-child of alternative finance, witnessed disappointment with the drying up of bank funding and a less than timely intervention by RBI and the government. Both of these sectors are found searching for opportunities to repair their reputations and build their businesses. While insurers are looking forward to innovative low cost distribution channels, the microfinance institutions (MFIs) are striving to re-innovate and diversify their product portfolios. Microinsurance, as the silent offspring of the two industries will have to adapt to the emerging trends in both the industries.

Some of the possible future trends are enumerated in the sections below.

### 6.1. Microinsurance credit life will soon exclusively be a group insurance category

In the absence of a strong need to sell microinsurance products for the rural sector obligation, the cost-conscious insurers are expected to abandon the costly individual term-credit-life microinsurance, in favour of group-term products. LIC is also expected to follow the model, since their individual microinsurance is sold as an endowment product.

### 6.2. Savings linked products, as an opportune product category, will emerge

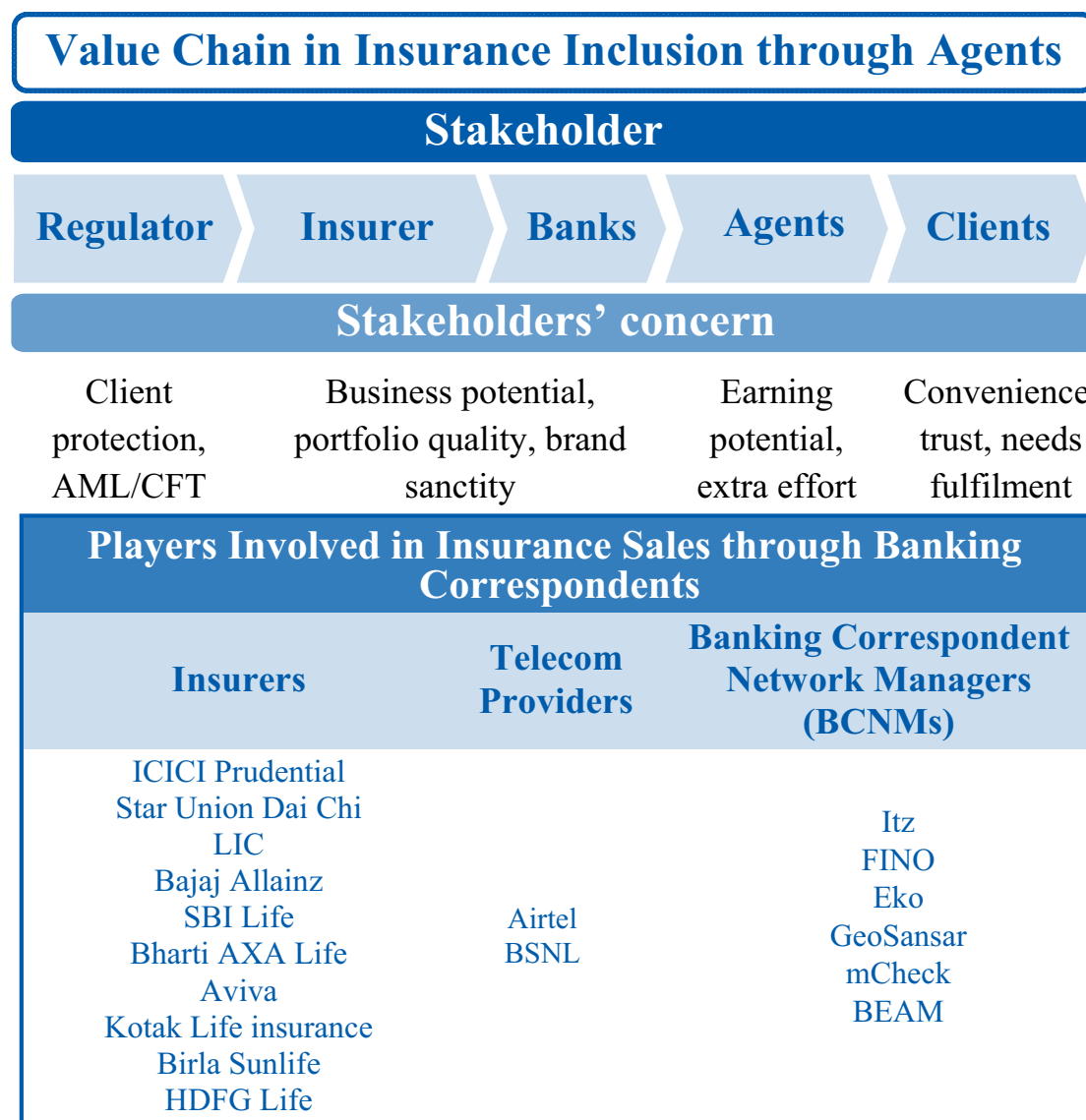
The demonstration effect of *Jeevan Madhur* will necessarily motivate some more private insurers to experiment with voluntary endowment or ULIP products in the microinsurance sector. Moreover, post the microfinance crisis, the MFIs have also acknowledged the value of providing multiple products and services to the clients, instead of plain vanilla group microcredit. They realise that a comprehensive product portfolio can create client loyalty, which is vital for their operations. Besides, in the absence of adequate bank funding, insurance business can prove to be an alternate income source for these MFIs. The MFIs, as aggregators, therefore, are expected to demand new products from the insurers, which can cater to the needs and demands of their clients’.

### 6.3. Business Correspondents of Banks may emerge as the channel of choice

The business correspondent channel (banking agents) promoted by RBI and implemented by banks, is the front-runner in the government’s financial inclusion agenda. Under the *Swabhi-man* campaign, as of March 31, 2012 all villages having population of more than 2,000 individuals are already covered by banks through branchless banking agents. Currently, there are

nearly 80,000 Business Correspondents (BC) and more than 20-30 Business Correspondent Network Manager (BCNM) in India<sup>32</sup>. Since there is a value alignment for all stakeholders in the channel, business correspondents, as an emerging channel has the potential to unleash the growth of microinsurance in near future<sup>33</sup>.

Already there are 5-6 implementations in insurance through different combinations of mobile network providers, banking correspondent network managers and insurers. IRDA is already considering the channel favourably for distribution of microinsurance. Though the economics of agent banking channel depends largely on product rationalisation, in the near future, the sector can expect innovation in both product and processes around this distribution channel.



<sup>32</sup>Directory of Business Correspondents in India, Citi Foundation, Access-Assist; National Survey of Branchless Banking in India, CGAP, June 2012

<sup>33</sup>For details on value of business correspondent agents in insurance, refer to "MicroSave Briefing Note 123: Agent Banking and Insurance: Is There A Value Alignment?"; June 2012

# Securing the Silent Health Microinsurance



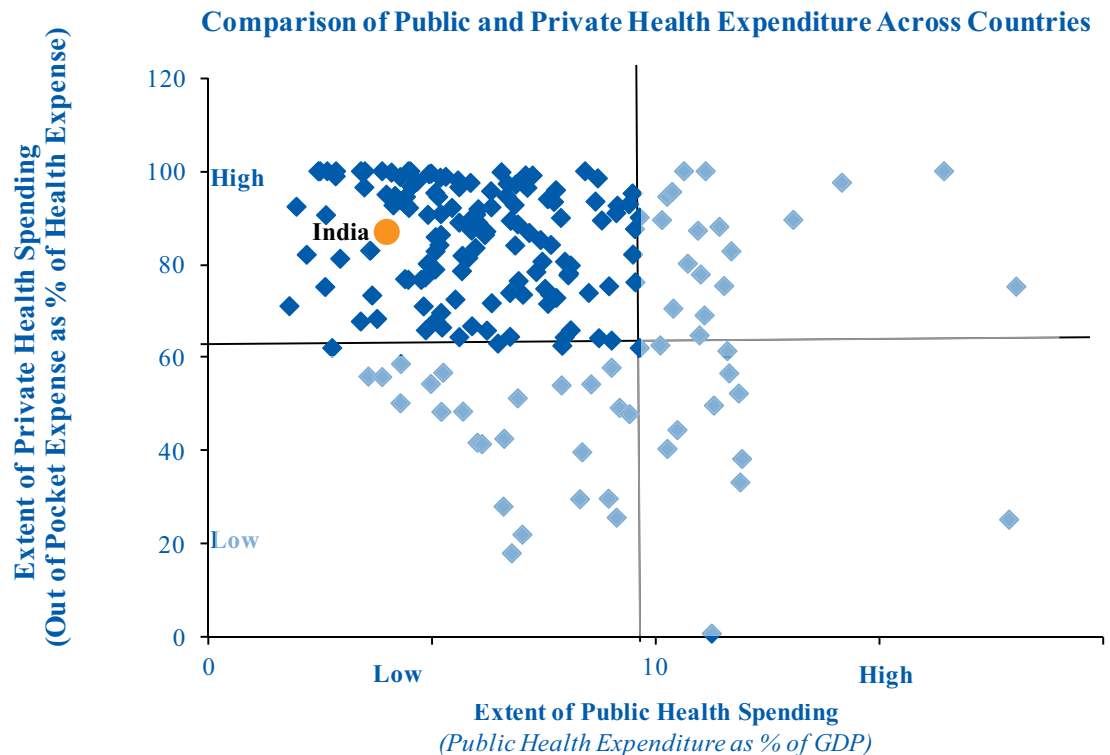
*MicroSave - Market-led solution for financial services*

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## 1. Introduction: The Need for Health Microinsurance is High in India

India is a country of increasing health expenditure. According to World Bank statistics, health expenditure constituted 4.05% of India's GDP in 2010, while public spending on health is only 1.18% of the GDP in the same year<sup>1</sup>. The remaining health expenditure is covered privately, and 86.4% of this expenditure is met through households' out of pocket payments<sup>2</sup>. On average, 65-68% of Indian households spend INR39-63 (USD0.80 – 1.28) per capita, every month on health expenditure<sup>3</sup>. In a country where more than half the population lives on less than USD 2 a day, any unforeseen increase in health care spending results in the family being pushed further into poverty, which in turn leads to greater challenges in health care. According to WHO, 3.2% of Indians fall back below the poverty line every year due to the cost of medical treatment. Further, 20-30% of people fail to seek medical help due to financial hardship, and 31-47% of hospitalisations in urban and rural areas are financed by high interest loans or sale of assets<sup>4</sup>. These statistics highlight the need for voluntary as well as state sponsored health insurance schemes in India.



**Source:** World Bank Statistics 2012; MicroSave Analysis

This part of the report will address the emergence of health microinsurance in India. The first section briefly discusses the chronology of health microinsurance development in India. While health microinsurance was first provided by community based organisations, in the last ten years the public sector has become more involved in helping poor households in mitigating

<sup>1</sup>World Bank Statistics

<sup>2</sup>World Bank Statistics

<sup>3</sup>66th Round of NSSO Survey, February, 2012

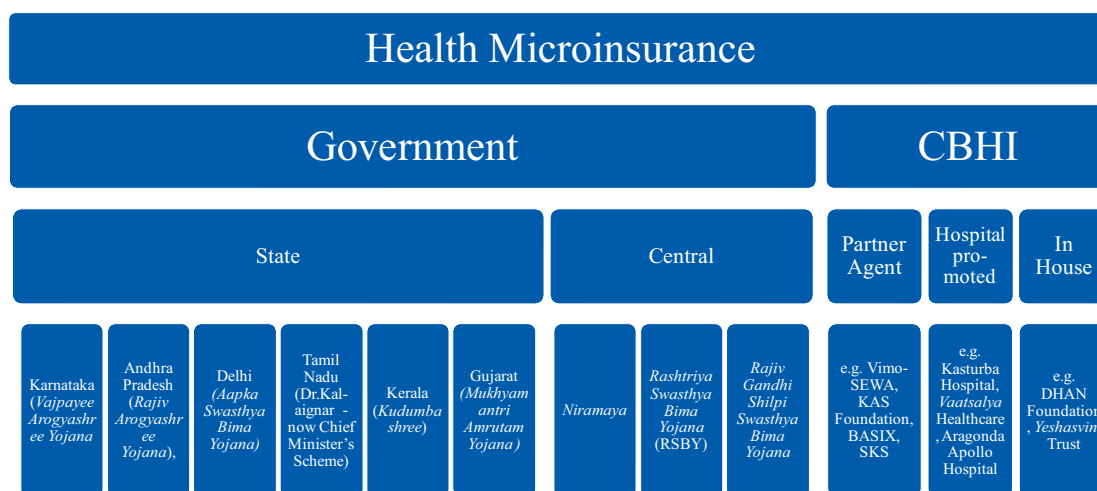
<sup>4</sup>Times of India, November 2, 2011



health risks. The next sections discuss the characteristics of community based and government insurance schemes. While community based insurance providers offered services targeted at the needs of their clients, the tailored product profile and strong community linkages have meant that many have not achieved scale. On the other hand, public schemes offer substantive tertiary care benefits and the outreach is on a large scale. Both types of organisations have experienced struggles with sustainability, and many have engaged commercial insurers as underwriters to promote sustainability. The final section will examine the role of commercial insurers in health microinsurance. Large public welfare health insurance schemes in particular have been a significant source of premium for these organisations. However, some insurers doubt the long term viability of these schemes.

## 2. Health Insurance Developed in Several Stages

Historically, comprehensive formal health insurance did not develop in India owing to its large informal workforce, its unorganised health care sector and limited government will. To meet the need for health cover, community based health insurance (CBHI)<sup>5</sup> of different kinds emerged.



Three basic models of health insurance emerged over time:

- In the **health service provider model** (e.g. *Kasturba Hospital, Vaatsalya Healthcare, and Aragonda Apollo Hospital*), a hospital plays the dual role of providing health services as well as health insurance.
- The next model is the **in-house insurance model**, where voluntary health insurance providers negotiate with one or several health service providers for provision of health services to their members. *DHAN Foundation, Yeshasvini Trust* etc. operate using this model.
- The latest community based model to emerge is the **partner-agent model**, where the voluntary organisation plays the role of an agent, purchasing care from health service providers and insurance cover from insurance companies. *VimoSEWA, all MFI initiated*

<sup>5</sup>Defined by Atim (1998) as “any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management.”

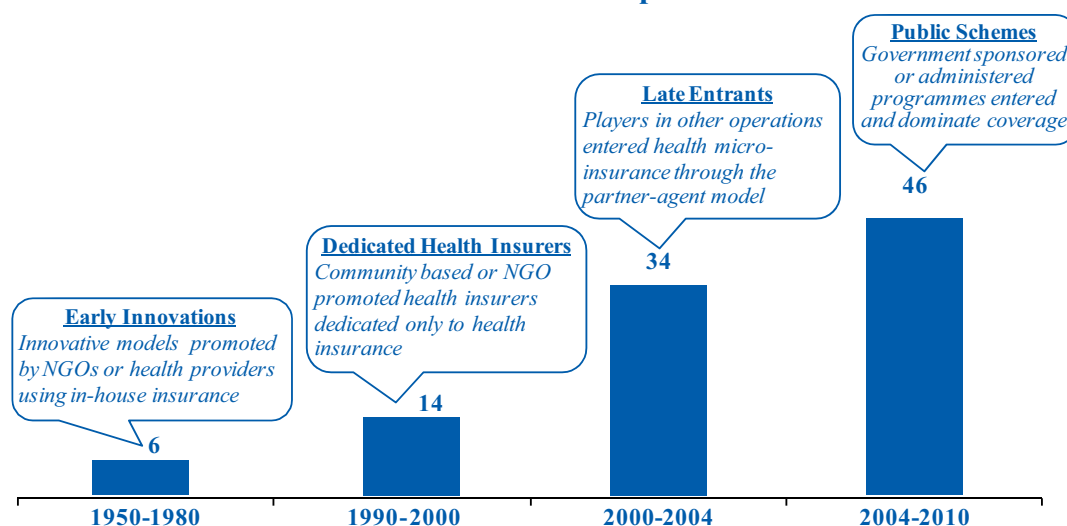


schemes (BASIX, SKS, *Grameen Koota*, Village Welfare Society) and KAS Foundation<sup>6</sup> operate through this model.

In recent years, the government has launched several publicly run and sponsored health microinsurance schemes. These schemes are run as public private partnerships (PPPs) and have adapted features of some community based schemes. As a result of generous budgetary allocation by the central and state governments, these schemes immediately reached millions of people hitherto un-served by earlier schemes.

Approximately 300 million people are currently covered by more than 100 health insurance schemes in India<sup>7</sup>. Government sponsored schemes launched in the last decade form the major share of this coverage.

### Health Microinsurance Development in India



Source: ILO 2009; MicroSave Analysis

## 2.1. Early health insurers build a base for later expansion

Since the formation of the first CBHI in 1952, the sector's evolution can be categorised into 4 distinct phases, described in the next sections.

## 2.2. 1950-1980: Early innovations continue until today

West Bengal based Students Health Home's insurance programme is one of the earliest reported health insurance initiatives (1952), followed by Chennai based Voluntary Health Scheme (1961), Karnataka based Mallur Health Cooperative (1973) and Wardha (Maharashtra) based Kasturba Hospital (1978). Most of these schemes started with primary health care support to a catchment community<sup>8</sup> and moved on to provide insurance coverage for them. These schemes

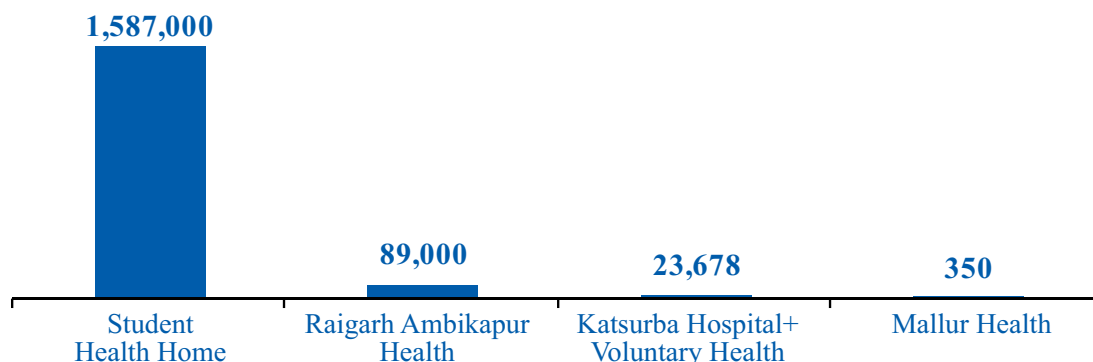
<sup>6</sup>Now Jagganath Financial Services Limited

<sup>7</sup>Planning Commission, 2011

<sup>8</sup>In case of Students Health Home, it is students from low income families, while Mallur Cooperative covers dairy cooperative members and Raigarh Ambikapur Health Association targets poor tribal families of Chhattisgarh.

continue to run in-house health insurance services without any partnership with insurance companies. Although most of these are limited in their outreach<sup>9</sup>, they are unique in their process of operation and sustainability of their model: more than 1.7 million people are still covered by these schemes.

### Current Outreach of Health Microinsurers Established from 1950 to 1980

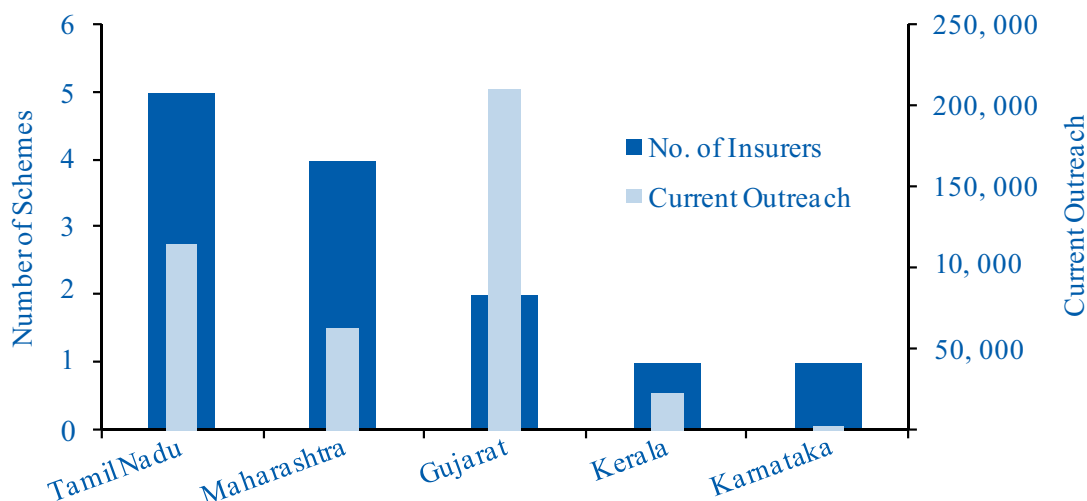


*Source: ILO, 2009; MicroSave Analysis*

### 2.3. 1990-2000: Exclusive community based health insurers (CBHI) emerge as concentrated experiments

While the 1980s did not witness major emergences, as many as 14 health microinsurance schemes were initiated from 1990 to 2000. This was the phase of rapid development of cooperatives and Self Help Groups (SHGs) in India. Many community owned institutions emerged

#### Health Microinsurers Established from 1990 to 2000 Are Geographically Concentrated



*Source: ILO, 2009; MicroSave Analysis*

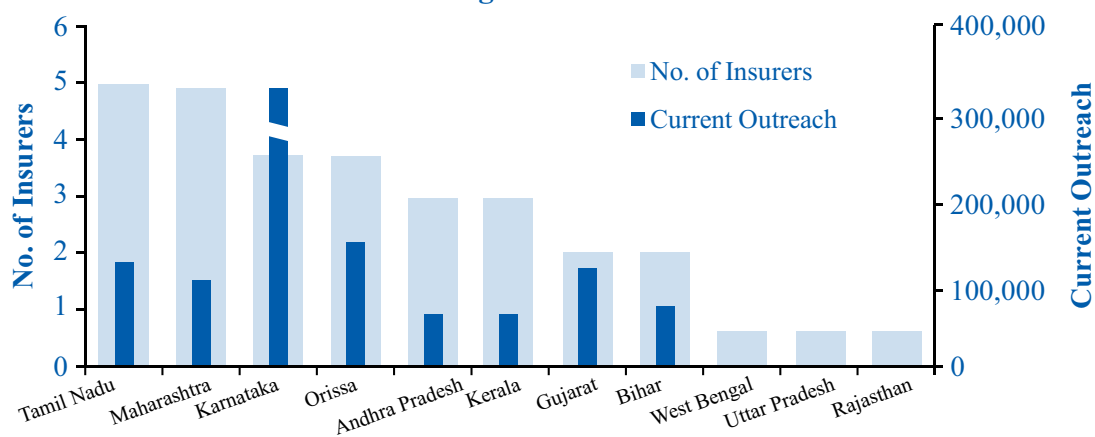
<sup>9</sup>Except Students Health Home, which has more than 1.5million members

exclusively to provide health insurance in this period. Initially these insurers managed their schemes in-house through owned facilities (e.g. ACCORD, Aga Khan Health Services) or through exclusive partnerships with health service providers (e.g. SHADE, New Life). However, many of these community based health insurers have moved to the partner-agent model due to sustainability concerns with earlier models.

## 2.4. 2000-2004: Players from diverse fields enter the sector to create successful models

Witnessing the success of the early innovators and CBHIs, many NGOs and SHGs entered the health microinsurance sector after 2000. Unlike the previous community based providers, NGO entrants in this period were not exclusively providing health insurance. Their original focus varied from microfinance (e.g. Welfare Service Ernakulam, Buldana Urban Credit Cooperative Society) to sustainable livelihood development (e.g. BAIF, DHAN Foundation), tribal development (e.g. PREM), women’s empowerment (e.g. *Shanti Dhan*, Working Women’s Forum) and even religious development (e.g. SKDRDP, Mayapur Trust). These organisations had limited hospital tie-ups and they mostly entered the sector through insurance company partnerships.

**Geographic Distribution and Current Outreach of Micro Health Insurer Entering between 2000-2004**

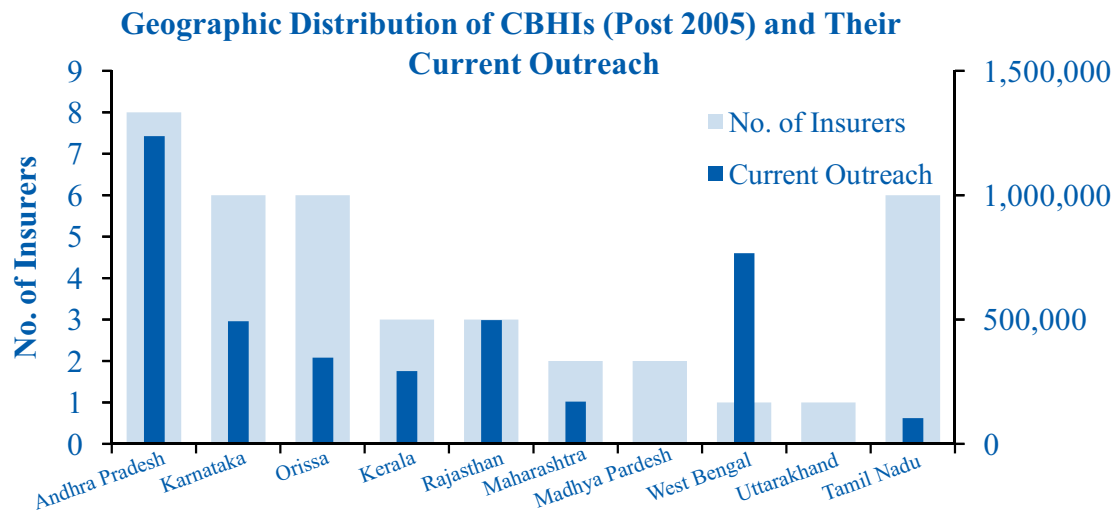


*Source: ILO, 2009; MicroSave Analysis*

This period also saw the birth of private trusts (e.g. Healing Fields Foundation, Tribhuwandas Foundation, *Karuna* Trust), public private partnerships (e.g. *Yeshasvini* Trust), and mutual health insurance schemes (e.g. Uplift Mutual) that went on to become leading health insurance models in India. In this period, health microinsurance began to expand beyond the southern states, where most of the previous schemes had focused.

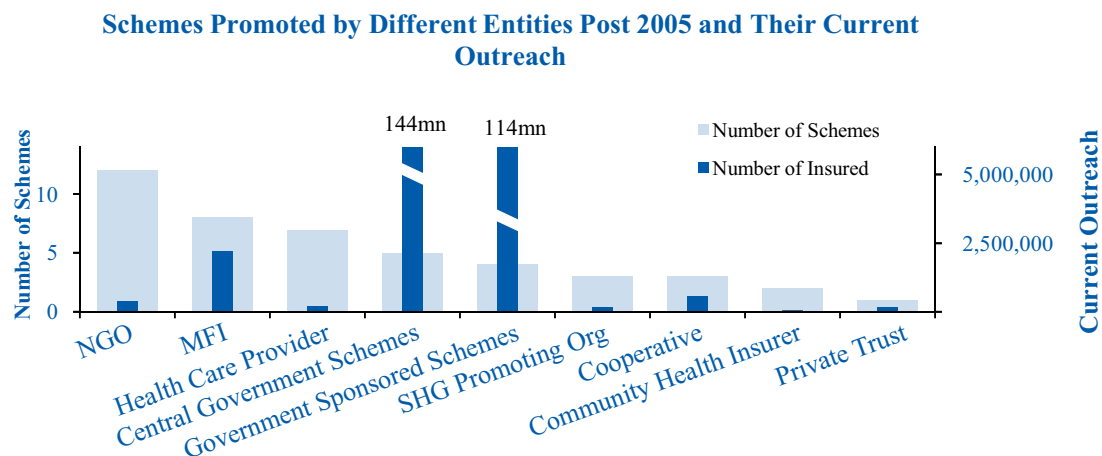
## 2.5. Post 2005: Public health microinsurance schemes ensure high outreach

Since 2005, the micro health space has been dominated by government sponsored schemes. Various ministries launched five central government schemes, including the flagship Rashtriya



Source: ILO, 2009; MicroSave Analysis

Swasthya Bima Yojana (RSBY) in 2008. Several state government and local government institutions also promoted health insurance schemes of their own. Some of the state governments (Andhra Pradesh, Tamil Nadu, and Karnataka) have promoted private trusts through the public private partnership (PPP) model. Kerala’s government used its existing SHG programme (*Kudumbashree*) to advance health microinsurance. As a result of generous government co-contributions, all of these schemes flourished quickly. These schemes are discussed in greater detail in Section 4<sup>10</sup>.



NGOs (e.g. Myrada, Nandi Foundation), community owned institutions (e.g. *Sampoorna Kutumba Arogya Prathakam*), health service providers (e.g. *Vaatsalya* Healthcare, Aragonda Apollo Hospitals), private trusts (e.g. *Arogya Roksha Yojana*) and MFIs (e.g. BASIX, SKS, *Grameen Koota*, Village Welfare Society) also continued to enter the health microinsurance sector post 2004. Nearly 40 such non-government schemes started in India after 2004, which

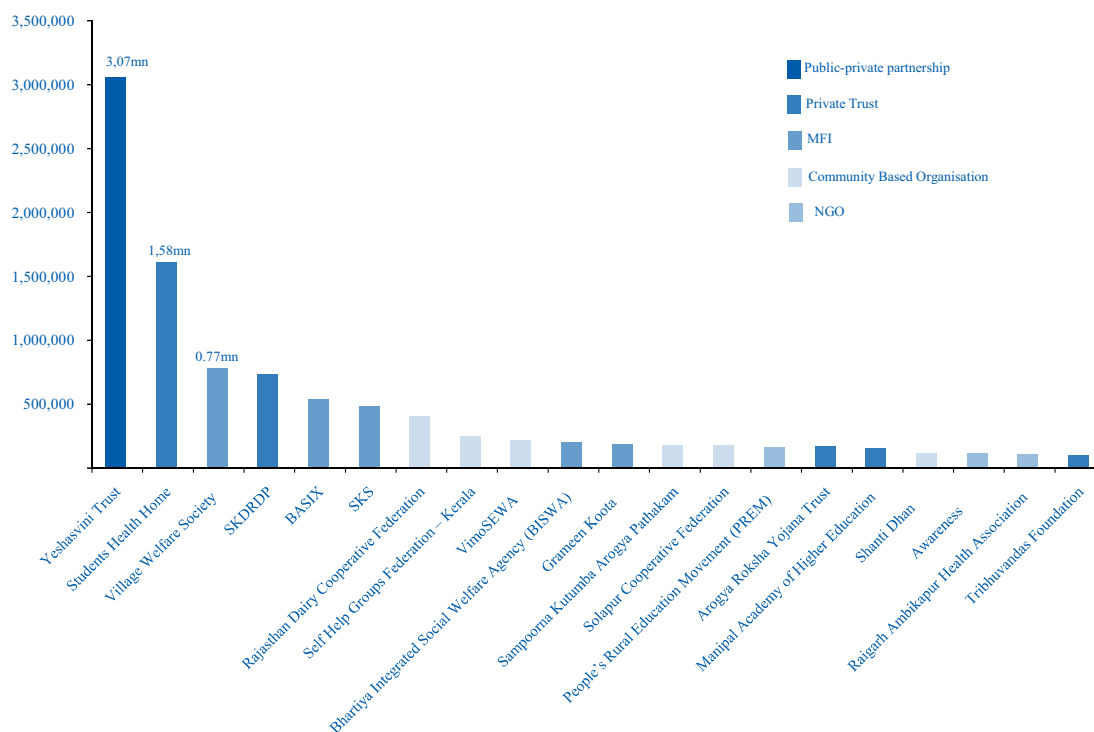
<sup>10</sup>Government schemes generally use the family as the unit of enrollment. This figure is an extrapolation based on the number of enrollments and the number of family members that can be covered under one enrollment.

cumulatively cover nearly 4 million people<sup>11</sup>. The continued involvement of non-government players attests to the relative dynamism of health microinsurance.

### 3. Non-Government Health Microinsurance Schemes Emerged as Flag Bearers

While government run and sponsored programmes enabled the rapid outreach of health insurance, CBHIs paved the way for future public schemes by experimenting with coverage, distribution and operating models. Currently, there are nearly 90 such CBHI schemes cumulatively covering 10 million people across the country. While some schemes have reached more than a million members (e.g. *Yeshasvini* and Students Health Home), 70% of these schemes have an outreach of less than 50,000.

#### Top 20 Non-Government Health Insurance Schemes in India



Source: ILO, 2009; MicroSave Analysis

#### 3.1. Non-government schemes are client centric but have not achieved scale

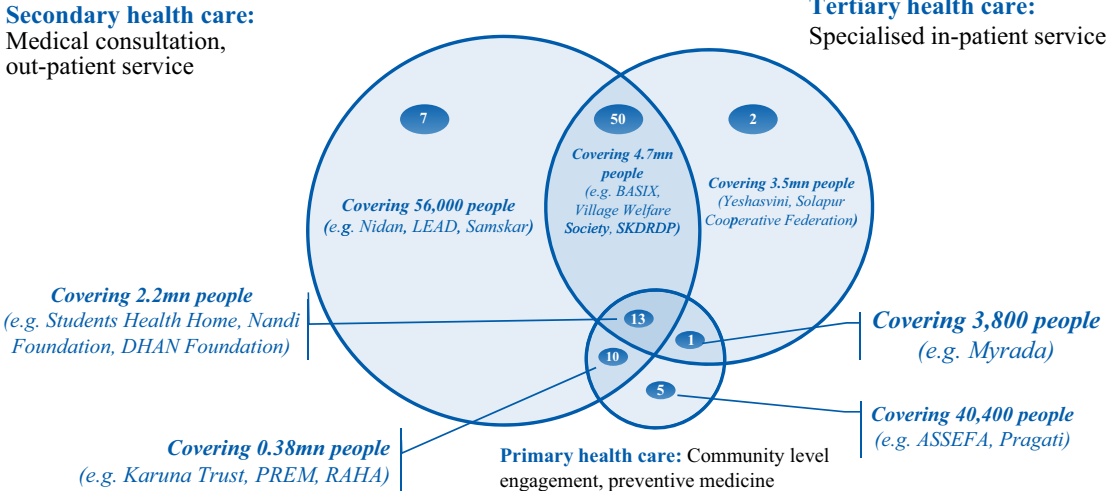
##### 3.1.1. Non-government schemes offer a wide range of benefits to target populations

The coverage of many CBHIs is comprehensive and adapted to the target clientele. Twenty-nine schemes (of a total of almost 90 CBHIs) offer primary health care, while 13 schemes

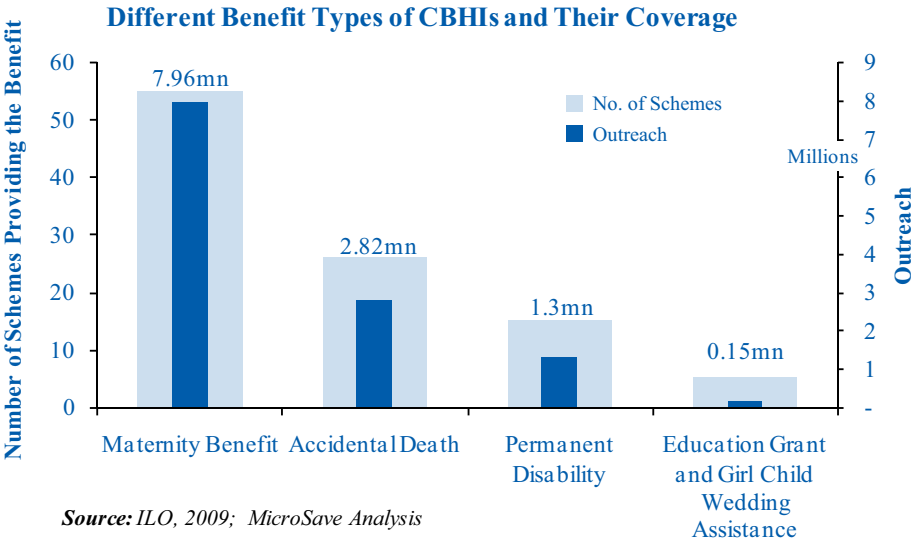
<sup>11</sup>By 2009

offer primary, secondary and tertiary health care to their beneficiaries. Since many NGOs and all the MFIs had mainly female clients, approximately 70% of insured members of all CBHIs are women. Over, 60% of these schemes cover maternity benefit (e.g. Village Welfare Society, SKS, BASIX among MFIs; Working Women’s Forum, SKDRDP among NGOs; and Rajasthan Dairy Cooperative and VimoSEWA among community owned institutions).

### Number of CBHIs and Their Outreach According to Health Coverage Type



Source: ILO, 2009; MicroSave Analysis



Source: ILO, 2009; MicroSave Analysis

Many of these schemes also provide benefits in addition to comprehensive health insurance coverage. Some examples include:

- Education grants for children of the insured (e.g. Healing Fields Foundation, Raigarh Ambikapur Health Association),



- Funeral expenses (e.g. ESAF in Kerala, RRDC in Orissa),
- Subsidised medicine (e.g. PREM); free diagnostic support; direct telemedicine facilities (e.g. *Arogya Raksha Yojana*),
- Coverage of wage loss due to ailment (e.g. Buldana Credit Cooperative Society, DHAN Foundation).

CBHIs also offer cover to unconventional client groups. CBHIs have provided coverage to school going children of low income families (e.g. Students Health Home, Nandi Foundation), tribal communities (e.g. PREM, *Asha Kiran Society*), senior citizens (Pandit Din Dayal Upadhyay *Varishta Jan Swasthya Bima*) and transgender individuals (Tamil Nadu AIDS Initiative).

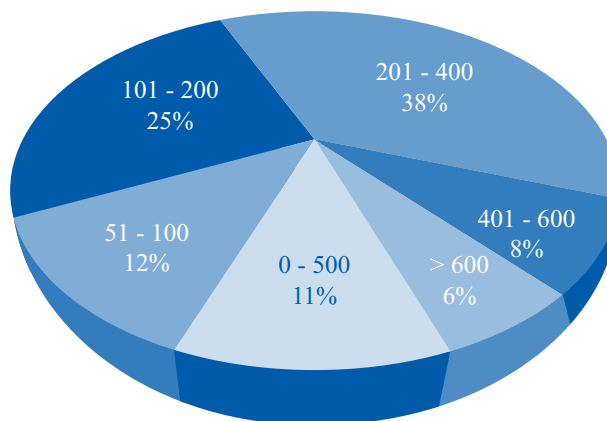
Additional Benefits	CBHI Example
<b>Health Camps for Primary Health Care and Promotion</b>	<i>Mahasemam</i> Trust, New Life, <i>Samskar</i> , SHEPHERD, BISWA, <i>Vaatsalya</i> Health-care
<b>Health Education Programme</b>	ACCORD, <i>Chaitanya</i> , <i>Arogya Raksha Yojana</i> , <i>Shati Dhan</i> , <i>Seva Mandir</i> , <i>Asha Kiran Society</i>
<b>Discounted Medicine</b>	<i>Arogya Raksha Yojana</i> , Karuna Trust, PREM
<b>Mobile Health Clinic</b>	Nandi Foundation, SKAP, Uplift Mutual, <i>Seba</i> Cooperative Health Society, Welfare Service Ernakulam
<b>Community Health Workers</b>	<i>Antodaya</i> , DHAN Foundation, Kasturba Hospital, Mayapur Trust, Mallur Health Cooperative
<b>Compensation for Loss of Wage</b>	Basix, Buldana Urban Coperative Society, DHAN Foundation, <i>Grameen Koota</i> , SKDRDP, <i>Mandeshi Mahila Sahakari Bank</i>

### 3.1.2. Premium design is customised to client lifestyles

Since most CBHIs evolved from grassroots NGOs and MFIs, the design of their products is often customised to suit the needs and livelihoods of their target clientele. In *Jowar Arogya Yojana* of Kasturba Hospital, for example, premium is taken in the form of millet during the harvest season. Similarly, in Raigarh Ambikapur Health Association, premium collection is through the rice harvest. Tribhuwandas Foundation and Rajasthan Dairy Cooperative appropriate client premium payments from the milk supplied by members of the cooperative.

CBHIs have also adapted premium collection to suit clients' financial realities and preferences. With VimoSEWA, clients can make a fixed deposit, and VimoSEWA then uses the interest proceeds on the deposit as premium for the health policy. In places where the target community cannot afford upfront premium payment, some NGOs and MFIs provide soft loans to the clients. Other CBHIs pay the premium upfront (from their own resources) and collect it from their client on an on-going basis

**Number of CBHIs with Different Levels of Annual Premium**



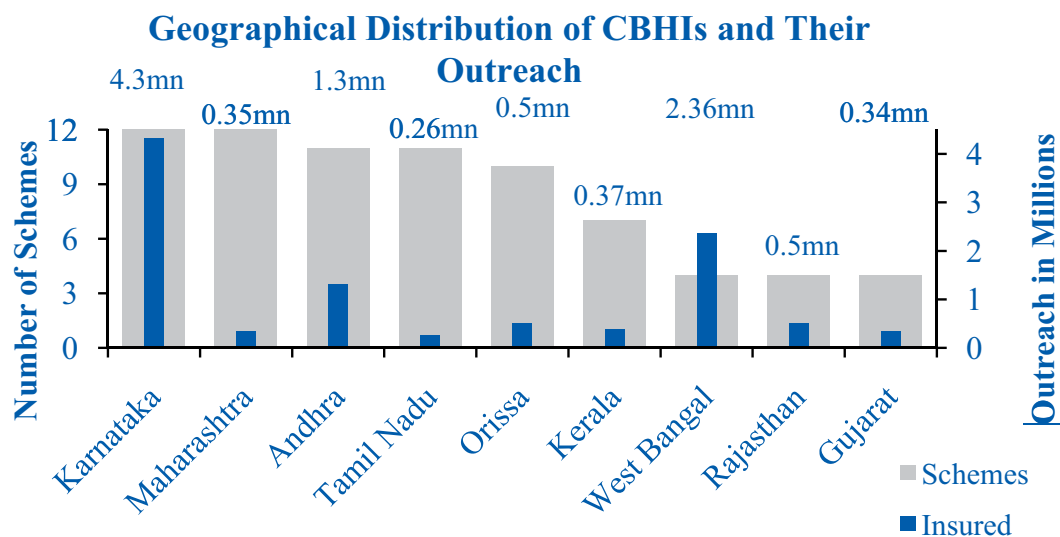
*Source: ILO, 2009; MicroSave Analysis*

through a series of regular payments. Leveraging the savings of SHGs for premium is also common amongst CBHIs.

Model of Premium Funding	CBHI Example
<b>Pay upfront premium to insurer from own fund and appropriate it through a series of regular payments</b>	SHEPHERD, Organisation for Development of People, Solapur Cooperative Federation, Bihar Milk Cooperative Federation, <i>Mahasemam</i> Trust
<b>Provide soft loan to clients for funding their premium</b>	SKS, Village Welfare Society, Basix, BISWA, OASIS, PREM, <i>Pragati</i> , <i>Grameen Koota</i> , Uplift Mutual, RUH-SA, Buldana Credit Cooperative Society, Karuna Trust
<b>Use SHG savings as insurance premium</b>	SHADE, SKDRDP, SPARC, GSGSKK, DHAN Foundation, Mandeshi <i>Mahila Sahakari</i> Bank

### 3.1.3. However, most of the CBHIs are concentrated geographically

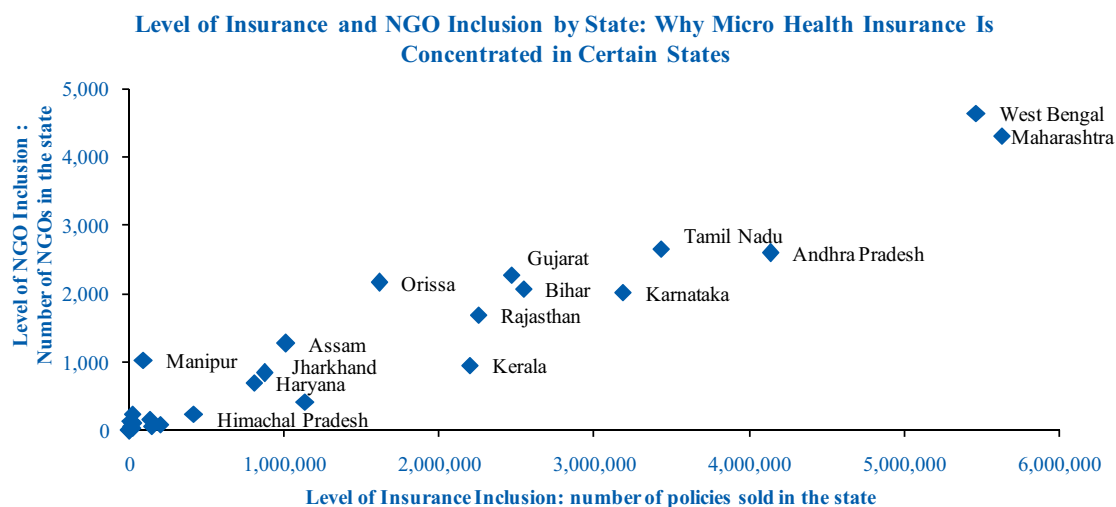
CBHIs in India are highly concentrated. Of the nearly 90 CBHIs, only 7 have operations in more than one state. Moreover, these schemes are highly concentrated in the four southern states of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu. While these states account for only 33% of the total health insurance industry, 60 % of CBHI coverage is in these four states. In part, this concentration reflects the generally higher concentration of NGOs in the South as well as a high rate of insurance inclusion in these states.



Source: ILO, 2009 and MicroSave Analysis

With the advent of state government sponsored schemes in Andhra Pradesh (*Rajiv Arogyashree Yojana*), Karnataka (*Vajpayee Arogyashree Yojana*), Kerala (*Kudumbaraksha*) and Tamil Nadu (Chief Minister's Comprehensive Health Scheme) the concentration of health microinsurance in the southern part of India has become more prominent in recent years.

The 23 in-house CBHI schemes which have their own hospital facilities are even more concentrated than the other schemes. These CBHIs cover around 2 million people, but most of them deliver all benefits from a single base hospital (e.g. Charotar *Arogya Mandal*, Kasturba Hospital, *Vaatsalya Healthcare*). Some others have also established a network with private and public health clinics to extend their service (e.g. Students Health Home).



Source: IRDA; Planning Commission of India's NGO Partnership System

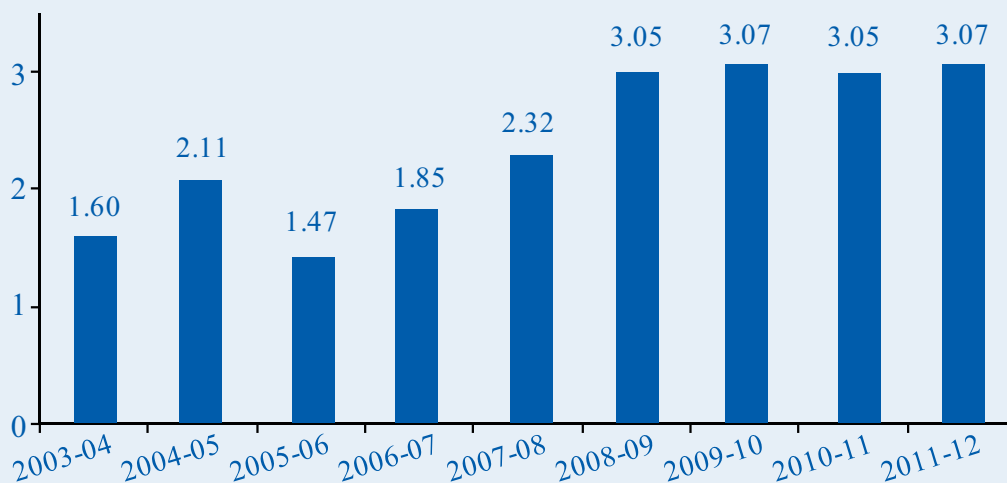
## Yeshasvini: The Largest CBHI

“Yeshasvini Cooperative Farmers Health Care Scheme” (Yeshasvini Scheme) is the largest community based health microinsurance scheme in India. It is a contributory scheme wherein the beneficiaries receive cashless treatment for any of the 800+ defined surgeries for any family members during the coverage period. The scheme is distributed through the Department of Cooperation of Karnataka.

**Benefit Coverage:** Per year coverage is up to INR 200,000 (approx.USD 4,080) for 800+ defined surgeries. The coverage includes the costs of medicines, consumables during the hospital stay, use of operation theatre, anaesthesia, surgeon’s fee, professional charge, consultant fee, nursing fee and general ward bed charge. Free outpatient consultation is also available in all the network hospitals. Clients also get a discount on lab investigations and tests.

**Distribution:** Yeshasvini’s insurance is distributed through the cooperative structure in Karnataka. The scheme has also been opened to all rural co-operative society members; members of SHGs/Shree Shakti Groups having financial transactions with the Cooperative Society/Banks, and members of the Weavers, Beedi Workers and Fisherman Cooperative Societies.

Outreach of Yeshasvini (in millions)

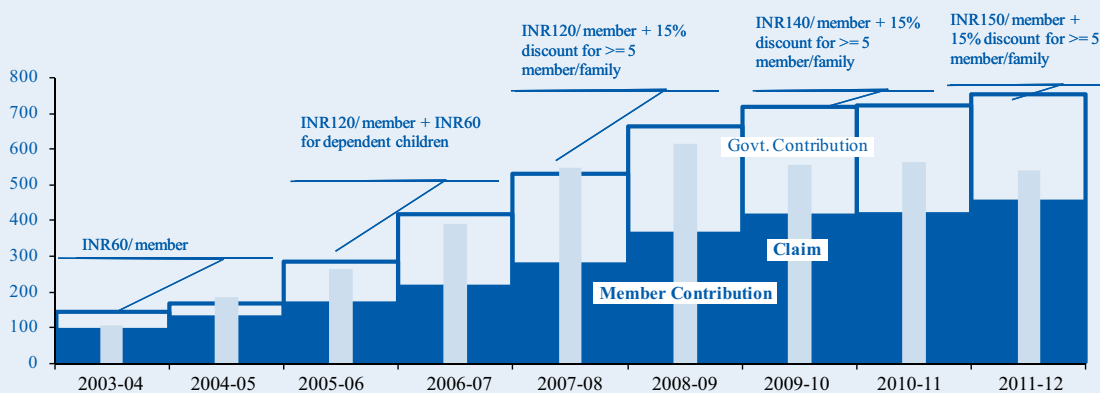


Source: Yeshasvini Website; MicroSave Analysis

**Process of Claim:** Being a cashless system, the hospitals and not the clients receive the claim for surgery costs from the Trust. FHPL (the third party administrator) authorises the client to undergo surgery in a specific hospital based on the need of the patient. After the surgery/operation, the treating network hospital sends all the final documents and the claim to FHPL. After checking the documents, FHPL sanctions the claims after approval by the Board of the Trust.

**Outreach:** Due to its association with cooperatives, Yeshasvini reached millions of people almost immediately. The scheme currently covers nearly 3.07 million people across rural Karnataka.

**Price and co-contribution:** There is no denial that *Yeshasvini* became popular due to its association with the government of Karnataka. Although not initiated by the government, the scheme received substantial funding from the government right from the beginning. While the scheme takes INR150 (USD3.00)\* from every member per year as premium, it receives INR300 million (USD6.12 million) from the state government. Even though the premium rate is increased almost every year, the high level of claims can only be paid for thanks to government contributions.

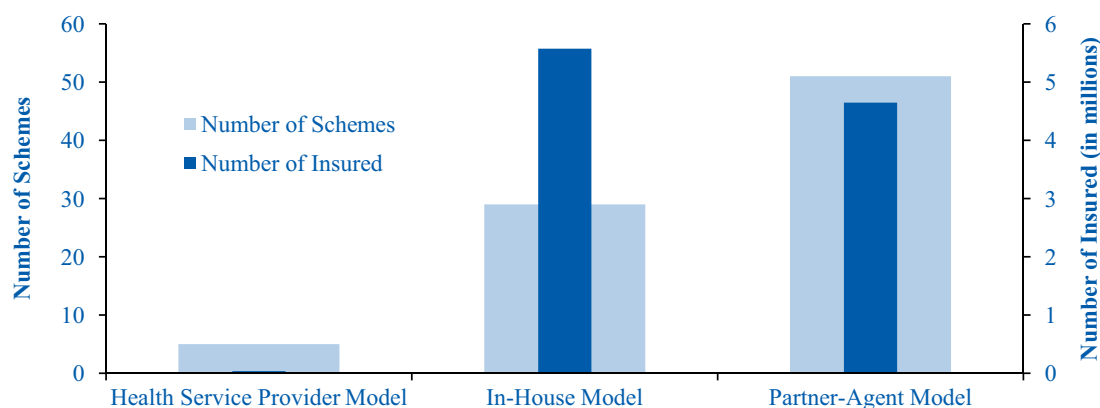


Since 2008-09 the cooperative can take an additional INR10 for administrative costs.

### 3.2. Partner-agent model is becoming dominant among CBHIs

Of the nearly 90 CBHI schemes, around 60% now use the partner-agent model (35 continue to be in-house). These schemes cover 4.7 million people. In the partner-agent model, the CBHI mainly plays the role of a distributor for the insurer.

**Number of Schemes and Outreach of Different Models of Health Microinsurance**



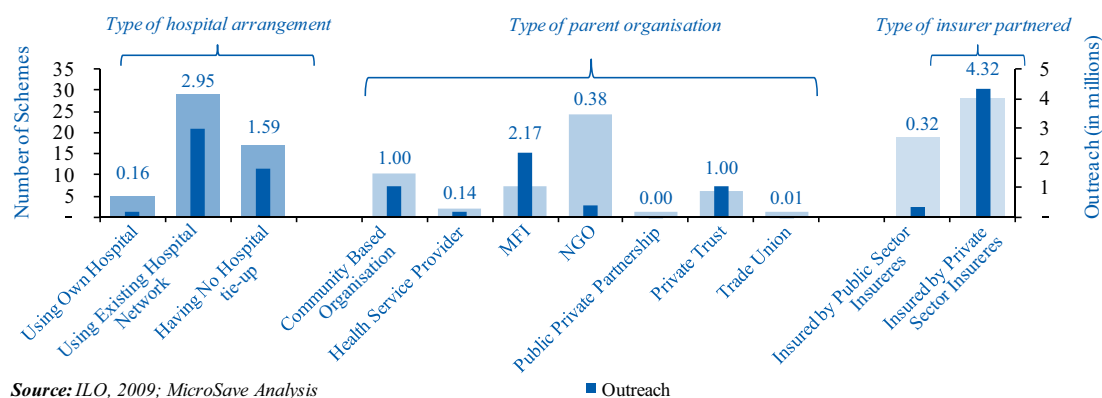
*Source: ILO, 2009; MicroSave Analysis*

Previously, most CBHIs faced problems with sustainability. The products of many cooperatives and NGOs were priced based on affordability to the target clientele rather than on actuarial principles. Although this approach helped in popularising the concept of insurance, many of these schemes witnessed unsustainable claim ratios, either on a regular basis or due to catastro-

phes. For example, VimoSEWA had to move towards the partner-agent model after an earthquake in Gujarat caused high levels of claims.

The liberalisation of the insurance industry in 2000 also witnessed the entry of private insurers into the commercial insurance sector. These insurers found the established CBHIs as ready distribution partners for products that they wanted to sell to achieve regulatory rural and social sector targets (see Section 5). Currently, around 45% of CBHI insured individuals are covered through the partner-agent model.

### Distribution of CBHIs with a Partner Agent Model



#### 3.2.1. CBHIs retain leverage even under the partner-agent model

In spite of insurance company dominance, many CBHIs still maintain some part of their original model even after subscribing to the partner-agent model. For example, five schemes (e.g. Aragonda Apollo Hospitals) continue to deliver health services through their own hospitals. Twenty-nine schemes (e.g. *Nidan*, *New Life*, *SKDRDP*) maintain their existing partnerships with local hospitals.

Many of these schemes also continue to charge less than the actuarial premium to the client. For example, in the case of *ACCORD*, the clients pay only INR25 (USD0.51), while the premium that goes to the insurance company is INR45 (USD0.92). The rest is paid by the parent organisation *Ashiwini*. In the case of *Karuna* Trust, the premium is fixed at INR22 (USD0.45), with an understanding with the insurer that any claim above 150% will be borne by the trust.

Thanks to their early success, some CBHIs have also successfully lobbied third parties for support. *Yeshasvini*, *Arogya Raksha* Trust and *Nandi* Foundation have all ensured significant contributions by government and private entities to ease the pressure of premium payment on clients. These examples imply that CBHIs often drive health insurance forward instead of acting simply as a client relationship manager for a larger government or private sector provider.



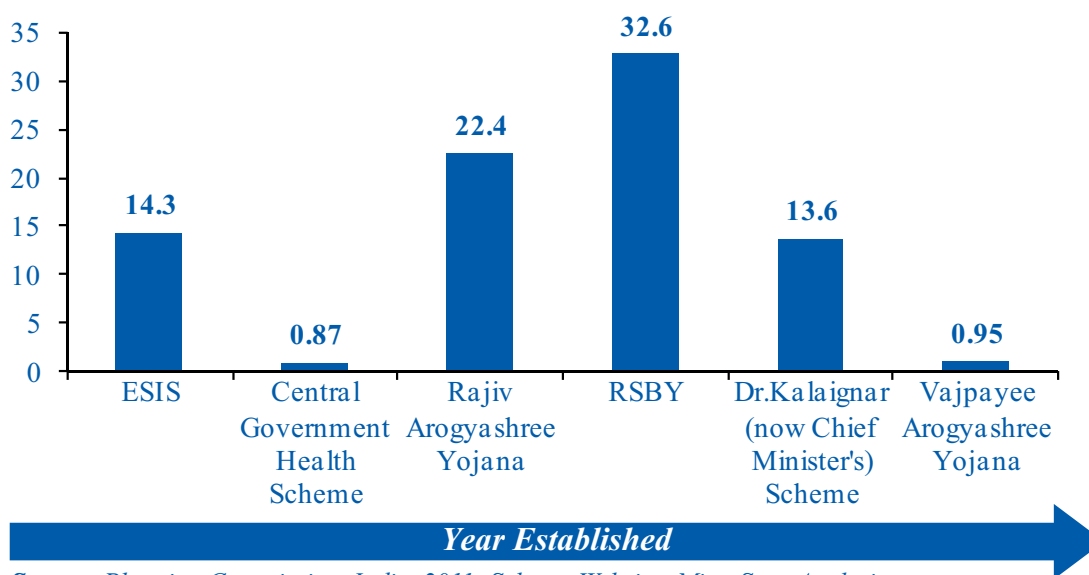
## 4. Government Schemes Provide Tertiary Care for Low Income Families

While government sponsored health insurance schemes started early, the large unorganised sector remained largely without government coverage until recently. However, these recent schemes have succeeded in providing tertiary health coverage to a large part of India's population. While coverage has been good and the schemes have managed to limit costs by outsourcing many operations to third parties, the schemes may face challenges in the future because of high claims ratios and dependence on political will.

### 4.1. Government schemes for low income families only recently started

The first government health insurance scheme was established soon after India's independence. The central government started the mandatory Employee State Insurance Scheme (ESIS) in 1952, the same year that Students Health Home was established. This contributory health insurance scheme, which targeted low income<sup>12</sup> formal sector employees, was followed by the Central Government Health Scheme (CGHS) in 1954. CGHS covered all the central government employees, and it is also mandatory. However, with the focus on government and other formal sector workers, a large part of the low income and unorganised section of population was excluded.

**Number of Families Insured by Public Health Insurance Schemes**



*Source: Planning Commission, India, 2011; Scheme Website; MicroSave Analysis*

Between the implementation of CGHS and 2005, the government concentrated more on providing health care directly to the poor. Only in the last five years has there been a shift at the state and central level towards providing more public sector health microinsurance, with health

<sup>12</sup>Ceiling of INR15,000 (USD306) monthly income

insurance expenditure reaching 19% of total government health expenditure by 2010<sup>13</sup>.

In this period, several central government ministries initiated voluntary health microinsurance schemes. Together, *Niramaya* (for individuals with certain disabilities) by Ministry of Social Justice and *Rajiv Gandhi Shilpi Swasthya Bima Yojana* (for artisans) by Ministry of Textiles covered nearly 3 million people as at 2010.

Towering among the central government schemes is the fully subsidised *Rashtriya Swasthya Bima Yojana* (RSBY), which was launched by Ministry of Labour in 2008. RSBY targets a much larger population than the other schemes – it is aimed at all those below the poverty line— and it has covered more than 32 million families so far.

At the state level, the successful PPP experience of *Yeshasvini* prompted all the southern states (Andhra Pradesh, Karnataka, Kerala and Tamil Nadu) to use their enhanced health budgets<sup>14</sup> to launch health microinsurance schemes. As noted above, Andhra Pradesh (*Rajiv Arogyashree Yojana* or RAY), Karnataka (*Vajpayee Arogyashree Yojana* (VAY) in addition to co-funding in *Yeshasvini*) and Tamil Nadu (Dr. Kalaignar – now Chief Minister’s Comprehensive Scheme) followed the PPP route. Kerala leveraged its SHG federation structure by implementing its health scheme through the state run SHG promoting entity *Kudumbashree*. Delhi (*Aapka Swasthya Bima Yojana*) and Gujarat (*Mukhyamantri Amrutam Yojana*) are also launching their own health insurance schemes, and other states have gone on study missions to the South.

## 4.2. Product design focuses on universal coverage for tertiary care

All the new voluntary public schemes consider families as the unit of coverage, which helps to bring a large population under coverage with relatively little transaction cost. While most of these schemes started with the below poverty line (BPL) population, most have extended their coverage to other unorganised workers, MGNREGA beneficiaries,<sup>15</sup> and/or to families having less than a certain threshold annual income.<sup>16</sup>

While these voluntary public schemes now cover a large population, most of them cover only tertiary care (in-patient service and chronic illness). In contrast, there is a greater dominance of primary and secondary care among the CBHIs. The state level schemes also offer a much higher sum assured, providing a better level of coverage than RSBY.<sup>17</sup> The scheme’s maximum sum assured has also increased. Tamil Nadu increased the limit on claims from INR100,000 (USD2,040) to INR150,000 (USD3,060) when it redesigned its scheme, and Gujarat’s new *Mukhyamantri Amrutam Yojana* sets the limit at INR200,000 (USD4,080).

<sup>13</sup>A Critical Assessment of the Existing Health Insurance Models in India, PHFI, 2010

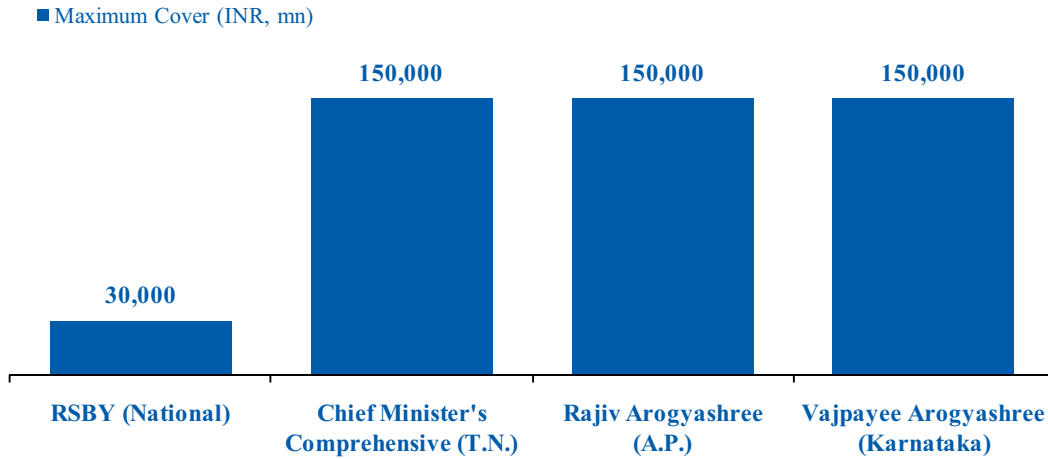
<sup>14</sup>In 2010-11, 8.76% of government health spending has been directed towards health insurance. In case of Andhra Pradesh, 23% of states’ health budget is apportioned towards *Rajiv Arogyashree Yojana* in 2011-12

<sup>15</sup>Under RSBY

<sup>16</sup>Less than INR75,000 (USD1,530) under RAY, or less than INR72,000 (USD1,470) under the Chief Minister’s Comprehensive Scheme

<sup>17</sup> In RSBY Plus, however, the clients can avail additional coverage by contributing towards premium

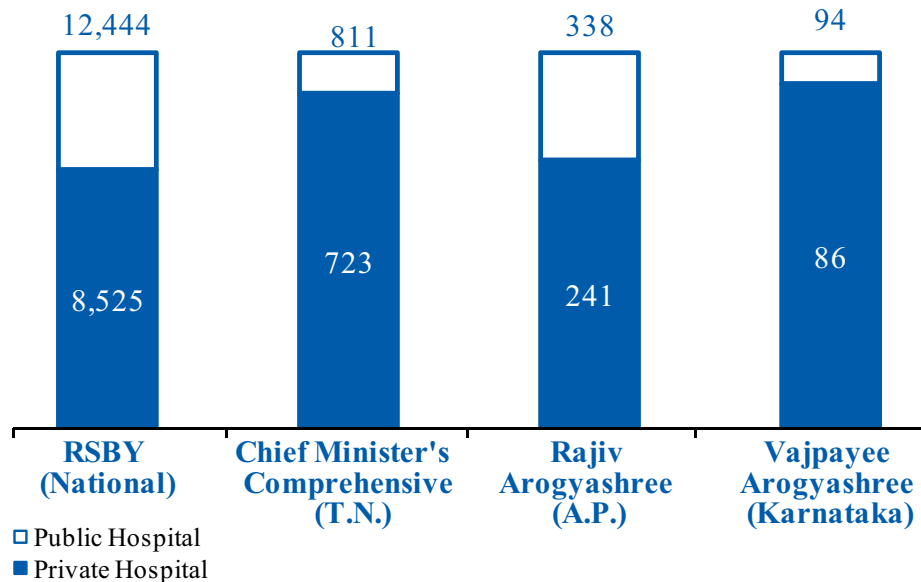
## Maximum Cover



### 4.3. Public health insurance schemes rely mostly on private hospitals

While ESIS provided care mainly through its self-owned hospitals, the newly emerging public schemes depend mainly on private hospitals. 70% of network hospitals of these schemes belong to the private sector. The top 20 hospitals in terms of admissions are also from the private sector.

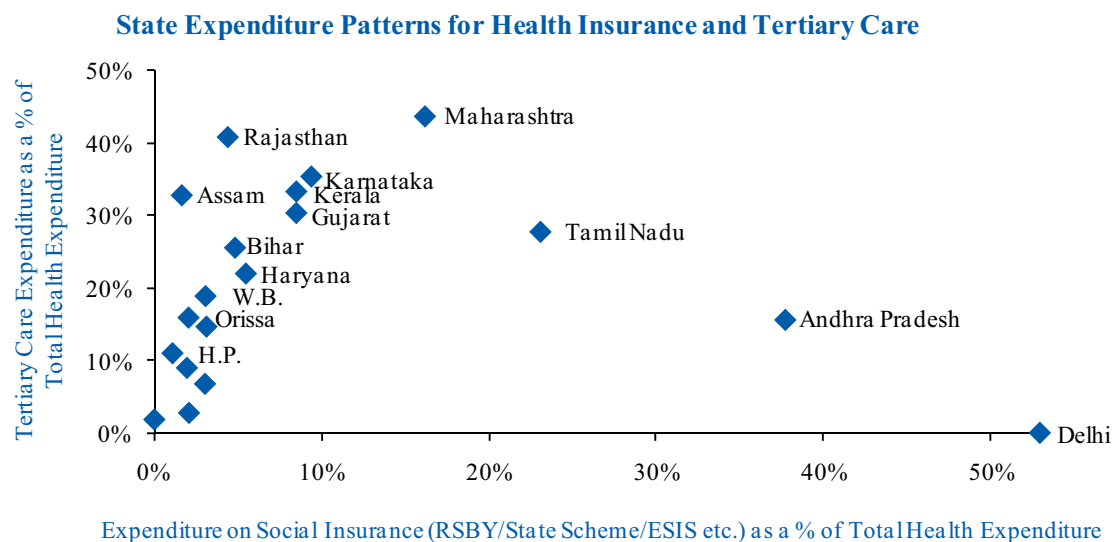
#### Percentage of Private Hospitals Among Hospital Networks of Major Public Schemes



**Source:** Scheme Website; Planning Commission, India 2011; MicroSave Analysis

All schemes have found it challenging to ensure that members get access to quality service. The Dr. Kalaignar (now Chief Minister's) Scheme of Tamil Nadu has attempted to overcome quality issues by conceiving a unique grading criterion for hospital selection. RAY and VAY have also adopted the grading scheme.

However, many of the hospitals in smaller cities and semi-urban areas, where most poor subscribers go for treatment, struggle to comply with these strict grading criteria. Moreover, owing to the unorganised nature of these hospitals, the rate for treatment varies across schemes, and across districts in the same scheme. Due to the rapid acceleration of these schemes in the southern states, many private hospitals have emerged in recent years.



**Source:** Planning Commission, India, 2011; MicroSave Analysis

#### 4.4. Government scheme economics: an outsourced, underfunded scheme?

##### 4.4.1. New public schemes keep overheads down using outsourcing and IT

While the state and central governments collectively contribute 100% of the insurance premium for these plans, they keep costs low through outsourcing and IT.

Firstly, the schemes reduce the burden of hiring long term government employees by outsourcing. None of the newly emergent health microinsurance schemes are run by the government departments directly. RAY is managed by *Arogyashree* Health Care Trust, VAY is managed by *Suvarna Arogya Suraksha* Trust, and the Dr. Kalaignar (now Chief Minister's) Scheme is managed by the independent Tamil Nadu Health Systems Society. RSBY runs as an independent unit under the Ministry of Labour and Employment. In addition, the insurance risk of some of the schemes is carried by insurance companies<sup>18</sup>, and claim processes are managed by third party administrators (TPA). As a result of outsourcing, most of the schemes have less than 150 staff, whose primary responsibility is in monitoring and quality maintenance.

Most of these schemes use IT systems extensively to reduce the cost of operations and monitoring. In the RSBY, RAY and Dr. Kalaignar (now Chief Minister's) schemes, clients are issued biometric smart cards which are portable across service providers. The claims processing back-

<sup>18</sup>In 2011-12 RAY severed its ties with its insurance company partner Star Health Insurance Company to gain more control over the fund. Although low in staff strength, Arogyamithras are recruited to RAY. These Arogyamithras then work as the primary contact person for the clients. There are nearly 3,057\* Arogyamithras in RAY. (\*Source: Arogyashree HI: The AP Experience; Ranjan Shukla, Veena Shatrugna)

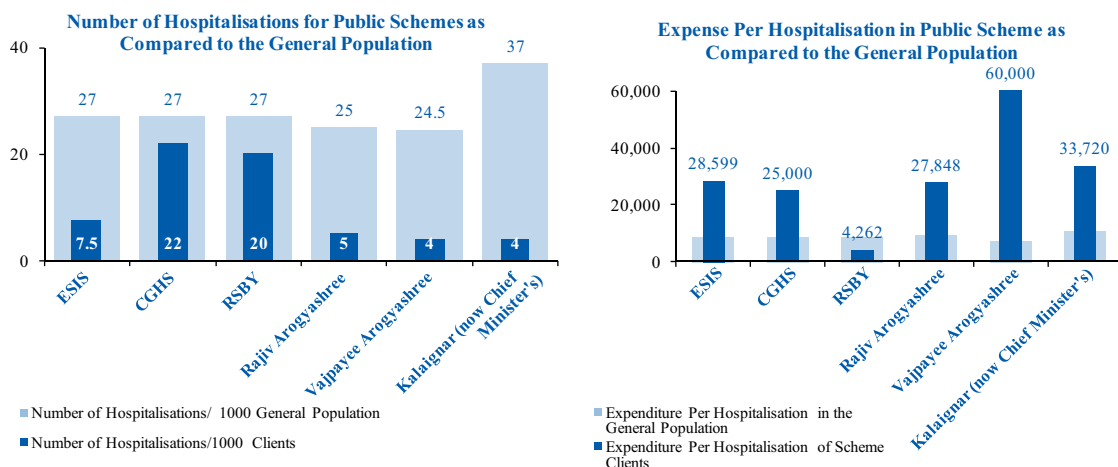
end has also been smoothed by integrated MIS in these schemes.

Overall, these new public programmes have shown greater management efficiency than earlier government schemes. In CGHS, INR16 billion (USD326 million) was spent to cover 3 million people. In comparison, under RAY and the Chief Minister’s Scheme, nearly 85 million and 35 million people are covered with a fiscal outlay of INR12 billion (USD244.8 million) and INR5.17 billion (USD 105.5 million) respectively.

#### 4.4.2. *Despite operational efficiency, high claims ratios raise concerns of moral hazard and fraudulent practice*

As more individuals become aware of access to hospital services under public schemes, one might expect enrolments and consequently claims ratios to increase. While claims ratios vary widely by state, high and growing hospitalisation rates coupled with a high cost per hospitalisation could signal problems for sustainability.

The claims ratio may become too high for insurers to operate the scheme without making losses. Although it is too early to tell, a 2011 RSBY working paper found that in 47 (or 20%) out of 229 districts, the total expense ratio exceeded 100%, implying that the insurer made a loss in that district in the first year of the business. The high expense ratios were driven by a higher claims ratio, and the problem with high average expense ratios only aggravated in the second year of operations<sup>19</sup>.



Source: Scheme Websites; Planning Commission, India, 2011; MicroSave Analysis

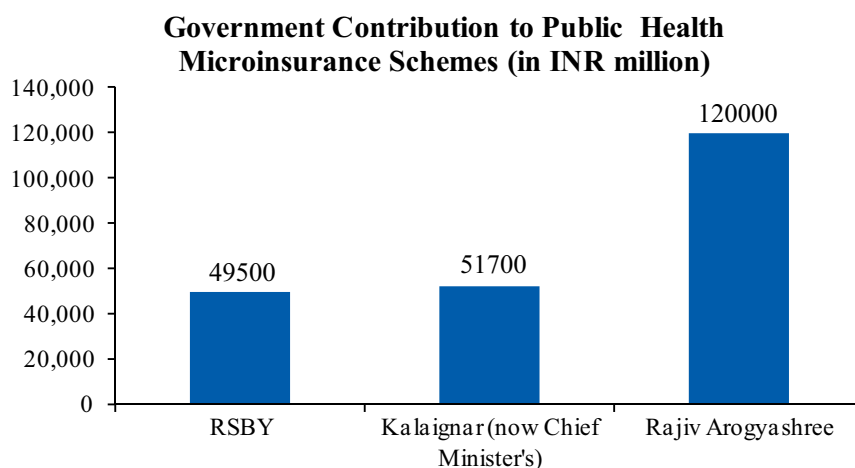
Since the government schemes are virtually free for clients with no co-payment, moral hazard is a risk. The issue with moral hazard may in time dominate the positive effect on adverse selection that results from covering a large pool via a fully subsidised scheme.

A particular challenge to sustainability is the high cost per hospitalisation. Although the number of hospitalisations in these schemes follows the trend in the general population (as per NSSO data), the expense per hospitalisation is significantly higher. Part of this can be explained by the

<sup>19</sup>Dror and Vellakkal in Indian Journal of Medical Research, 2012

higher end surgeries covered under the government schemes. However, high charges may also suggest that a moral hazard problem has arisen: since clients don't see the costs of their medical bills, they are happy to seek medical care frequently and to accept expensive treatments that the hospitals suggest.

There have also been cases of not only moral hazard problems, but also outright fraud. Up to 30-60% of client claims are reported by only 20 private hospitals in these schemes, which may stem from systematic overstatement of claims. RSBY estimates that in 20-30% of cases, claims are overstated. In addition, there have even been news reports of collusion between patients and hospitals for overstating claims. Due to such fraudulent activities, 95 hospitals in RAY and 272 hospitals in RSBY have been de-empanelled.



*Source: Planning Commission, India, 2011; MicroSave Analysis*

#### 4.5. High dependence on the fiscal exchequer is a concern for sustainability

The state and central governments of India have clearly enhanced their focus on health micro-insurance schemes in recent years. However, the increased political focus has also made the newly emergent public schemes dependent entirely on the government exchequer instead of relying substantially on subscriber premiums. In contrast, in earlier schemes like *Yeshasvini*, government sponsorship is limited at INR300 million (USD6.12 million) and client contributions form 58% of the total premium.

This dependence on fiscal funding is important for the long term sustainability of these schemes. For example RSBY is currently underfunded if we consider current claims ratios and the size of the target population. While the estimated annual fiscal expenditure stands at INR24.65 billion (USD502.9 million) to INR33.53 billion (USD684 million), which is 0.2-0.3% of the total budget based on current trends<sup>20</sup>, the budgetary allocation in 2012-13 is only INR10.96 billion (USD223.6 million). The sustainability of the scheme is, therefore, perpetually dependent on

<sup>20</sup>Dror and Vellakkal in Indian Journal of Medical Research, 2012



government's ability and willingness to increase fund allocation on an ad hoc basis.

At the state level, the political nature of schemes may make funding volatile. Schemes implemented at the state level offer a chance for political parties to put their name to the tangible benefits that the scheme offers. The southern states have taken advantage of this by naming schemes after political leaders. Once the political party in power changes, the political origins of the scheme may cause substantial changes in the health coverage model. This proved to be the case when Tamil Nadu changed the Dr. Kalaignar Scheme to the Chief Minister's Scheme.

There may also be adverse effects to individual coverage if state schemes fully replace other schemes. Of the six states that have announced state level plans (the four southern states, Gujarat and Delhi), two (Tamil Nadu and Andhra Pradesh) are not participating in the All India RSBY. The state level plans offer higher coverage but do not contribute to the goal of a universal and portable plan.

### *Rashtriya Swasthya Bima Yojana*

***Rashtriya Swasthya Bima Yojana*** (RSBY) is the flagship health insurance scheme of the government of India. It targets BPL families, unorganised Beedi workers, street vendors and MNREGA beneficiaries. As on 30 September 2012, nearly 32.63 million families (more than 160 million people) have been covered in this scheme. While general insurers buy the risk through a bidding process, the premium in RSBY is paid by the central and state governments (75:25). RSBY provides hospitalisation expense coverage of up to INR30,000 (USD 667) per family at any of its 12,444 empanelled hospitals.

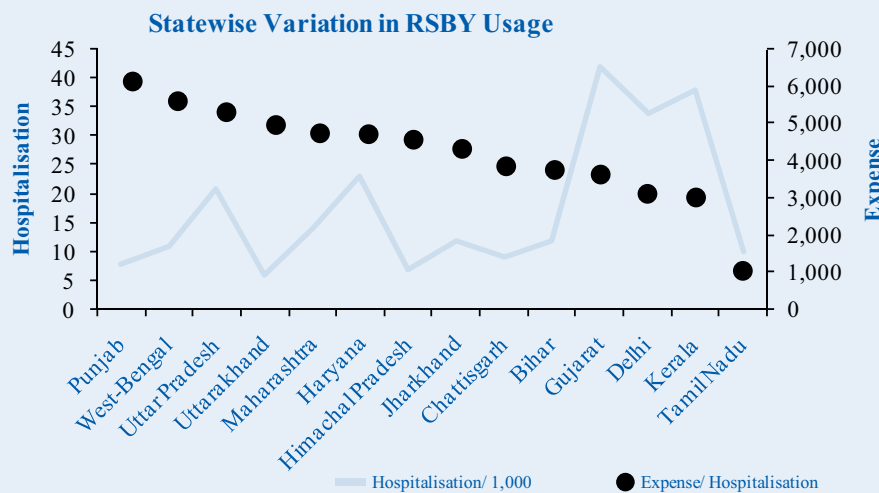
***Coverage and Network*** : RSBY is spread over 25 states in India. Enrolment of beneficiaries has been completed in 283 districts in these states and enrolment is getting carried out in 148 more districts. Potentially, the scheme aims to cover 459 districts and 65.05 million low income households.

Since the premium is paid by the government and subscription is automatic, insurance companies saw this scheme as an opportunity to reach millions of clients. So far, 14 commercial insurance companies have taken part in the scheme, collecting INR10 billion (USD204 million) as premium from government. ICICI Lombard, Oriental Insurance Company and United India Insurance are leading insurers covering around 40% of the coverage districts. 17 Third Party Administrators (TPAs) also engaged in the scheme, FINO and E-Meditek being the leaders.

***Gender specific focus of the programme*** : RSBY is gender neutral in its design. The smart cards are issued in the name of the head of the family, which is a male member in 63.12% of the cases. Although low in enrolment, utilisation has been higher by female. As against 413,337 (59.9%) males that went to the hospitals (2010) the number of females was 275,566 (40.1%). In the districts where enrolments have happened in last two years, the female utilisation rate is higher than the males. Female utilisation also witnessed state specific diversity. Uttarakhand appears to be an outlier on account of meagre female hospitalisation

ratio (0.59%) as compared to males (2.39%). On the other end of the spectrum is Jharkhand where female hospitalisation ratio is 1.23% as compared to males at 0.79%.

**Sustainability of the programme :** The claim ratio of RSBY for 2009-10 is 80%<sup>21</sup>, which is low as compared to the other publicly funded, private or community based health insurance schemes in India. In the first year of operation, the expense ratio (expense on claim, smart card and service tax) was an inspiring 77%, indicating sustainability of the scheme. In the second year of operation, however, expense ratio was 143%, making most of the insurers face losses<sup>22</sup>. Many of the private general insurers kept themselves away from RSBY, since they are not sure of the adequacy of the premium proposed by RSBY. However, the claims ratio and burn-out ratio<sup>23</sup> are highly state specific. The burn-out ratio varies from as low as 27% in Assam to as high as 136% in Nagaland.



It is interesting to see that high expense per hospitalisation is reported by the states where the number of hospitalisations is low. Overstating claims is reported as a main reason for this anomaly. Punjab, Uttar Pradesh, Uttarakhand, Maharashtra, Haryana, Jharkhand and Chhattisgarh contribute the maximum number of hospitals de-empaneled by RSBY for such fraudulent activities, which adds credibility to this claim.

## 5. Commercial Insurers Support Health Microinsurance

While the government and community organisations have been pushing health cover for BPL and other low income individuals, the private health industry has become a backbone for many of these initiatives. Underwriting community or government schemes is an important component of rural and social business for commercial insurers. Many insurers also have their own insurer led micro products.

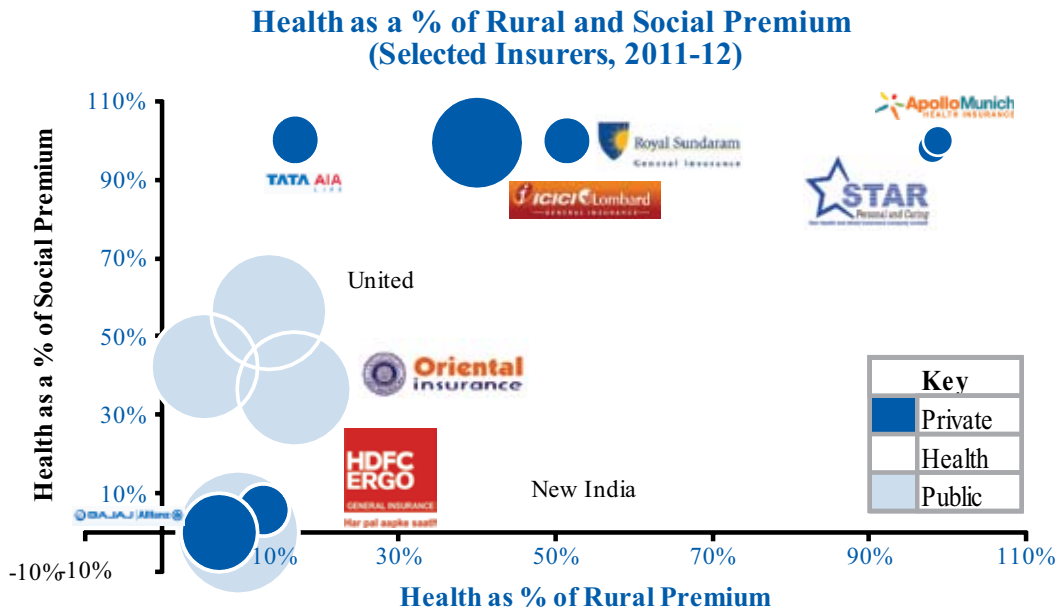
<sup>21</sup>A Critical Assessment of the Existing Health Insurance Models in India, PHFI, 2010

<sup>22</sup>Performance Trends and Policy Recommendations: An Evaluation of the Mass Health Insurance Scheme of Government of India; Karuna Krishnaswamy and Rupalee Ruchismita; September, 2011

<sup>23</sup>The outgo from Insurance Company in terms of percentage of expenditure incurred in payments made to the hospitals, smart card cost and service tax as against the total premium received. It does not contain the other administrative expenditure.

## 5.1. Health microinsurance for private insurers is less about meeting statutory targets

General insurance companies must meet annual quotas for serving rural and socially disadvantaged segments of society. However, the quotas do not drive the health microinsurance business in the same way they drive life microinsurance. On paper, the quota for general insurance is more stringent than it is for life because it is based on gross written premium instead of lives covered or policies. If rural and social clients pay lower premiums, it takes many more policies to meet the criteria.



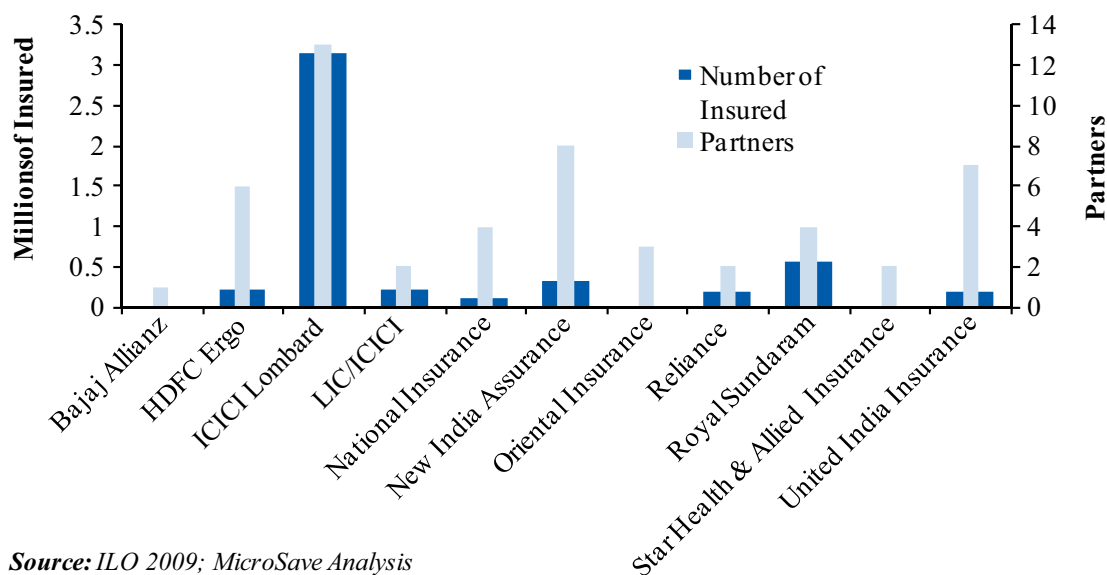
*Source: IRDA Company Public Disclosures; MicroSave Analysis*

However, the rural and social obligations can be met by many general insurance types (personal accident, fire, workmen's compensation etc.). Motor insurance is mandatory, and so it can give a boost to the figures within the rural segment in particular. As a result, the regulations do not drive health microinsurance in the same way that they drive life microinsurance.

## 5.2. In part, this is because of government and non-government demand for underwriting

There are many potential partners which can tie up with commercial insurance companies to meet rural and social obligations. Government schemes are one of the primary partners. Contracts to extend the government scheme RSBY are awarded to private and public commercial insurers on a district by district basis. (This strategy differs from government life schemes (JBY and AABY), which are backed exclusively by LIC). Insurance provided under these schemes counts towards rural and social obligations. CBHI players who have shifted towards the partner-agent model and other community organisations also demand underwriters.

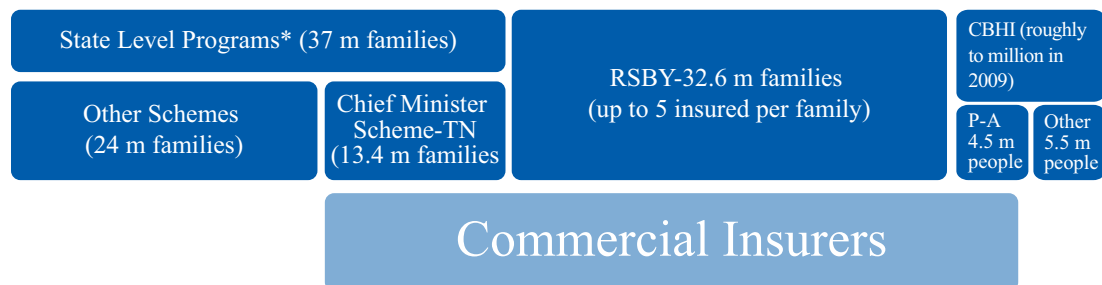
### Some Insurers Embrace CBHIs More Than Others



Source: ILO 2009; MicroSave Analysis

### 5.3. Around 65% of government and community schemes are backed by commercial insurers

The role of private Insurers in community based and government micro health



As a result of these partnerships, much of India’s health microinsurance provision depends on the commercial insurers. Commercial insurers cover over 45 million families through government schemes and around 4.5 million people through non-government programs. United India Insurance Company (which covers 81 districts under RSBY and an estimated 36 million insured under Tamil Nadu’s state scheme) and ICICI Lombard (which covers 72 districts under RSBY and has 3 million insured under CBHIs)<sup>24</sup> are currently leaders in micro partnerships and government contracts.

RSBY districts by insurer	
Insurer	Districts
United India Insurance	81
ICICI Lombard	72
Oriental Insurance	43
Royal Sundaram	41
Chola MS	34
IFFCO TOKIO	33
National Insurance	33
New India Assurance	30
Tata AIG	23
Apollo Munich	21
Reliance	20
Star Health	18
HDFC ERGO	4

Source: RSBY Connect, September 2012

<sup>24</sup>Data sources: ILO, 2009; Planning Commission India, 2011; World Bank 2012

#### 5.4. And yet, competition allows government schemes to call the shots

Despite the importance of insurers in the aggregate, there is currently little government dependence on specific insurers. RSBY is implemented by different insurers in different districts. In addition, governments have been easily able to shift contracts between commercial insurers. Tamil Nadu's state scheme moved from Star Health to United India Insurance, while RSBY contracts can be reassigned. Andhra Pradesh's state scheme opted to move business in house instead of giving new business to its earlier commercial insurance partner, Star Health.

##### *Government Business Can Be Volatile: The Story of Star Health*

Dependence on government micro health schemes may create volatility for some players. After a change in government in Tamil Nadu, the health scheme previously underwritten by Star Health changed. Star Health lost its role as the insurer for the state financed health scheme. Also, from 2012, government related business in Andhra Pradesh - where Star Health had implemented the state's *Rajiv Arogyashree Yojana* – declined as the scheme started to use in-house models. Following these changes, in the first quarter of the 2012-13 fiscal year, Star Health's reported revenue almost halved from a year earlier, mainly due to loss of business in Andhra Pradesh.

#### 5.5. As government schemes dominate the market, policy changes can greatly impact insurers

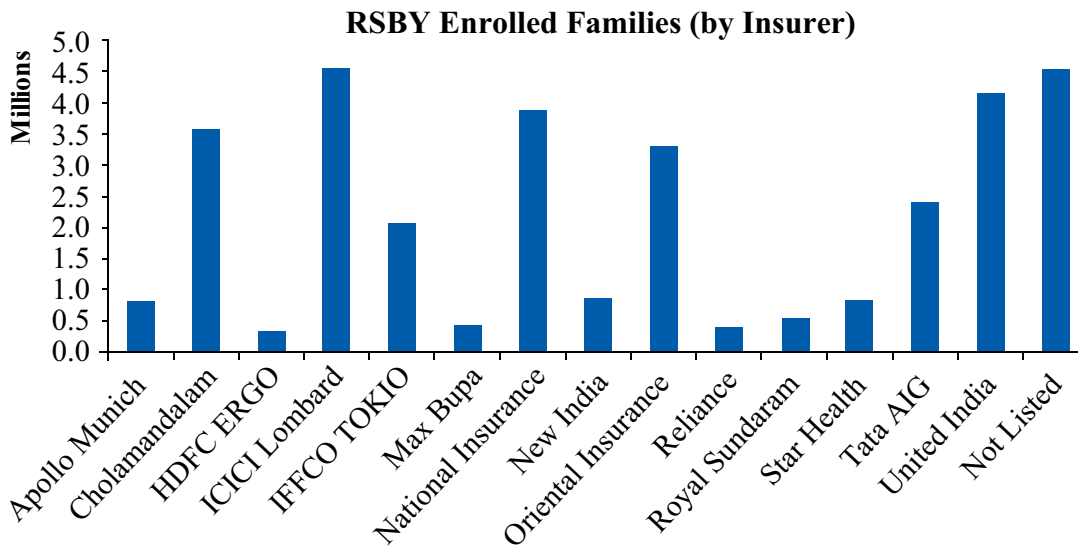
Given the scale of government programmes, they have become important for certain insurance companies. Overall, in FY 2010-11, government health schemes accounted for 20% of health insurance premiums by commercial insurers, and about 4.5% of insurers' gross written premiums<sup>25</sup>. Some insurers are particularly dependent on such schemes: government health premium represented 11% of ICICI Lombard's total gross written premium in 2010-11 and almost 9% of Cholamandalam's<sup>26</sup>. Some health specific general insurers (Star, Max Bupa, and Apollo Munich) have taken on a large amount of government business.

The Star Health case (see the text box *Government Business Can be Volatile: The Story of Star Health*) demonstrates how the risks of a government led industry could extend to other commercial industry players. The government health insurance schemes are vulnerable to political and fiscal changes (see Section 4.5), which can bring volatility regarding the premium that government will pay for a certain sum assured, and the partners it chooses<sup>27</sup>. These issues, combined with high claims ratios (see Section 4) have led some insurers to stay away from the bidding process. If volatility and high claims ratios continue, government may find it difficult to find partners to implement its schemes.

<sup>25</sup>Based on data from IRDA 2010-11 Annual Report

<sup>26</sup>ICICI Lombard had about 10% general insurance market share in 2010-11 (based on gross premiums). Based on data from the IRDA 2010-11 Annual Report

<sup>27</sup>Performance Trends and Policy Recommendations: An Evaluation of the Mass Health Insurance Scheme of Government of India; Karuna Krishnaswamy and Rupalee Ruchismita; September, 2011



*Source: RSBY\*, Microsave Analysis*

*\*based on district level last reported contacts, some districts have changed insurer*

## 6. Concluding Remarks

The landscape for health microinsurance has changed substantially in the last several years. After a long period of pioneering initiatives by community organisations, recent government initiatives have greatly expanded health coverage —especially in tertiary care—for low income families across India. Today, the coexistence of both smaller scale initiatives and large government plans provides a fertile environment for experimentation with new approaches and their application to a broad population.

However, while the momentum of health microinsurance is currently strong, there are fundamental concerns about the long term sustainability of this current trend. After starting with in-house models, many community based initiatives partnered with commercial insurers to better manage their risk. Some of the large public initiatives have similarly engaged the commercial insurance industry to underwrite their schemes. These moves help to professionalise health microinsurance, but they may not have resolved core issues around the economics of the product and scale and outreach. The high expense and claims ratios experienced by commercial insurers when underwriting third party schemes (government schemes in particular) suggest that scheme changes cannot be ruled out in future. Similarly, some of the community based health schemes rely on external contributions to assist clients in paying the premium.

In view of these issues, the durability of health microinsurance is not yet certain. Given the diversity of schemes, there is no one solution to these concerns. For the large government schemes, monitoring the hospitals to reduce overstatement of costs will be important to control the claims ratios. For some community based organisations, it may be more important to leverage technology to reduce costs without undermining cover. Overall, there is still progress to be made in composing a package that delivers good client service at a sustainable price, but the focus and ability to find appropriate solutions is present.



## Glossary

**Adverse Selection:** A problem in the insurance industry when the individuals that self-select into buying insurance have a higher risk than the population at large. In other words, it is a phenomena in which people with high risk are selected for insurance cover.

**Bancassurance:** Selling of insurance products through banks

**Business Correspondent:** An individual agent appointed by the bank to connect people with banking services outside of branches.

**Claims Ratio:** Claims filed under insurance policies divided by the premium collected for those policies

**Commercial Insurer:** Private and public insurance companies in India that are registered under the regulator IRDA to sell insurance policies

**Corporate Agents:** Organisations (as opposed to individuals) that can serve as distributors for insurance policies

**Credit-life Insurance:** A product that aims at repaying the outstanding loan of a client in the event of his/her death.

**Community Based Health Insurer:** Any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management

**Cover Continuance Period:** Period during which the policy holder continues to be covered for life insurance under a ULIP even if premium do not continue to be paid

**De-empanelment:** When hospitals authorised to provide care under a health insurance scheme are relieved of their authorisation

**Expense Ratio:** The percentage of premium used to pay all the costs of acquiring, writing, and servicing insurance and reinsurance.

**First-year Premium:** Premium falling due during the first year the policy is in force.

**Group Policy:** A policy sold to an entity, which provides cover to its individual members.

**General Insurance Company:** Insurance company that covers risks such as fire, health, motor, etc. These entities do not provide life insurance.

**Individual Policy:** A policy sold to the individual directly instead of to a group.

**In-house model:** Insurance risk that is managed by the distributing organisation rather than an external insurance company

**Insurance Density:** Insurance premium collected by the industry divided by the total population

**Insurance Penetration:** Insurance premium as a percentage of the area's GDP

**Lapse Ratio:** Lapses of insurance policies (including forfeitures) during the year divided by the arithmetic mean of the business in force at the beginning and at the end of the year

**Lives Covered:** The number of lives that are covered under a group life insurance policy, or through individual policies.

**Lock-in Period:** For a ULIP, the period during which no residuary payments are made to the policy holder on any lapsed, surrendered, or discontinued policies. Any amounts payable can only be received at the end of the lock-in period.

**Management Expense:** An expense measure of the insurance business which includes operating expenses, business acquisition cost, and expenses on marketing and advertising.

**Maturity Benefit:** The sum paid to an individual when the policy term ends.

**Microinsurance:** "Protection of low-income people (not having access to commercial insurance or social protection) against specific perils (that causes vulnerability in their livelihood) in exchange for regular payment of pre-

mium proportionate to the likelihood and cost of the risk involved.” In short, it covers any Insurance product that provides risk cover to low income individuals.

**Microinsurance Agent:** An agent authorised to sell microinsurance products that are registered under the Microinsurance Regulations (2005). These agents can be Self Help Groups, non-governmental organisations, and microfinance institutions, as well as other more conventional agent types.

**Microinsurance Regulations (2005):** Specific regulation for microinsurance that the industry regulator IRDA promoted in 2005. These regulations enabled new organisations to act as agents for insurance companies and specified microinsurance product types that would be counted towards insurers’ rural and social sector quotas

**Moral Hazard:** Changes in the behavior of individuals when they do not bear the full cost of their actions and are thus more likely to take such actions.

**NAV (Net Asset Value):** The market value of a single unit of an investment in a fund or unit linked policy.

**New Business Premium:** Premium in a period that relate to a) single premium policy payments b) first year premium from policies written in the period c) first year premium from policies written earlier

**Operating Expense Ratio:** Operating expenses, as a per cent of gross premium underwritten

**Partner-agent model:** Model where an insurer and a distributing entity (e.g. an NGO, MFI) form a partnership to underwrite and distribute insurance

**Persistency Ratio:** The proportion of policies remaining in force at the end of the period out of the total policies in force at the beginning of the period. This indicator measures the magnitude of renewal or continuation of policies without lapsation (in paying renewal premium) or surrender. It is a parameter indicating the customer satisfaction and quality of the sales force.

**Policy:** A contract of insurance that describes the key aspects of coverage (term, coverage amount, premium, etc.).

**Premium:** The amount of money an insurer charges to provide the coverage described in the policy.

**Primary Care:** Treatment for minor illnesses on an out-patient basis

**Public- Private- Partnership:** An arrangement between a public entity and a private entity to provide services, goods, or infrastructure investment.

**Registered Microinsurance Product:** A product registered with IRDA (in the “file and use” system) under the Microinsurance Regulations (2005).

**Rural and Social Obligations:** Obligations notified by industry regulator IRDA in 2002 that require insurers to sell a certain amount of insurance to the rural and socially disadvantaged segments.

**Savings Linked Life Insurance:** Life insurance policies that combine a term life policy with an endowment product (or ULIP), allowing the individual to accumulate capital and earn returns on that capital.

**Secondary Care:** Treatment for non critical illnesses that require hospitalisation

**Self Help Group:** Typically a group of 10 to 20 women which serves as an intermediary for credit and promotes savings. SHGs are promoted by the Government of India and NABARD.

**Soft Loan:** Loan offered at a rate that is cheaper than the market rate

**Sum Assured (health):** The maximum amount which can be claimed under the insurance policy in a in a certain period.

**Sum Assured (life):** The amount that the insurance company pays out the beneficiaries of the policy in the event of the death of the life covered

**Tertiary Care:** Treatment for critical ailments that require sophisticated service and facilities

**Tied Agent:** An individual that distributes insurance products on behalf of an insurer.

**Unit Linked Insurance Plan (ULIP):** A life insurance plan where part of the premium is invested in securities markets and the insured individual earns market-linked returns on this investment in addition to life cover.

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 **MicroSave** Offices

**Head Office**

B-52, Kapoorthala Crossing, Mahanagar Extension,  
Lucknow – 226006, Uttar Pradesh, India  
Tel: +91 522 2335734 Fax: +91 522 4063773

Website: [www.MicroSave.net](http://www.MicroSave.net)  
Email: [info@MicroSave.net](mailto:info@MicroSave.net)

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