Micro-Insurance in India

By

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Micro Finance Health Insurance in India: Is it a way ahead for increasing awareness and penetration of Health Insurance?

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INSTITUTE OF HEALTH
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IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Miss Namrata Gupta student of MBA Health and Hospital Management from The IIHMR University, Jaipur has undergone dissertation training at Reliance General Insurance from February 8th 2016 to April 30th 2016.
She successfully completed her dissertation under my guidance on a study titled "Microinsurance in India."

The Candidate has successfully carried out the study designated to her during dissertation training and her approach to the study has been sincere, scientific and analytical. This training is in fulfillment of the course requirements.

I wish her all success in all future endeavors.

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We wish her all the best in her future endeavors.

Reliance General Insurance Co Ltd

Akhila Seshadri
(Human Resources)

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled ''Microinsurance in India" and submitted by Miss Namrata Gupta Enrollment No IIHMR-U/MBA-HM/2014-16/19-1575 under the supervision of Dr. Gautam Sadhu for award of Postgraduate Diploma in Hospital and Health Management of the University carried out during the period from 2014 to 2016 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Namrata

ABSTRACT

Introduction

Every year, an estimated 25 million households or more than 100 million people — are plunged into poverty when they or their relatives become ill and they must struggle to pay for health-care services out of their own pockets, according to the 2006 World Health Organization bulletin on healthcare financing in developing countries (Braine, 2006). The goal of micro health insurance is to improve the financial protection of the poor uninsured populations in developing countries against excessive health expenditures.

90%3 of the Indian population and 88%4 of the Indian workforce (the majority of which is the unorganised sector) are still excluded from any kind of insurance and pension coverUNDP, 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 million6.

Microfinance insurance is the protection of low-income people against specific perils in exchange for regular premium payment proportionate to the likelihood and cost of the risks involved. India continues to be the home of the largest microfinance industry in the world. This globalmarket dominance has continued since the late 1990s. *The State of the Microcredit Summit CampaignReport 2011* shows that there are a little more than 93 million microfinance clients in India. This represents close to one-half of the estimated 205 million microfinance clients reached worldwide (Reed, 2011)

In general, there are four main methods for offering Microinsurance:-

- Partner agent model
- Full service model
- Provider-driven model
- Community-based/mutual

Research Question

Micro Finance Health Insurance in India: Is it a way ahead for increasing awareness and penetration of Health Insurance?

Objectives

1) To understand the current scenario of Microfinance health insurance in India

2) To compare the various microfinance health insurance models

3) To identify the existing gaps and suggest ways of increasing the effectiveness of the model in India

Methodology

Qualitative descriptive study -The paper largely depends upon the systematic review of secondary sources based on the literature reviews, journals, books, etc.

Findings

1. There are majorly 4 categories of insurance products – Life, Asset, Health, Crop and Livestock. The 3 major players are – Insurance companies, Government and Community based health insurance schemes. The 2 major characteristics – low cost and vast delivery channel. There are currently 192 (approx.) products in Indian market. Majority of market is captured by Public insurers and among providers its dominated by Private hospitals.

2. Major CBHI models are- Yeshasvini trust, student health home, Village welfare society,SKDRDP,BASIX,SKS.Majority of them operating in rural southern India.Some have tie ups with major banks of India.Governement Scheme Models- RSBY, Rajiv Aarogyashree Yojana, Chief Minister's Scheme,VajpayeeAarogyashree Scheme, Central government health scheme.Again majorly operating in Southern India.Insurance Companies- jeevanmadhur by lic, iciciprudentiallifesarvjanasuraksha, new india-nbhagyalakshmi child welfare policy.Others- agriculture pump set insurance- new india assurance co ltd, cattle insurance by the new india assurance co ltd,hdfc ergo insurance co ltd, pradhanmantrijeevanjyotibima yojana (pmjjby),pradhanmantrifasalbima yojana

3. Majority of schemes located in southern India, exclusion criterias, lessinnnovations in distribution channels, lack of database and strategies to deal with them include launching policies in northern India,customized distribution channels, more involvement of private players, regular updation of database to list a few.

Conclusion

Microinsurance is definitely an answer to improving the penetration of Microinsurance in India as 90% of the Indian population majority of which belongs to unorganised sector is uncovered by any kind of insurance or pension plan. Also it can be an effective poverty reduction strategy. Major work on developing PPP models, innovative distribution channels, regular updatation ofdatabase,evidence based decision making and efficient payment of claims can increase its penetration in Indian Market.

Acknowledgement

With immense pleasure I express my heartful gratitude to the Director of IIHMR Jaipur, Dr.S.D.Gupta, and Dean, Col. (Dr.) Ashok Kaushik and my guide Dr Goutam Sadhu for having given me this opportunity to undergo training.

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List of Abbreviations

CBHI	Community based health Insurance
MFI	Microfinance Institution
SNA	State nodal agency
SHG	Self-help group
MIA	MICROINSURANCE agent
PPP	Public private partnership
NGO	Nongovernment organisation
DHAN	Development of humane action
SKDRDP	Shri KshetraDharmasthala Rural Development Project
SKS	SwayamKrishiSangam
IRDA	Insurance Regulatory and Development Authority of India
ACCORD	Action for Community Organisation, Rehabilitation and Development
GDP	Gross Domestic Product
UNDP	United Nation's Development Programme
TPA	Third Party Administrators

Executive Summary

India has perhaps the most exciting and dynamic Microinsurance sector in the world. The aim ofthis report is to provide an overview of existing knowledge, understanding gaps and developing strategies on improving Microinsurance penetration in India.

In the first section the report explores the developmental history Microinsurance industryalong with it defines the objectives, rationales, methodology and literature review of the study. Microinsurance models now includes various successful PPP models, key issues related to product designing ,pricing, how flexibility of premium payment is an important task to deal with.

The second section includes the understanding of the different dimensions of Microinsurance in detail. The life and non-life Microinsurance products, guidelines- age limits, premium, benefits offered, stakeholders and distributors involved and key characteristics of the model.

The third section includes listing of all the companies currently offering Microinsurance along with the list of products offered by them. It presents segregation based on private vs public involvement, most benefits provided, scheme most popular etc. It studies the various models – government, insurance companies, PPP models, CBHI models, crop, asset insurance models etc.

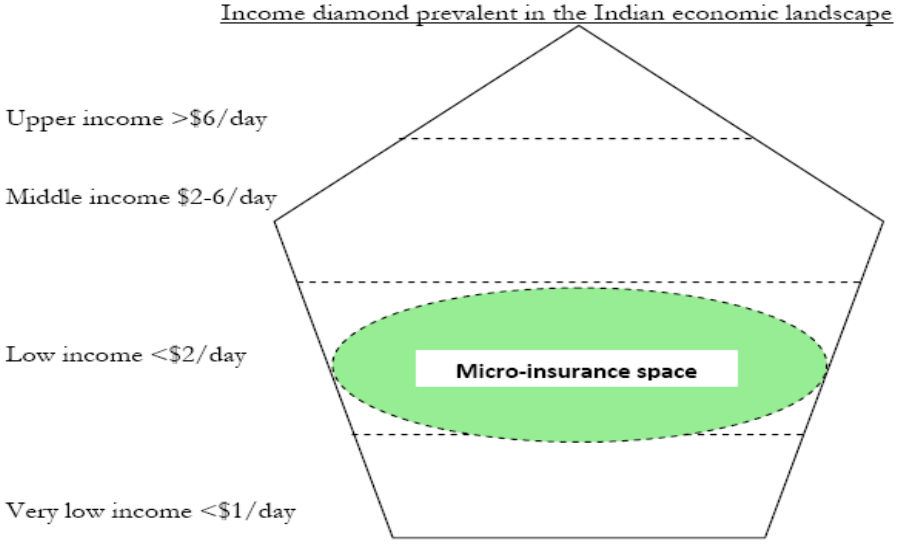
The fourth section identifies the challenges, various gaps like most of the policies being offered in the southern part of India, less involvement of private insurers, lack of formal distribution channels in the insurance delivery process and the strategies like focusing on northern states, innovative distribution channels, more involvement of private sector, regular data collection etc needed to address the gaps along with the conclusion remarks.

1. INTRODUCTION

Micro-insurance, the term is used to refer to insurance to the low-income people, isdifferent from insurance in general as it is a low value product which requires different design and distribution strategies such as premium based on community risk rating (as opposed to individual risk rating),active involvement of an intermediate agency representing the target community and so forth.

Enhancing the ability of the poor to deal with various risks is increasingly being considered integral to any **poverty reduction strategy** (Holzmann and Jorgensen 2000, Siegel et al. 2001).

Figure 1.1
Income diamond prevalent in the Indian economic landscape



Source: Adapted from Athreya, V, 2007. Tata AIG Life Insurance Company presentation at the Munich Re Conference on Microinsurance, Mumbai, November 2007.

Development of Microinsurance

In the initial years no formal health insurance model was available due to vast unorganised workforce and limited government will.NGO or community based health insurance programmes with in house models –where every process was handled by them solely were the pioneers, eg Student Health Home West Bengal, Chennai based voulntary health scheme.Then era of SHGs and cooperatives providing exclusively health insurance started.eg- ACCORD. Later partner agent model came into picture where partnerships with healthservice providers,MFIs, banks came into picutre, focused on social development along woth health insurance.eg- SKDRDP, DHAN foundation.Curently government sponsered schemes, PPP models have widest coverage and are most successful in India.eg –RSBY.

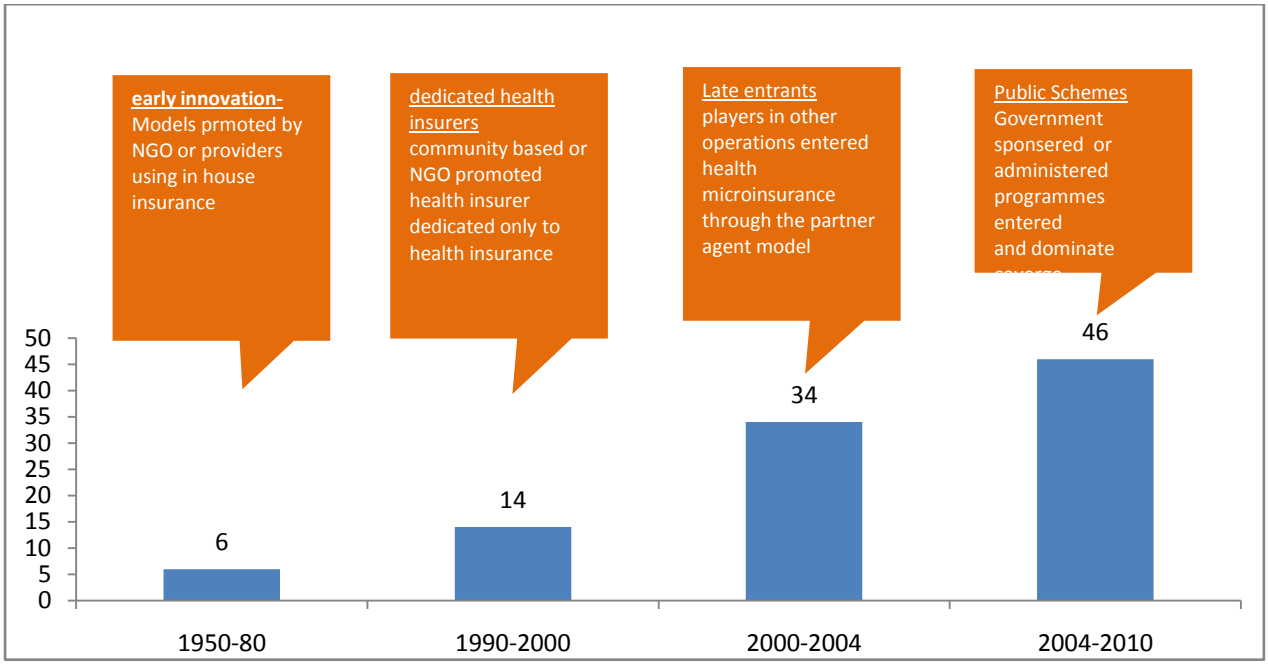


Figure- 1.2Source- ILO 2009, microsave analysis

1.1 Research Questions

Micro Finance Health Insurance in India: Is it a way ahead for increasing awareness and penetration of Health Insurance?

1.2 Objectives

1) To understand the current scenario of Microfinance health insurance in India

2) To study the various microfinance health insurance models

3) To identify the existing gaps and suggest ways of increasing the effectiveness of the model in India

1.3 Methodology

Qualitative descriptive study -The paper largely depends upon the systematic review of secondary sources based on the literature reviews, journals, books, etc.

1.4 Literature Review

Wagstaff and Pradhan, 2005

Health insurance is one of the most important policy issues today in the developing world.Developing countries suffer most of the global disease burden but represent only one tenth of the world's spending on healthcare.More than half of health expenditures in poor countries are out-of-pocket payments by individual households. Health shocks and associated high medical expenses can cause destitute families to sell productive assets, such as agriculture necessary for earning a livelihood, or reduce consumption to the point where economic wellbeing is endangered and the famiy's health and children's educational opportunities are compromised.Two main branches of policy considerations to be analyzed: first, the market consequences of a household-level demand for insurance, and second, given a demand for health insurance, economically efficient strategies that will facilitate building a sustainable supply of microinsurance for health care.The greatest challenge for microinsurance lies in the combination of viability and sustainability with wide outreach.

Insurance foundation of India, June 2013

In **India**, the study finds that this country currently has the most dynamic Microinsurance sector in the world. Liberalization of the economy and the insurance sector has created new opportunities for insurance to reach the vast majority of the poor, including those working in the informal sector. Even so, market penetration is largely driven by supply, not demand.Microinsurance in India has valuable lessons for rest of the world, particularly in the regulation of the industry.

Microinsurance is a low-price, high-volume business, and in any such business keepingdistribution costs down is the road to success.. NGOs and most MFIs are often dependent on variable aid flows, making them potentially less reliable over the long term. Furthermore, most relevant NGOs and MFIs already have partnerships in place, and since these are typically exclusive, incoming insurance companies may not be able to find partners. The report finds that banks have a great deal of unexplored potential as partners. Perhaps the most successful insurance distribution infrastructure in low -income neighbourhoods to date is that developed by Tata-AIG in Andhra Pradesh: partnership firms of four or five women, usually recruited from Self -Help Groups, become informal brokers and can earn an ongoing income from the business.

Allianz ag, gtz and UNDP public private partnership, August 2006

Currently public and private insurance companies are adopting strategiesof developing collaborations with the various civil society associations. The presence ofthese associations as a mediating agency, or what we call a **nodal agency**, that represents, and acts on behalf of

the target community is essential in extending insurance coverto the poor. The nodal agency helps the formal insurance providers overcome both informational disadvantage and high transaction costs in providing insurance to the low-income people. This way micro-insurance combines positive features of formal insurance (prepaid, scientifically organized scheme) as well as those of informal insurance (by using local information and resources that helps in designing appropriate schemes delivered in a cost effective way).

In the absence of a nodal agency, the low resource base of the poor, coupled with high transaction costs (relative to the magnitude of transactions) gives rise to the affordability issue. Lack of affordability preventstheir latent demand from expressing itself in the market. Hence the nodal agencies thatorganise the poor, impart training, and work for the welfare of the low-income people play an important role both in generating both the demand for insurance as well as the supply of cost-effective insurance.

Securing the silent, Microinsurance in India

The **key issues** of concern for community-based schemes include:
Pricing – Often the process of pricing is focused on what people say they can payrather than being linked to the cost structure of benefits that the group wants to receive. Insurance is subject to cash flow fluctuations and thus requires significant reserves.These schemes frequently have insufficient reserves or no reserves at all.
Controls on management are weak and temptation is strong. Fraud by management isfrequently a problem. These schemes are limited in size to those people within the defined local area. Thisreduces their ability to diversify a rather small risk pool, and enhances the potentialfor adverse selection, both of which make sustainability a serious challenge for local management.
In many countries there is no legal framework for these schemes. Indeedregulators are often unwilling to allow such schemes for fear that they will not be ableto adequately supervise many small schemes run by non-professionals. This is thecase in India. Service providers, most typically hospitals and other healthcareproviders have offered pre-financing mechanisms that act somewhat like insurance.These products, it is argued, will attract more people to the facility and the peoplewho come will be able to pay for the services. Often this becomes a problem becauseproviders have limited ability to manage the insurance administration issues.

Health Micro-insurance in India– An overview, July 2013

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.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.

Micro-Insurance Regulation in the Indian financial landscape

Key features of Microinsurance :-

Product Characteristics.Micro-insurance products in the market have short policy contractterms and are overwhelmingly (but no longer exclusively) underwritten on a group basis.
A number of the new products offered by formal insurers may be individually underwritten but the numbers of such policies is still minuscule.
• Demarcation. Formal insurers are required either to provide life or non-life insurance exclusively though health insurance may be provided by either category of insurer.
• Low outreach of community-based insurance. Community-based health insurance systems managed by NGOs are available but, except in a couple of cases, has minuscule outreach. The limited prudential risk vis-à-vis payments made by the covered population means that the regulator has not yet taken a significant interest in these.
• Dominance of loan linked products. This is the largest product in the market driven by the compulsion of borrowers to purchase insurance schemes mainly to provide protective cover to the MFIs
• New distribution models. Rural and social sector obligations imposed on formal insurers by the market regulator have compelled insurance companies to experiment with new distribution models through NGOs, MFIs and the rural banking network.
• Adviceless selling. Micro-insurance is sold overwhelmingly without advice while the higher end of the insurance market is served by brokers providing advice. Micro-insurance agents are specifically restricted to working with a single life and single non-life insurer.

Micro-Insurance In India:Trends And Strategies For Further Extension

In the IRDA's concept note on micro-insurance there is no provision thatexplicitly calls for allowing flexibility in premium collection which is necessary forextending the reach of micro-insurance. Although some micro-insurance products allow for half-yearly, quarterly and even monthly payment of premium, most products whether life or non-life require single, yearly payment of premium upon subscription. This can be a serious drawback in extending the reach of insurance to the low-income people, especially in rural areas. Often nodal agencies adopt several methods to facilitate premium collection. These methods may take the form of soft loans for paying premium, collecting premium in kind, collecting smaller amounts but more frequently, having insurance contract of shorter durations and so forth.

Rural incomes display seasonality. Moreover, for the low income people premiumConstitutes a significant proportion of their income. Therefore, flexibility in premium

Collection has a bearing on their joining or not joining an insurance scheme, and hence, on the membership size. The cash flow varies for different categories ofworkers. For example, the cash flows in case of farmers would depend on the number of crop cycles in a year as well as on the timings of harvest whereas a self-employed household worker may have a more stable income stream. Therefore, synchronizing premium collection with the harvest time is necessary for farmers whereas for self employedhousehold workers paying premium in small but regular instalments may be easier.

2. OBJECTIVE 1- CURRENT SCENARIO

2.1 Why We Need Micro-insurance?

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. The remaining health expenditure is covered privately and 86.4% of this expenditure is met through households' out of pocket payments. On average,65-68% of Indian households spend INR39-63 (USD0.80 – 1.28) per capita, every month on health expenditure. In a country where more than half the population lives on less than USD 2 per 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.These statistics highlight the need for voluntary as well as state sponsored health insurance schemes in India.

2.2 Potential Market

90%of the Indian population and 88%4 of the Indian workforce (the majority of which is the unorganised sector) are still excluded from any kind ofinsurance 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 India5. 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.

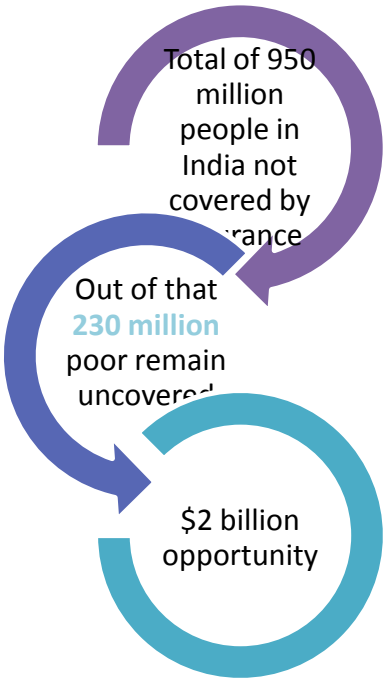


Figure 2.1

2.3 Categories of Products

1. -Life
2. -Asset
3. -Health
4. -Crop
5. –Livestock

2.4 Product Guidelines

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.

Table No – 2.1

LIFE INSURANCE	NON- LIFE INSURANCE
Health Insurance (Individual/family) Amount of cover – INR 5000-30000 Term – 1-7 years Age Bracket- Insurer's discretion	**Health Insurance (Individual/family)** Amount of cover – INR 5000-30000 Term – 1year Age Bracket- Insurer's discretion
Accident Benefit Rider Amount of cover – INR 10000-50000 Term – 5-15 years Age Bracket- 18-60 years	**Personal accident (per life/ earning member of family)** Amount of cover – INR 10000-50000 Term – 1year Age Bracket- 5-70 years
Endowment Insurance Amount of cover – INR 5000-30000 Term – 5-15 years Age Bracket- 18-60 years	**Dwelling or contents/Livestock** /Tools/Assets/Crop Insurance Amount of cover – INR 5000-30000 per asset cover Term – 1year Age Bracket – NA
Term(with or without return of premium) Amount of Cover – INR 5000- 50000 Term – 5-15 years Age Bracket- 18-60 years	

2.5 Key Stakeholders

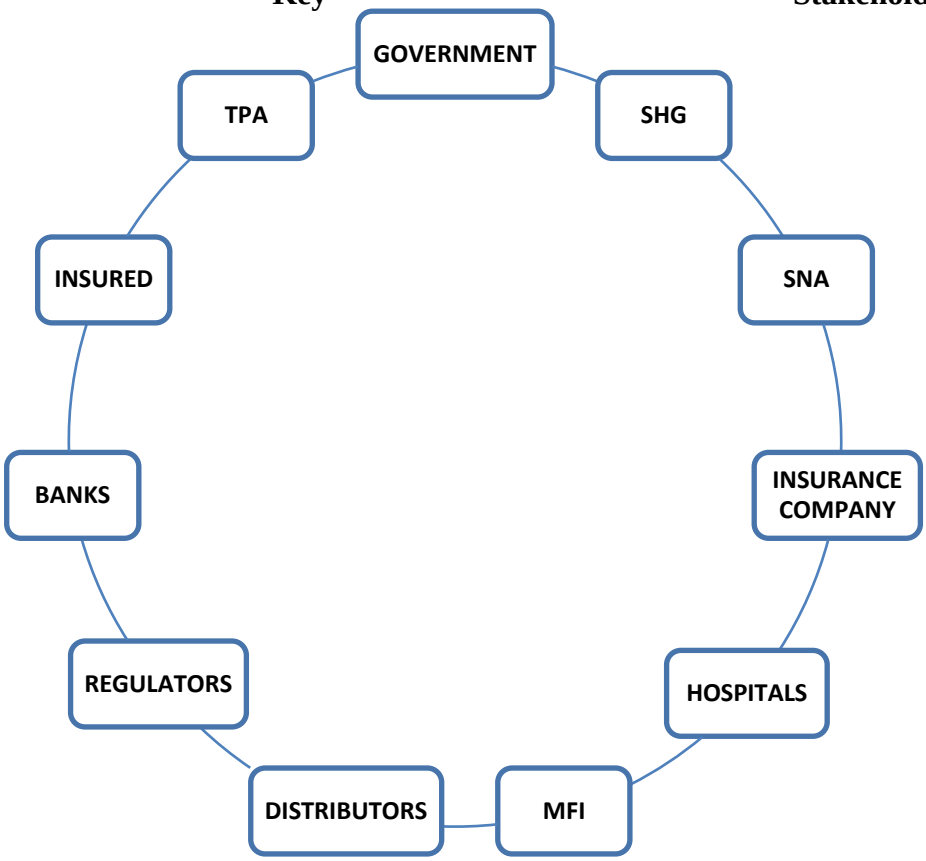


Figure No- 2.2

Stakeholder's Concern

Table No 2.2

Regulator	Client Protection, AML/CFT
Insurer, Banks	Business potential, Portfolio quality, Brand sanctity
Agents	Earning potential, extra effort
Clients	Convenience, trust, needs fulfilment

Distributors

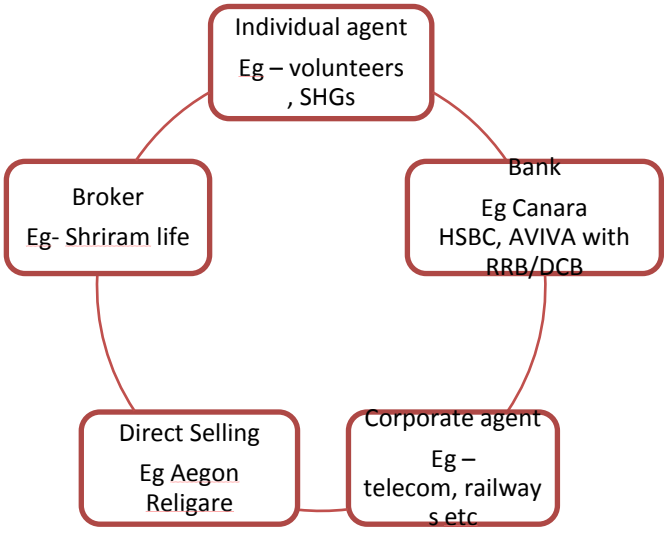


Figure No- 2.3

2.6 MICROINSURANCE MODEL

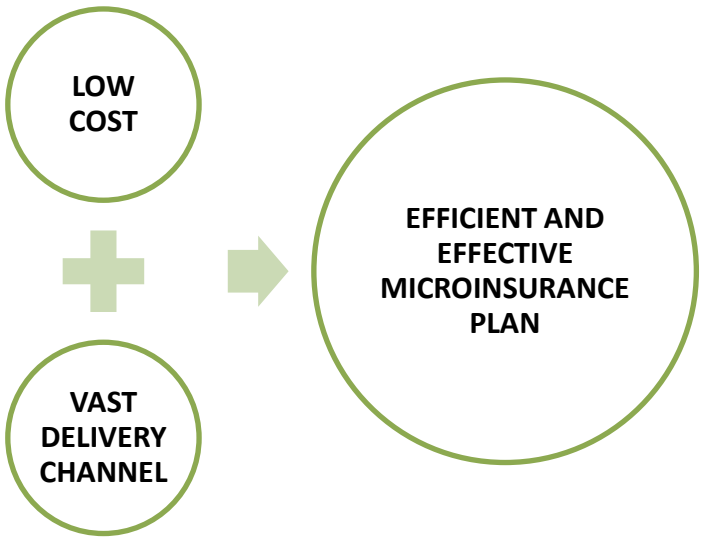


Figure No- 2.4

2.7 TYPES OF HEALTH MICROINSURANCE MODEL

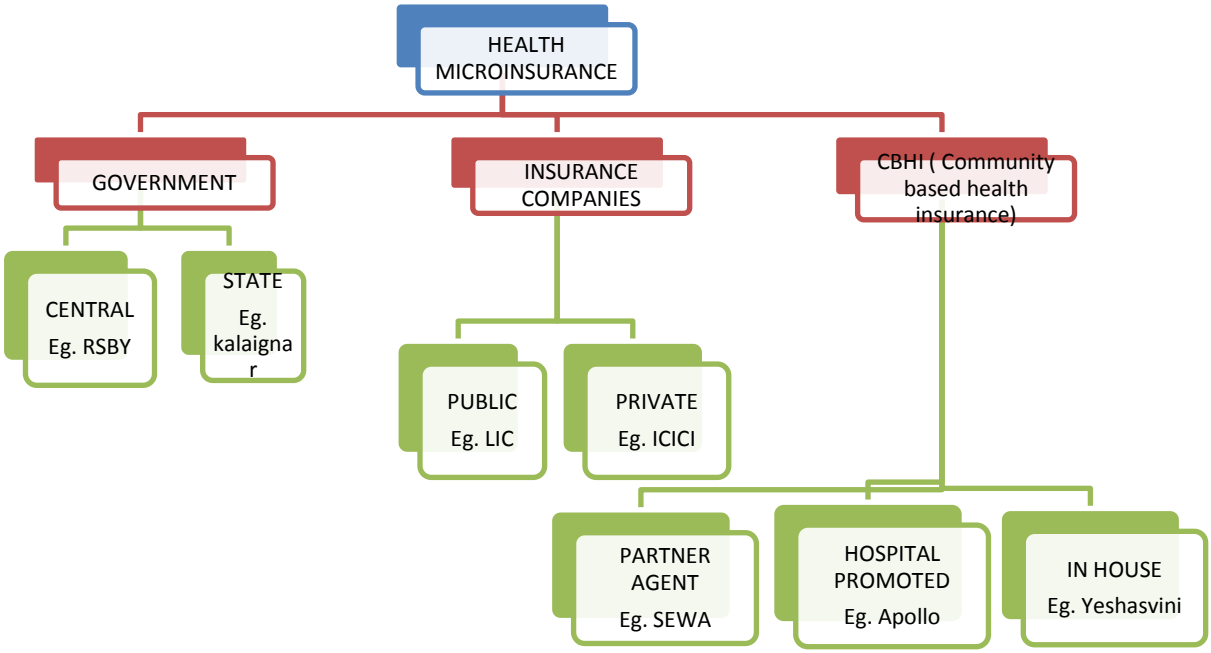


Figure No-2.5

2.8 PUBLIC AND PRIVATE INSURERS

Table No – 2.3

PUBLIC INSURANCE COMPANIES	PRIVATE INSURANCE COMPANIES
1) Life insurance corporation (LIC) 2) United India Insurance Company- 3) The New India assurance Company limited GIC 4) National Insurance Company 5) The oriental insurance company limited	1) ICICI Prudential Life Insurance 2) Bajaj Allianz Life Insurance 3) AVIVA life insurance 4) Birla sunlife insurance 5) HDFC standard life insurance 6) Sahara life insurance 7) SBI Life insurance 8) Tata-AIG Life insurance 9) Shriram insurance 10)Kotak life insurance 11)IFFCO- Tokio general insurance 12)ICICI Lombard general insurance 13)HDFC ergo general insurance 14)Cholamandalamgeneralinsurance 15)canarahsbc oriental insurance 16)DHFL prameria insurance 17)Edelweiss tokio life insurance 18)IDBFI life insurance 19) PNB metlife insurance

PRODUCTS OFFERED:-

Table No – 2.4

THE NEW INDIA ASSURANCE CO LTD	UNITED INDIA INSURANCE COMPANY LTD
• Agricultural Pump Set Insurance Scheme • Animal Driven Cart Insurance Scheme • Bhagyashree Child Welfare Scheme • Camel Insurance • Cattle Insurance • Composite Package For Tribal • Comprehensive Floriculture Insurance • Dog Insurance • Duck Insurance Scheme • Elephant Insurance • Farmer Package Policy • Gramin Personal Accident Policy • Gobar Gas Insurance Scheme • Honey Bee Insurance • Horticulture/Plantation Insurance • Horse/Pony/Mule/Donkey Insurance • Hut Insurance • Inland Fish Insurance Scheme • Janata Personal Accident Insurance • Lift Irrigation Insurance • Pedal Cycle Insurance • Pig Insurance Scheme • Poultry Insurance Scheme • Rabbit Insurance • Raja RajeshwariMahilaKalyan Yojana • Silkworm Insurance Scheme • Sheep And Goat Insurance • Zoo And Circus Animal Insurance Scheme	• agricultural pump set policy • animal driven cart insurance scheme • bhagyashree child welfare scheme • bio gas plant insurance • cattle and livestock insurance • dairy package policy • farmer package policy • floriculture insurance • gramin accident policy • honey bee insurance • hut insurance • janarogyabima policy • janatha personal accident insurance • kissan credit card • mother teresa women and children policy • package policies • raja rajeshwarimahilakalyan yojana • rural accident policy • rural women’s package policy • sericulture insurance • swathyabima policy • travel policies • tribal/ rural accident policy package • uni micro insurance policy • universal health insurance scheme

LIFE INSURANCE CORPORATION	NATIONAL INSURANCE	ORIENTAL INSURANCE
New jeevanmangal Bhagyalakshmi plan MadhurJeevan	New janta personal accident New graminsuswathya policy New graminsuraksha policy	Janta personal accident Products By Private Insurers

Products By Private Insurers

ICICI PRUDENTIAL LIFE INSURANCE	BAJAJ ALLIANZ LIFE INSURANCE	AVIVA LIFE INSURANCE
Anmol bachat Sarvjanasuraksha	BimaDhan Suraksha Yojana	Jana Suraksha Credit Suraksha Credit plus Group life protect NayiGrameen Suraksha

BIRLA SUNLIFE INSURANCE	HDFC STANDARD LIFE INSURANCE	SAHARA INDIA LIFE INSURANCE
Grameen Jeevan raksha plan Bimakavach yojana Bimadhansanchay Bimasuraksha super	Sarvgrameenbachat yojana	Sahara surakshitpariwarjeevanbima

SBI LIFE INSURANCE	TATA AIA LIFE INSURANCE	SHRIRAM LIFE INSURANCE
Grameenshakti Grameen super suraksha Grameenbima	Navkalyan yojana Saatsaath	Shri sahay (AP) Shri sahay (SP) Shriramgrameenasuraksha

KOTAK LIFE INSURANCE	IFFCO-TOKIO GENERAL INSURANCE	ICICI LOMBARD GENERAL INSURANCE
Kotak sampoornabima Kotak graminbima yojana	Jan surakshabima Pashudhanbima yojana	Health insurance J&K gov employee group mediclaim Weather insurance

HDFC ERGO GENERAL INSURANCE	CHOLAMANDALAM GENERAL INSURANCE	CANARA HSBC ORIENTAL BANK OF COMMERCE LIFE INSURANCE COMPANY LTD
Cattle insurance rainfall index insurance	Products in each category-health, personal accident, critical illness, asset, micro, combos, weather and cattle insurance	Sampoornakavach plan

DHFL PRAMERIA LIFE INSURANCE	EDELWEISS TOKIO LIFE INSURANCE	IDBI FEDERAL LIFE INSURANCE
DHFL Prameriasarvsuraksha	Edelweiss Tokio Life-Dhanniveshbima yojana (indi)Dhanniveshbima yojana	Group microinsurance plan Sampoornasuraksha

PNB METLIFE INSURANCE
Metlifebachatyojna Metlifebhavishya plus Metlifegrameenashray

CBHIs

Table No – 2.5

1) People's solidarity association (PSA)	
2) Cashpor financial and technical services limited(CFTS)	12)raigarhambikapur health association(RAHA)
3) Grameen development services(GDS)	13) Mayapur trust/ srimayapurvikas sangha(SMVS)
3) Bharathi integrated rural development society(BIRDS)	14) Apollo hospitals
4) Bridge foundation (TBF)	15) Kasturba hospital
5) Swayamkrushi/youth charitable organisation(YCO)	16)Voluntary Health services (VHS)
6) Sanghamitra	17) Mathadi hospital trust
7) South indian federation of fishermen society	18) Students health home (SHH)
8) kagadkachpatrakashtakari panchayat/ waste picker union	19) Tribhuvandas foundation/ Annual diary cooperative
9) cooperative development foundation (CDF)	20) Health programme aga khan health services (AKHS)
10) Indo-dutch project management services(IDPMS)	21) Mallur health cooperative
11) Gandhi smakrkagramasevakendram(GSGSK)	22) Goalpara

23)Seba cooperative health society	34) Society for the promotion of Area Resources(SPARC)
24)Friends of women's world banking	35) Organization for development of people (ODP)
25)Self employed women's association (SEWA)	36) Activists for social alternatives (ASA)
26)Nidan	37) Action for community services society (ACTS)
27)League for education and development (LEAD)	38) Development of humane action foundation (DHAN)
28)Annapuranamahilamandal	39) Self help promotion for health and rural development (SHEPHERD)

29)Association for sarvasewa farms (ASSEFA)	40) Star youth association (STAR)
30)Trivandrum district fischermen's federation (TDFF)	41) Gram vikas
31)Basix	42) Spandana
32)Working women's forum (WWF)	43) Ankuram
33)Bandhan	44) Action for community organization, rehabilitation and development (ACCORD)

45)People 's rural education movement (PREM)	55)Indian Association for savings and credit (IASC)
46)Casp Plan Organization (CPO)	56)ndore financial services for the poor project (IFSP)
47)Yeshasvini	57)Swayamkrishisangam (SKS)
48)Community heath insurance	58)Baif development research foundation (BAIF)
49)Anthyodaya health promotion scheme (AHPS)	59)Sabuj sangha
50)South asia research society	60)Emmanuel hospital association (EHA)
51)Professional assistance for development action (PRADAN)	61)Cashe innovations fund
52)Society for helping awakening rural poor through education (SHARE)	62)Livestock insurance scheme – Central Government
53)Pradhanmantrijeevanjyoti yojana	63) Atal pension scheme
54)Pradhanmantrisurakshabima yojana ??	64)Pradhanmantrijandhan yojana
65) Pradhanmantrifasalbima yojana	

TOTAL PRODUCTS IN MARKET18

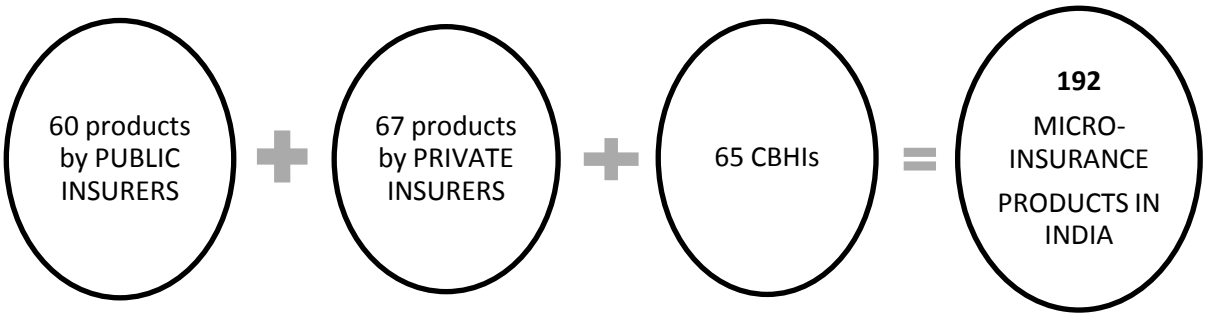


Figure No – 2.6

The figure 2.7 depicts the split of private and public Microinsurance policies in India. The graph shows that out of 3.65 million policies sold approximately 5 lakh policies were private ones rest belonged to public category, indicating the dominance of public sector in Microinsurance.

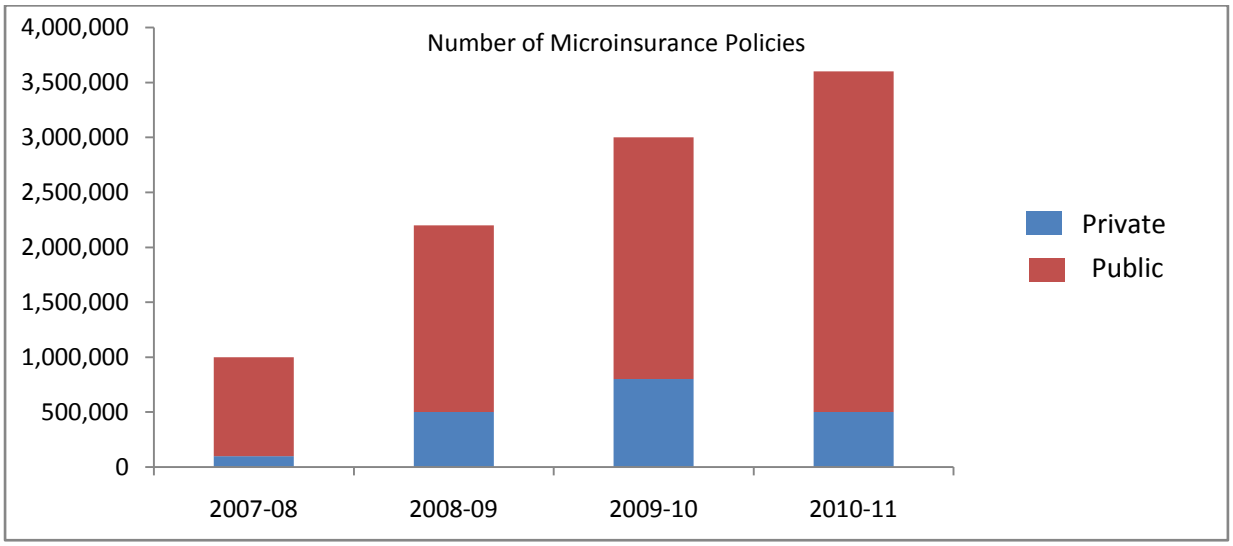


Figure No.- 2.7 Source Microsave analysis

As already established, Figure 2.8 shares Microinsurance market is dominated by public Insurers. Below figure clearly depicts the Market share of LIC in different segments. Dominance of LIC in Microinsurance market is clearly visible. Brand value and trust among customers being the two winning factors for LIC.

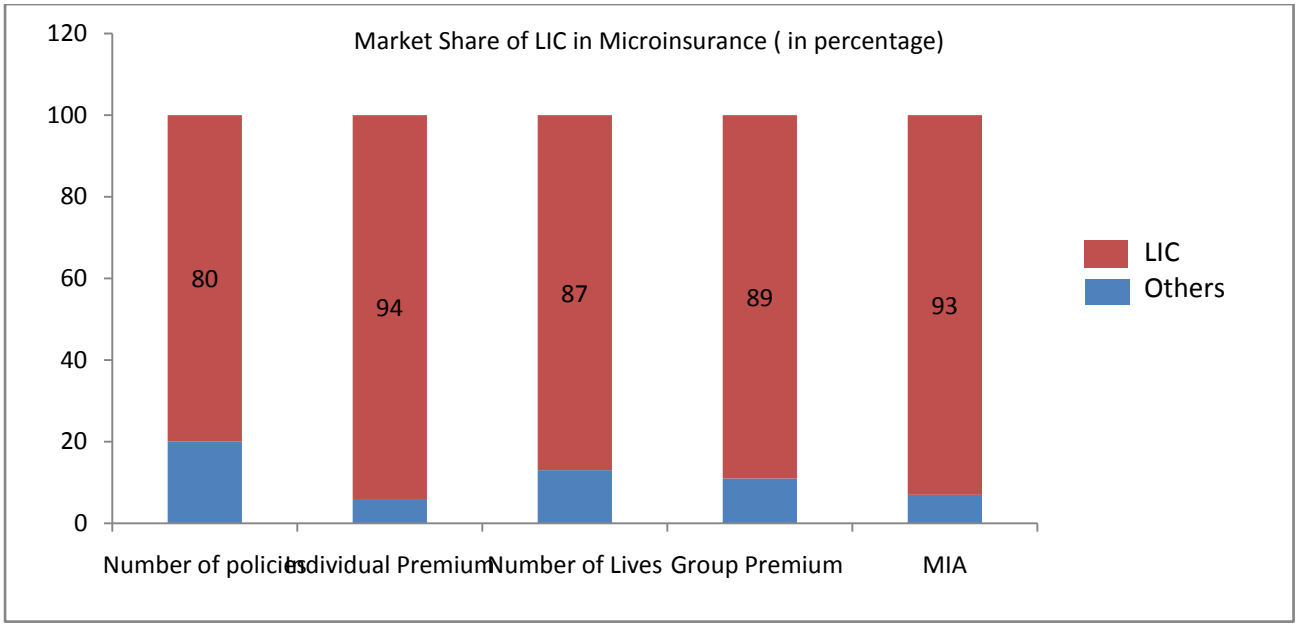


Figure2.8 source – Munich Re

The State of the Microcredit Summit Campaign Report 2011shows that there are a little more than 93 million microfinance clients in India. This represents (close to one-half)of the estimated 205 million microfinance clients reached worldwide (Reed, 2011).

Most schemes (74%) operate in 4 southern states of India:-

- Andhra Pradesh (27%)
- Tamil Nadu (23%),
- Karnataka (17%)
- Kerala (8%)

In the northern and north eastern parts of the country, where poverty is the most pervasive, growth of SHGs has been slow. The Multidimensional Poverty Index estimates that about 54 percent of India's population lives in poverty, with large variations from state to state. For example while only 10 percent of the population in Kerala lives in poverty, over 81 percent of Bihar's people are poor.

Government Schemes

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 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, also shown in figure 2.9

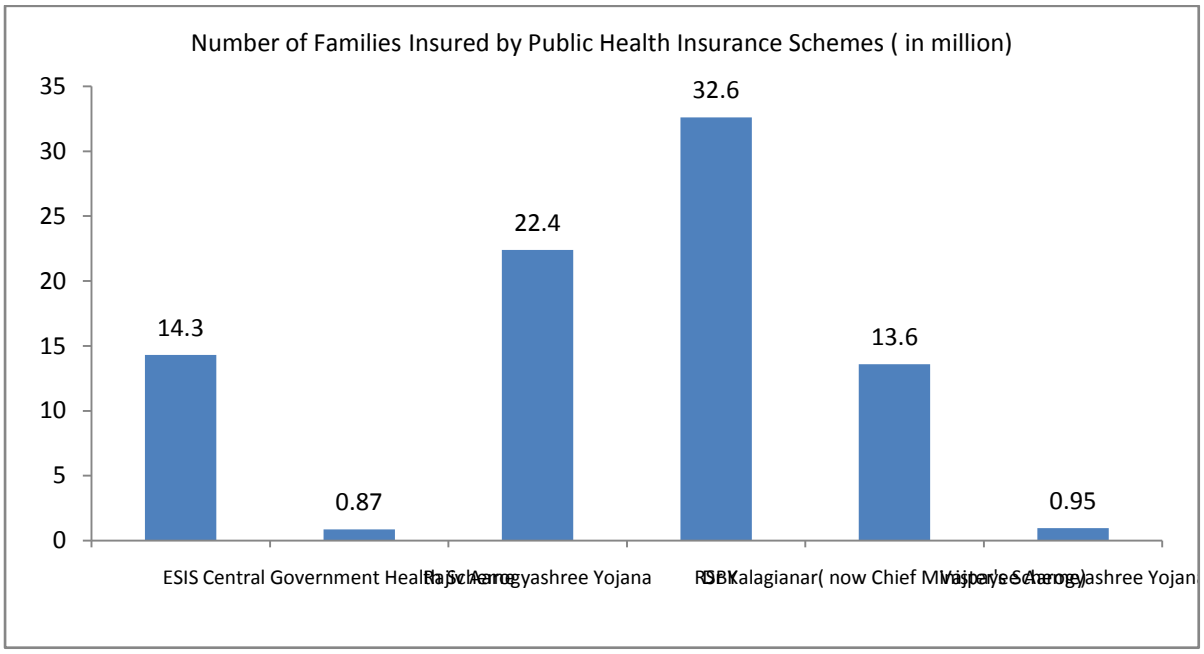


Figure 2.9 Source- Microensure

Towering among the central government schemes is the fully subsidised *RashtriyaSwasthya 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 povertyline— and it has covered more than 32 million families so far.
The newly emerging publicschemes depend mainly on private hospitals. Majority 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.

CBHIs

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 anoutreach of less than 50,000.

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 to launch health microinsurance schemes. As noted above, Andhra Pradesh (*Rajiv ArogyashreeYojana* 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 (*AapkaSwasthyaBima Yojana*) and Gujarat (*MukhyamantriAmrutam Yojana*) are also launching their own health insurance schemes, and other states have gone on study missions to the South.

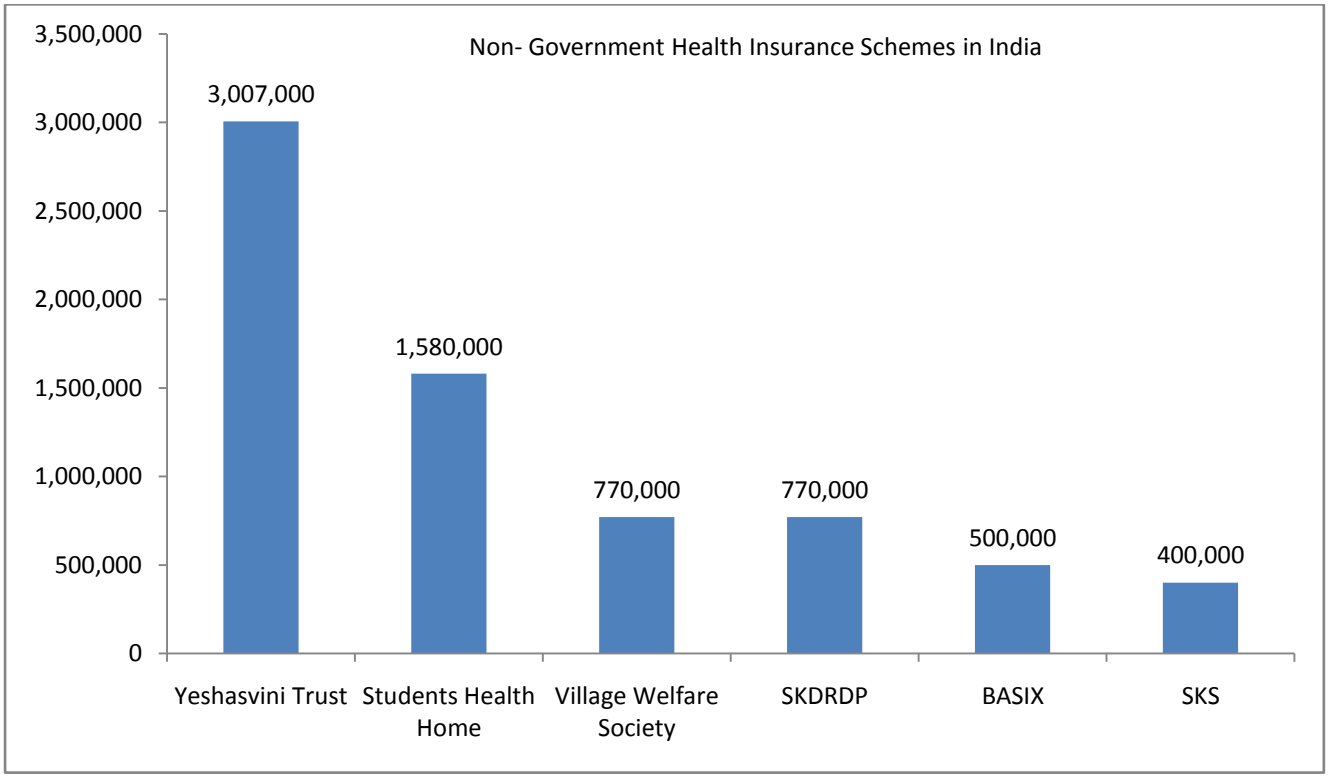


Figure 2.10 Source munich re

Approximately 70% of insured members of all CBHIs are women. Figure 2.11 show 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)

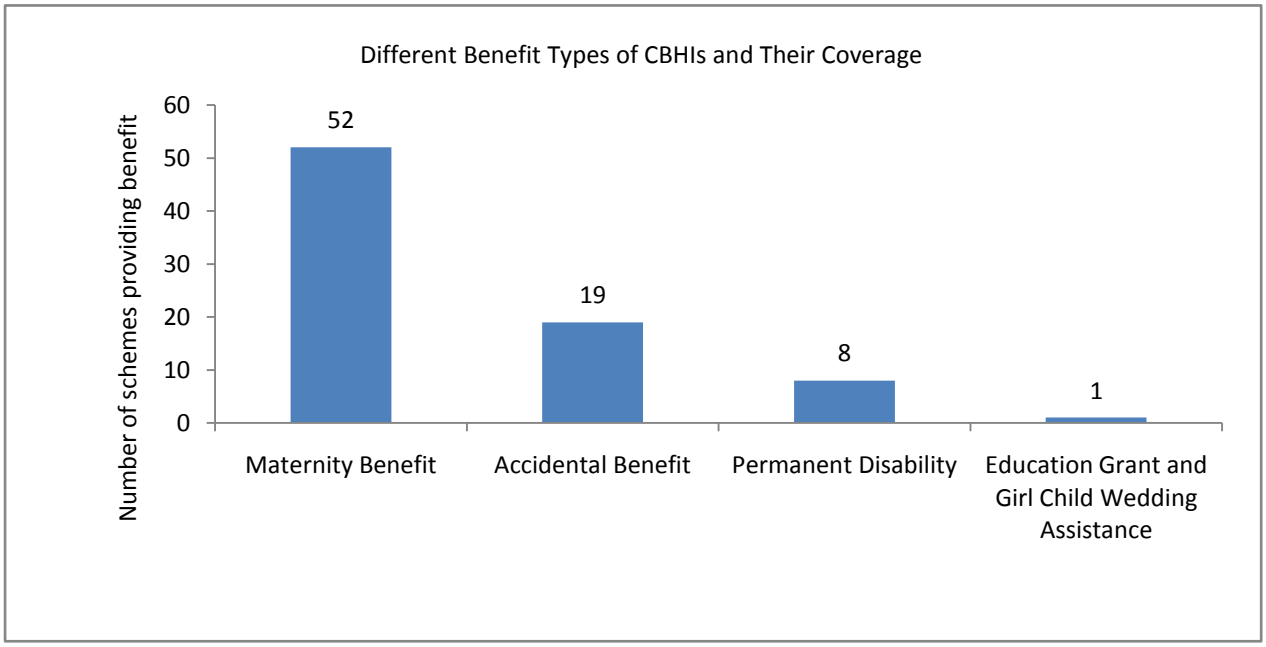


Figure 2.11 source microsave analysis

Table No – 2.6

Additional Benefits	**CBHI Example**
Health Camps for Primary Health Care and Promotion	Mahasemam Trust, New Life, Samskar, SHEPHERD,BISWA,Vaatsalya Healthcare
Health Education Programme	ACCORD, Chaitanya, ArogyaRaksha Yojana, Shatt Dhan, SevaMandir, Asha Kiran Society
Discounted Medicine	ArogyaRaksha Yojana, Karuna Trust, PREM
Mobile Health Clinic	Nandi Foundation, Skap, Uplift Mutual, Seba Cooperative Health Society,Welfare Service Ernakulam
Community Health Workers	Atodaya, DHAN Foundation, Kasturba Hospital, Mayapur Trust, Mallur Health Cooperative
Compensation for Loss of Wage	Basix, Buldana Urban Cooperative Society,DHAN Foundation, GrameenKoota, SKDRDP, MandeshiMahilaSahakari Bank

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 *JowarArogya Yojana* of Kasturba Hospital, for example, premium is taken in the form of millet during the harvest season. Similarly, in RaigarhAmbikapur 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

Table No – 2.7

Model of Premium Funding	**CBHI Example**
Pay upfront premium to insurer from own fund and appropriate it through a series of regular payments	SHEPHERD, Organisation for Development of People, Solapur Cooperative Federation, Bihar Milk Cooperative Federation, Mahasemam Trust
Provide soft loan to clients for funding their premium	SKS, Village Welfare Society, Basix, BISWA, OASIS, PREM, Pragati, GrameenKoota, Uplift Mutual, RUHSA, Buldana Credit Cooperative Society, Karuna Trust
Use SHG saving as insurance premium	SHADE, SKDRDP, SPARC, GSGSKK, DHAN Foundation, MandeshiMahilaSahakari Bank

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.

As shown in figure 2.12 of all CBHI schemes, majority now use the partner-agent model. These schemes cover 4.7 million people. In the partner-agent model, the CBHImainly plays the role of a distributor for the insurer.

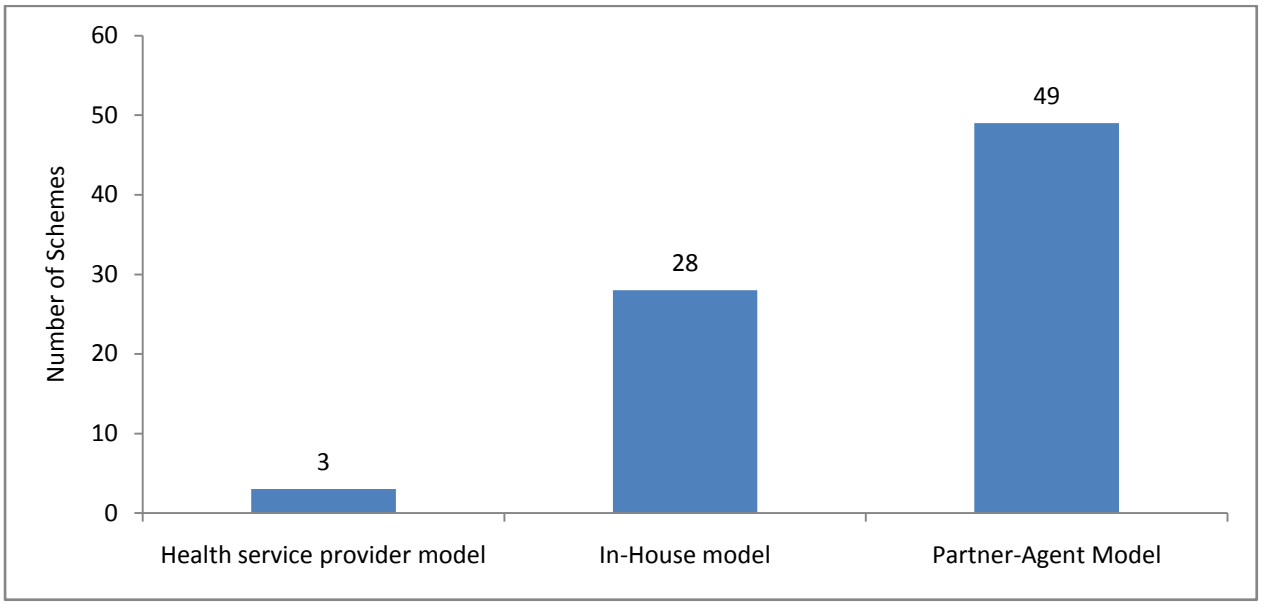


Figure No- 2.12source microsave analysis

Benefits

- The schemes reduce burden of hiring long term government employees by outsourcing.The insurance risk of some of the schemes is carried by insurance companiesand 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. Kaliagnar (now Chief Minister's) schemes, clients are issued biometric smart cards which are portable across service providers. The claims processing back-end has also been smoothened by integrated MIS in these schemes.

Threats

- As more individuals become aware of access to hospital services under pubic schemes, one might expect enrolments and consequently claims ratios to increase. The claims ratio may become too high for insurers to operate the scheme without making losses.

- Since the government schemes are virtually free for clients with no co-payment, moralhazard is a risk.

OBJECTIVE-2

2.11 COMPARISON OF MAJOR INSURANCE MODELS

Table No- 2.6

	YESHASVINI TRUST	STUDENT HEALTH HOME	VILLAGE WELFARE SOCIETY
KEY FEATURES	Easy payment mechanism Additional benefits/discounts improvement in terms of access and quality direct subsidy		Addresses all the key issues related to poverty
START YEAR	2002	1952	1982
STATE	KARNATAKA	WEST BENGAL	WEST BENGAL
SCHEME TYPE	IN HOUSE	IN HOUSE	IN HOUSE
AREA OF INTEREST	RURAL	RURAL/URBAN	RURAL
RISK COVERED	HEALTHCARE	HEALTHCARE	ALL
PREMIUM SIZE (Rs)	130	-	-
MAXIMUM COVER (Rs)	2,00,000	-	-

	SKDRDP	BASIX	SKS
KEY FEATURE	Use SHG savings as insurance premium , compensation for loss of wage	Provide soft loans to clients for funding their premium , compensation for loss of wage	Provide soft loans to clients for funding their premium
START YEAR	2002	2001	1998
STATE	KARNATAKA	INDIA	KARNATAKA
SCHEME TYPE	Partner agent	Partner agent	Partner agent
AREA OF INTEREST	RURAL	RURAL	RURAL
RISK COVERED	HEALTHCARE	ALL	LIFE
PREMIUM SIZE (Rs)	190-1225 per person depending on no of family members, 650 for 5 family members	-	-
MAXIMUM COVER (Rs)	2,00,000	-	-
TIE UPs	ICICI lombard for hospitalisation cover only	AVIVA-credit life , ICICI Lombard-weather, Royal Sundaram- enterprise & livestock	Bajaj Allianz and banks

GOVERNMENT SCHEMES MODEL

	RSBY	**RAJIV AAROGYASHREE YOJANA**
KEY FEATURE	Includes almost all health conditions and pre-existing conditions too , smart cards @ Rs 30	Health for all initiative by state gov, cashless transactions , private and public hospitals
START YEAR	2008	2007
STATE	INDIA	ANDHRA PRADESH
AREA OF INTEREST	RURAL	RURAL
RISK COVERED	HEALTHCARE	HEALTHCARE
PREMIUM SIZE (Rs)	130	210
MAXIMUM COVER (Rs)	30,000	2,00,000

	CHIEF MINISTER'S SCHEME	VAJPAYEE AAROGYASHREE SCHEME	CENTRAL GOV HEALTH SCHEME
KEY FEATURE	State gov scheme along with United India insurance scheme for families below annual income of Rs 72,000	Health for all initiative by state gov, cashless transactions	Medical facilities to central gov employees, pensioners and their dependents, dispensaries are backbone
START YEAR	2002	2007	1954
STATE	TAMIL NADU	KARNATAKA	INDIA
AREA OF INTEREST	RURAL	RURAL	URBAN/RURAL
RISK COVERED	HEALTHCARE	HEALTHCARE	HEALTHCARE
PREMIUM SIZE (Rs)	-	-	-
MAXIMUM COVER (Rs)	1,50,000	2,00,000	5,00,000

PUBLIC AND PRIVATE INSURER MODELS

	JEEVAN MADHUR BY LIC	icici prudential life sarv jana suraksha	BAJAJ ALLIANZ SWAYAM SHAKTI SURAKSHA
KEY FEATURE	Standalone micro-insurance product, year on year growth rate of48.67%,		Covered 1.7 million lives in 10 months
TYPE	Endowment Plan	term plan	term plan
SCOPE	Simple savings related life insurance plan	Non linked , nonparticipating	life insurance
BENEFICIARY	18- 60 years	18-55	
RISK	30,000	50,000	5000
KEY BENEFITS	Death and disability, auto cover, paid up value, surrendervalue	Death	Life, accidental death and disability benefits
MIA	MFIs, SHGs and NGO	-	SKS

	NEW INDIA – BHAGYALAKSHMI CHILD WELFARE POLICY	**ICICI LOMBARD FAMILY HEALTH FLOATER**
KEY FEATURE	One girl child, 24 hour risk basis, group discount	Any member of the family can claim up to Sum Insured, any number of times during the policy period.
TYPE	Endowment Plan	term plan
SCOPE	Accidental death cover	health cover
BENEFICIARY	0-18 years	91 days to 60 years
RISK	25,000	
KEY BENEFITS	ONE girl child in a family who loses either the father or the mother due to accidental death	cashless hospitalization , Reimbursement
MIA	MFIs, SHGs and NGO	MFIs

ASSET INSURANCE MODEL

Table No-2.7

AGRICULTURE PUMP SET INSURANCE- NEW INDIA ASSURANCE CO LTD
Cover for Centrifugal PumpSets(Electrical and Diesel/Oil) and submersible pump sets used for agricultural purposes only. It includes Pump, Driving Unit and Starter.
1-9 years
Mechanical/Electrical Breakdown\ Fire and Lightning Theft and Burglary Riot, Strikes, Malicious Damage and Terrorism Flood (on payment of extra premium @2% of Sum insured, 1% of Sum Insured in Submersible Pump set).
Long term discount
100% of Market Value at the time of issuance of cover or present replacement value for Submersible Pump sets

LIVESTOCK INSURANCE MODEL

Table No- 2.8

CATTLE INSURANCE BY THE NEW INDIA ASSURANCE CO LTD	**HDFC ERGO INSURANCE CO LTD**
Accident , Diseases contracted or occurring during the period of this policy. Surgical Operations, Riot and Strike.	Death and disability cover
Veterinarian's Report. photograph, Veterinary Health Certificate	Sex and health verified by veterinary doctor, photograph
Based on benefits purchased	Based on benefits purchased

CROP INSURANCE

Table No- 2.9

INDEX BASED	**PRADHANMANTRI FASAL BIMA YOJANA**
BASIX and ICICI Lombard	Multiple agencies are involved
Parameters – rainfall, soil moisture, temperature	Area approach basis
Started in 2003	
Advantages- reduces moral hazard, adverse selection, administrative costs,	Sum assured depends on the threshold yield and minimum support price

CENTRAL GOVERNMENT SCHEME MODELS

Table No- 2.10

PRADHANMANTRI JEEVAN JYOTI BIMA YOJANA (PMJJBY)	**PRADHANMANTRI JAN DHAN YOJANA (PMJDY- Life cover with LIC)**
Government-backed Life insurance scheme in India	Financial Inclusion in an affordable manner, 1.5 Crore (15 million) bank accounts were opened under this scheme
For 18-50 years of age with bank accounts	
It has an annual premium of Rs330 (US$4.90) excluding service tax, which is above 14% of the premium	Basic Banking Accounts" with overdraft facility of 5,000 after s6 months and RuPay Debit card with inbuilt accident insurance cover of 100000, RuPayKisan Card
Sum assured – Rs 2,00,000	-

PRADHAN MANTRI SURAKSHA BIMA YOJANA	ATAL PENSION YOJANA
Government-backed accident insurance scheme in india	Government-backed pension scheme in india targeted at the unorganised sector
For 18 and 70 years of age with bank accounts	For 18-40 years
Annual premium of rs 12 (18¢ US) excluding service tax, which is about 14% of the premium	For every contribution made to the pension fund, the central government would also co-contribute 50% of the total contribution or rs 1,000 per annum, whichever is lower, to each eligible subscriber account, for A period of 5 years
Sum assured – rs 2,00,000/1,00,000	Subscribers are required to opt for A monthly pension from rs. 1000 - rs. 5000 and ensure payment of stipulated monthly contribution regularly

OBJECTIVE-3

3.1 CHALLENGES

1) UNINSURED TARGET SEGMENT

- Low product awareness
- Aversion to purchase an intangible asset
- perception of insufficient benefit
- product not suitable for specific strata
- time required to claim settlement too long as compared to urgency
- lack of trust

2) DISTRIBUTION CHANNEL

- population spread over a large area
- lack of sufficient incentives to cover operation costs
- lack of understanding of product fitment to customer needs
- risk of losing respect if a claim isn't honoured

3) INSURANCE COMPANY

- high transaction cost
- poor documentation
- largely un- banked target customers
- high distribution and transaction expenses
- limited infrastructure
- low renewal rate
- coverage limited to fulfilment

3.2 GAPS IN DEMAND AND SUPPLY

1. Irregular coverage only 10 percent of the population in Kerala lives in poverty, over 81 percentof Bihar's people are poor. Most of work done in southern part of India.
2. MFIs in survey indicated that maternal care and childhood illnesses were two of thehighest priorities, followed by malnutrition, HIV/AIDS, and hygiene sanitation. Not many policies designed for these illnesses.
3. Most of the health insurance products specifically exclude deliveries and other pregnancy-related illnesses. Most of these products also mention amongst their exclusion clauses,HIV/AIDS.
4. Few innovations in various distribution channels.
5. Less involvement of the private players.
6. Less PPP models with wide outreach currently working in India.
7. Segregation of life and non-life insurance products.
8. Lack of valid database
9. Less involvement of public hospitals in providing healthcare under Microinsurance
10. Less number of government schemes working in this area.

3.3STRATEGIES AHEAD

1) More products need to be designed for the northern and north-eastern states of India, along with awareness drives towards Microinsurance

2) Policies need to be designed according to the changing needs of the community.

3) Innovative distribution models of Microinsurance are required to increase the outreach of Microinsurance among rural people.

4) Innovative measures need to be taken to motivate the private players to get involved. Eg- some form of government benefits- tax deductions, recognition , rewards etc.

5) Designing the policies which include both life and non-life insurance products, as their demand will be more due to wider coverage.

6) More involvement of public hospitals in providing treatment under Microinsurance by improving the facilities, infrastructure, healthcare provided by them.

7) More government schemes like RSBY need to be established as they have wider coverage.

8) Designing policies based on cost structure of benefits that the group wants to receive rather than focused on what people say they can pay.

9) Collection of database to improve evidence based decision making.

10) Working on providing credit linked and loan linked Microinsurance products.

3.4 **CONCLUSION**

Microinsurance is definitely an answer to improving the penetration of Microinsurance in India as 90% of the Indian population majority of which belongs to unorganised sector is uncovered by any kind of insurance or pension plan. Also it can be an effective poverty reduction strategy.

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 lowincome 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.

The landscape of health micro-insurance is changing fast. Coexistence of small initiatives and large government plans has expanded its coverage. Formalisation of CBHIs with private insurers has improved their efficiency. It's important to leverage technology to reduce cost without undermining cover. Innovation is the key along with that correctly identifying needs of the poor at a given location, promotion and education, partnering with MFIs and local authority can also be of great help.

BEST FORM OF MARKET EDUCATION IS A GOOD PRODUCT WITH CLAIMS PAID EFFICIENTLY.

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