access to insurance initiative

Making insurance markets work for the poor:
microinsurance policy, regulation and supervision

Indian case study

BILL & MELINDA GATES foundation

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This document presents the findings from the Indian component of a five-country case study on the role of regulation in the development of microinsurance markets. The objectives of this project were to map the experience in a sample of five developing countries (Colombia, India, the Philippines, South Africa and Uganda) where microinsurance products have evolved and to consider the influence that policy, regulation and supervision on the development of these markets. From this evidence base, cross-country lessons were extracted that seek to offer guidance to policymakers, regulators and supervisors who are looking to support the development of microinsurance in their jurisdiction. It must be emphasized that these findings do not provide an easy recipe for developing microinsurance but only identifies some of the key issues that need to be considered. In fact, the findings emphasize the need for a comprehensive approach informed by and tailored to domestic conditions and adjusted continuously as the environment evolves.

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Table of Contents

List of figures

List of tables

List of boxes

Executive Summary

The sheer scale of the Indian low-income market creates enormous scope and need for microinsurance. Potential voluntary demand is strong, particularly for micro health cover. A strong political imperative exists for financial inclusion, resonating in regulation that mandates low-income market expansion, as well as a dedicated microinsurance space. Yet the actual extent of microinsurance penetration in India remains very small. The legacy of a state-owned insurance monopoly still looms large. Private insurers as well as the insurance regulatory authority are very new and have found it difficult to prioritise microinsurance in the face of other pressing concerns. The regulatory strategy to compel insurers to reach down-market has triggered some interest in the low-income market, but rarely beyond that required by law. Furthermore, general insurance regulation as well the specific provisions for microinsurance impose restrictions that contribute to the fact that microinsurance has achieved limited success thus far.

Context

With a population of around 1.1bn, India is the second-most populated country in the world. In recent years, strong GDP growth has been experienced. Yet poverty remains high, especially among the 70% of the population that resides in rural areas. Government nationalised the insurance industry in the 1950s and it was only liberalised in 1999 to allow private insurers. Since then insurance premiums have grown rapidly on the back of new entry. Yet the two state-owned insurers remain the largest insurers in the market. India is unique in that the government plays a proactive role in providing insurance to the very poor (those below the $1/per day threshold) through various social security programmes and subsidised insurance schemes. Therefore the microinsurance market in India should largely be regarded as the low-income population living on more than $1/day.

Regulatory framework for microinsurance

Microinsurance distribution space created. India is one of the first countries in the world to have introduced micro-insurance regulation. This comprises a product definition, based on which a category of microinsurance agents is then created for the distribution of microinsurance, subject to more favourable regulatory requirements, but limited to non-profit entities such as NGOs or self-help groups. The dedicated microinsurance space has therefore been limited to the distribution/market conduct side.

Impact of regulation on the market. As discussed in this report, this regulation has been welcomed as an innovative move to maximise insurance outreach. While the two years elapsed since the introduction of this measure are insufficient to reach a definitive conclusion on the long term impact of the regulation, initial experience and considered feedback from insurers, aggregators and others provides a sufficient understanding of the impact of the regulation to enable some analysis. Such an analysis has been undertaken in this report. The net result can be summarized based on the diagram below.

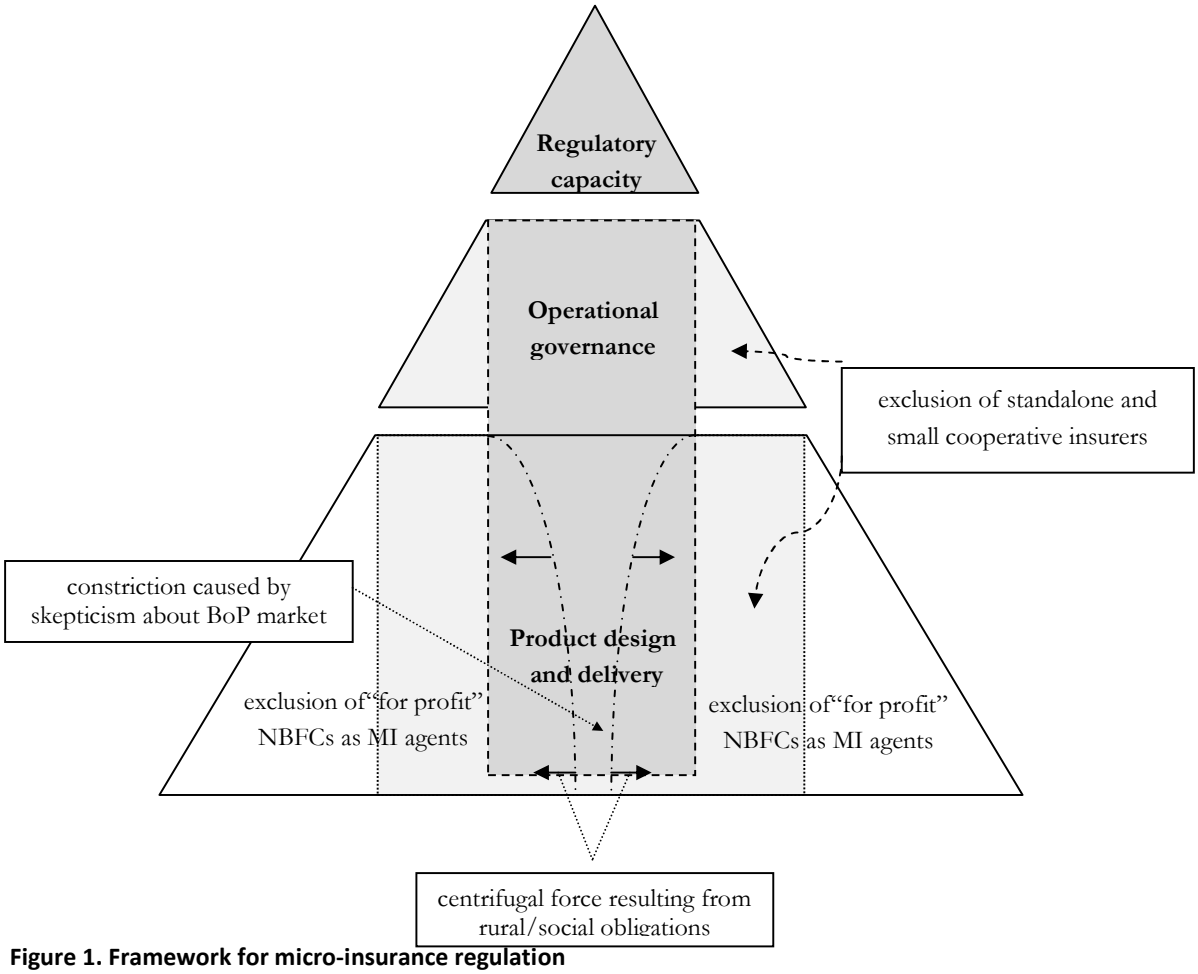

Figure 1. Framework for micro-insurance regulation

Note: Figure adapted from Finmark Trust/Genesis Analytics synthesis presentation.

No prudential space for microinsurance results in market restrictions. Conscious of the relatively recent experience of insurance regulation and the lack of its own capacity to implement a strong regulatory regime, the regulator – the Insurance Regulatory and Development Authority (IRDA) – has limited the scope within which micro-insurance may be offered (see dark shaded areas of the figure above). Since the regulator's capacity to supervise is limited, legal activities in the insurance (particularly micro-insurance) space have been restricted to the types of insurers that are deemed to have appropriate operational governance. These are corporate entities with substantial (>$25 million) capital investments to the exclusion of smaller, specialized, standalone insurers and also small cooperative insurers. These large companies do not have an intrinsic interest in the bottom of the pyramid market since they expect costs to be high and revenue volumes to be small. Thus, their inclination is to ignore micro-insurance, if possible. However, the rural and social obligations imposed by the regulator have forced these

companies to look seriously at the BoP market as a *quid pro quo* for being allowed to function in the commercial/urban insurance market.

Regulation not necessarily tailored to risk. Yet micro-insurance is defined as cover that (at $750) is actually less than the national GDP per capita for general insurance and 1.4 times GDP per capita for life insurance. Thus the actual level of risk for the insurer is relatively small. A more risk-based approach would enable strict governance requirements to substitute for close supervision and facilitate the expansion of the micro-insurance space to specialized standalone and cooperative insurers (thus covering the light shaded areas of the figure above). The recent decision to permit (not-for-profit) Section 25 companies to become micro-insurance agents has added to the potential for this space to expand but the actual appointment of such agents by insurers is constricted by extensive market conduct rules, especially commission caps, limitations on the number of insurers an agent can deal with and the central bank's restrictive approach that defines any amounts collected by MFIs on behalf of a client as deposits (that Section 25 companies are not allowed to take). And, "for profit" NBFCs remain excluded from this space despite their outreach to over 7 million microfinance clients who constitute a ready market for micro-insurance. As a result, considerable energy has been devoted by these MFIs (as aggregators of microinsurance clients) to the by-passing of the market conduct rules established by the regulator resulting in the delivery of the micro-insurance service at a higher cost than necessary.

Characteristics of the microinsurance market

The net result of this situation is illustrated in the picture of the micro-insurance market in India presented in Figure 2. The study team estimates that some 14 million adults are covered by life micro-insurance in India. In a country with some 120 million families living on less than $2 a day, this is a very small proportion of the potential micro-insurance market.

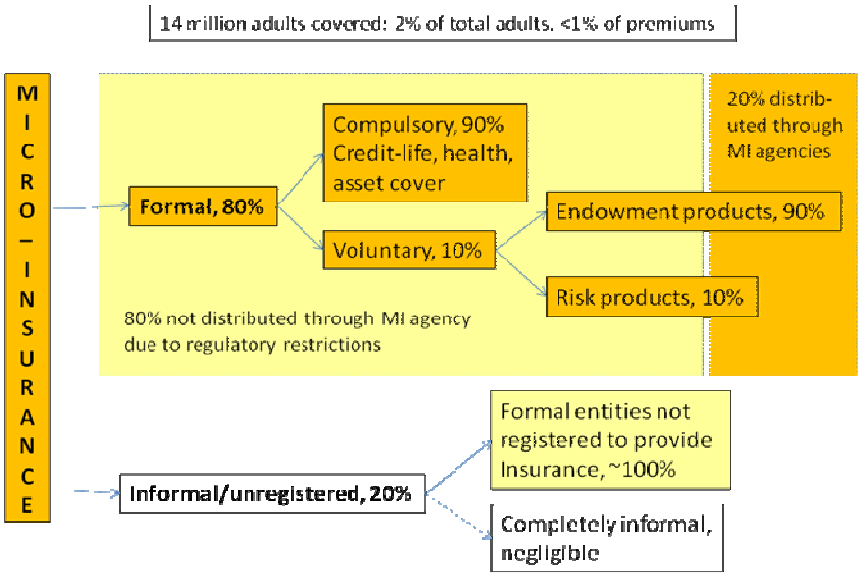

Figure 2. Coverage of micro-insurance in India

High share of compulsory products; low share of microinsurance agents in distribution. An overwhelming proportion of microinsurance in India is provided as compulsory credit-life insurance through aggregators such as MFIs, rural banks and cooperative banks. A significant amount of health cover is provided through MFIs and cooperative health insurers also but much of this cover occurs by default – by virtue of an individual being a member of, borrower from or other service user of the aggregator. Since aggregators are mainly institutions that are ineligible to become microinsurance agents, only a small proportion (20%) of micro-insurance in India is estimated to be distributed through agents with the remaining amount being sold through aggregators that earn service fees rather than commissions. The commission structure being controlled, even well known NGOs eligible to become microinsurance agents often decline to do so, preferring instead to negotiate (higher) service fees for enabling the sales of the insurer.

Endowment products dominate voluntary sales. Overall, voluntary life insurance is sold mainly as endowment products where the insured has the satisfaction of getting some money back at the end of the term rather than simply seeing the premium "consumed" by the insurance company if there is no occasion to make a claim.

Low informality. Even in the informal market, most of the cover provided is by registered NGOs or cooperatives (such as the Yeshasvini Trust in Karnataka) that run in-house insurance programmes. These programmes are usually facilitated or subsidized by the government or other donors and therefore have some form of official oversight. There are virtually no completely informal insurance programmes known to be operating in India.

Consumer awareness as restriction on market development. The overall size of the Indian micro-insurance market is restricted by a general lack of awareness of the benefits of insurance amongst the low income segments of the population. Given the high levels of vulnerability and the limitation of the government's nascent social protection schemes to the 60 million families living below the poverty line, there is a substantial role for awareness creation about insurance amongst the population. Awareness creation in India is a role for the regulator – who is also charged with developmental responsibilities – and who has the financial resources (but not yet the will) to use these resources boldly in the larger interests of the public. The regulator has generated supply-side interest in micro-insurance via a special set of regulations coupled with the rural sector obligation imposed on insurers. Combining this with creating demand-side interest in micro-insurance would go a long way in furthering the interests of economic inclusion and reducing vulnerability amongst large segments of the low income population.

1. Introduction

This document presents the findings from the Indian component of a five-country case study on the role of regulation in the development of microinsurance markets. The objectives of this project are to map the experience in a sample of five developing countries (Colombia, India, the Philippines, South Africa and Uganda) where microinsurance products have evolved and to consider the influence of policy, regulation and supervision on the development of these markets. From this evidence base, cross-country lessons are extracted that seek to offer guidance to policymakers, regulators and supervisors who are looking to support the development of microinsurance in their jurisdiction. It must be emphasized that these findings do not provide an easy recipe for developing microinsurance but only identify some of the key issues that need to be considered. In fact, the findings emphasize the need for a comprehensive approach informed by and tailored to domestic conditions and adjusted continuously as the environment evolves.

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2. Analytical framework

This study applies a number of lenses to the evolution of microinsurance markets in the five countries. These lenses, collectively referred to as the analytical framework, in turn inform the synthesis of drivers and findings in the cross-country report. The full analytical framework is contained in Appendix 1. It covers:

- The financial inclusion framework
- The goal of microinsurance, namely increased welfare for the poor through risk mitigation to reduce vulnerability.
- The definition of microinsurance, namely insurance managed according to insurance principles, in exchange for a premium, that is accessed by or accessible to the low-income market.

[3] Funded by the UK Department for International Development – DFID.

[4] Bundesministerium für Wirtschaftliche Zusammenarbeit und Entwicklung - Federal Ministry of Economic Cooperation and Development

- The parts of the insurance value chain covered, including underwriting, administration and intermediation/distribution.

- The distinction between formal and informal insurance and intermediation.

- The categories of risk identified, namely prudential risk, market conduct risk and supervisory risk.

- A typology of public policy instruments, namely policy, regulation and supervision.

- An overview of the insurance regulatory scheme (most notably financial inclusion policy or regulation, prudential regulation, market conduct regulation and institutional regulation)

Please refer to Appendix 1 for a detailed analysis of each of these areas.

2.1. Methodological approach

The **structure** of the analysis is as follows:

- *Understanding the microinsurance market*. The microinsurance market is described in terms of: (i) the various players (corporate and mutual/cooperative, formal and informal) active in the low-income market; (ii) the products available and any low-income market product innovations; (iii) usage among the low-income population of formal and informal insurance products; as well as (iii) distribution channels employed in the low-income market and any distribution innovations. These findings are used to conclude on the key characteristics of the microinsurance market. Focus group research was used to identify the need for and understanding of insurance among the target market. This included an investigation into the risk experience, provider, product and channel preferences of the focus group participants, as well their trust in the insurance market in general.

- *Understanding the insurance regulatory framework*. Furthermore, the study gives an overview of the insurance regulatory framework, in general and as pertaining to microinsurance.

- *Drivers of microinsurance*. In light of the above, it seeks to draw out respectively the non-regulatory (market, macroeconomic and political economy context-related) and regulatory drivers of the state of microinsurance. These drivers are synthesised in the cross-country document.

- *Conclusion*. The drivers are used as the basis for highlighting conclusions on the development of the market, the impact thereon of regulation and other factors and the way forward for microinsurance policy, regulation and supervision.

The **methodology** consisted of desktop research as well as consultations with industry role players, regulators, supervisors and other stakeholders. It involved:

- Traditional demand and supply mapping

- Qualitative focus group research
- Regulatory and policy analysis
- Controlling for context and the distinctive evolution of the broader insurance market

2.2. Project scope

The scope of the study covers all life and non-life insurance products targeted at the low-income market, including savings products provided by insurers (endowments) where it includes an element of guarantee. Pure savings products and retirement savings products are excluded from the scope of the study, as is government social welfare and social security provision.

Indemnity health insurance is an extremely important product for the low-income market, but is often regulated and supervised differently to other insurance business and is a complex field, intricately linked to health service provision. It was therefore excluded from the overall scope of the cross-country study, with the exception of India, where it is included in the analysis below. This is due to the important role that such insurance plays in the microinsurance market in India.

The study covers all categories of providers and intermediaries, including informal markets.

3. Microinsurance in India

3.1. A historical perspective of insurance in India

3.1.1. Life insurance

The history of life insurance in India dates from 1818 when this instrument was conceived means to provide risk cover to the families of Englishmen then serving in India. The Bombay Mutual Life Insurance Society, the first Indian owned life insurance company, was established in 1870. It was the first company to charge the same premium for both Indian and non-Indian lives. The Oriental Assurance Company (life business) came into being in 1880.

Several frauds which occurred during the 1920s and 1930s sullied the image of the insurance business in India. By 1938, 176 insurance companies had been established in India. The insurance business grew at a faster pace after independence in 1947. Indian companies strengthened their hold on this business but, despite the growth, insurance remained primarily an urban phenomenon.

In 1956, the Government of India brought together over 240 private life insurers and provident societies under one nationalised monopoly corporation and the Life Insurance Corporation of India (LIC) was born with the enactment of the Life Insurance Corporation Act, 1956. Nationalisation was justified on the grounds that it would generate the much needed funds for rapid industrialization. This was in conformity with the Government's chosen path of state led planning and development.

3.1.2. General insurance

The general insurance business in India, traces its roots to the Triton Insurance Company Limited, the first general insurance company established by the British in Calcutta in 1850. The first Indian company, the Indian Mercantile Insurance Ltd was set up in 1907. This was the first company to transact all classes of general insurance business.

The general insurance business continued to thrive under the private sector till 1972. The cover provided by the general insurance companies was, however, limited to organized trade and industry in large cities. The 107 insurers of the general insurance industry were nationalised in 1972 and amalgamated and grouped into four companies – National Insurance Company, New India Assurance Company, Oriental Insurance Company and United India Insurance Company. These four companies were structured as subsidiaries of a holding company, the General Insurance Company (GIC).

3.1.3. Insurance legislation in India

The Indian Life Assurance Companies Act was enacted in 1912 as the first statute to regulate the life insurance business. The Indian Insurance Companies Act came into being in 1928 to enable the government to collect statistical information about both life and non-life insurance businesses. These pieces of legislation were consolidated and amended by the Insurance Act in 1938 with the objective of protecting the interests of the insuring public, both in the life as well as in the non-life sector.

The General Insurance Council, a wing of the Insurance Association of India, framed a code of conduct for ensuring fair conduct and sound business practices in 1957. The Insurance Act, 1938 was amended to regulate investments and set minimum solvency margins and the Tariff Advisory Committee set up in 1968.

3.2. Insurance in the Indian financial landscape

Efforts to enhance the provision of micro-insurance services have become an important talking point if not necessarily a prominent feature of the Indian financial landscape in recent years. Its implications for reducing economic vulnerability amongst the low income strata of the population has, in any case, ensured that micro-insurance is recognised as an essential aspect of financial inclusion. It is from this perspective that micro-insurance is defined for the purpose of this study as “insurance that is provided to the low income segments of the population in accordance with generally accepted insurance practices”.

It is commonly accepted that such services need, at the current level of minuscule micro-insurance outreach, to be provided under more favourable conditions than does the normal insurance service. To the extent, that this becomes a privileged service, thereby, its users are limited by the small size of the products available. By their very design, these products are unsuitable for anyone with larger needs. In an international context, the clients of the micro-insurance service can be depicted within the

"truncated diamond" now commonly used by commercial organisations in India to analyse the market.[5] As Figure 3 shows, the envisaged space for micro-insurance lies in the strata of the population earning between $1-2 a day per capita, though it covers more of the upper stratum than the lower one. It is assumed that the less than one dollar a day stratum is more in need of social security than insurance.

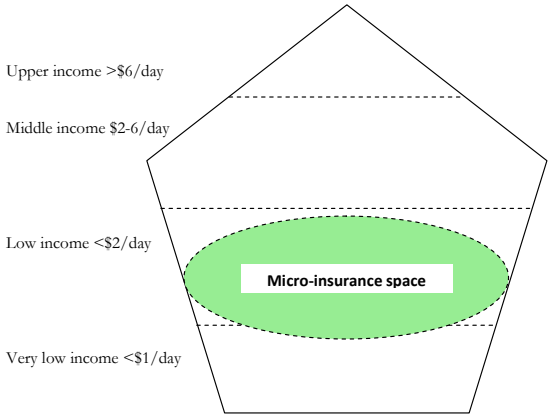

Figure 3. Income diamond prevalent in the Indian economic landscape

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

3.3. Insurance penetration

India is characterised by a relatively low but increasing insurance penetration. Insurance penetration in India, at 3.5% of GDP in 2006 is very low compared to the average of 9.2% for industrialized countries but higher than the average of 2.7% reported for emerging markets.[6] It has grown fast over the past few years, however, increasing from 1.93% in 1998-99[7] to the present level. The life insurance business in India is growing particularly strongly with premiums registering an average growth of 25% per annum over the five year period 2001-02 to 2006-07 (as shown in Table 1) while general insurance registered a growth of 17.6% per annum.[8]

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[5] This significantly modifies the "income pyramid" used by Prof CK Prahalad to depict the market in developing countries, see Prahlad, 2004.

[6] Swiss Re, 2006.

[7] IRDA, 2001.

[8] Years in this report are typically double-barrelled to reflect the Indian financial year; 2006-07 refers to April 2006 to March 2007.

	2001-02 ($ million)	2002-03 ($ million)	2003-04 ($ million)	2004-05 ($ million)	2005-06 ($ million)	2006-07 ($ million)	Growth rate
Life Insurance							
LIC	10,380	11,876	14,037	16,332	20,176	24,419	18.7%
Private insurers	57	241	693	1,680	3,352	7,442	165.2%
Total – Life	**10,436**	**12,117**	**14,731**	**18,012**	**23,528**	**31,860**	**25.0%**
Private/total	0.5%	2.0%	4.7%	9.3%	14.2%	23.4%	
Growth rate/year		16.1%	21.6%	22.3%	30.6%	35.4%	
General Insurance							
GIC subsidiaries	2,483	2,939	3,174	3,250	3,550	3,953	9.8%
Private insurers	97	293	502	763	1,191	1,860	80.4%
Total – General	**2,580**	**3,233**	**3,676**	**4,012**	**4,742**	**5,814**	**17.6%**
Private/total	3.8%	9.1%	13.6%	19.0%	25.1%	32.0%	
Growth rate/year		25.3%	13.7%	9.1%	18.2%	22.6%	
Total premiums	**13,017**	**15,350**	**18,407**	**22,024**	**28,270**	**37,674**	
Life/total	80.2%	78.9%	80.0%	81.8%	83.2%	84.6%	

Table 1. Growth and distribution of premium income in India

Source: IRDA Annual Reports for the respective years

Part of this high growth over the past few years is attributable to the high (over 8%) growth of the GDP during this period but some is also on account of the entry of private insurance service providers since 2001. These have more than doubled their life insurance business every year since inception while their general insurance business has also grown at around 80% per year. The public sector has grown at a more sedate pace on a substantially larger base. As a result the private sector now accounts for around one-third of general insurance premiums collected in India and nearly 25% of life insurance. The high growth of the life insurance market means that its dominance in the insurance field has actually strengthened in the recent era of policy liberalisation from around 80% at the turn of the century to nearly 85% now. This is partly an indication of the extent to which the Indian market associates insurance with long term household savings as opposed to immediate risk mitigation.[9]

Until the advent of policy liberalisation, the provision of formal micro-insurance in India was virtually non-existent. Along with economic growth and permission to the private sector to offer insurance services has come an enhanced interest in ensuring that the benefits of insurance services reach the excluded, low income sections of the population. The regulator, the Insurance Regulatory and Development Authority (IRDA), has sought to ensure the provision of micro-insurance services virtually as a *quid pro quo* for according the formal service providers the permission to operate in the insurance sector. This has led to the introduction of obligations for the provision of services to the social and rural sectors of the economy and to the development of (apparently more liberal) regulations for the provision of micro-insurance services than those applicable to normal insurance. In response, some

[9] An issue that is discussed further in **Section 3**.

attention has started to be focussed on micro-insurance services that are growing in terms of the numbers of individual policy holders but which continue to be minuscule both in terms of the proportion of population covered and the overall premiums collected.

3.4. Limitations of this study

A distinction is made in this report between insurance and social security schemes. While both micro-insurance and social security are essentially in their infancy in India, micro-insurance is a little better advanced in terms of having a formalised structure and more systematic thought devoted to its design than social security schemes have been able to receive so far. This report covers the considerations and regulations governing the design and intermediation of micro-insurance in detail and describes nascent social security schemes for the very low income segments of the population, essentially in passing. The aim is to fill out the picture in relation to financial services for risk mitigation for the poor in India.

The regulator in India – the IRDA – has expressed an active interest in learning more about the effects of its guidelines and regulations on the provision of micro-insurance services and this has added to the importance and potential utility of this exercise. Since this report is devoted to considerations that determine micro-insurance regulation, a more detailed coverage of social security schemes has not been attempted.

3.5. Report structure

The following four sections of this report cover the following

- **Section 4**: An overview of the insurance regulatory framework in India, in terms of the insurance legislation and its relevant characteristics. Understanding the insurance regulatory framework more broadly is key to developing the principles for ensuring that the framework facilitates micro-insurance as extensively as possible.

- **Section 5**: The current market for micro-insurance in India. It delineates the providers, intermediation, products offered and uptake of micro-insurance, in order to discuss the key features and trends characterising the market.

- **Section 6**: Emerging from the previous two sections, the drivers of micro-insurance outreach in India, specifically establishing the non-regulatory and regulatory drivers.

- From these findings, **Section 7** concludes

4. The insurance regulatory framework in India

4.1. Overview of insurance regulation

The insurance sector in India is regulated under the Insurance Act, 1938 and the IRDA Act, 1999. The Insurance Act, 1938 defines four categories of insurance – life, fire, marine and miscellaneous. In

general, two categories of insurers are licensed – life and general (covering the last three product categories). Insurers are not allowed to offer life and general insurance together (although the regulator has relaxed this somewhat for the micro-insurance environment). Health insurance may be provided under either a life or a general insurance license.

4.1.1. Registration requirements and joint ventures with foreign partners

Every insurer seeking to carry out the business of insurance in India is required to obtain a certificate of registration from the Insurance Regulatory and Development Authority (IRDA) prior to the commencement of business. The pre-conditions for applying for such registration have been set out under the Insurance Act, the IRDA Act and the various regulations prescribed by the IRDA.

The applicant has to be a company registered under the Indian Companies Act, 1956. The aggregate equity participation of a foreign company (either by itself or through its subsidiary companies or its nominees) in the applicant company cannot exceed 26% of the paid up capital of the insurance company. This rule applies to life and general insurance start-ups. Separate companies would have to be established if the applicant were to conduct more than one business. An Indian promoter has been defined by the IRDA (Registration of Indian Insurance Companies) Regulations 2000 under Section 2(g) which *inter alia* permits a cooperative society to form an insurance company. There is no provision for establishing a Mutual Insurance company in India at present.

4.1.2. Minimum capital requirements

The current regulation requires a minimum capital of Rs100 crores ($25m) to establish an insurance provider irrespective of the type of product offered. This is far higher than in countries such as South Africa and represents a significant barrier to entry. It could impede the growth of micro-insurance because of the adoption of a “one-size fits-all” policy (treating micro-insurance on par with commercial life and non-life insurance). By comparison, private companies in the telecommunication sector in India were allowed to operate liberally along with the state owned telecommunication companies BSNL and MTNL resulting in the exponential growth of mobile telephone use making telecommunications accessible even to poor families in both rural and urban areas.

4.1.3. Cooperative insurers

Cooperative insurers are allowed but must comply with the full regulatory load and entry capital requirements. Just one cooperative insurer has been established so far; the IFFCO-Tokio General Insurance Company, which was established in 2000, specializes in agricultural insurance even though it transacts other general insurance business as well.

4.1.4. The Insurance Regulatory and Development Authority (IRDA) Act, 1999

In 1993, a Committee chaired by former finance secretary and Reserve Bank of India (RBI) Governor R N Malhotra was formed to evaluate the Indian insurance industry and recommend measures for its future direction. The Malhotra Committee was set up with the objective of complementing the reforms

initiated in the financial sector. The reforms were aimed at creating a more efficient and competitive financial system suitable for the requirements of the economy in an era of structural changes. The committee's report, submitted in 1994, laid down a road map for the growth of the industry in a competitive environment.

The committee stressed the need to provide greater autonomy to insurance companies in order to improve their performance and enable them to act as independent companies with economic impetus. For this purpose, it proposed the setting up of an independent regulatory body, the Insurance Regulatory and Development Authority (IRDA).

Reforms in the insurance sector were initiated with the passage of the IRDA Bill in Parliament in December 1999. Since its incorporation as a statutory body in April 2000, the IRDA has ensured the framing of regulations and registering of private sector insurance companies. As an independent statutory body, the IRDA has put in a framework of globally compatible comprehensive regulations. The Authority has also been providing support systems to the insurance sector with the launch of the IRDA online service for issue and renewal of licenses to agents. The approval of institutions by IRDA for imparting training to agents was intended to ensure that the insurance companies have a trained workforce of insurance agents to sell their products.

4.1.5. Insurance Association of India, Councils and Committees

All insurers and provident societies incorporated or domiciled in India are members of the Insurance Association of India ("Insurance Association"). There are two councils of the Insurance Association, namely the Life Insurance Council and the General Insurance Council. The Life Insurance Council, through its Executive Committee, conducts examinations for individuals wishing to qualify as insurance agents. It also fixes the limits for actual expenses by which the insurer carrying on life insurance business or any group of insurers can exceed the prescribed limits under the Insurance Act. Likewise, the General Insurance Council, through its Executive Committee, may fix the limits by which the actual expenses of management incurred by an insurer carrying on general insurance business may exceed the limits as prescribed in the Insurance Act.

Both these Councils, function as a type of self regulatory organization (SRO) for the life and general insurance wings of the industry.

4.2. Current issues

4.2.1. Detariffing

Until recently, the pricing of insurance policies in India was undertaken with the approval of the Tariff Advisory Committee within a comprehensive set of guidelines established by it. This meant that there was, effectively price control that was exercised by a committee of professionals. Premium had to be determined within the parameters established by the committee. It has now become accepted that, in order to improve the efficiency of the insurance market, there is a need to introduce good underwriting

practices as well as to deepen and widen the market. For this purpose, the IRDA had announced its intention of detariffing the general insurance business from 1 January, 2007.

Detariffing means that the pricing of insurance policies is left to the individual insurance companies concerned to decide and offer premiums based on their own analysis and perception of risk.

This decision to undertake detariffing was a historic one after the opening up of the insurance industry to private participation. To this end, the IRDA had laid down a road map for the smooth transition from a regulated market to a non-regulated market. The Authority held discussions with various stakeholders, issued detailed guidelines on "file and use" procedures, stressing the need for transparent underwriting procedures and assigned roles and responsibilities for the insurers on different functions besides impressing upon them the importance and need for the maintenance of a data base. It has been increasing its own capabilities for overseeing the 'file and use' of products.

The Authority faces a challenge in moving towards detariffing as there could be hiccups in the early stages. Detariffing motor insurance affects the public at large. As the average policyholder does not understand the principles of pricing insurance products, it becomes difficult to convince clients in case there is an increase in the price. In the long run consumers will benefit as it is believed that deregulation increases efficiency and lowers prices through healthy competition. However, ensuring that the benefits reach the consumer is a challenge for the Authority.

During 2007, general insurance tariffs were partially deregulated. Discounts could, for the first time, be offered with prudential limits on the discounts made. As a result, premium rates on fire, engineering and motor (own damage) insurance are reported to have fallen by 35-40%. From January 2008, the prudential limits have also been removed and insurers have the freedom to decide appropriate rates. Third party vehicle insurance premiums continue to be controlled but health insurance cover has now been deregulated. This is widely expected to lead to an increase in insurance premiums on medical insurance. According to Mr CS Rao, Chairman of IRDA, "Earlier, insurers were able to offset losses on medical portfolios with the gains from fire and engineering portfolios. But that cushion is not available now – this could prompt them to widen the base in the medical insurance segment...But it is also true that premium amounts cannot remain at the same level. It has to increase depending on the claim, costs of medical treatment and the longevity of the person concerned."[10]

The IRDA intends, however, not to allow insurance companies to refuse medical cover purely on the grounds of claims made in the previous year (even if higher premiums had to be charged); continuity would be ensured. From 2008, the approach of the IRDA is that the regulator will concentrate on solvency issues while allowing the insurance councils to act as self-regulatory bodies in addressing matters related to market conduct. The immediate impact of this full deregulation has been so sharp

[10] Chairman of IRDA, CS Rao in Economic Times, 2007.

that property insurance rates are reported to have fallen as much as 75-80% on the very first day (1 January 2008) of free pricing in the non-life insurance market.[11]

4.2.2. Consumer protection

The protection of policyholders' interest is an important function of the Authority. The Authority has set up a grievance cell in its office and is pursuing with the insurance companies the expeditious disposal of policyholders' grievances. Grievances of a general nature are discussed in the Authority and, if need be, clarifications are issued. However, developing the market keeping in mind the policyholders' interest is a complex issue. This is a general issue facing all the insurance regulators across the globe.

The standardization of concepts, policy forms in simple language, moving towards acceptable accounting standards, bringing transparency in business operations and disclosure of financial statements of the insurance companies are some of the actions which the Authority is taking at present. These will help in moving the insurance industry towards adopting good practices and will help both the insurers and insured as it reduces information asymmetry to a large extent.

4.2.3. Development role of the Authority

This is another challenge for the IRDA. In order to ensure that relatively poor people also get the benefit of insurance, the IRDA introduced micro-insurance regulations in 2005. The Authority relaxed some of the conditions for insurers in the case of these products. These regulations have been seen by other national regulators as a novel concept and they are keenly watching India's experience. The idea of these regulations is to encourage insurance companies to introduce appropriate products at an affordable price for the low income people. The aim is to increase the present low level of insurance penetration in India.

The detariffing process is not of direct concern for micro-insurance. Since India's micro-insurance guidelines were seen as part of the process of liberalizing the regulation of the insurance sector no attempt was made, in the first place, to regulate tariffs on micro-insurance products.

4.3. Policy and general

4.3.1. The evolution of micro insurance business in India

The evolution of the micro-insurance business in India can be gleaned from three sources

1. The Life Insurance Corporation Act, 1956 which, for the first time, enunciated the concern of the government towards the disadvantaged, low income population, especially those living in rural areas. The Act's statement of objects and reasons declared "To ensure absolute security to the

[11] Economic Times, 2008.

policyholder in the matter of life insurance protection, to spread insurance **much more widely and in particular to the rural areas** and as a further step in the direction of more effective mobilization of public savings, Government have decided to nationalize life insurance business in India". (emphasis added).

2. The Insurance Regulatory and Development Authority (Obligations of insurers of rural social sectors) Regulations was promulgated by IRDA in 2002. Under this regulation, the insurance companies were obligated to procure insurance business on a quota basis from pre-defined rural areas and social sectors.

   Rural areas are defined by the Census of India as places which simultaneously satisfy or are expected to satisfy the following criteria:

   - A minimum population of 5,000
   - At least 25% of the male working population engaged in agricultural economic pursuits and
   - A population density of at least 400 per square kilometer (1,000 per square mile). In these areas, life insurance must account for 5-16% of total policies from Years 1-5 of the operation of a new life insurance company, and for general insurance 2-5% of the total gross premium underwritten in Years 1-5.

   The **social sectors** are defined as "unorganized workers, economically vulnerable or backward classes in urban and rural areas". Here, each insurer has to maintain at least 5,000 policies in Year 1 rising to 20,000 in Year 5, for both life and general insurance. This is regardless of the size of operations.

   The obligation details as set out in the Regulations are:

   (a) Rural sector obligations

In respect of life insurers	In respect of general insurers
5% in the first financial year; 7% in the second financial year; 10% in the third financial year; 12% in the fourth financial year; 15% in the fifth year (of total policies written direct in that year)	2% in the first financial year; 3% in the second financial year; 5% thereafter (of total gross premium income written direct in that year)
6th to 10th year - 18% to 20%	6th to 10th* year - 5% to 7%

   (b) Social sector obligations

In respect of all insurers
5,000 policies in the first financial year; 7,500 policies in the second financial year; 10,000 policies in the third financial year; 15,000 policies in the fourth financial year; 20,000 policies in the fifth year.
25,000 to 55,000 policies for 6th to 10th year

The outcome from these quota requirements is not clear. Companies failing to fulfil the targets in this area could face financial penalties and in the event of repeated violations, the insurers could lose their license. Since the uninsured population to be reached is really vast, these obligations could be considered more in the nature of creating greater awareness than imposing an onerous obligation. Some of the private insurers have, as a result, worked on strategies based on the notion that the poor are a viable business proposition which would give them the reach and potential business in the future. The state insurers, having been in the field for a long time, do not seem to face any problems in fulfilling their quotas.

3. The latest in this process was the introduction of the micro-insurance regulations in November 2005. The concern of the regulator was to make appropriate products available for low income families as was also reflected in the IRDA report for the year 2005-06. A discussion of these regulations forms the core of this report.

4.3.2. Other policies

This section discusses some of the related concepts and policies which have synergies with the micro-insurance regulations.

Financial inclusion policy

The Reserve Bank of India (RBI) – the banking regulator, has initiated a series of measures to promote financial inclusion in order to increase the reach of the banking system to disadvantaged and low income groups of the population in rural as well as in urban areas. Among the recent initiatives are the development of a "no frills" bank account, the introduction of bank facilitators, and bank correspondents enabling the use of organizations like Post Offices, cooperatives, Farmers' Clubs, insurance agents, Village Knowledge Centers, Agri-business Centers, vegetables sellers and tiffin carriers (*dabbavalas*) as intermediaries for providing banking services including the identification of borrowers, creating awareness about savings, promotion and nurturing Self Helps Groups as well as post-sanction monitoring.

The issuance of electronically readable cards in the hands of "no frills" bank account holders which can be used by banks' correspondents at the time of the transaction is expected to promote greater financial inclusion amongst the unbanked sections of the population. "With barely 34% of its population engaged in formal banking, India has the second highest number of financially excluded households in the world at about 135 million," said a recent report of the Boston Consultancy Group (BCG).[12] Initiatives are also being undertaken to reform the financial cooperative sector and two financial

[12] Sinha, J and A Subramanian, The Next Billion Consumers – A Road Map for Expanding Financial Inlcusion in India, Report by Boston Consulting Group, November 2007.

inclusion funds have been established to focus on developing business as well as supporting the introduction of appropriate technology for the purpose.

From the perspective of financial inclusion, almost all retail banks, whether in the public or private sector, are now engaged in collaborations with life or non-life insurers for introducing bancassurance. The financial inclusion initiatives, such as "no frills" banking, if pursued vigorously, could expand the micro- insurance market both in rural and urban areas as the footprint of the banking sector expands. For now, these efforts are at a nascent stage and the impact of the bancassurance initiative will only become apparent some 3-4 years from now.

The National Bank for Agriculture and Rural Development (NABARD) is a prime mover of micro-credit in the country. NABARD is working on formulating an appropriate strategy on financial inclusion. NABARD is the proposed regulator for MFIs who are also active in the area of micro-insurance. Some of these are non-bank finance companies (NBFC) that have been excluded from the purview of the microfinance legislation – a matter that affects the pursuit of micro-insurance.

As part of the Government of India's thrust on inclusive growth, a committee was appointed by the Ministry of Finance in June 2006 to assess the financial services and systems in the country and to devise and recommend measures that would promote financial inclusion. The committee, chaired by another highly respected former Governor of the Reserve Bank of India, Dr C Rangarajan, submitted its report to the Government in early February 2008. Its recommendations included a raft of measures for the banking and cooperative sectors. When analysed dispassionately, these consisted mainly of exhortations to the financial institutions to do their job in a more inclusive manner, opening of branches in under-served areas and of target setting – such as the opening of 250 zero balance accounts per rural and semi-urban branch per year – rather than of any real incentive or progressive programmes to facilitate inclusion. Subsequently, the Finance Minister in his budget speech for 2008, announced the acceptance of a few of these recommendations but, to informed observers, the net result is unexciting.

Presence of informal and unregistered underwriting at community level

Accurate data on the penetration of formal and informal insurance products is not available. Some insurance protection, especially in the area of health insurance, is provided by MFIs or other aggregators. Some of the MFIs who were earlier offering insurance cover informally have now switched over to formal insurance coverage, as discussed in the following section.

The current insurance law does not provide for a lower compliance regime for community-based or smaller cooperative insurers.

Social security insurance schemes

The employees working in the organized sector get the following risk cover:

Disablement	Workmen's Compensation Act, 1923 Employee's State Insurance Act, 1948
Death	Workmen's Compensation Act, 1923

	Employee's State Insurance Act, 1948
Maternity	Maternity Benefit Act, 1961 Employee's State Insurance Act, 1948
Old-age Income Security and Pension	Coal Mines P. F. & Bonus Scheme Act, 1948 Employees P. F. & Miscellaneous Act, 1952 Assam Tea Plantations P. F Scheme Act, 1955 Seamen's Provident Fund Scheme Act, 1955
Funeral	Employee's State Insurance Act, 1948

Of the estimated 397 million workers in India – formal and informal, agricultural and non-agricultural – the above social security coverage benefits only 8%.[13] In addition to the above legal coverage other state and central government initiatives for the "weaker sections of society" include the Aam Aadmi Bima Yojana (Common man's insurance) which is administered by the Life Insurance Corporation of India (LIC) and the Universal Health Insurance Scheme (UHIS) 2004 administered by the central government (refer **Appendix 2** for details.

4.4. The Micro-insurance Regulations, 2005

Regulations on micro-insurance were officially gazetted by the IRDA on 30 November 2005. The salient features of the regulation are presented below

4.4.1. The regulation defines micro-insurance products

The regulation provides definitions of micro-insurance products covering life and general insurance

"General micro insurance product" means any health insurance contract, any contract covering the belongings, such as, hut, livestock or tools or instruments or any personal accident contract, either on individual or group basis, as per terms stated in Schedule-I appended to these regulations.

"Life micro insurance product" means any term insurance contract with or without return of premium, and endowment insurance contract or health insurance contract, with our without an accident benefit rider, either on individual or group basis, as per terms stated in Schedule-II appended to these regulations.

- "micro-insurance policy" means an insurance policy sold under a plan which has been specifically approved by the Authority as a micro insurance Product.

- "micro-insurance product" includes a general micro-insurance product or life insurance product, proposal form and all marketing materials in respect thereof.

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[13] Singh, Sharad & Meraj Ashraf, Alternative Mechanism of Social Protection for Unorganised Sector in India,

Conference Proceeding, 2007 extracted on 9th December 2007 http://www.issa.int/pdf/warsaw07/PTT/24Singh.ppt.

- Every insurer shall be subject to the "file and use" procedure with the IRDA.

- No one other than insurer – be it a micro-insurance agent or anyone else – can underwrite a micro-insurance proposal.

- Rural business transacted under micro-insurance by an insurer will be counted for quota fulfillment both for rural as well as social sector obligations.

Table 2 and Table 3 present the product guidelines for life and general insurers:

	Type of Cover	Min. Amt. Cover (Rs)	Max Amt. Cover (Rs)	Min. Term of Cover	Max. Term of Cover	Min. Age of Entry	Max. Age of Entry
1	Terms insurance with or without return of premium	5,000	50,000	5 year	15 year	18	60
2	Endowment insurance	5,000	30,000	5 year	15 year	18	60
3	Health insurance (Individual)	5,000	30,000	1 year	7 year	Insurer's Discretion	
4	Health insurance (family)	10,000	30,000	1 year	7 year	Insurer's Discretion	
5	Accident benefit as rider	10,000	50,000	5 Year	15 Year	18	60

Note 1: Group Insurance products may be renewable on a yearly basis

Note 2: The minimum number of members comprising a group shall be at least twenty for group insurance

Table 2. Life products: Sum assured, plan and term

	Type of Cover	Min. Amt. Cover (Rs)	Max Amt. Cover (Rs)	Min. Term of Cover	Max. Term of Cover	Min. Age of Entry	Max. Age of Entry
1	Dwelling or contents, or live stock or tools or other named assets/or crop ins.	5,000	30,000	1 year	1 year	NA	NA
2	Health insurance (Individual)	5,000	30,000	1 year	1 year	Insurer's Discretion	
3	Health insurance (family) – (option to avail limit for individual/float on family)	10,000	30,000	1 year	1 year	Insurer's Discretion	
4	Personal accident (per life/ earning member of family)	10,000	30,000	1 year	1 year	5	70

Note: The minimum number of members comprising a group is at least twenty for group insurance.

Table 3. Non-life products: Sum assured, plan and term

4.4.2. It promotes the extensive use of intermediaries

The micro-insurance regulations promote extensive use of intermediaries by the insurers for selling and servicing various micro-insurance products. The regulation also creates a new intermediary called the micro-insurance agent. The regulation clearly defines MI agents and has imposed minima in terms of the number of years of experience (at least 3) of working with low income groups. It also emphasises the need for such agents to have appropriate aims and objectives, a good track record, transparency and accountability stated in the bye-laws with demonstrated involvement of committed people. This has been done in order to prevent the engagement of unscrupulous operators in the activity. However, the onus for the selection of appropriate MI agents and their capacity building lies with the insurance company.

Intermediary: The micro insurance agent, can be a Non-Governmental Organization (NGO), MFI or other community organization such as Self Help Groups (SHG) appointed by an insurer to distribute micro-insurance through specified persons. Micro-insurance agents enter into a "deed of agreement" with the insurer. They abide by the code of conduct defined by the IRDA and attend 25 hours of training (down from 100 hours originally required for conventional insurance agents but now reduced to 50 hours) in the local language at the expense of the insurer. There is no qualifying examination, unlike the case of ordinary insurance agents.

According to the regulation,

- Non-Government Organization (NGO) means a non-profit organization registered as a society under any law, and has been working at least for three years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency and accountability as outlined in its memorandum, rule, by-laws or regulations as the case may be, and demonstrates involvement of committed people.

- Self Help Groups (SHG) means any informal group consisting of ten to twenty or more persons and has been working at least for three years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency and accountability as outlined in its memorandum, rules, by-laws or regulations, as the case may be, and demonstrates involvement of committed people.

- Micro-Finance Institutions (MFI) means any institution or entity or association registered under any law for the registration of societies or co-operative societies, as the case may be, inter alia, for sanctioning loan/finance to its members.

IRDA has recognized four categories of intermediaries: brokers, agents, corporate agents, and Micro-insurance (MI) agents. Categories other than MI agents may sell micro-insurance but they do not benefit from the concessions allowed for the MI agents. However, a micro-insurance agent shall not distribute any product other than a micro insurance product.

The regulation provides for MI agents to perform the following functions

- Collection of proposal forms

- Collection of self declaration from the proposer that he/she is in good health.

- Collection and remittance of premium

- Distribution of policy documents

- Maintenance of registers of all those insured and their dependants covered under the microinsurance scheme, together with details of name, sex, age, address, nominees and thumb impression/signature of the policyholder.

- Assistance in the settlement of claims

- Ensuring nomination to be made by the insured

- Any policy administration service

4.4.3. The regulation's attempt to manage the cost of intermediation

A cap has been put on commission, between 10 and 20% of premiums per year according to type and mode of insurance payment, which is in excess of what conventional agents would normally earn. The rates of commission applicable to MI agents are:

Life insurance business	General insurance business
Single Premium policies – 15% of the single premium Non-single premium policies – 20% of the premium for all the years of the premium paying term	15% of the premium

The commission rates prescribed above are more liberal than the 60% (of a single year's premium) payable under ordinary business in the case of life insurance and 10% in the case of general insurance. This is based on the logic that an MI agent has to perform a number of functions which mainstream agents do not have to undertake. MI agents may thus receive commission at different rates from those applicable to other intermediaries. The commission structure is, however, changed to remove up-front payments in favour of payments upon the performance of certain functions. For group insurance products, the insurer may decide the commission subject to the overall limits specified by IRDA.

MI agents may route premiums and claims payments through their books (such as receive individual premiums and pay it over as one amount). This is not allowed for other intermediaries and is considered important in managing the cost of intermediation.

4.4.4. Collaborations between life insurers and non-life insurers

The regulations allow for the bundling of life and non-life elements in one single product provided there is clear separation of premium and risk at the insurer's level. Where an insurer carrying on life insurance business offers any general micro-insurance product, he shall have a tie-up with the insurer carrying on general insurance business for this purpose, and subject to the provisions of section 64 VB of the Insurance Act (governing the remittance of the premium amount to the insurance company), the premium attributable to the general micro-insurance product may be collected from the prospect (proposer) by the insurer carrying on life insurance business, either directly or through any of the distributing entities of micro-insurance products. In the event of any claim in regard to general micro-insurance, the insurer carrying on life business or the agent shall forward the claim to the insurer carrying on general insurance business. The same arrangement holds true for life claims faced by non-life vendors of a micro-insurance product. In both cases, the respective primary first insurer would render all assistance in claim settlement by coordinating with his opposite number.

4.4.5. The limitations of the micro-insurance regulations

The impact of the MI regulations is likely to be limited for a number of reasons:

Definition of MI agents: The regulations define MI agents to include NGOs SHGs and MFIs. The definition of MFI is, however, limited to societies, trusts and cooperatives societies and thus excludes a large proportion of MFIs operating through other legal forms (like for-profit and not-for-profit companies). The result is that all profit-driven corporate intermediaries as well as some of the largest aggregators in micro-insurance are currently excluded from benefiting from the MI regulations. Though the formalisation of MI agents as a type has been welcomed by the insurance companies as a positive beginning, the exclusion of MFIs registered under the Companies Act[14] is viewed with concern (as discussed in Box 1).

[14] Non-bank finance companies (NBFCs) and not for profit companies (known as Section 25 companies).

Box 1. The restrictive definition of micro-insurance agents and the regulatory conundrum

All the insurers covered during the study were of the opinion that the scale of operation in micro-insurance is very important for the insurance company to offer sustainable products. The current regulation seems to have overlooked this aspect as the organizations that have scale – NBFCs and Section 25 (not-for-profit) Companies – have been left out. As a recent analysis by M-CRIL shows, as much as 80% of the clients covered by MFIs are served by such companies so their exclusion from the list of organisations eligible to be selected as micro-insurance agents, actually limits the outreach of MI products in the short term.[15] Not only is outreach an issue but the selling and servicing of MI products requires good systems and capacities which are relatively limited with NGOs (that are not accustomed to financial transactions) and non-corporate MFIs since all the best MFIs transform into companies.

Since insurance companies prefer not to invest in developing the systems and technology of MI agents, they would rather work with organizations that already have these. To the extent such capacities are available, these exist mainly with NBFCs and Sec-25 Companies which are not allowed to act as MI agents. This is why most private insurers have not been able to identify MI agents so far.

Further, even if IRDA regulations allow NBFCs and Sec-25 Companies to act as micro-insurance agents there is a restriction from the RBI (which regulates finance companies) on the collection of savings in any form or even routing of payments through the institution's account books. In practice, this is another regulatory constraint on the collection and remittance of premiums by such organisations.

Limitation on the number of insurance companies an MFI can work with: The MI Regulations restrict a MI agent to working with one life and/or one general insurer respectively. This is problematic and does not accommodate models currently used in the MI market. Most insurers do not want to underwrite all risks and tend to specialize in particular types of risk. For example if a MI agent is tied to specialized health insurer, they cannot work with another general insurer to sell other asset insurance products.

Know Your Customer (KYC) / Anti Money Laundering (AML) Norms: Micro insurance agents have expressed their concern at the difficulties faced by them in accessing KYC documents from proposers in rural areas, such as electoral identity card or ration card or electricity bill which are generally accepted as proves of residence.

Commission capping: MI commissions are capped at 20% per annum for life across the term of the policy. Non-MI products typically pay commission on a front-loaded basis with 30-35% in year one with 7% in year 2. The up-front structure provides little incentive for renewals, particularly as premiums have to be collected in cash/ cheque. At the same time 20% may not be enough to incentivise sales. It is a common (but illegal under Section 48 of the Insurance Act) practice for agents to use the higher first year commission to give a discount to policyholders in the first year. Some thought would need to be given to the minimum absolute cost to sell a policy and the commission structures needed to ensure that this could be covered. Lapse rates of 30-40% are much higher for MI than traditional policies. This is because the cost/effort of premium collection/renewal exceed the commission. Besides, the incidence

[15] See M-CRIL/MIX, 2007. In the long run, such clients can be reached in other ways, but the restriction adds to the degree of difficulty entailed in the task.

of the service tax of 12.36% payable by the agents is a further point of dissatisfaction for the MI agents, especially considering the long distance travel they have to make in rural areas to procure and service business. The view of insurance companies on commission caps is presented in Box 2.

Box 2. Views on commission caps

There have been mixed views on this provision; some insurance companies as well as aggregators feel that it is a good step that has allowed agents to earn a higher proportionate commission than other insurance agents (who are limited to a total of 60% of the annual commission over the entire term of the policy). Others are of the opinion that micro-insurance commissions should be flexible and the insurance companies should be allowed to decide these on the basis of product experience. In this context, any cap on the commission on MI products could be restrictive and result in limiting the growth of this type of product. The regulation, at the same time, does not address the sharing of commissions to specified persons/sub-agents and there is a high chance of them being exploited by the main MI agent. Overall, the commissions allowed are regarded as not remunerative because of the small average size of MI policies meaning that the MI agent would have to attain scale to become sustainable.

Conflicting regulations: Enabling provisions introduced in the MI regulations are undermined by restrictions in RBI regulations. For example, the insurance regulation allows receipt of premiums in the form of money instruments (not cash), which must be remitted within 24 hours. RBI in 2002, however, issued regulations stating that certain types of NBFCs (including most MFIs) may not route any premiums through their books. The implication is that the NBFC intermediary must make out demand drafts for individual transactions and send them to the insurer. Significant efficiencies can be gained if these intermediaries were to be allowed to process all the payments through their systems and make a single payment to insurers.

Rural Regional Banks (RRB) and Cooperative Banks: It is worth further examination as to whether RRB who have been given the status of corporate agents and the cooperative banks can be brought into the ambit of MI agents in view of their outreach in rural areas.

4.4.6. However the micro-insurance regulation has been facilitative in…

Limiting the training requirements of MI agents: The MI Regulation has been facilitative in terms of reducing the mandatory training requirements for insurance agents from 50 hours to just 25 hours in the case of MI. Most insurance companies have welcomed this move but feel that the technological innovations in developing better systems at the level of the MI agent and real awareness creation amongst potential clients/policy holders are a much larger challenge that would go a long way in developing the micro-insurance market.[16]

[16] Like capturing and maintaining actuarial data, remittances, issuance of ID cards (particularly for micro-health insurance) and use of mobile devices for collection of payments/providing recepts

Allowing MI agents to take greater responsibilities: The regulator has allowed MI agents to take up greater responsibilities than are permitted to mainstream agents, for example, the collection of premiums on behalf of the insurance companies and the servicing of claims. IRDA believes that if the MI agents are able to carry out these functions effectively, it will help in minimising the transaction costs that the insurance companies have to incur, thereby leading to lower premiums for the clients in the long run.

Treating benignly apparent infringements of the regulations by community-based organisations: There are restrictive entry norms for organizations that are explicitly licensed to provide insurance to the general public. Insurance companies need a large amount of start-up capital of Rs100 crore (~US $25 million) to get a licence from the IRDA. This entry norm is applicable for community based insurance as well if they want to underwrite risk. IRDA has treated the existing cases of in-house insurance with benign neglect.

Essentially, this approach is dictated by the relatively limited experience and low supervisory capacity of the IRDA. Compared to the vast numbers of people in need of social protection in India, the coverage provided by both formal and, even more so, by community insurance programmes is so low that the role of regulation seems fairly limited. The creation of a two-tier space where the insurance companies are regulated and supervised and community insurance is not is *de facto* recognition of this fact.

The IRDA's approach is that it is pointless to have regulations that are not properly enforced as long as community insurance agencies provide cover to a limited population that is clearly defined (either geographically or socially or through other forms of association), they can be allowed to function without being regulated. It is here that the regulations are not very clear for MFIs or NGOs, where the membership cannot be clearly defined. Although generally limited within a geographical territory, the scale of some MFIs or NGOs is significant and spans across several states.

4.4.7. Taxation issues

By a notification of 16 July 2001, the Government of India brought insurance auxiliary services under the ambit of Service Tax. The following important definitions and references are relevant in this context.

As per section 65(31), "***insurance auxiliary service***" means any service provided by an actuary, an intermediary or insurance intermediary or an insurance agent in relation to general insurance business and includes risk assessment, claim settlement, survey and loss assessment. '***Taxable event and scope of service***' means any service provided to a policyholder or insurer by an actuary or intermediary or insurance intermediary or insurance agent, in relation to the insurance auxiliary service.

The service providers are insurance agents, insurance surveyors and loss adjusters, actuaries and insurance consultants. In the case of insurance surveyors and loss adjusters, actuaries and insurance consultants, the service is provided mainly to the insurance companies (insurer) while in the case of insurance agents, the service is provided to both the insurer and the policy holder. Service Tax is liable to be paid by the insurance auxiliary service provider except in case of insurance agents. Insurance agents normally do not charge the policyholder. However, the insurance company pays the agent a

commission (usually as a percentage of the insurance premium) on a periodic basis. In the case of an insurance agent, it has been provided in the Service Tax Rules that the person liable to pay Service Tax will be the concerned insurance company who has appointed the agent.[17]

However as practised by the companies, no service tax is paid by the agents. The service tax is payable by the person whose life is assured and the current rate is 12.36 % on the premium paid to the life insurance companies. If an agent's accumulated commission for the year reaches Rs20,000 ($500), tax is deducted (at source) by the company at the rate of 11.33% (as prescribed by the income tax rules) from the commission of the agent.

The service tax on premiums adds to the price of insurance. An assessment of the impact of this tax on the cost of micro-insurance is needed. From the perspective of inclusion, enabling the penetration of insurance services to low income people and in rural areas, there could be a case for exempting micro-insurance from the payment of service tax.

4.4.8. Concluding remarks

The IRDA Regulation of 2005 can be viewed as an important step towards expanding micro-insurance in India. However, critics argue that this regulation is very narrow because it focuses on just one approach, the partner-agent model. They also argue that there should be greater flexibility with the companies for putting out suitable and market driven micro-insurance products without being circumscribed by the present restrictions on products and other features. The supervisor could recommend to the government that the capital requirements for health insurance be reduced by half to increase the number of health micro-insurance operators. A similar approach could also be considered for promoting micro-insurance.

The new micro-insurance regulations show one path to enhancing distribution efficiency, by a partial relaxation of training and remuneration norms and by the bundling of products, without compromising the risk-taking ability of a commercial insurer. However, on balance, the present regulatory framework for micro-insurance is weighed in favour of prudential operations rather than using regulation as a vehicle for ensuring accelerated outreach of micro-insurance in India.

5. The microinsurance market in India

This section provides an overview of the micro-insurance market in India, covering the service providers in the market, the distribution models employed, the products offered and their uptake amongst the low-income population. Salient features of the market are highlighted and discussed from the perspective of maximizing insurance coverage. The market in India is overwhelmingly formal since

[17] Notification no. 5/2001-ST refers. (Ministry's F.No.B-11/1/2001-TRU dt.09.07.2001)

informal insurance systems are relatively unknown in the country. While traditional systems of insurance do not extend beyond the small degree of guaranteed return provided by such devices as RoSCAs, other (mainly) NGO-managed community based insurance systems provide more significant benefit to those covered. While there are a few dozen such efforts around the country, their focus is almost entirely on health risk and the overall numbers of those insured by such systems are still minuscule relative to the large proportions of the population that do not (at present) have any form of risk cover. Box 3 summarises the main findings that emerge from the discussion in this section.

Box 3. Key features of the micro-insurance market in India

- *Product characteristics.* Micro-insurance products in the market have short policy contract terms 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 under-written but the numbers of such policies is still minuscule even relative to the low overall outreach of micro-insurance.
- *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. Community-based insurance systems are largely limited to health cover.
- *Health prominence.* Health insurance is prominent in community-based systems because health risk is generally seen as potentially the most devastating type of systemic risk likely to upset the lives and economic livelihoods of the low-income population. Formal micro-insurance schemes are yet to cover health in any significant way on account of the difficulties of ensuring service delivery and the dangers of moral hazard in a highly informal health service provision network.
- *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
- *Micro-insurance category.* The advent of separate micro-insurance guidelines provided by the insurance regulator has seen the launch of new micro-insurance products in the formal market.
- *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.

5.1. Insurance providers – *dominated by government owned companies but the private sector is increasingly active*

Formal insurance service providers – the insurance companies that are legally registered with the government and supervised by the industry regulator, the Insurance Regulatory and Development Authority (IRDA) – dominate the insurance market in India. Micro-insurance is in its infancy in the

country but growing fast through the activities of the formal insurance companies under the impetus provided by the rural social sector obligations imposed by the IRDA. A considerable effort is now being made by these companies to design innovative products but even more so to experiment with distribution channels. It is generally thought that efficient and effective distribution channels hold the key to reducing cost in the delivery of micro-insurance services. This will enable an overall reduction in the premium charged by micro-insurers, leading to greater uptake of the supply of such services being offered. There are also cooperative and community-based insurance systems but, apart from the cooperative-linked Yeshasvini Trust of Karnataka, these are managed mainly by a few dozen NGOs in the south and west of the country, providing a relatively small number of people with limited forms of health cover.

In addition, with increasing economic growth in India, the government has become concerned about the exclusion of the low-income population from the growth process. Within the liberal democratic framework of India's political economy the engagement of the government with social protection and economic inclusion is seen as inevitable across the political spectrum ranging from right-wing nationalist opinion to far-left Marxist-oriented political thought. It is this framework that makes the government's engagement in social protection measures for the low income segments of the population inevitable.

It is within this framework that the government is increasingly turning its attention to insurance as a form of social protection. This has led to the launch of a number of country-wide pilots for health and/or life insurance for the poor and even some experiments with state-wide schemes. While the challenge for the insurance companies is to discover viable distribution models, that for the government is to gear its delivery mechanisms to ensure that the benefits of the cover are not negated by information asymmetries and misappropriation. In most government social security/insurance schemes the covered population is largely unaware of the existence and terms of the policy. This is compounded by misappropriation resulting from ineligible people being able to claim benefits or from other forms of moral hazard made possible by inefficiencies and corruption in programme implementation. Figure 4 below maps out the micro-insurance market in India.

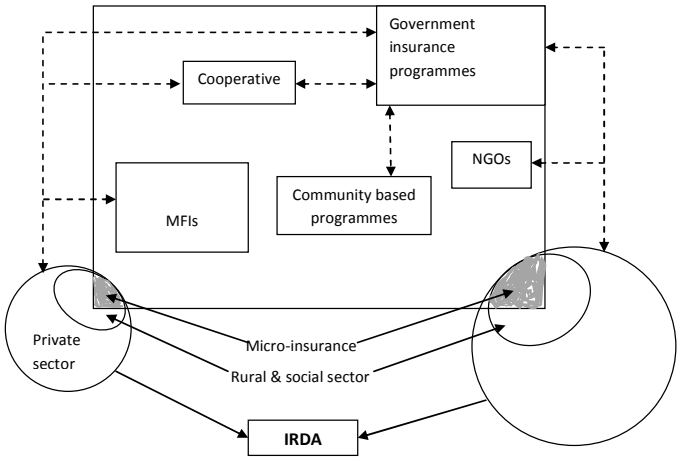

Figure 4. Representation of the microinsurance market in India

Source: authors

In the figure, the micro-insurance space refers to the low income families for whom micro-insurance products are intended. The institutions within the space work directly with low income families while the private and government owned insurance companies are external entities that offer services to the micro-insurance clients through partnerships with those within the space. The community institutions working directly with micro-insurance clients are MFIs (registered under various acts – refer **Appendix 4** – other NGOs (not involved in finance), financial and non-financial Cooperatives, SHGs and community based organizations (CBOs) as well as government agencies responsible for social security programmes. While most of the micro-insurance activities are in collaboration with the insurance companies a number are independently managed by the community institutions and some are government promoted schemes as well. Some of the government insurance programmes are also managed by NGOs and, in a few cases, the government has actually bought cover for low income families from insurance companies. The broken arrows (above) show the linkages among various organizations providing micro-insurance services to low income families. These are discussed in detail in the sections that follow.

The diagram also shows that micro-insurance is just a small proportion of the rural and social sector obligations which are easily fulfilled by serving the middle and upper income classes in rural areas. IRDA regulates and supervises the functioning of only the formal insurance companies and regards community organizations as outside its purview.

5.1.1. Formal sector insurance – *still dominated by government-owned companies but increasingly obliged to experiment with micro-insurance*

Despite the recent advent of the government into insurance as a social security mechanism for low income families, the formal insurance companies[18] are still the dominant providers of insurance services

[18] All companies – private and government-owned – that are licensed and authorized by IRDA

in India. In March 2006 there were 15 companies registered with IRDA for providing life insurance and 12 general insurance companies (Table 2 and Table 3) along with two specialist public sector insurers, the Export Credit Guarantee Corporation and Agricultural Insurance Company. This industry structure has emerged out of a public sector insurance monopoly that consisted of a single life insurance company, the Life Insurance Corporation of India (LIC)[19] and four general insurance subsidiaries of the General Insurance Corporation (GIC).[20] The insurance monopoly was ended in 2000 when the IRDA relaxed the barriers to entry specifically for the purpose of attracting private and foreign companies into the insurance sector.

As Table 4 shows, the size of the insurance sector has grown rapidly over the past few years. Premium underwritten in 2005-06 ($28.05 billion, Rs126,234 crores) was 2.76 times that in 2000-01, at an annual growth rate of 22.5%. However, the industry continues to be dominated by the public sector companies with LIC accounting for nearly 85.8% of life insurance premiums and the four subsidiaries of GIC underwriting 73.7% of the general insurance business. The life insurance segment of the market is substantially larger than general insurance with the former accounting for nearly 84% of the total premium underwritten.[21] As the table shows, apart from LIC there are only two really significant insurers in the life insurance segment with the general insurance associates of the same companies also being the two significant private sector insurers in that segment of the market. GIC is the only re-insurer registered in India.

[19] Originally formed in 1956 by nationalizing and merging 240 private insurance companies for the stated purpose of countering high levels of insurance fraud and improving the spread of insurance across the country for better economic security of the public.

[20] Non-life insurance companies were nationalized in 1972.

[21] Information on the number of policies is not available but discussion with insurers suggests that this analysis would not change much if the number of policies was used.

Table 4 (a and b): growth and size of the Indian insurance sector

(a) Growth of the insurance sector in India since the entry of the private sector

Rs crore

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07 (estimated)	Annual growth rate
Life Insurance							
LIC	49,822	54,628	63,168	75,127	90,792	105,000	16.1%
Private insurers	273	1,110	3,120	7,728	15,084	30,000	156.1%
Total – Life	**50,094**	**55,738**	**66,288**	**82,855**	**105,876**	**135,000**	**21.9%**
Private insurers	0.5%	2.0%	4.7%	9.3%	14.2%	22.2%	
General Insurance							
GIC subsidiaries	11,918	13,520	14,285	14,949	15,976	17,000	7.4%
Private insurers	468	1,350	2,258	3,508	5,362	7,800	75.6%
Total – General	**12,385**	**14,870**	**16,542**	**18,456**	**21,338**	**24,800**	**14.9%**
Private insurers	3.8%	9.1%	13.6%	19.0%	25.1%	31.5%	

(b) Size of the insurance sector in India, 2005-06

Life insurer	Total	
	Rs crores	Proportion
LIC	90,792	85.8%
ING Vysya	425	0.4%
HDFC Std Life	1,570	1.5%
Birla Sun Life	1,260	1.2%
ICICI Prulife	4,261	4.0%
Kotak Mahindra	622	0.6%
Tata AIG	880	0.8%
SBI Life	1,075	1.0%
Bajaj Allianz	3,134	3.0%
Max New York	788	0.7%
Metlife	206	0.2%
Reliance Life	224	0.2%
Aviva	600	0.6%
Sahara	28	0.0%
Shriram Life	10	0.0%
Private total	**15,084**	**14.2%**
Total	**105,876**	**100.0%**

General Insurer	Total premium in India	
	Rs crores	Proportion
National	3,524	17.3%
New India	4,792	23.5%
Oriental	3,527	17.3%
United	3,155	15.5%
Sub-total	**14,997**	**73.7%**
Royal Sundaram	459	2.3%
Reliance	162	0.8%
IFFCO – TOKIO	893	4.4%
TATA AIG	573	2.8%
ICICI LOMBARD	1,583	7.8%
Bajaj Allianz	1,272	6.2%
Cholamandalam	220	1.1%
HDFC CHUBB	200	1.0%
Sub-total	**5,362**	**26.3%**
Total	**20,359**	**100.0%**

1 crore = 10 million; Rs1 crore = $0.25 million

Segregated information on the provision of micro-insurance by the corporate sector is not available. However, the indications from information available from a few companies responding as part of this study indicates that, during 2006-07, the micro-insurance business of these companies represented less than 1% of their total turnover. The IRDA's micro-insurance guidelines were, of course, released only in November 2005, so it is too early to comment on the micro-insurance performance of these insurance companies. However, as late as September 2007, there were only 12 micro-insurance products registered with the IRDA by 6 companies. Currently there are no formal insurance companies focused exclusively, or even extensively, on the micro-insurance market but the rural and social sector obligations have compelled the companies to take a close look at the micro-insurance market and there is an increasing degree of experimentation with it. The distribution channels employed by the insurance companies for extending micro-insurance are discussed in **Section 5.2**.

5.1.2. Community insurance schemes – *informal cover*

As indicated above, there is a variety of community and cooperative insurance schemes available in the country. A survey undertaken by the International Labour Organisation (ILO) in India identified about 50 such schemes. These are listed in **Appendix 5** and summarized in Table 5 below. It is apparent from the table that virtually all of these are health insurance schemes with a few having add-on under-writing of life, housing and/or productive assets. The schemes vary in size from the 1.5 million beneficiaries of Karnataka's Yeshasvini Trust to relatively small schemes with just a few hundred persons covered. The insurance is offered either directly by NGOs/cooperatives or in partnership with (effectively re-insured by) insurance companies.

Region	No. of agencies	Types of Agencies	Coverage States	Areas of intervention	Risks covered	Total clients
North	4	NGO MFI TPA CBOs State Government	Chattisgarh, Madhya Pradesh	Mix of rural and urban	Health care with riders including maternity, life, accident, income loss, disability, accidental death, productive assets, housing and daughter's marriage	308,353
East	8		West Bengal, Orissa, Bihar	Predominantly rural		1,779,630
West	11		Maharastra, Gujarat, Rajasthan	Mainly rural & pockets of urban		365,811
South	28		Andhra Pradesh, Karnataka, Tamil Nadu & Kerala	Mix of rural and urban		2,630,301
	51		**12**			**5,084,095**

Table 5. Health insurance schemes in India

In a number of cases the aggregator provides insurance to its members directly and the risk is not necessarily passed on to an insurance company. These are often referred to as in-house insurance providers (see Figure 5). Thus, the aggregator becomes the underwriter in this model. The model is based on the original historical idea of insurance, which was initially insurance provided by mutual liability institutions – known as mutuals – to a limited member base.

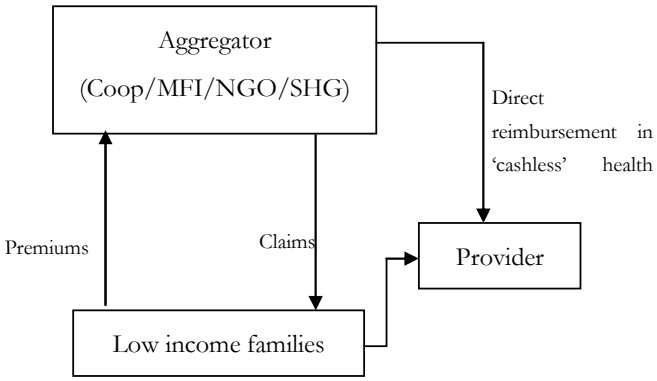

Figure 5. The in-house insurance model

In the context of micro-health insurance, the aggregator in the in-house insurance model may be an NGO, an MFI, an SHG, a cooperative or any other community institution having a significant member base among low-income families. There are a few examples of in-house insurance in India. Some of these in-house programmes have received support from the government as well in the form of subsidies. The case of the largest of these, the Yeshasvini health insurance scheme in Karnataka is described in Box 4. The insurance regulations in India do not specifically allow, such agencies to provide insurance services but (as indicated in Section 4), apparently on account of the importance of such schemes for the low income population, the regulator ignores the provision of micro-insurance schemes by community-based organisations – treating them with benign neglect.

Box 4 Yeshasvini health insurance scheme[22]

The *Yeshaswini* Insurance Scheme for farmers in Karnataka is the most often quoted example of a mutual/community insurance scheme in India. For a premium of Rs90 per person per annum (of which, Rs30 ($0.75) was initially contributed by the state government), the scheme provides health insurance cover of upto Rs200,000 ($5,000) per year for surgeries in identified hospitals. The scheme also covers out-patient consulting costs at the network of hospitals. However, this is limited to doctor's fees and the cost of diagnostic services; the cost of medication is not covered.

The Yeshasvini Scheme was the initiative of Dr Devi Shetty, a renowned cardiac surgeon who runs a hospital in Karnataka and has pioneered telemedicine in rural areas. By the end of March 2004, the scheme had 1.6 million subscribers – all of them farmers – spread across 27 districts of Karnataka's 30 districts and by the end of 2004, the outreach had increased to 2.2 million. However, in the third year of the operation of the scheme (2005), when the state subsidy was stopped and the premium was increased to Rs120 per person (for adults), the membership had dropped to 1.5 million by October 2005[23]. The scheme has linkages with a network of public sector and private hospitals across Karnataka state. As of March 2004, the scheme had 118 linked hospitals.

This case is discussed in more detail in **Appendix 2**

[22] Kuruvilla, et al. 2005. "The Karnataka Yeshasvini Health Insurance Scheme for Rural Farmers & Peasants: Towards Comprehensive Health Insurance Coverage for Karnataka?"

[23] www.microhealthinsurance-india.org/content/e22/e341/e713/update2_october2005.pdf

In discussion with the study team, a number of insurance experts have suggested that this model works best when the ownership and management are both vested with the community. Where the assistance of qualified persons is required (if the members of the community institution do not have the capacity to manage the programme, due to the technicalities involved in product design, fund management and investment), such persons could be hired as employees. The governance structure of such a community owned institution would have to consist of democratically elected members and all employees hired for day-to-day management would report to the Board. It has been suggested that this community-elected Board should decide on the admission of new members and also on the sanctioning of claims. This would avoid the risks of adverse selection and moral hazard.

5.1.3. Social security – *a growing effort at economic inclusion*

Social security insurance (also referred to as pension linked products) is available in the market, mainly for the middle and upper income segments. These products are mostly linked to mutual funds and are known as Unit Linked Insurance Products (ULIP) with life cover. Efforts to provide social security to low income households/unorganized sector enterprises are at a nascent stage. There have been government initiatives both at state and national levels[24] for "below poverty line" (BPL) households but these have had limited success, so far, due to the lack of client education and information as well as inappropriate product design. Recently the Unit Trust of India (UTI) has initiated a pension scheme by launching a Retirement Benefit Pension Fund, followed by ICICI Prudential's 'Micro Systematic Investment Plan' (MSIP) for low income households. These are believed to be the only investment-oriented schemes available for promoting inclusion (of low income households) in the economic and capital market growth of the country. Though such schemes are beyond the scope of this study, a brief note on these is provided in **Appendix 2**. The experience of the Bihar State Co-operative Milk Producers' Federation Ltd in implementing a micro-pension scheme is presented in Box 5**.**

Box 5. Micro pensions – The COMPFED experience

Bihar State Co-operative Milk Producers' Federation Ltd (COMPFED) is constituted of five Milk Producer's Unions (MPUs). It has around 300,000 members and reaches 5,500 villages in Bihar state. In September 2006, COMPFED launched a micro-pension scheme for its members. Under the scheme the members of the MPUs contribute Rs100 per month towards the UTI-Retirement Benefit Pension Fund up to the age of 55 years and are then eligible to receive regular cash flows as pensions after they reach the age of 58 years. This is a unit linked policy and, therefore, the pension amount depends on the NAV of the fund at the time the client attains the threshold age of 58 years. Until now 40,000 members of MPUs have opted for this scheme.

While members of the MPUs have welcomed this scheme there has also been a demand for insurance schemes for life and health. COMPFED plans to introduce an insurance package for its members in the near future. These would be add-on schemes offered along with the micro-pension scheme provided by the UTI Mutual Fund. The members will have to pay an additional Rs30 per year per member. The insurance will cover life with an accident rider and health rider. This will be a term

[24] These include schemes –old age pension scheme and family benefit scheme – introduced under National Social Assistance Programme (NSAP) state initiatives like pension scheme for poor craftsmen by Andhra Pradesh Handicrafts Development Corporation Ltd (APHDCL)

policy covering risk for one year – Rs100,000 cover for accidental death, Rs25,000 for normal death and Rs10,000 for medical treatment. This risk will be underwritten by the National Insurance Company (NIC) on a group basis and the policies sold by the UTI Mutual Fund through COMPFED.

The terms of business between UTI Mutual Fund and NIC as well as between COMPFED and UTI Mutual Fund have been fixed and the proposal is currently under the consideration of the Securities and Exchange Board of India (the stock market and mutual funds regulator). The product will be launched when approval has been obtained.

The Government of India (GoI) has also launched its new social security initiative – *Aam Admi Bima Yojana* (Common Person's Insurance Programme) – for poor families that do not own agricultural land. The Finance Minister, in his budget speech set aside Rs1,000 crore ($250 million) to subsidize and extend death and disability coverage to an estimated 15 million rural and landless households. Under the programme, which translates into an insurance plan for the common man, the state and union governments are expected to bear the premium of Rs200 for every policy holder who is insured to the extent of Rs50,000 ($1,250) in case of natural death and Rs75,000 ($1,850) in case of an accident. The government owned Life Insurance Corporation of India (LIC) has been appointed manager of the fund.[25] In addressing the gathering of international participants at the Munich Re Micro-Insurance Conference in Mumbai (on 13 November 2007) the Finance Minister of India announced that this was one of the most ambitious social security plans of the Government of India (GoI) and is targeted to reach 10 million persons by October 2008. In addition, there is accident insurance of Rs50,000 ($1,200) for 64 million holders of the farmers' lines of credit (known as Kisan Credit Cards) and to a few million holders of the artisan[26] credit cards.

5.2. Distribution – *mainly through microfinance institutions as partners or agents of formal insurance companies*

The limiting features of micro-insurance products – low premiums, on the one hand, and (relatively) high transaction costs (for insurers), on the other – make it necessary for these products to be offered through special vehicles that have been variously described as 'nodal agencies[27]' or 'aggregators'. These are agencies that already have access to and commercial or financial relationships with large groups of low-income families in a certain geographical area. These agencies form an essential part of the delivery mechanism for micro-insurance in India. Typically, these agencies are

- Microfinance Institutions (MFIs)
- Non-Government Organisations (NGOs)

[25] Budget 2007. http://www.livemint.com/2007/03/06022252/LIC-wants-clarity-on-Rs1000-c.html

[26] Micro-entrepreneurs engaged in production/processing activities.

[27] Ahuja, Rajeev. 2005. Published in the India Insurance Report: Series I. "Micro-insurance in India". Birla Institute of Management and Technology, Greater Noida.

- Self-Help Groups (SHGs) or associations of SHGs
- Co-operative societies
- Other community benefit institutions

In addition to the above agencies, other organizations or persons who have regular interactions with low-income families – such as seed distributors, fertilizer distributors and Panchayati Raj Institutions – have also been targeted for delivery of micro-insurance products. Recognising the importance of such 'aggregators', IRDA has referred to them as 'micro-insurance agents' in the Micro-insurance Regulations, 2005. However, the definition of agents has been restrictive as discussed in **Section 6.2.2** because of exclusion of MFIs registered under the Companies Act.

While the most common form of delivery is the **partner-agent model**, which is also encouraged by the regulatory framework, some NGOs and MFIs also provide in-house insurance (discussed in **Section 5.1.2**), by collecting 'premiums' from their members. The partner-agent model was being practised by insurance companies much before its formalisation by the IRDA micro-insurance regulations. As discussed in Section 4.4, the regulations provide for three forms of 'aggregators' – NGOs, MFIs and SHGs – to be facilitators for providing insurance (life and non-life) products to low-income households in the country. The regulation has allowed insurance companies to identify such 'aggregators' and provide mandatory training on insurance products and delivery (of at least 25 hours) to their staff to enable them to act as 'MI agents'.

The figure tries to encompass all types of partnerships of insurance companies with aggregators including health insurance. The aggregators are responsible for selling the policies (life and non-life) to their clients, collect premium, transfer it to the insurance companies and process claims.

For health insurance, in addition to the partnership with the aggregator a medical service provider is also involved and sometimes also a TPA for administering claims payments. However, in most cases the aggregator acts as the TPA for the insurance company. In the partnership model, the insurers that underwrite the risk remain in the background while the aggregators are the public face of the companies. This became evident during the field survey; the clients of MFIs were found to be aware of the terms of the microinsurance purchased by them but not of the identity of the insurer. In fact it was only the public sector LIC – due to its long history as a provider of insurance services in India – that featured prominently as a company known by the respondents (see **Appendix 3**)

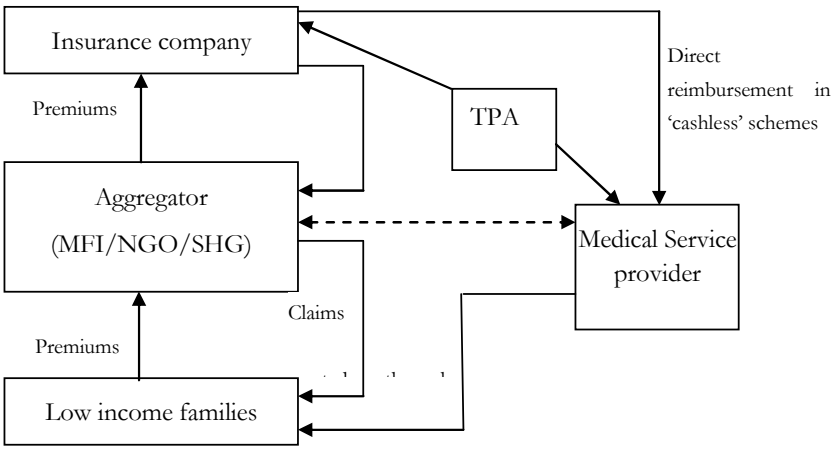

Figure 6. The partner-agent delivery model for micro-insurance

Though the partner-agent model is the most common channel adopted by the insurance companies to market their micro-insurance products, it is surprising that apart from LIC (which has around 2,500 registered MI agents – see LIC experience in selling micro-insurance products through micro-insurance agents in **Appendix 2**) none of the other companies' partners conform to the IRDA definition of MI agent. Another case of partnership of an NGO (AIDMI) with public sector insurance companies to provide life and asset insurance is described in **Appendix 2**. Most insurance companies have partnerships with MFIs that are registered as companies to access the large client bases of such organisations. Some insurers partner with Cooperative Banks (see Box 6) and individuals (like local grain traders (*arhathis)*, shopkeepers, school teachers) to sell micro-insurance.

It is perhaps not surprising that the IRDA treats such facilitation with 'benign neglect', ignoring the collaborations as long as client protection is not compromised. However, these are grey areas that the MI regulations do not cover and have allowed intermediation by unauthorised agencies to flourish. A large number of such partnerships still try to follow the insurance norms through quasi-agents/brokers to ensure a modicum of legal protection. Such regulatory uncertainty adds to the cost of the product on account of the elaborate payment systems and arrangements that must be made to fulfil the regulatory requirements. These costs clearly could be avoided if more facilitative regulation was put into place.

Such partnerships have also allowed the 'aggregators' to collaborate with multiple life and non-life companies to offer products best suited to their members while MI agents are limited to just one life and one non-life company. Yet, it is widely believed that for MI agents, micro-insurance cannot be a full-time engagement due the small earnings that would result. Therefore, this regulation is seen as a restrictive step that limits the viability of micro-insurance as a business opportunity, compounding the limitation resulting from the small size of these products.

Box 6. Selling insurance through Cooperative and Rural Banks: The Aviva experience

Aviva was the first insurer to experiment with the distribution of insurance products through District Cooperative Banks (DCB). This model is commonly referred to as bancassurance in which the aggregator shares the existing client data with the insurer who are then approaches the clients

directly for selling insurance policies. The banks are paid a fixed percentage of the premium collected. The proportion varies from bank to bank, on the basis of numbers, type of policy, term and frequency of the premium payment.

In addition to Cooperative Banks, Aviva has also tied-up with Regional Rural Banks (RRB). Across India, Aviva has such arrangements with 27-30 RRBs and DCBs for using their client base to sell its insurance products. Other companies have also started using this model now. In 2006-07, 60-70 % of the total business of Aviva came from this channel.

This model has worked well for Aviva because the credibility of the products increased when sold through the DCB/RRB channel. Trust is a big issue while purchasing financial products and insurance is no different. Customers inquire with the DCB/RRB about the insurance company and their staff assures them about the authenticity and reliability of Aviva. Though the conversion rate (number of people who are actually contacted and who finally buy the products) differs across branches, the overall rate of 35-40% achieved by AVIVA through this channel is regarded as good.

A more detailed case study of this channel is contained in **Appendix 2.**

The restriction to only one company of each type is based on the assumption that the complexity of insurance products is high and that "too much information" would be a burden both for the MI agent and the client. This restriction makes it impossible to combine the best products from different companies into a bouquet that will suit the needs of particular types of clients. BASIX – a leading NBFC MFI that facilitates micro-insurance linkages has been able to provide such a bouquet of insurance products to its clients as it is not an MI agent (see Box 7 below). The fears about confusion in the selling of products appear to be misplaced since it is unlikely to become a full-time occupation and, therefore, highly unlikely that any MI agent would engage in *de facto* brokering – which is really what concerns the regulator.

Box 7. Collaboration of Basix with various insurance companies

Basix is a leading MFI and has collaborated with Aviva Life Insurance Company for credit-life, ICICI Lombard for weather insurance and Royal Sundaram for enterprise and livestock insurance. Since its core business is providing financial services to its clients, Basix – a micro-finance group with around 250,000 clients – would like to offer other services and products that are appropriate and complementary with its microfinance products.

The micro-insurance experience of Basix started with the credit-life (compulsory) product of AVIVA. This insures the life of the client and also Basix's loan in case of the death of the client. With experience, the premium per client on this product has gone down and the cover has been extended to the spouse of the borrower as well.[28] However, just life cover was not sufficient for the borrowers of Basix as a large proportion had taken loans for agriculture, livestock and micro/small enterprises.

Since AVIVA does not provide non-life insurance, Basix scanned the market for the most suitable products and identified ICICI Lombard and Royal Sundaram for weather and enterprise insurance respectively. The general observation is that not only Basix but other leading MFIs in India have multiple collaborations with life as well as non-life companies in order to make the best possible insurance options available to their clients.

[28] Gunaranjan, 2007. "The challenges of micro-insurance" IRDA Journal Nov 2007

5.3. Products and Outreach – *not only low insurance penetration but also very limited distribution amongst the low income segments of the market*

While the rapid increase in insurance penetration in India, apparent from the discussion earlier in this section and in **Section 3**, is a good augury for the future of insurance coverage and economic security in India, indications for the present coverage of the low-income micro-insurance market are not good. No direct information on micro-insurance cover is available but information from the 59th round of the National Sample Survey conducted in 2002-03 (as of end-June 2002) shows a highly skewed distribution of household assets.[29] Since the overwhelming majority of the insurance products sold in the Indian market and, indeed, the thrust of the marketing undertaken by the insurance companies is on the selling of "endowment" products, it is apparent that the average policy holder sees insurance as a form of saving. In this context the use of the available information on the distribution of financial deposits as a proxy for the current distribution of insurance penetration seems appropriate. The distribution of deposits by the distribution of household wealth levels is presented in Figure 7.

[29] NSSO, 2005.

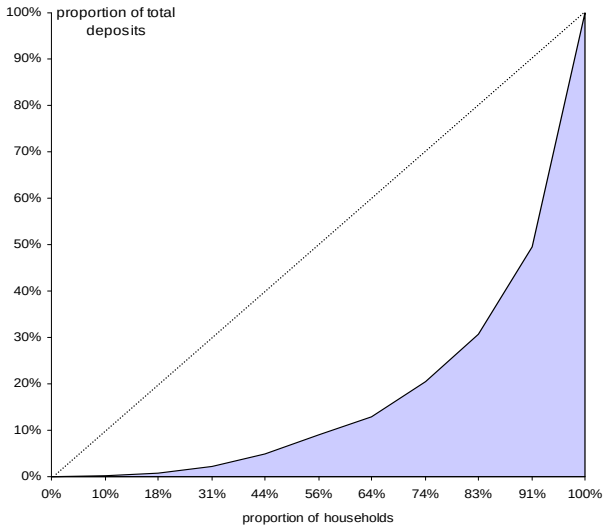

Figure 7. Distribution of deposits by households across wealth classes

As the figure shows, the bottom 56% of households own just 9% of total financial deposits while the wealthiest 9% of households own over 50% of financial deposits. This yields a Gini coefficient of deposit distribution of 0.627, a highly unequal situation though better than the 0.74 coefficient of land distribution in India (measured in 2003).[30] This indicates the likely levels of investment and in insurance by the low income sections of the population. It suggests that insurance cover of the bottom 56% of the population is not likely to be any more than 9-10% of the total insurance cover taken by households in India. On this argument, the bottom 30% of the population – the main target of the microinsurance effort – would account for an even lower 2.3% of total insurance. The impression of the study team, based on an informal assessment, is that even this low estimate of overall insurance premium emanating from the bottom 30% of the population is optimistic.

5.3.1. Micro-insurance cover by insurance companies

Systematic information on micro-insurance cover provided by the insurance companies is not available. However, data obtained on rural and social sector obligations (discussed in **Section 4.3.1**) show that most insurance companies have been able to meet their obligations – Table 6 (detailed table in **Appendix 6**). It is clear from the numbers and emerging from interviews of insurance company managements with this study team that most of the insurance companies have made an effort to fulfil the statutory obligations.

	2002-3		2003-4		2004-5	
Life insurers	**Achv./Trgt.**	**No. of**	**Achv./Trgt.**	**No. of**	**Achv./Trgt.**	**No. of**

[30] Coefficient of land distribution cited in Bardhan, 2007.

	2002-3		2003-4		2004-5	
	Ratio	Policies	Ratio	Policies	Ratio	policies
Private	1.54	109,326	1.31	258,599	1.38	414,909
Public	1.16	4,545,841	1.42	6,146,023	1.43	5,488,592
Overall life	1.49	4,655,167	1.32	6,404,621	1.38	5,903,502
Non-life insurers	**Achv./Trgt. Ratio**	**Gross premium u/w (Rs lakh)**	**Achv./Trgt. Ratio**	**Gross premium u/w (Rs lakh)**	**Achv./Trgt. Ratio**	**Gross premium u/w (Rs lakh)**
Private	1.03	5,339	1.07	11,803	1.30	25,110
Public	1.43	91,115	1.53	100,924	1.64	111,902
Overall non-life	1.21	96,455	1.23	112,726	1.41	137,011

Source: Analysis of data collected from Rajya Sabha Unstarred Question No.4016, dated 23.05.2006 and IRDA Journals for May 2003, 2004, 2005 and 2006

Table 6. Compliance with rural sector obligations by insurance companies

In terms of growth the number of policies underwritten by private life insurance companies under the rural sector have almost trebled (~140% p.a) from 2002-3 to 2004-5 while that of LIC has just increased by 10% p.a. The growth status of the non-life insurance companies is similar – gross premium underwritten by private companies in the rural sector grew at 185% p.a while the public sector companies grew by 11% p.a from 2002-3 to 2004-5.

As Table 7 shows, all insurance companies (life and non-life) were also able to meet their social sector targets. While most have tried just to achieve their targets some life insurers like SBI Life, Aviva & LIC and non-life insurers like IFFCO Tokyo, ICICI Lombard, HDFC Chubb, Cholamandalam and the four public sector non-life companies were able to exceed their targets significantly in 2004-5. However, the number of lives covered by non-life insurance companies have shown a decline during these years mainly due to huge drop lives covered by New India Insurance Company and National Insurance Company (– 45% p.a each).

	2002-3		2003-4		2004-5	
Life insurers	**Achv./Trgt. Ratio**	**No. of lives covered (mio)**	**Achv./Trgt. Ratio**	**No. of lives covered (mio)**	**Achv./Trgt. Ratio**	**No. of lives covered (mio)**
Private	1.74	0.17	2.53	0.32	8.63	1.70
Public	1.01	0.76	2.30	1.74	5.58	4.21
Overall life	1.09	0.93	2.34	2.06	6.21	5.91
Non-life insurers						
Private	29.14	0.89	21.23	1.11	15.23	1.22
Public		33.16		19.97		9.08
Overall non-life		34.04		21.09		10.30

Table 7. Compliance of social sector obligations by insurance companies[12]

Source: As for Table 6.

In terms of rural market share, the share of public sector insurance companies (both life and non-life) remains substantial but it declined from around 98% for life companies and 95% for non-life companies in 2002-3 to 82% for both in 2004-5, confirming that the private sector is also making some inroads in this market.

Though the numbers on coverage of rural and social sector obligations appear encouraging, there is limited information on the coverage of low income families by the insurance companies through micro-insurance. Interactions of the study team with the insurance companies reveal that the focus is mainly on the rural rich and surplus categories of rural families in a presumed continuum that divides the rural population into four economic classes – rich, surplus, poor and very poor. While some insurers have started to target the poor as well, the opinion of the companies is that the lowest level, the "bottom of the pyramid" in international parlance (or the bottom of the truncated diamond as explained in **Section 3**), should be supported by the government with social security schemes and development programmes to improve their economic status, and not be turned into a millstone for the insurance sector.

The regulatory obligations for a proportion of underwriting being for the rural and social sectors have nevertheless forced the new (private) insurance companies to assess the needs of these less immediately attractive markets and to experiment with products, distribution channels and delivery systems appropriate to these markets. With more or less enthusiasm, these companies see the rural and social sectors as well as the micro-insurance market as one that has income generating potential in the distant (if not the immediate) future.

5.3.2. Market trends

In 2003-4, the insurance sector filed 12 micro-insurance products from six insurers. These products were approved in 2003-4[31] but became operational only after the introduction of MI regulations in 2005. Table 8 shows that the small number of micro-insurance products initially filed with the IRDA, apparent from the table, suggests that most insurers did not immediately invest much thought into treating micro-insurance as a business opportunity, considering it more as a Government obligation to be satisfied with the minimum of effort.[32]

Products	**Life products**		**Non-life products**		**Total products**	
	Public	**Private**	**Public**	**Private**	**Public**	**Private**
All insurance products	6	49	20	45	26	94
Micro-insurance products	–	–	1	1	1	1
Total (during 2005-6)	**6**	**49**	**21**	**46**	**27**	**95**
MI products initially filed (2003-4)	–	3	6	3	6	6
Overall MI products registered (Nov-07) [33]	**1**	**11**		**8**	**12**	**8**

Source: IRDA Annual Report 2003-4 and 2005-6; IRDA website

Table 8. New products approved by IRDA

The number of MI products now approved by the IRDA is 12 life products from 6 life insurers and 8 non-life products from 4 non-life insurers. The life products are mostly endowment (single & regular

[31] UNDP 2007. "Building security for the poor – potential & prospects for micro-insurance in India"

[32] *Ibid.*

[33] Prabhakara G, IRDA 2007. MI Conference 2007, Mumbai

premium policies) and term assurance (with risk and return of premiums) while the non-life are mostly health insurance, package cover and crop insurance products. The insurance companies have launched several products for targeting the rural markets as well though some of these cannot be categorized under the micro-insurance. **Appendix 6** provides the main features of the products offered in rural areas. A consideration of the products offered in the micro-insurance market reveals the trends in product design, distribution and up-take.

- *Micro-insurance market dominated by credit-life and loan linked asset insurance*

The domination of credit-life and loan linked asset insurance business by the insurance companies is directly correlated to the rapid growth of the micro-finance sector in India over the past few years. The micro-finance sector in India is broadly characterized by mainly credit and (limited, usually compulsory) deposit services provided to low income families by (i) government programmes (including the linkage of self help groups (SHGs) to commercial banks) and (ii) by private for-profit or not-for-profit microfinance institutions (MFIs).

The SHG-Bank linkage programme (SBLP) covered an additional 9.6 million persons in 2006-7, over 90% of them women and perhaps half classified as having incomes below the government-defined poverty line. The total number of SHG members who ever received credit through the programme has grown, therefore, to 41 million persons. MFIs, grew even more strongly and added an estimated 3 million new borrowers to reach a total coverage of about 10.5 million borrowers. Both programmes taken together have, therefore, reached about 50 million households though perhaps around 30-35 million of these are currently being served.[34]

The growth of micro-insurance products in bundled form has been mainly due to the micro-financiers' (the MFIs) need to protect their loans in the event of the untimely death or loss of assets of their borrowers. The MFIs as well as rural (RRB and Cooperative) banking system have provided the insurers with ready access to their huge rural client base enabling the latter to comply with the rural and social sector obligations while enabling them to experiment with and learn about the microfinance and rural finance industry as a distribution channel. The role of the microfinance rating agencies in encouraging the MFIs to engage with the insurance companies rather than try to undertake "in house" underwriting has also been important in the growth of micro-insurance in India through the partner-agent model – see Box 8. That micro-insurance has started mainly as a loan protection tool for MFIs rather than as a financial cushion for their clients is perhaps an inevitable consequence of the presently undeveloped nature of the market. However, as indicated above, it has initiated a process of growing experience with product development, servicing of policies and client awareness that could facilitate the development of the MI market in the future, presumably with credit-life policies covering more than just the credit taken by the client and providing some real benefit to the family in case of the unfortunate demise of the insured person.

[34] Ghate Prabhu 2007. "Microfinance in India – A state of the sector report 2007"

Box 8. Role of microfinance raters in promoting micro-insurance[35]

Agencies rating microfinance institutions in India have played an important role in shaping the insurance practices undertaken by MFIs. When the microfinance sector was at its nascent stage in the late 1990s, a large number of MFIs were providing insurance cover (mainly life) to their current borrowers. This was done usually through an insurance fund created by collecting a small proportion (1-2%) of the loan amount from their borrowers. M-CRIL, the leading microfinance rater, viewed this as imposing a substantial contingent risk on the MFI on account (of the covariance of) their operations in limited areas. This affected the overall rating of the MFI and discouraged them from the practice of independent insurance under-writing. This resulted in MFIs seeking distribution arrangements with insurance companies so as to pass the risk on to them. In addition, to reducing their own risk the MFIs were, thereby, able to earn commissions/service fees for this business from the insurance companies.

Table 9 provides an indication of the insurance cover available to the clients of some selected MFIs.

~March 2007

MFI	Customers covered					
	Life	Health	Accident	Livestock	Micro-enterprises	Weather
BISWA	58,743	153,223	47,386	237	3,862	
KAS Foundation	2,794		190,357	1,934	5,505	
KDS	25,000	5,000				
CASHPOR	27,879					
ASA	49,623					
BASIX	372,344	356,545		10,098	1,263	10,711
ESAF	287	13,510	68,521			
KBSLAB	17,892	17,892		953		1,005
Mahasemam Trust	221,613	30,498				
Saadhana Society	101,901					
SWAWS	48,154	48,154				
SKDRDP		721,203				
SKS Microfinance	603,933	990				
Spandana	1,020,000					

Table 9. Insurance coverage by selected MFIs[36]

- *Preference for endowment over term products*

[35] This study of micro-insurance is undertaken by a team led by M-CRIL – the main microfinance rater in India and the most active specialized microfinance rating agency in the world.

[36] Ghate, 2007.

Traditionally, insurance in India has been promoted mainly as a savings product which provides some returns at the end of the tenure so that risk coverage is just an additional benefit. The rural population, which anyway does not have much knowledge of insurance, is unable to comprehend the benefits of pure risk policies on which the premium is written off (for the client) if there is no claim before the end of the term. The field research corroborates this observation. The discussion in **Appendix 3** shows that clients are more inclined to buy products which provide them returns than pure risk policies that are seen as forced upon them along with loans obtained from MFIs. However, the preference for composite products (which are mainly pure risk based) like those provided by SEWA and its partner NGOs was found to be high particularly if it was bundled with a health product.

Term policies are also not favoured by insurance companies since their earnings on such policies are much lower than those on endowment policies. On micro-insurance they are even more reluctant to do so. The reason cited by insurers is that micro-insurance is equivalent to medically underwritten[37] policies in terms of the risk of booking such policies. This is mainly on account of the poor health of the population and limited health facilities in rural areas where the micro-insurance clients are based. Therefore the health risk is naturally high and ideally requires high premiums particularly for individual products. This is why, even for rural markets, the insurance companies prefer to market endowment products underwritten on a group basis, carrying a smaller proportion of risk for the insurer. It is clear that this apparent "win-win" of the endowment product is a bad value proposition for the client but continues in the absence of appropriate consumer education. There is no incentive for the insurance companies to disillusion their clients in this matter.

- *Health insurance has a naturally high demand*

Health insurance has a naturally high demand in rural as well as urban markets. This is evident from the number of health insurance policies (see **Appendix 5**) offered by various types of organization across the country. According to a World Bank study[38], the economic status of about one-fourth of Indians who are hospitalized falls below the poverty line[39] on account of their hospital stays and similarly, more than 40% of hospitalized patients take loans or sell assets to pay for their hospitalization.

The FGDs conducted by the study team also show the high preference for health insurance among existing insurance buyers. In the context of insurance, health was found to be the top priority for 61.6% of respondents as they associate illness with unplanned expenses as well as the loss of income causing a

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[37] Insurance works on the assumption that the insured is a healthy person. Also, even in case of ill health the insured has access to medical facilities. In rural areas this scenario is lacking due to lack of medical infrastructure and the probability of dying without getting proper treatment is high. Therefore MI by default makes adverse selection and leads to booking of sub-standard lives.

[38] Peters, et al. 2002. "Better Health Systems for India's Poor: Findings, Analysis and Options". The World Bank, Washington DC

[39] The poverty line referred to here is as defined by the World Bank, where a person is considered poor if his/her average income is less than US$1.0 per day.

huge impact on their cash-flows. The more aware groups (in the South and West of the country) were even able to break this preference down further. For them, cover for common illnesses (as out-patients) was the most important risk that requires insurance (**Appendix 3**).

Health insurance is usually offered through group products offered to the members/clients of MFIs and NGOs and to specific sections of the population (such as all the BPL families in a state) by the state government. Research[40] shows that MFIs/NGOs offer health insurance to the poor in two different ways: (i) through collaborations with a formal insurance provider, where the MFI/NGO acts as an intermediary; and (ii) where the MFI/NGO manages the health-insurance scheme in-house, by arrangement with a health-care provider.

In the case of collaborations with a formal insurance provider, typically, health insurance cover is provided as a fixed sum in case of the hospitalisation of the client. These products are offered as group insurance products and may be bundled with accident benefits. Table 10 illustrates the health insurance products offered by three MFIs/NGOs in partnership with mainstream insurance companies.

Product feature	**SHEPHERD**	**SKDRDP**	**SEWA**
Delivery model	Group product Partner-agent with United India Insurance Corporation	Group product Partner-agent with ICICI Lombard Insurance (for hospitalisation cover only)	Group product Partner-agent with ICICI Lombard, LIC, Om Kotak and Bajaj Allianz
Term	One year	One year	One year
Eligibility	Age: 18-60 years	Age: 18-55 years	Age: 18-55 years
Compulsion	Voluntary	Voluntary	Voluntary
Product benefits	Rs15,000 for accidental death Rs15,000 for permanent disability Rs250 per month for a maximum of three months (to compensate for lost wages in case of hospitalisation or disability) Rs5,000 for hospitalisation expenses Rs5,000 in case of house getting destroyed by fire and allied perils 30-days of pre-hospitalisation expenses and 60-days of post-hospitalisation expenses included	Rs20,000 for accidental death of head of family Rs5,000 for normal/accidental death of head of family Rs12,500 for partial disability and Rs25,000 for permanent disability Rs50 per day for 30 days to compensate for loss of pay Rs5,000-50,000 for hospitalisation expenses (cashless – in network of hospitals) – floater policy Reimbursement of maternity expenses – Rs2,000-4,000 Rs1,000 in case of house being destroyed by natural calamity	Rs40,000-Rs65,000 for accidental death of member or spouse Rs7,500-Rs20,000 for natural death of member or spouse Rs2,000-Rs6,000 for hospitalisation of member or spouse Rs2,500 for hospitalisation of one or more children Rs10,000-Rs20,000 for loss of assets Maternity benefits of Rs300, Support for dentures: Rs600 and for hearing aids: Rs1,000 to members paying premium as fixed deposit
Pricing	Member pays Rs100; Rs84 goes to the insurance company (an additional Rs20 is charged for thatched roof houses)	Annual premium from Rs190-Rs1,225 per person depending on number of family members Annual premium of Rs650 for a family of 5	Rs325-Rs550 per annum or Rs3,600-Rs9,000 as one time deposit

Source: SHEPHERD: Roth, et al. 2005. SEWA: www.sewainsurance.org; SKDRDP: information provided by orgn.

[40] Ahuja, Rajeev. 2005, op cit, pg 28.

Table 10. Partnership micro-insurance products

Note: SHEPHERD is an NGO-MFI in Tamil Nadu with a client-base of 5,300 on 31 March 2006. SEWA (Self-Employed Women's Association) is a trade union of working women mainly in Gujarat. SEWA is the largest co-operative of working women in India, with nearly 960,000 members (31 March 2006). SKDRDP is an NGO run by a Temple Trust in Karnataka. SKDRDP's microfinance programme covered ~400,000 clients (30 September 2006).

As discussed earlier, the second approach of MFIs/NGOs in offering micro-health insurance products to low-income families is where the NGO/MFI offers the product in-house (also called mutual insurance). Though not very common, this arrangement is worth considering. Several NGOs and MFIs including SEWA, Gujarat had been providing insurance in-house before they started collaborating up with the insurance companies.[41] Case studies on Healing Fields and Vimo SEWA insurance programmes respectively are presented in **Appendix 2**.

The prominent health insurance schemes offered by the Government (both Central and state governments) in India for low-income families include[42] - Central Government Health Scheme (CGHS), Employee State Insurance Scheme (ESIS), Universal Health Insurance Scheme and other schemes funded by State governments and central Ministries. Public schemes, only reach a small proportion of the population. Experts in the industry estimate that only 10 to 20 million persons have health insurance.[43] As indicated in Box 9, these low outreach parameters are confirmed by a recent study by the National Insurance Academy. A write-up on the government schemes is provided in **Appendix 2**.

Box 9. A study by National Insurance Academy, Pune

Though the health insurance sector recorded a healthy 38% growth during 2006-7, only 1.08% of the over one billion Indians have secured medical insurance cover since 1986 when health insurance was first introduced in the country. A shortage of hospitals as well as insurance providers, poverty and lack of coordination between hospitals and insurance companies as well as people's belief in destiny have been cited as some of the reasons for the poor response. The potential market for health insurance is about Rs30,000 crore ($120 billion), but, at present, it is limited to just Rs1,400 crore ($5.6 billion). And moneywise, the health insurance sector stands at just 3% of the insurance sector.

These are the findings of the latest study conducted by National Insurance Academy, one of the premium institutes in the insurance sector. The data for the study was collected from 16 insurance companies providing medical insurance. The findings also suggest that a majority of the insurance schemes have remained restricted to the five metropolitan cities – Mumbai, Delhi, Kolkata, Bangalore & Chennai.

K N Mishra, NIA Director also mentioned in his recent discussion with a leading daily newspaper – Times of

[41] SEWA abandoned its in-house insurance product when it faced high losses resulting from the Gujarat earthquake of 2002.

[42] Chakraborty, Manab. 2005. "Study on Linkages between Statutory Social Security Schemes and Community Based Social Protection Mechanisms to Extend Coverage: India Case Study". ILO/SSA/AIM

[43] Garand, Denis, 2005. "CGAP Working Group on Microinsurance - Good and Bad Practices Case Study No. 16"

India – that there were restrictive players and not enough hospitals to enable people to take the benefit of health insurance. Very few people can afford to buy insurance policies due to poverty and very few insurance firms have branches in semi-urban and rural areas. The majority of the semi-urban and rural population remains neglected.

Source: Gitesh Shelka and Rupa Chapalgaonkar, Correspondent Report, Times of India 25 Nov 2007

Among the health-insurance initiatives of the central/state governments the prominent ones are:

- The Ministry of Textiles' health insurance scheme[44] for 300,000 weavers in 2005, providing cover to the weaver, his wife and two children for all pre-existing diseases. Out of the total annual premium of Rs1,000, the Central government contributes Rs800 and the weaver has to pay the remaining Rs200.

- The health insurance scheme for the poor launched by the Government of Kerala around July 2006, but revoked by the new Left Democratic Front Government in November 2006[45]. The scheme was envisaged to cover 2.5 million BPL families and provide a package of benefits that included Rs30,000 a year as the total medical expenses for a family of five; up to Rs60,000 a year for treatment at home, if required; up to Rs15,000 a year for maternity needs; a subsistence allowance of Rs50 a day (if the bread-winner was hospitalised); a bystander allowance of Rs50 a day; coverage of all "existing" illnesses, and cashless medical treatment on production of the photo identity cards supplied by the insurer. The scheme also included an accident insurance benefit of Rs1.0 lakh ($2,500) for death or full disability and Rs50,000 for partial disability. The insurance cover was provided by ICICI Lombard General Insurance Company Ltd. The total premium for a "typical" five-member BPL family was Rs399 a year. The beneficiary's contribution was Rs33. A Central government subsidy of Rs300 under the Universal Health Insurance Scheme (UHIS) and an additional subsidy of Rs33 each from the State government and the local body concerned accounted for the balance. The scheme was to be implemented through "neighbourhood groups" (similar to Self-Help Groups) under the State government sponsored "*Kudumbasree*" programme.

- *The rural and social sector obligations are of prime importance*

The rural and social sector obligations have generated considerable pressure on insurers to sell micro-insurance. Without selling micro-insurance, the regulator will not let them sell their more profitable products. To date the IRDA has fined a number of insurers for failing to meet their targets. Continued non-compliance with the rural and social obligations could result in suspension of the license to operate.

Insurers prefer to meet the rural targets rather than focus on the social ones since large farmers can be covered resulting in more viable operations. During 2003-4, all 12 private life insurers and LIC met their

[44] Chakraborty, Manab. 2005. Op cit, pg 4

[45] Source: www.hinduonnet.com/fline/fl2322/stories/20061117001305000.htm

rural sector targets. However, under the social sector two private companies, Tata AIG and Om Kotak, did not meet their targets, with a shortfall in the number of lives covered under the social sector. Among the private non-life insurers the exception was HDFC Chubb which failed to meet both rural and social targets, while two public sector companies did not achieve the social sector obligations (UNDP 2007). It is to fulfill these requirements that insurers even started on the process of looking at developing products that suit MFI requirements so that they could target the large client bases of those institutions. The concern is that the resulting focus may have been too much on credit-life products rather than those customized for the comprehensive needs of low income families. This is further articulated in Box 10.

Box 10. The impact of quotas may not be all positive

There have been unverified reports that some insurers are dumping poorly serviced products on clients solely to meet their targets. As soon as they have met their targets, such companies immediately stop selling micro-insurance during that year. This practice is difficult to regulate, as it is harder to police the quality of insurance sold and serviced than its quantity. It would certainly be unfortunate if the regulation resulted in a mass of poorly serviced products sold at a loss, to enable insurers to concentrate on their more profitable markets. This situation would not result in meaningful sustainable financial deepening, since it is more akin to charity forced on insurers as a condition for doing business in India. (James & Vijay, 2005).

The information in Table 7 (above) shows that target-achievement ratios of the insurers have not improved much over the years, being more or less constant around 1.3 to 1.4. This is an indication that the insurance companies have actually not made a significant effort to go beyond a certain limit in meeting their rural and social obligations.

However, the quotas have contributed to the creation of awareness among insurers of the potential of the low-income population as insurance clients and forced them to look at the opportunities available. This has led them to devise several innovative products and schemes for the low-income population resulting in the insurers starting to look at this segment more positively.

- *No composite products yet*

The micro-insurance regulations allow insurers to offer composite life + non-life products provided there is an agreement between the life and non-life insurance companies for this purpose. However, the underwriting of risk for life/non-life has to be done by the respective specialised companies. The agreement would provide a composite product for consumers – enabling better marketing and easier claims processing. However, composite products have not been offered so far on account of non-regulatory dynamics. The insurance companies are reluctant to get into any contract with each other for offering micro-insurance products as this could restrict them in collaborating with other life/non-life agencies in the future if a more remunerative commercial opportunity arises. It is for this reason that even sister concerns like ICICI (Prulife & Lombard) or HDFC (CHUBB & Standard Life) or TATA AIG (Life & General) have not collaborated with each other to offer composite products. Another reason cited by the insurers is that each company (life or non-life) specialises in covering a certain type of risk and there are regional leaderships as well. Therefore, collaborations with one company will restrict them in collaborations with other companies that are market leaders in certain regions or products. Further, the amount of effort required for negotiating and concluding such agreements is widely thought to be out of proportion with the small amount of benefit that would accrue from the micro-insurance market.

- *High concentration in the southern region of India*

A high proportion of micro-insurance business (for both life as well as non-life companies) comes from the southern region of India – in the states of Andhra Pradesh, Karnataka, Tamil Nadu, and Kerala. The reasons are similar to the growth of the microfinance sector in the southern region – a large number of good quality NGOs, more vibrant local economies in the southern states as compared to the less developed states in the north and east and higher literacy and participation rates of women in the local economy make them suitable clients for MFIs.

The MFIs in the southern region account for more than 50% of MFIs in India and the clients served by these MFIs are more than 80% of the total MFI outreach in India.[46] This has provided easy access for the insurance companies to the rural client base. Of LIC's rural business, 67% comes from the southern region and the businesses of other companies are similar. The very poor areas of the states of several East and North-East region remain uncovered by the insurance companies.

- *Use of technology in micro-insurance*

The use of technology in micro-insurance is at a very nascent stage in India and most of the initiatives are at the pilot stage. TATA AIG Life is one of the insurance companies which have been proactive in attempting to use technology. It has introduced a cash collection and receipting system using a hand held machine to address the front-end concerns in remote rural areas. With the present system of equipping NGO partners with handheld devices that can issue receipts seamlessly, TATA AIG has empowered the NGOs to issue receipts on collection of money and also get real time information, every 24 hrs, on collection details. This has helped in reducing the time lag between the collection of premium from customers and the payment to TATA AIG while the cash receipt system has enhanced the credibility of the NGO staff. This has helped to overcome the customers' earlier reluctance to pay money to the staff of the NGO.[47]

SKS – a leading MFI in India – has also been experimenting with the use of technology and has develop an integrated module for an insurance management system, financial accounting, management information and customer information system. The software generates receipts in the vernacular and branch wise reports on insurance products purchased by clients. SKS is now exploring the possibility of mobile banking for premium collection, reminder services, product information/marketing, claims registration, processing and settlement.[48]

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[46] M-CRIL, 2007.

[47] Athreye Vijay 2007. "A presentation on TATA AIG experience on use of technology for improving efficiency and enhancing benefits" Source: Presented at Munich Re Micro-insurance Conference at Mumbai

[48] Divya Vishwanath 2007. "A presentation on SKS experience on use of technology for improving efficiency and enhancing benefits"

5.3.4. Micro-insurance product features

The key features of micro-insurance products in India that distinguish these from other insurance products are

Simplicity: The micro-insurance regulations specify that contracts for products demarcated as micro-insurance have to be issued in vernacular language that is simple and easily understood by policyholders. Even for group policies separate certificates have to be provided to each member of the group providing proof of insurance and details of the terms. Further, these products may also be distributed through micro-insurance agents (in addition to insurance agents, corporate agent and/or broker licensed under the Act). The micro-insurance agents are supposed to perform several additional functions like collection of proposal forms, collection of remittances of premium, distribution of policy documents, assistance in the settlement of claims and other policy administration services. All this warrants the products to be simple for better understanding by the client (who in most cases would have lower levels of education and awareness) and better servicing by the micro-insurance agent.

Range of prices: The regulation has set limits for micro-insurance products and the maximum cover cannot increase more than Rs50,000 ($1,250) under any circumstances. The policy term also cannot exceed 15 years for non-life and for life the term is annual. Pricing depends on the types of risk covered, savings based or pure risk products and group based underwriting. There is a range of products available for the low income segment ranging from relatively costly health insurance to low priced group-based credit-life/asset insurance for members of MFIs.

Group-based underwriting: At present, the micro-insurance sector mainly caters to the enormous client base of MFIs and members of SHGs formed under various government programmes. Since most of the clients/members are in groups, group-based underwriting provides very cheap cover to them, though in most cases this does not exceed the loan amount.

Limited benefit values: Since the products are for low income households the size of benefits is kept as limited as possible to limit the premium. Group-based underwriting also propagates limited benefits. The regulations limit the size of benefits by restricting the cover to Rs50,000 ($1,250). Some additional non-financial benefits offered by insurance companies include various payment options (annual, half-yearly, quarterly, monthly), a free-look period of 15 or 30 days and surrender value for policies that have been in force for even a limited period.

The ILO/STEP, 2005 working paper on insurance products provided by insurance companies (through partnership or in-house models) to the disadvantaged in India listed 83 micro-insurance products of which 55% covered a single risk. Most products covered life, which is a relatively simple entry point for micro-insurers.

Standardized government products with a large subsidy component: Most government programmes on insurance offer standardized products for the low income population irrespective of their geographical location and inherent risk profiles. An example is the Universal Health Insurance policy announced by the government and implemented by the four public sector insurance companies. Similarly the

Janashree Bima Yojana succeeded by (the recently announced) *Aam Admi Bima Yojana* are also standard products implemented by the LIC. Another characteristic of government insurance programmes is the subsidized premium.

5.4. Conclusion: Key Market Features

The discussions above have highlighted the characteristics of the micro-insurance market in India in terms of the players, distribution models and challenges, products and outreach. The following salient features emerge.

- *Product characteristics.* Micro-insurance products in the market have short policy contract terms 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 under-written but the numbers of such policies is still minuscule even relative to the already low overall outreach of micro-insurance. The size of benefits of micro-insurance products is also limited by micro-insurance regulations.

- *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. Community-based insurance systems are largely limited to health cover. However, the micro-insurance regulation allows the offering of life/non-life composite products provided there is a formal agreement between one life and one non-life company with each underwriting the respective risks and providing a unified service to clients.

- *Health prominence.* Health insurance is prominent in community-based systems because the health risk is generally seen as potentially the most devastating type of systemic risk likely to upset the lives and economic livelihoods of the low-income population. Formal micro-insurance schemes are yet to cover health in any significant way on account of the difficulties of ensuring service delivery and the dangers of moral hazard in a highly informal health service network.

- *Low outreach of community-based insurance.* Community-based health insurance systems managed by NGOs is 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*. It is probably the largest market driven by the compulsion of borrowers to purchase insurance schemes mainly to provide protective cover to the MFIs. The domination of credit-life and loan linked asset insurance business by the insurance companies is directly correlated to the rapid growth of the microfinance sector in India. This is also beneficial for the insurers who gain access to the huge rural client base of MFIs thereby enabling them to comply more easily with the rural and social sector obligations.

- *Micro-insurance category.* The advent of separate micro-insurance guidelines provided by the insurance regulator has seen the launch of new micro-insurance products in the formal market. At

present there are 12 life micro-insurance products by 6 life insurers and 8 non-life products by 4 non-life insurers approved by registered with the regulator.

- *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. However, very few formal relationships for the distribution of micro-insurance products have been seen so far, mainly because for-profit MFIs, which cover a very large proportion of microfinance outreach in India, have been left out of the ambit of the regulation.

- *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. However, micro-insurance agents have been entrusted with a much larger scope of service functions to be carried out by them.

Overall, while there is much in the Indian micro-insurance regulation that is designed to promote such products through its liberal and developmental approach, there are crucial omissions and design glitches that limit its efficacy. Specifically, the exclusion of corporate MFIs, the restriction of collaborations to one life and one non-life insurer and the limitations placed on pricing have a dampening effect on the micro-insurance market. These are issues that need to be examined in more detail and are the key factors addressed in the following section on the drivers of the micro-insurance market in India.

6. Drivers of the microinsurance market

The improved performance of the Indian economy, with GDP growth in excess of 8% since 2003, is reflected in the insurance industry. The premium underwritten in India and abroad by life insurers in 2005-06 increased by 27.8%, higher than the 24.3% growth in 2004-05. In the case of non-life insurers the corresponding growth was 15.6% compared to the 11.6% growth of the previous year. At the primary level, therefore, there is a macro-economic driver for the insurance market in India. Given concerns about the relatively exclusive nature of this economic growth, however, the extent to which it has a direct impact on the micro-insurance market is open to question. This is a question that cannot be resolved in the short term since adequate data on regional development is not immediately available.

Other non-regulatory as well as regulatory drivers of the micro-insurance market identified in the course of this study are discussed in this section.

6.1. Non-regulatory drivers of market characteristics

There are a number of non-regulatory drivers that are enabling (or limiting) the growth and development of the micro-insurance market in India. While some are related to the lack of certain basic facilities for the rural/semi-urban low income population – the target client segment for micro-insurance in India – others are stimulated by the growth of the microfinance sector in the country. The discussion that follows, though not exhaustive, examines the nature and magnitude of the effect of these drivers (and limitations).

6.1.1. Growth of microfinance has facilitated outreach and the resulting limitation on product design is starting to change

The growth of microfinance has led to the creation of a rural/low income client base for micro- financial services and has become a ready market for insurers. From the MFI perspective, more than 95% of the lending they do is unsecured and repayments are highly dependent on peer pressure and the client-MFI relationship. However, in case of the death of the client or loss of assets on account of natural or manmade disasters, the loan becomes bad and the chances of getting it back (from the group or family of the deceased) are low. Therefore, the MFIs welcome a loan protection mechanism to safeguard their portfolio from such unfortunate events. This has led to a symbiotic relationship between the insurers and MFIs and the insurance companies have started designing products that are suitable for them. The MFIs act as client aggregators for insurance companies resulting in effective and relatively economical distribution of micro-insurance products.

It is for this reason that the micro-insurance market is dominated by credit-life policies; compulsory products for the clients of most of the MFI aggregators. This means that any client borrowing money from an aggregator MFI has to purchase a life or asset insurance policy – or rather receives a life or asset insurance policy bundled with it. In most cases life cover is provided for the term of the loan and the sum assured is equivalent to the loan amount. Some of the larger MFIs that provide financial products to their clients for asset building and enterprise creation (for example purchase of livestock, agricultural tools and equipment, establishment of grocery shops, readymade garments shops, cycle repairs and servicing) have also introduced (or are in the process of introducing) loan linked asset insurance. There are also a few instances of composite products at the level of the MFI (for example the Vimo SEWA's integrated insurance product [49]– for further details see **Appendix 2**), which has not happened at the level of insurance companies.

Overall, on account of the sheer size of their client base – currently aggregating around 10 million – MFIs are able to bargain with insurance companies for offering products suitable for their clients. In the case of Basix (Box 11) with experience the coverage offered by the insurer has even been increased for the same (or lower) value of premium.

To this extent the major limitation of working with MFIs as aggregators – overwhelming interest in credit-linked products – may be starting to erode as the experience of working together grows and each type of institution learns more about the other as a partner in micro-insurance market development.

Box 11. Providing sustainable and competitive insurance products to rural customers[50]

Basix, a livelihood promotion institution set up in 1996, provides both financial and technical

[49] Vimo SEWA offers integrated insurance products covering multiple risks. Once a member has bought her coverage, she can also insure her husband and children. Risks covered under Scheme 1 includes natural death, health, asset loss, accidental death and spouse accidental death while Scheme 2 covers the same risks but with a higher sum assured. (Source: Garand Denis 2005. "CGAP Working Group on Micro-insurance – Good and Bad Practices – *Case Study No. 16)*

[50] Gunaranjan Sai, 2007. Chapter 7 in "Microfinance in India – A State of Sector Report 2007"

assistance services to about half a million households spread over 8 states in India. In October 2002, it began its initiative to provide life insurance cover to customers who took micro-credit. Basix took a group policy from AVIVA which covered its borrower for 1.5 times the loan amount taken by him/her during the loan tenor. In the absence of any past experience of mortality of the customer profile served by Basix, AVIVA priced the product conservatively at Rs8.61 per thousand sum insured. By October 2004, the experience of covering more than 50,000 persons was completed. The positive performance of the product by this stage allowed the insurance company to lower the premium rate to Rs6.89 per thousand of sum insured. A year later in 2005, over 100,000 person years were covered cumulatively. The claims experience gained till then allowed the insurance company to reduce the premium rate to Rs3.98 per thousand sum insured. Based on the actual performance of the product, Basix and AVIVA were able to reduce the premium rate by more than 50% in a three year period. This further allowed Basix to extend cover to the spouses of their borrowers, as the premium became more affordable. This experience proves that a sustainable approach to pricing of micro-insurance combined with proper administration of the products, allows the partners to add value to the small premiums paid by their customers.

6.1.2. Group based risk management and distribution has played a positive role

Since microfinance is delivered mainly on a group basis, it is perhaps not surprising that most of the micro-insurance policies in India are underwritten on a group basis. This is mainly due to a combination of factors

- the SHG movement in India is the backbone of the current microfinance industry,
- low awareness about insurance is more easily overcome if clients are organized into groups, and
- group underwriting limits premiums and improves affordability of insurance products.

The SHG movement has been the major factor in group-based risk management and distribution as a vast majority of low income/rural microfinance clients are mobilized in groups for various kinds of activities. At present, the microfinance sector outreach is estimated by some at around 50 million[51] households but is more likely to be around 30 million of which some 30-40% are estimated to be poor (BPL). Assuming that each family has an average of 4 members, the current microfinance outreach of poor clients is about 20% of the IRDA estimated micro-life insurance market of 240 million BPL individuals. In a country the size of India, these constitute large numbers, resulting in the micro-insurance company getting easy access to this client base through the organizations promoting such groups. Since these low income families have similar types of risk and they are able to use their membership of the group to access risk coping mechanisms such as insurance.

Since awareness of insurance is low amongst the low income families (as well as the more affluent in India) marketing individual products is, in any case, a difficult proposition – the field survey supports this

[51] Ghate Prabhu 2007.

observation (refer **Appendix 3**) – refer to Box below on the main observations from the FGDs on client awareness levels. The insurance companies, themselves testify to the relative benefit of distribution and servicing of policies through these groups. However, there is also the feeling that, over time and with growing awareness and buying capacity of micro-insurance clients the demand for small (but not micro-) insurance policies will increase as their economic status improves. In this situation, insurers will have to start designing appropriate individual products for them if the overall size of the market is to realize its enormous long term potential. It is only in this way that the diverse needs of individual families can be met.

The natural efficiencies of working with (readymade) groups has, of course, reduced the cost of underwriting relative to that of individual products that must be sold as retail products and are, therefore, relatively less affordable. Premium size inevitably increases for low income clients as the administrative as well as marketing cost of selling individual products is proportionately higher.

Box 12. Client awareness level

The FGD findings show that clients' awareness level on insurance as a financial product is low but varies widely across regions. The level of awareness depends on access to financial services, geographical proximity and exposure to insurance companies but not as much on the economic status of low income respondents. Though respondents were able to understand the risks faced by them and the need for risk cover insurance is regarded as a sunk expense which is unlikely to yield returns. However, respondents who had purchased insurance products and benefitted from these were able to appreciate the utility of the service much better than the non-clients. Further, the awareness level of insurance products available and of insurers themselves is low.

Clearly the awareness level of clients is comparatively better than that of non-clients. At the regional level clients in South India were found to be more aware than in other parts of the country. The high concentration of microfinance operations in the South, which has provided a good market and scale for the insurance companies has contributed to this.

Further details in **Appendix 3.**

6.1.3. But the lack of access to health services is a major limitation…

The guidelines for national health planning in India were provided by a number of committees dating back to the Bhore Committee in 1946, which laid the foundations of a comprehensive primary health care delivery system in the country, not too different from the National Health Service of the UK and other tax-funded health provision models in other countries. Over the past six decades, India has attempted to build up a large public health infrastructure at primary, secondary and tertiary level. However, the public health sector continues to be plagued by problems like poorly motivated manpower, inadequacy of funding, skewed geographical distribution and other access issues. In rural and remote areas, even qualified providers from the private sector are conspicuous by their absence. In addition to this, despite a multitude of legislation on the subject, the providers of health care in India continue to be poorly regulated, with no checks on pricing and often no checks on service quality. The

absence of influence from large organized purchasers of healthcare (like insurance companies) has also contributed to this situation.[52]

It is clear that for micro-health insurance to be successful and sustainable there have to be adequate health care facilities in rural areas. In the absence of this, micro-health insurance is not a viable product at levels of premium that would be affordable for the majority of the low-income population. Yet, low income families perceive health as the most important risk that needs to be covered (as is apparent from the discussion in **Appendix 3** – see Box 13 for a summary of field observations). In fact the lack of proper health care facilities has had an adverse impact on the premium for life-cover as well since, as a result, insurers are covering what might be termed "sub-standard lives".

Box 13. Priority of health and other risks among consumers

FGD respondents prioritise the risks (to be covered) mainly on the basis of the frequency of occurrence and perception of the immediate impact it could have on their livelihoods. Thus health insurance was the top priority for most of the respondents while life was relatively unimportant.

Health is the top priority for 61.6% of respondents as they associate illness with unplanned expenses as well as loss of income that causes a huge impact on their cash-flows. The more aware groups (in the South and West) were able to break this preference down further and for them cover for common illnesses (as out-patients) is the most important service. This is in contrast to the tendency for most insurance companies to offer cover only for in-patient care of selected health service providers.

Overall, life insurance is the second priority (14.2%) but this is very low compared to the priority accorded to health as a large number of respondents felt that the benefit of their death goes to their family and not to them; their concern is more with what happens if they live than with what happens if they die. The risks which could be clubbed together as the third priority include livestock (6.3%), household assets (6.8%) and business/enterprise assets (4.7%). The other risks identified by the groups were crop loss and loss on account of accidents/natural calamities.

Further details in **Appendix 3.**

6.1.4. As is lack of awareness of insurance as a financial product

Until now, insurance in India has been driven primarily by either tax incentives or as a requirement mandated by financiers to protect their own interests. Insurance as a measure of protection against adversity is relatively low. It is only now that people are slowly realizing the value of insurance as a means of protecting the family's income in the event of the unfortunate death or incapacitation of the breadwinner. While this is the state of affairs in the high and middle income groups, the poor – lacking knowledge and awareness of insurance – are almost totally outside its realm of coverage.[53]

[52] Dr Devadasan N & Dr Nagpal Somil 2007. "Perspective and prospects in micro-health insurance" in IRDA Journal November 2007

[53] Rao C S 2007. "IRDA Journal Nov 2007 – Focus on Micro-insurance"

The above opinion of the Chairman of IRDA indicates the lack of awareness of insurance amongst the more affluent population and, relatively, the level of awareness about insurance among low-income families is virtually negligible (refer **Appendix 3** & Box 12 above). One of the reasons for this lack of awareness is that in the past insurance was promoted as a savings mechanism with insurance as an add-on facility rather than as a means of financial/risk coverage. This has become ingrained in the psyche of Indian consumers (at all levels – upper, middle and lower income) and it is difficult for consumers now to appreciate the benefits of a pure risk policy which does not provide any returns except upon the occurrence of the event for which the risk cover has been bought.

It is for this reason that even low-income families prefer savings-based insurance over risk based products (refer **Appendix 3** & Box 14 on field observations). For the insurers this is a win-win situation as it gives them a higher premium while the corresponding coverage is lower in comparison with risk based policies of the same value. In some cases the insurers also gain when savings based policies lapse and low income consumers (not being aware of their rights) do not claim the savings portion of the premium which then becomes part of the insurer's revenue stream.

Box 14. Product priorities

The FGDs show that low income clients are more inclined to buy products which provide them returns. It is for this reason that the preference for savings linked life insurance products is high. Pure risk policies are seen mainly as a forced option for respondents who have obtained loans from MFIs. This is mainly the case in South India. However, the understanding of the respondents of the benefits and drawbacks of pure risk and savings-linked policies is low. For them, the only differentiating factor is that pure risk is a sunk cost while savings-linked policies provide returns in addition to cover.

The preference for composite products is particularly high if there is a health component attached. The affordability of premium was also found to be an important factor for the respondents to make decisions and the average acceptable level of premium was reported to be around Rs350-400 (~$10). The occupational profile of the respondents also defines their priorities; farmers prefer crop insurance, dairy entrepreneurs want cattle insurance.

Further details in **Appendix 3.**

6.1.5. And lack of access to formal financial services

Lack of formal financial services in rural areas has been well documented and is one of the prime reasons for the success of microfinance in India. Access to financial services is essential for the delivery and servicing of micro-insurance products as well. There are a number of issues related to remittances for payment of premium and claims servicing which ultimately have an impact on the pricing of the product.

The micro-insurance regulations have given extra responsibilities to micro-insurance agents. These responsibilities include collection and remittance of premium and other policy administration services. In the absence of a formal financial infrastructure the agent is handicapped in delivering the services effectively. Insurers consider the policy as active only when they receive the premium payments and there is often a substantial time lag between the collection of payment from the client and receipt of

premium by the insurer. There are now other ways in which this issue could be addressed. These include the use of mobile payment systems (paying through airtime) as mobiles now have very good outreach in rural areas. Some insurance companies like TATA AIG and ICICI Lombard are even experimenting with payments through hand held devices but, at the present level of technology, there are still cost and sustainability issues for micro-insurance agents. There are also regulatory issues in the use of mobile phone technology in relation to the financial (rather than the insurance) system that are being actively considered by the financial services regulator (the Reserve Bank of India) but are yet to be formally resolved.

Aggregators, particularly for the private insurers, are for-profit companies and do not fit into the definition of micro-insurance agents. Though MFIs have the capacity to collect premium and remit these to the insurance companies, something they have already partly proved through their microfinance operations, they are hampered by both insurance and financial services regulation. Regulation does not permit them to (i) become micro-insurance agents and (ii) collect or remit premium through their books of account (as the funds, however temporarily held, are considered to be client deposits). This is discussed further in **Section 6.2.2**.

6.1.6. As well as lack of actuarial data

While the public sector insurance companies have more than 50 years[54] of experience, the private insurance sector is just 5-7 years old. The rural and social sector obligations were introduced only in October 2002 when the IRDA made it mandatory for insurance companies to fulfill certain obligations. Though public as well as private companies were selling insurance in rural areas before this as well, 2002 is considered as the watershed year when the insurance companies started to work out strategies for targeting the rural population. Therefore, 'formal' experience in the underwriting of rural insurance policies is just 5 years old.

The private insurance companies initially used LIC and public non-life company data for pricing their products. Despite this, it is widely accepted that rural policies are overpriced due to the absence of information on the occurrence of events that trigger payments. Lack of information hampers the rational pricing of insurance and results in over-pricing to ensure that the insurer covers its own risk. The example of the Basix-AVIVA experience (**Box 4.1**) is a testimony to this observation; premium on an over-priced policy was reduced based on field experience. Thus, it is only in situations where the aggregator is alert to the possibilities of improved terms from insurers that accumulating experience can result in lower premiums or in improvement in other conditions (such as simpler claims procedures) for micro-insurance clients.

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[54] Insurance business was nationalised in 1956, when Life Insurance Corporation Act was passed, giving birth to the Life Insurance Corporation of India (LIC). 154 Indian-owned insurance companies, 16 non-Indian companies and 75 provident funds were taken over by the state.

6.2. Regulatory drivers of market characteristics

6.2.1. Inclusion of micro-insurance within the rural & social obligation norms

It is apparent from the discussion in this and the previous section that the rural obligation norm has encouraged the development of products for low income clients resulting in some *de facto* micro-insurance outreach. The inclusion of micro-insurance in the rural obligation norms has, however, not encouraged the insurance companies to view it as a separate market segment. The first aim of all insurers is to achieve the rural and social obligations and there is the tendency to do this either by targeting upper and middle income families in rural areas or by entering into agreements with rural finance institutions. This means that some insurance companies have limited outreach to the low-income families which are the target clients for micro-insurance or serve them mainly through credit-life type products that provide very limited coverage and mitigate risk more for the financial institutions than for low income policy holders.

Most insurance companies admit that the micro-insurance sector offers limited business potential and they are still trying to ascertain how this could be converted into a commercially viable opportunity. The micro-insurance regulation has not so far stimulated much of a response, as most insurers have worked out how to achieve their rural and social obligations without any need to focus specifically on micro-insurance. The recent relaxation in the definition of a 'rural area' (earlier defined in terms of population size) has now allowed the insurers to qualify any products sold in any non-municipal area. This has reduced the regulatory burden for insurance companies but has, in some ways, been detrimental to the degree of interest taken by them in the provision of micro-insurance services.

6.2.2. Limiting the definition of a micro-insurance agent…

The micro-insurance regulation allows only organizations registered as not-for profit NGOs (Societies or Trusts) and cooperatives or SHGs consisting of 20 or more members to become micro-insurance agents. This has omitted that section of MFIs that have the highest outreach to low income families. These organizations are Non Bank Finance Companies (NBFCs), not-for profit Companies (registered under Section 25 of the Companies Act and known as Section 25 companies), Cooperative Banks and Regional Rural Banks which specialize in providing micro-or small value credit to their members. This has meant that insurers cannot appoint these MFIs as micro-insurance agents and therefore could potentially forgo relatively easy outreach to a large number of potential micro-insurance clients. This approach of the regulator is consistent with that of the Reserve Bank of India, the financial services regulator, which forbids NBFCs from collecting deposits except under very stringent conditions. This cautious approach follows from several dramatic cases of imprudent and irresponsible management of depositor funds by NBFCs in the 1990s.

A number of companies have approached the IRDA to broaden the definition of micro-insurance agent. However, it appears that even if IRDA were to allow company MFIs to become micro-insurance agents nothing much would change since Reserve Bank of India (RBI) regulations classify funds collected from clients as deposits and most NBFCs and all Section 25 companies are specifically prohibited from

undertaking this activity. This would severely limit the ability and flexibility of such institutions to collect and remit premiums to insurance companies.

In practice, despite this limitation imposed by the micro-insurance regulation, the insurers and MFIs together have found a way around it by becoming partners, with the latter being paid for services rendered to the insurers rather than through commissions on the premium.

Based on the concerns expressed by MFIs and the recommendations of a government committee, the IRDA has now liberalized this provision. The latest development on the definition of MI agents is presented in Box 15**:**

Box 15. Changes in the definition of MI agent

The latest development in the definition of an MI agent emanates from the Financial Inclusion Committee (FIC)'s recent recommendations.[55] The committee says that there is a need to recognize a separate category of microfinance – Non Banking Finance Companies (MF–NBFCs), without any relaxation on start-up capital and subject to the regulatory prescriptions applicable for NBFCs. Such MF-NBFCs could provide thrift, credit, micro-insurance, remittances and other financial services up to a specified amount to the poor in rural, semi-urban and urban areas. Such MF-NBFCs may also be recognized as Business Correspondents of banks for providing only savings and remittance services and also act as micro-insurance agents.

IRDA has been prompt in implementing the recommendation of the FIC by announcing in its circular[56] that Section-25 companies will be allowed to become micro-insurance agents. However, the restrictions from the RBI on allowing such entities to collect premiums (which are considered deposits) continue and it will be a major bottleneck for Sec 25 companies to function as registered MI agents. It is also yet to be seen whether the change in regulations actually encourages and enables Sec25 companies to become formal MI agents or whether they prefer to remain partners of insurance companies. This depends, to a large extent, on whether such companies forego the extra income they earning as partners than the income that the caps on agents' premium would allow.

6.2.3. …combined with commission caps imposed for social reasons does not help

The aim of the commission cap is to control pricing on the assumption that there is a socially acceptable limit to the premium that should be charged to low income clients. In terms of proportion, the commissions permitted to micro-insurance agents are higher than those permitted to mainstream insurance agents. The following (Box 16) provides the commission structure for micro-insurance agents.

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[55] Press release by Ministry of Finance, GoI. Press Information Bureau, 5 February 2008. (www.pib.nic)

[56] Circular No. IRDA/F&A/062/Mar-08. www.irdaindia.org

Box 16. Commission structure for micro-insurance agents	
Life insurance business	
Single premium policies	10% of the single premium
Non-single premium policies	20% of the premium for all the years of the premium paying term – this compares with 65% over the first five years of a non-micro policy
General insurance business	15% of the premium

However, the general opinion of the insurers is that this commission is not commensurate with the responsibilities to be carried out by micro-insurance agents. Since the overall size of micro-insurance products is small, even a 20% commission does not constitute a significant sum of money unless the agent is able to expand to a large scale.

Again, the regulation has, in any case been by-passed as NGOs/MFIs engaged in working with the insurance companies are paid by way of a service fee rather than through commissions on premium. Through this method independent pricing models for facilitation services are being evolved. The service fee earned by one well known health insurance facilitator (which ironically is registered as a Society and could, theoretically, become a micro-insurance agent) amounts to around 30% of the premium; an amount well in excess of the 15% commission cap decreed by regulation. Another well known MFI receives a service fee of the order of 25% of the premium. As this suggests, the regulation itself provides an insufficient incentive to any type of institution to become a micro-insurance agent.

6.2.4. Taxation on premium and commissions reduces returns…

All micro-insurance policies are subject to service tax and so are the commissions earned by the micro-insurance agents. A service tax of 12.36% is levied on all commissions earned by the micro-insurance agents and also impacts the pricing as the insurance company has to pay the service tax on the premium collected. This has been seen as a detriment to the sustainable functioning of micro-insurance agents whose earnings are already limited by commission caps.

Representations have been made to the Ministry of Finance requesting the removal of service tax on qualified micro-insurance plans but the Government has yet to take action on this matter.

6.2.5. …and the limitation to one life and one non-life partner could also be a constraint

The regulation also limits the relationship of a micro-insurance agent to one life insurance company and one non-life insurance company. The model was conceived to promote the partner-agent model in which the insurer appoints an NGO-MFI as micro-insurance agent. It is based on the assumption that it is best for micro-insurance clients if micro-insurance agents do not get into multiple arrangements. Too many arrangements, it is presumed, would confuse the not-so-well educated employees of micro-insurance agencies and too much information would cause further confusion for the average micro-insurance client who has limited literacy skills.

However, MFIs argue that their core activity is providing financial services to their clients, they understand their clients' needs and they would like to provide the products best suited to those clients in the best possible combination. Therefore, the MFIs do not want to be restricted to the choice of just one life and one non-life insurer to partner with. They would rather scan the environment and bargain with various insurers for the best product for each type of risk cover needed by their clients. There are numerous examples of the partner-agent model (though mostly outside the regulatory definition) in which the MFI has a partnership with one life and multiple non-life companies; Basix, SKS and SEWA are some of the leading examples.

6.2.6. …but is mitigated by supervisory forbearance

As the discussion above shows, a number of activities in the micro-insurance sector could lead to supervisory intervention as these may be *prima facie* contrary to the regulation. Such activities include for-profit MFIs acting as aggregators or facilitators for insurance companies, the collaboration of facilitators with multiple life and non-life companies – though as aggregators rather than micro-insurance agents they are not actually prohibited from doing this. In addition, there are several community based in-house insurance programmes in operation in which the organization provides insurance cover through risk pooling mechanisms, some even supported by the central and state governments.

The regulator has ignored these developments and this supervisory forbearance has helped in the growth of micro-insurance, also creating awareness among rural and low-income households (though participation in this market segment has been mainly from members of MFIs). Given the large numbers contributed by both MFIs and the rural banking system – perhaps over 90% of all micro-insurance clients – such forbearance can be deemed to be a significant factor in the growth of micro-insurance in India.

6.2.7. Greater responsibility to micro-insurance agents could facilitate growth

The delivery of micro-insurance products to low income families has similar operational bottlenecks that the microfinance sector has faced in delivering credit to borrowers. In both cases the key is to attain scale as quickly as possible and to keep a check on operational costs. Therefore, if the insurance companies were to set up branches in rural areas for delivery and servicing of policies, micro-insurance would become unaffordable. The regulation has been facilitative on this front as it has allowed for micro-insurance agents to take-up a number of responsibilities which has not been given to mainstream insurance agents. There are a number of functions which, if carried out effectively and professionally at a large enough scale by micro-insurance agents would help in minimizing cost and would allow the insurance companies to offer lower premiums to their clients. However, the other aspects of regulation, discussed above, have limited the appointment of micro-insurance agents and constrained the activities of aggregators/facilitators, thereby restraining the entire activity.

6.2.8. Though uniform capital requirements and other restrictions also limit participation

Finally, any institution that wants to underwrite risk in India must invest a minimum of Rs100 crore ($25 million) in capital. The maximum amount of foreign equity investment allowed in an insurance company

is 26%. This condition is uniform for all insurance companies irrespective of the type of their products or the area of their operations. While the larger companies have the resources to make this level of investment, there are smaller specialized insurers in South Africa and developed countries that would neither like to start with capital investments of this size, nor do they have large enough counterparts in India capable of investing more than three times as much. In India, the smaller organizations already underwriting risk are mutual insurers (mainly cooperative organizations) and these are neither recognized by IRDA nor do they have sufficient capital to partner with the specialized foreign insurers who could provide the experience and expertise to develop and grow the micro-insurance market. The limitations of a one size fits all prudential policy vis-à-vis the micro-insurance market are apparent.

7. Summary and conclusions

This document provided an overview of the microinsurance market, its evolution and regulatory framework in India in order to identify the core market and regulatory drivers of the development and current state of the microinsurance market.

- **Section 1** introduced the study
- **Section 2** set out the methodology and approach
- **Section 3** provided an introduction to the microinsurance landscape in India
- **Section 4** described the regulatory framework for insurance in India and set the microinsurance regulations within that framework
- **Section 5** went on to outline the nature and scale of the micro-insurance market in India, and
- **Section 6** identified the key factors (drivers) influencing that micro-insurance market.

The appendices to the report fill out some of the detail on the nature and utility of the microinsurance products offered in the Indian market, on the one hand, and client knowledge and perceptions of both insurance as a service and of the microinsurance products on offer in the Indian market, on the other.

The following key insights emerge from the analysis:

Market context. Over the past 30 years and more, insurance in India has been monopolised by government-owned companies as a result of nationalisations in 1956 of life insurance companies and in 1972 of general insurance companies. It was only in 2000 that the entry of private companies into insurance was allowed again. The one public sector life insurance company until 2000 has now grown to 14 life insurance providers and the four general insurance companies have increased to 18 by March 2008. Since the re-entry of private companies into insurance, the sector has registered very high growth rates with life insurance premium increasing at a rate of 25% per annum between 2001-02 and 2006-07 and general insurance premium increasing at 17.6% per annum. Nevertheless, despite the very fast

growth of the private sector, public sector insurers continue to account for more than 75% of all life insurance business and around two-thirds of general insurance business in India.

The policy, regulation and supervision context. For regulatory purposes, the insurance sector in India is categorised into life and general insurers with companies being allowed to offer one or the other but not both. Health insurance may be provided by holders of either type of licence. The provision of insurance services is governed by the Insurance Regulatory and Development Authority (IRDA) established as the statutory regulator in year 2000. Since then, IRDA has attempted to put in place a framework of globally compatible comprehensive regulations. The Authority has also been providing support systems for the insurance sector in relation to the training of agents and the issue and renewal of licences. In addition, it has laid down a roadmap for a smooth transition of the insurance market in India from regulated to non-regulated. The approach is for the regulator to concentrate increasingly on solvency issues while allowing insurance councils to act as self-regulatory bodies in addressing matters of market conduct.

In order to ensure that relatively poor and financially excluded people also get the benefit of insurance the regulator has imposed certain obligations on insurance companies since 2002 as well as introducing micro-insurance regulations in 2005. The rural and social obligations impose quotas on companies to procure insurance business from pre-defined rural areas and social sectors. The subsequent introduction of microinsurance regulations was aimed at liberalising the regulation for the specific provision of insurance services to the financially excluded. This regulation supplements the overall policy approach of the Government of India to increase social security coverage by incentivising and paying (mainly) the public insurance companies to offer life, accident and health insurance to low income agricultural workers and artisans.

Salient features of the microinsurance market. The microinsurance market in India is characterised by products that have short policy terms and group-based underwriting. These are largely loan-linked products driven by the compulsion of borrowers to purchase insurance schemes bundled with credit, mainly providing protective cover to microlenders (MFIs or rural banks). The rural and social sector obligations have been the key driver in forcing insurance companies to seek alliances with the rural finance network. Community based, not-for-profit, insurance systems are not covered by regulation and are largely restricted to health cover because health risk is generally seen as potentially the most devastating type of systemic risk likely to upset the lives and livelihoods of the low income population. Formal microinsurance is yet to cover health risk in any significant way on account of the difficulties of ensuring service delivery and the dangers of moral hazard in a highly informal health service provision network. Yet community-based health insurance networks have relatively minuscule outreach.

The overall outreach of life micro-insurance is currently of the order of 14 million clients, less than 2% of the total adult population of the country. Over 80% of this cover is channelled by formal insurance companies via the micro- and rural finance network. Some 90% of this formal cover is provided via compulsory credit-life insurance products. The 10% of micro-insurance taken up voluntarily – also often through the rural finance network – consists mainly of endowment products with very limited pure risk cover.

Drivers of market development. Perhaps the key **non-regulatory** driver of micro-insurance in India is the growth of the micro- and rural finance network. This has facilitated the outreach of microinsurance products albeit mainly as compulsory credit-life insurance. Since microfinance delivery is mainly on a group basis, it is not surprising that most of the microinsurance policies in India are underwritten on a group basis. Such an approach reduces administrative expenses and limits premiums, improving the affordability of insurance products. However, both the lack of experience of insurance companies at working with low income populations and the lack of availability of reliable actuarial data for such people has meant that the insurance companies have tended to over-price microinsurance products to ensure that they cover every conceivable risk. With increasing experience, rural finance providers are able to negotiate with insurers to obtain a more rational pricing regime.

It is apparent from the discussion above that the key **regulatory** driver of microinsurance in India is the rural and social sector obligation. As indicated above, it is this that has compelled the insurance companies to engage with the micro- and rural finance network. In addition, the microinsurance agent definition has relaxed the distribution requirements for microinsurance. However, since most rural finance providers are "for profit" institutions, they are not allowed to be classified as micro-insurance agents. Therefore there is some waste built into the system as a means have to be found by which insurers can compensate aggregators without the payment being defined as commissions (i.e. without them strictly speaking acting as insurance intermediaries). It is mainly the high degree of supervisory forbearance exercised by IRDA that has allowed this arrangement to proceed to the extent that it has. Finally, any "for profit" institution that wants to underwrite risk in India must invest a minimum of Rs100 crore ($25 million) in capital. The maximum amount of foreign equity investment allowed in an insurance company is 26%. This condition is uniform for all insurance companies irrespective of the type of their products or their areas of operation. This effectively excludes smaller specialised Indian insurers from being established and foreign insurers from finding appropriate Indian partners; companies for whom the microinsurance market would be a more attractive proposition. The limitations of a "one size fits all" prudential policy vis-a-vis microinsurance are apparent.

Key issues for the regulation of microinsurance in India going forward. The uptake of microinsurance has seen some increase but is mainly linked to the growth of the microfinance sector rather than microinsurance per se. Uptake of non-credit linked insurance is still very limited. This begs the question: is the Indian experience of a proactive/direct regulatory mandate for low-income portfolio expansion a good example for others to follow? Regulatory reform is still at a nascent stage and time will tell its true impact. This research has flagged various challenges as listed above. The regulations have however to some extent created supply side interest. This needs to be reinforced by designing prudential requirements to enable the entry of specialised insurers for the special needs of low income populations, on the one hand, and to enable "for profit" rural finance companies to act as microinsurance agents on the other.

Combining this with efforts to create demand-side interest is also important. This requires a substantial effort to generate knowledge and understanding of microinsurance through financial literacy programmes and advertising campaigns in the public media. Greater knowledge and understanding of the benefits of insurance, on the one hand, and the key features of microinsurance products, on the other, would greatly increase interest in and demand for microinsurance. An increased outreach of

microinsurance services would go a long way in furthering the interests of economic inclusion and reducing vulnerability amongst large segments of the low income population of India.

Appendix 1: Analytical framework

Financial inclusion framework

The five country studies explored the drivers of financial inclusion within the insurance market, in particular considering the impact of regulation. Ultimately, more inclusive financial systems are the desired outcome of the emerging guidelines proposed in this report.

Financial inclusion is achieved when consumers across the income spectrum in a country can access and sustainably use financial services that are affordable and appropriate to their needs. The overall level of inclusion achieved is determined by a variety of factors affecting the individual directly (demand-side factors) as well as the institutions providing the services (supply-side factors). Figure 8 indicates this schematically:

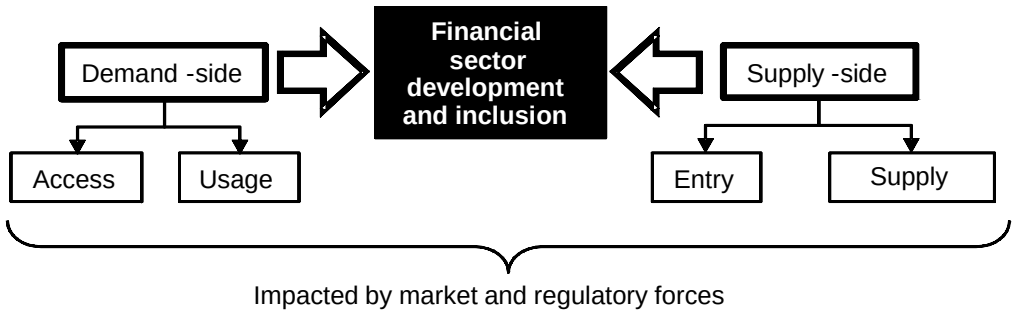

Figure 8. Financial inclusion framework

Source: Da Silva & Chamberlain, 2008

These factors may explicitly exclude individuals from using a particular service (referred to as **access** barriers) or may discourage users from using a particular service even if they are not explicitly excluded (referred to as **usage** barriers). Similarly, impacts may completely exclude or may discourage financial service providers from providing a particular financial service to the lower-income market – termed **entry** and **supply** barriers respectively. These concepts are briefly explained below.

- **Access** barriers consider the factors that make it impossible for a individual to use a particular financial service. The FinMark access methodology57 identifies five factors that impact on access: physical proximity, affordability, eligibility, appropriate product features/terms and regulation.

[57] For more information see the discussion contained in Chamberlain (2005).

- **Usage** focuses on factors that may discourage individuals to take up formal financial services even if they do not present an absolute barrier. Usage decisions involve the exercise of judgment by individuals on the value of the product and its ability to meet their needs based on their experience and knowledge. This judgment is exercised within a complex set of considerations, constraints and priorities. Usage drivers may include: the value proposition of the formal product (e.g. the perception of "throwing money in the water" by paying insurance premiums when you do not necessarily claim); relative cost (e.g. compared to informal alternatives); the "hassle factor" (e.g. of filling out forms); and perceptions of formal products and institutions (e.g. the fear of "officialdom" and the belief that financial institutions are for the rich).

- **Entry** factors include market and regulatory forces that may prevent particular players from operating in the low-income market, or may make it difficult for informal providers to become formal sector players. This may include regulations restricting the type of legal entity that may for example provide insurance.

- Similar to the demand-side, **supply** factors do not explicitly prohibit institutions to enter into the low-income market but may discourage them from doing so. These may for example include proportionately increased regulatory costs on low-value transactions that undermine their already marginal profitability. While not necessarily making it impossible to serve the low-income market, it makes operating in this market unattractive.

The state of financial inclusion in a particular country is a composite of these four factors. The particular question that this project seeks to answer is how **regulation**, propagated through the various drivers of access, usage, entry and supply, impacts the overall level of financial inclusion in the insurance sector.

Goal of microinsurance

The country studies presented in this report accordingly focus on the role that the insurance market can play in reducing the vulnerability of the poor. Why would one want to develop microinsurance markets? The ultimate goal of microinsurance is to enable the poor to mitigate their material risks through the insurance market, in order to reduce vulnerability, thereby increasing their welfare. To be successful, microinsurance should therefore mitigate the most material risks faced by the poor client in a way that is affordable and appropriate to the low-income market.

In the process of mitigating their risk, microinsurance may also stimulate the provision of other services that are important to the poor, for example, credit services, funeral services or health services. This is achieved by providing more predictable income flows to providers that ensure viability of the provision of such services to the low-income market. Therefore microinsurance enhances the welfare of the poor by addressing material risks as well as supporting the delivery of critical services.

It must be noted that the availability or even take-up of insurance *per se* is not sufficient to achieve the goal of reduced vulnerability and improved welfare. To deliver value, low-income insurance products should also be affordable and appropriate to the needs of the poor. This requires sufficient awareness of the availability and value of insurance amongst the poor as well as the ability to claim on policies.

Providers and intermediaries should also treat consumers fairly. If it is difficult or impossible for a low-income client to make a legitimate claim on their insurance policy it will not reduce vulnerability and renders the product of little value.

The country evidence discussed in this document shows that microinsurance take-up is often not the result of voluntary strategies by the poor to mitigate their material risks, but is rather the outcome of compulsion by *credit providers* seeking to cover their own exposure to default. In this case, microinsurance may still deliver significant value to the client but care needs to be taken to ensure fair treatment of the low-income consumer.

Definition of microinsurance

Conceptual definition. Microinsurance is defined by the IAIS (2007b) as "*insurance* that is *accessed by [or accessible to*[58]*] the low-income population*, provided by a variety of different entities, but run in accordance with generally accepted insurance practices (which should include the Insurance Core Principles). Importantly, this means that the risk insured under a microinsurance policy is managed based on insurance principles and funded by premiums". It therefore excludes social welfare as well as emergency assistance provided by governments, "as this is not funded by premiums relating to the risk, and benefits are not paid out of a pool of funds that is managed based on insurance and risk principles".

This definition encompasses three concepts that require further explanation in the context of this study: "insurance, "accessible to/accessed by", the "low-income population".

- *Insurance.* Generally, insurance denotes a contract in terms whereby an insurer, in return for a premium, undertakes to provide policy benefits. It is distinguished from e.g. social welfare in that it is funded by premiums relating to the risk, and in that benefits are paid out of a pool of funds that is managed based on insurance and risk principles (IAIS, 2007). Benefits may include one or more sums of money, services or other benefits, including an annuity. Microinsurance forms part of the broader insurance market, distinguished by its particular low-income market segment focus (that often requires distinctive methods of distribution or distinctly structured products).

- *Accessible to*. Microinsurance products need to be accessible and appropriate to the low-income population, i.e. that the low-income population be in a position to sustainably use such products (including claiming).

The low-income population. This study does not propose any specific income cut-off for the microinsurance target market. Instead, the target market should be defined within the local country context. Microinsurance is not strictly limited to those living under the national poverty line or the comparative measures (e.g. $1 or $2 adjusted for purchasing power parity). Many of these households may actually be beyond the reach (e.g. affordability) of an insurance mechanism and will remain the dependent on the social security system. Furthermore, generally low income levels means that even the

[58] Authors' own insertion.

middle-income class (not classified as poor under the national poverty line) in a particular country will have relatively low income levels and, therefore, require low-premium products.

Operational definition. Definitions based on the income levels of the purchaser or the client are difficult and costly to implement in practice. As result, the practical definitions applied by the market or regulator mostly define microinsurance policies by setting benefit or premium limits, thereby ensuring that it is mostly (but not exclusively) targeted at the poor. Other functional criteria used to define microinsurance (virtually always in c*ombination with a bene*fit cap) include the following:

- Product categories that particularly reflect the needs of the poor (e.g. funeral insurance, or insurance for motorcycles or cell phones important to the low-income market for business purposes)

- Distribution channels, especially channels accessible to the poor;

- Simplicity of terms, conditions and processes;

- Contract characteristics, for example limiting exclusions that may be difficult for clients to understand or allowing clients to catch up on occasionally missed premiums without lapsing the policy

The insurance value chain

Delivering an insurance product to a client comprises a number of activities collectively referred to as the insurance value chain. Unlike the transaction banking value chain, where the activities are often performed by the same legal entity, the various activities comprising the insurance value chain are typically performed by more than one legal entity. The risks attached to the various activities differ and they are regulated by different regulators and supervisors or not at all.

Figure 9 presents a picture of the generalised structure of the insurance value chain:

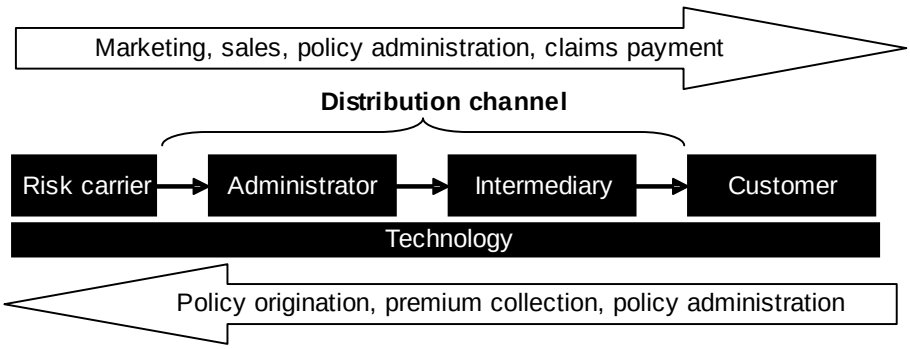

Figure 9. Insurance value chain

Source: Chamberlain, Bester et al, 2006, quoting Leach, FinMark 2005.

The functions of the various components of the insurance value chain are:

- *Underwriting:* This is the responsibility the risk carrier, defined as the entity that in the final instance is liable for the insurance risk. In the formal financial sector, the risk carrier is usually a registered insurer (that may obtain re-insurance) or another entity (such as a cooperative) authorised to provide insurance.

- *Administration:* Administration may be done at the level of risk carrier, intermediary or may even be outsourced to a specialised entity that often does not fall under the jurisdiction of the insurance supervisor. Administrative costs contribute a substantial proportion to overall insurance costs and innovation on this aspect is, therefore, of particular interest for microinsurance.

- *Intermediation:* Intermediation deals with all aspects of client contact and related activities (e.g. product origination) and may take a variety of forms including an insurer's direct sales division, captive or independent agents, retailers, banks and non-bank financial service providers, NGO MFIs, credit cooperatives, etc. Different types of intermediaries may be more or less suited to distribute microinsurance and may also be affected differently by regulation.

- *Technology:* Technology plays a role across the value chain and may include a variety of technologies ranging from sophisticated electronic solutions such as the use of mobile phones to social technologies such as premium collection through self-help groups. The appropriate use of technology may facilitate better risk management as well as lower the costs for microinsurance.

Understanding microinsurance in a particular market therefore requires focusing on more than just insurers and products. Particular attention has been paid to the intermediation of insurance in the markets reviewed in order to understand the regulatory ramifications on each part of the value chain. This is especially true for emerging technologies and innovations (for example mobile phone payments, distribution through retailers, etc.).

The distinction between formal and informal

Throughout this document, reference is made to informal and formal (or regulated and unregulated) markets, products, providers or distribution channels. Key issues to consider include the reasons for informality and what the appropriate policy and regulatory response should be. It is therefore important to clarify upfront what is implied by informality:

Formal. Formal financial products and services are defined as products or services provided by financial service providers[59] that are registered with a public authority in order to provide such services[60].

[59] In turn defined broadly as any provider of financial services – in this instance insurance.
[60] This is the definition generally applied by the World Bank.

Informal. Informal financial services, therefore, refers to everything that is not formal as defined above and includes a wide range of providers. At its simplest this includes completely informal societies that are often of a community and mutual nature. In some cases informal markets may also include formal legal entities (e.g. funeral parlours) providing insurance without being regulated for the purposes of doing so. Informal insurance is not necessarily illegal. Specific providers or products may be exempted from insurance regulation or may simply be operating in the absence of regulation. Where a particular section of the formal market is regulated in theory but not supervised in practice, it may actually present similar risk and challenges to the informal sector.

The informal financial sector can play a critical role in financial sector development. The existence of large informal markets can be a key indication of demand for insurance products not met by the formal market as well as potential barriers to formalisation and market development. Informal institutions often fill the vacuum created in the process of formalisation by acting as distribution mechanism or providing the service themselves. The scale and number of informal insurance providers may provide a reality check on the challenges facing supervisors and regulation that attempts to formalise these markets. In many cases, the supervision of this sector may simply fall beyond the logistical or resource capacity of the supervisor.

From an inclusion perspective, the objective is to facilitate the development of the formal sector and encourage formalisation while at the same time preserving the critical services provided by the informal sector.

Categories of risk

The definition and analysis of risk and its various drivers is central to the analysis and proposals contained in this document. In this section we note the definitions and concepts that are applied in the discussion of risk.

The Insurance Core Principles (ICPs - IAIS, 2003) hold that "the supervisory authority requires insurers to recognise the range of risks that they face and to assess and manage them effectively" (ICP 18) and to "evaluate and manage the risks that they underwrite, in particular through reinsurance, and to have the tools to establish an adequate level of premiums" (ICP 19). ICP 18 states that the insurance supervisor plays a critical role by reviewing the insurer's risk management controls and monitoring systems and by developing prudential requirements to contain these risks. In the final instance, it is the responsibility of the board (via good corporate governance practices) to ensure that risk is adequately managed.

The risk of insurance business stems from a variety of reasons. To simplify the discussion in this document we distinguish three (interdependent) categories of risks: prudential risk, market conduct risk[61] and supervisory risk:

[61] These categories as are in line with the solvency methodologies as outlined in IAA (2004) and IAIS (2007a).

- *Prudential risk* refers to the risk that the insurer is unable to meet its obligations under an insurance contract. Insurance provides benefits on a defined risk event in return for premiums that are paid in advance. A contractual commitment to provide benefits create the risk that the insurer's liabilities in respect of expected future claims at some point in time may exceed the assets they have available to meet those claims. This is driven by a number of more specific risks categorised by the International Actuarial Association as underwriting risk, credit risk, market risk, operational risk and liquidity risk (IAA, 2004). Prudential risk is in the first instance determined by the nature of the insurance products in an insurance portfolio (underwriting risk determined by the likelihood and size of exposure) and secondly by how the insurer is managing and providing for its obligations under these policies. Key features of the insurance product that impact on risk are: the nature of the risk event covered and its expected frequency and impact; the duration of the product contract; the benefit value; product complexity of the product. The product-driven nature of underwriting risk is a key feature of risk that we return to later in this document.

- *Market conduct risk*[62] refers to the risk that the client is not treated fairly and/or the does not receive a payout on a valid claim. Effectively this is the risk that clients will be sold products that they do not understand, are not appropriate to their needs, and/or will not be able to claim on. This risk is driven by various factors including: the nature of the product (e.g. product complexity, level of cover provided), the nature of the intermediation process (e.g. compulsory/voluntary nature of the purchase, standalone/embedded nature of the product, the level of disclosure or advice, nature of the claims process) and the nature of the client (e.g. level of sophistication and financial literacy). In some insurance literature market conduct risk may also refer to the risk arising from the insufficient disclosure of financial information by the insurer to investors and supervisors. This is **not** included in the definition of market conduct applied in this document.

- *Supervisory risk* refers to the risk that the supervisor is unable to sufficiently supervise (due to limited capacity) specific components of the market. The result of this is that an insurer or insurance product with low technical/underwriting risk may actually turn out to have a high risk to the system because it is not appropriately supervised.

Policy, regulation and supervision

Regulatory vs. non-regulatory drivers of market development

This report is about the impact of regulation on the development of microinsurance markets. Many insurance markets initially developed in an unregulated environment. The first pitfall to guard against is therefore to think that markets develop as a result of regulation. Largely they do not. The insurance sector is impacted by external factors in the financial sector and by the economic and country context more broadly, such as the macro-economic environment, the political economy, the general and financial sector infrastructure, and the demographic profile of the country (gender, age, income levels

[62] Market conduct concerns may impact on prudential risk in that the reputational damage may, e.g., lead to an insurer becoming insolvent but it is still quite distinct from it.

and the distribution of income). For example, a country undergoing financial liberalisation or recovering from a financial sector crisis or recession will face different policy challenges impacting on its insurance regulatory framework than other countries. Likewise, a country where the majority of the population is poor, or where the financial sector and other infrastructure is poorly developed, will face different circumstances and goals than other countries.

The first challenge is therefore to distinguish between the regulatory and non-regulatory drivers of market development. Whereas this distinction is quite clear in certain cases, causality is often a matter of degree and even opinion. The approach followed in this study is to identify the non-regulatory drivers of market development at a high level to provide the general context for tracing the impact of regulation. As far as possible we identify all the potential impacts of regulation, even though in many cases regulatory drivers may have been overridden by other market factors.

Purpose of insurance regulation

It is important to note that regulation is not an end-goal in itself, but is the means to ensure the existence and development of a well-functioning market. A well-functioning market includes serving the broadest possible client base, including the poor. In seeking to achieve the goal of a well-functioning market policymakers, regulators and supervisors pursue a number of more specific objectives including:

- *Stability of the sector*. This objective is sought by ensuring the soundness of operators and may resonate in capital requirements, corporate governance requirements, fit and proper requirements and other aspects of the regulatory framework. Among the regulatory objectives, this is often the one that has been pursued for the longest time.

- *Consumer protection*. While this is also an implicit goal in the stability objective, this objective most often resonates in market conduct/intermediation regulation (both in terms of the intermediation channels permitted, the due process to be followed, the commissions that can be charged and the requirements placed on the intermediaries themselves).

- *Improving market efficiency*. This may entail preventing anti-competitive behaviour and overcoming information asymmetries. In its application such regulation may overlap with both stability and market conduct regulation.

- *Market development* (or financial inclusion more specifically) is sometimes included as an explicit policy or regulatory/supervisory objective – for example in India, where the supervisor (IRDA) is also explicitly tasked with a development mandate.

- *Other strategic objectives*. This can for example include the prevention and control of financial crime as required by international standards imposed by the Financial Action Task Force or the economic empowerment of previously disadvantaged citizens as is the case in South Africa.

Given the ultimate goal, none of these individual objectives should be pursued at the cost of a well-functioning market. Some objectives may also conflict. For example: where an authority has the explicit

mandate to develop the market, this may require the relaxation of regulations imposed for stability purposes. Therefore the market development objective may clash with the way the stability objective was pursued. Often, various objectives however mutually enhance one another.

Public policy instruments

To achieve its stated objective, a government uses three categories of public policy instruments to influence markets:

- *Policy*. The term "policy" denotes the declared intention of a government on how it wishes to order the financial sector and the objectives that it wishes to achieve. The trade-offs between various government objectives (for example consumer protection and financial inclusion) is therefore managed within the policy domain. Such policy can be contained in a specific policy document (i.e. can comprise a dedicated policy framework), but can also be the stated intention of government more broadly/generally, be contained in speeches, in the preamble to legislation and in other documents (i.e. the general policy stance). Policy may sometimes be sufficient, in itself, to achieve government objectives even without regulation following from the policy. This may be the case particularly where government wants the market to achieve the stated goals. In most instances, however, policy is the canvas against which *regulation* is then developed.

- *Regulation*. Technically speaking, the statutes of a country are termed *legislation*. It is passed by the national legislative authority (be it parliament or congress). Legislation represents a relatively rigid public policy tool that is normally difficult and time consuming to pass and difficult to amend. In addition to legislation, *subordinate legislation* may be issued by the executive authority or regulator. Such instruments are more flexible, yet still have the force of law. In the event of conflicts, legislation will take precedence. In some jurisdictions, subordinate legislation is referred to as *regulations*. When referring to regulation, this document bestows a broader meaning on the term than subordinate legislation, namely: the various legal instruments with binding legal powers (legislation as well as subordinate legislation) that together comprise the regulatory body or regulatory framework pertaining to insurance. Regulation furthermore includes the action of regulating the insurance industry to achieve the policy goals. This in turn includes the development of *regulatory* requirements. The regulator may issue *guidance* in relation to regulation. Such guidance can be in the form of memoranda or circulars. It does not have the force of law, but can be converted into legally binding regulations if required.

- *Supervision*. Supervision describes the functions whereby the state seeks to ensure compliance with regulation. The supervisor's role can therefore be defined as the oversight and compliance, on behalf of the state, of the implementation of regulation by private entities, with the power to impose the penalties allowed for in regulation if not adhered to.

Generally, the policymaker will be the national government or the ministry with jurisdiction over the insurance industry, the regulator will be the ministry issuing the legislation pertaining to insurance or a statutory body issuing subsidiary rules, and the supervisor will be a statutory body for implementing such regulation, e.g. an insurance commission or financial services board, superintendence or authority

more broadly. In many jurisdictions the supervisor as defined here can therefore simultaneously be the regulator.

Insurance regulatory scheme

Different categories of regulation are used to influence the behaviour of participants in the insurance value chain. These are collectively referred to as the insurance regulatory scheme, which can be captured in the diagram below. The report uses this scheme to analyse the impact of policy and regulation on the development of microinsurance markets in the sample countries.

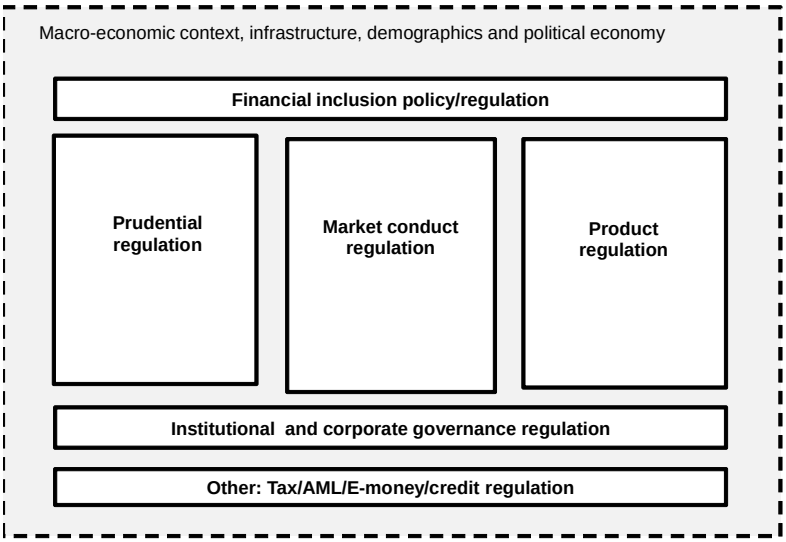

Figure 10. The insurance regulatory scheme

Source: authors

Financial inclusion policy/regulation refers to policy or regulation promulgated with the objective of extending access to and usage of formal financial services by persons who are either excluded from or who do not use formal financial services (provided by registered/licensed and supervised financial institutions). Such regulation can take various forms, for example compulsory or consensual quotas targeting defined population segments, financial literacy provisions, tax incentives, extending the reach of the formal payment system, etc. Sometimes a government may choose not to regulate financial inclusion, but simply to adopt financial inclusion policies with the explicit aim that financial institutions would pursue inclusion on a voluntary basis. Although these do not have the force of law, they will directly impact the conduct of providers.

Prudential regulation seeks to ensure that insurers are able to meet their contractual obligations to their clients. This is done by, for example, setting minimum entry requirements such as minimum levels of

capital and requiring compliance with a set of prudential regulations governing the functioning of the insurer.

Market conduct regulation refers to the regulation of the distribution or intermediation of insurance products. Regulation of this kind could include requirements as to who can intermediate insurance, fit and proper requirements for agents and brokers and other intermediaries, regulation of the selling process, including disclosure requirements and giving of advice, regulation of the payment of commission, statutory requirements that make the take-up of certain types of insurance compulsory (for example credit life insurance may be declared compulsory when taking out a non-collateralised loan), etc.

Product regulation can be distinguished from prudential and market conduct regulation in that it does not relate to the insurer or the sales/intermediation process, but rather to the product in question. While provisions relating to product regulation are usually contained within either prudential, institutional or market conduct legislation, it therefore represents a distinct regulatory angle. Product regulation aims to ensure stability and consumer protection by regulating the nature and structure of insurance products. In the most basic form, regulatory systems are often structured around definitions of specific products or product categories.

Box 17. Aspects of product regulation.

Product regulation may involve one or more of the following:

- *Registration/ approval*. In some jurisdictions, regulation stipulates that products need to be filed with the regulator/supervisor, with a window period for response by the supervisor, before the product is launched. If no objection is made by the supervisor within the stipulated time frame, the product is automatically approved. In other instances, explicit approval is required by the regulator before products may be offered. This may be used as a means of compensating for an otherwise light regulatory burden and to allow innovation.
- *Standards*. Regulation may require microinsurance to meet specific standards on simplification, standardisation, documentation, cool-off periods, term, exclusions, etc. In some instances, requirements relating to terms and provisions may be quite onerous; in others it may facilitate innovation.
- *Price control*. Regulation may set specific minimum or maximum prices for product categories. Premium floors are mostly aimed at trying to ensure solvency of the insurer by avoiding price competition, whereas premium ceilings are mostly motivated by consumer protection considerations (though in practice they often serve to protect insurers against intermediaries with bargaining power, rather than protecting the consumer.
- *Demarcation*. Regulation may also prohibit the provision of insurance products by particular players (e.g. non-corporates) or may determine that certain types of products may only be provided by certain types of providers (demarcation).Creating a product-based approach to microinsurance where a regulatory space is created for those who can comply with product standards is therefore a further instance of product regulation. The intention is to limit the risk, thereby justifying different market conduct and prudential standards.
- *Compulsory products*. Lastly, regulation may compel insurers to offer specific products.

Institutional regulation, which includes corporate governance regulation, refers to those statutory requirements that determine the legal forms or persons, for example public companies and cooperatives that can underwrite insurance, as well as the regulatory corporate governance requirements applicable to these legal forms. The nature and extent of the corporate governance requirements normally determine whether that particular legal institution is suitable to manage the risks inherent in underwriting insurance. The institutional and corporate governance regulation is generally not specific to the insurance sector (although some countries have a tradition of passing specific statutes for individual insurance firms, especially mutuals), but generic across sectors.

Other regulation. A number of other regulatory requirements could also impact the development of the microinsurance market. Although not insurance-specific, they impact the underwriting and intermediation of insurance products. Examples include anti-money laundering provisions, taxation, regulation of the payment system (that impacts the ease whereby premiums can be paid), regulation of the microfinance sector and credit regulation generally.

It is not only regulation *per se* that impacts market developments. The absence of regulation can play an equally powerful role. Similarly, even if regulation exists, a supervisory approach of "benign neglect" or "forbearance" can allow the market to develop in ways that cannot be foreseen ex ante by a regulator.

Appendix 2: Product Case Studies and Observations

Yeshasvini health insurance

Yeshasvini Trust operates under the Department of Cooperation, Government of Karnataka. The scheme has all attributes of a traditional health insurance policy but is considered as a social security programme supported by the state government. Since this scheme is not offered by an insurance company, it falls outside the purview of IRDA.

The Yeshasvini Scheme was started in 2003. Karnataka government held a view that health was one of the main reasons of indebtedness of the farmers. Hence on the aegis of the then chief minister of Karnataka Sri S M Krishna and renounced cardiologist Dr Devi Shetty the programme was launched. The wide spread network of cooperatives was chosen as the distribution channel. Initially only the farmer's cooperatives were targeted which was later scaled up to all other cooperatives in the rural areas such as sugar cooperative, fishermen cooperative, spinning cooperative and so on.

The condition of availing this facility was that the cooperative may be located in urban or semi urban region but the beneficiary should reside or have property in the rural area. At present the weaver cooperatives are being covered despite of their urban location. The health security product is also being provided to the women SHGs if they have transaction with cooperative bank (at least deposited money even if not availed loan). At present the scheme covers around 5,000 cooperatives in Karnataka.

The age limit for availing this facility is 75 (which is quiet high in comparison to similar insurance products that have maximum age limit of 60 years). The scheme was initially available to a married couple and their two children but later on it was extended to all children and then their parents as well. At present if a person is a member of a cooperative all his/her relatives belonging to the Hindu joint family defined by Indian judiciary can avail the benefit by paying premium. They all are issued separate identity cards popularly known as Yeshasvini card. The premium for an individual is Rs130 (which include Rs10 of service charge paid to the cooperative society). There is no waiting period for this policy. Also, there is no discrimination of rich and poor, in availing this policy.

There is a specified enrolment period in a year generally from January to May. This has been done so that people do not get enrolled only if they fall ill. Initially the premium amount charged was Rs60 by the Yeshasvini Trust and Rs30 was subsidy was provided by the state government per policy. This arrangement continued for three years till 2006. Then it was realized that with a contribution of Rs60 the programme cannot sustain. The premium was raised to Rs120 but for children of less than 18years it remained at Rs60. In 2007-8 a uniform premium of Rs120 has been introduced for all. The state government continues its support to the programme and a substantial part of the cover is still through subsidy. The table on the following page shows the performance of the Yeshasvini scheme since its inception.

Year	Members (lakhs)	New members (lakhs)	Renewed members (lakhs)	Premium collected (Rs crore)	Government contribution (Rs crore)	Number of claims processed	Amount of claims (Rs crore)	No. of free OPD service
2003-4	15.59	15.59	-	9.49	4.50	9,047	10.65	35,814
2004-5	21.05	13.55	7.50	12.87	3.57	15,236	18.47	50,174
2005-6	14.73	3.74	7.74	16.94	11.00	19,677	26.16	52,892
2006-7	18.54	7.04	11.49	21.56	19.85	39,441	38.51	206,977
2007-8	23.18	9.84	13.34	27.75	20.00*	No info	No info	No info

*Rs15 crore released till Dec 07

The programme experienced a sharp decline in the client base in the year 2005-6. This was mainly due to two reasons (i) the premium was doubled and (ii) for a brief period due to some undisclosed administrative issues the facilities was provided only to the emergency case patients which made others to drop out. It is also clear the programme is highly dependent on government assistance. The premium collected from the clients has been (more recently) almost equally matched by the government. The study team was told that the Govt. of Karnataka now considers this as the state's health cover scheme and funds from other programmes like Arogya Shree and Sanjeevini schemes have been siphoned to the Yeshasvini scheme.

The value of claims far exceeds the premium collected from clients and government contribution in most of the years. It is unclear how the other administrative expenses and staff costs of Yeshasvini Trust is covered. Assuming the staff of Yeshasvini Trust are deputed personnel of the Dept. of Cooperative, the value of government contribution is much more than reflected. The renewals rate has been good and the data shows around 70% of members renewing the policies. This indicates that the client values the utility of the scheme. It would be interesting to note what has been the client behavior whose families have not made any claims and the ratio of the healthy to sick clients.

Till last year the programme was covering 1,600 types of surgeries. Recently angioplasty, normal delivery, neo-natal care and medical emergencies like electric shock, snake bite, accidents during handling of agricultural implements and drowning have also been included in the list. The heart patients were availing open heart surgery where angioplasty would have been enough because open heart surgery was covered under the policy while angioplasty was not. Similar was the case with childbirth. Women were availing caesarian delivery because it was covered and normal birth was not. These measures were introduced to minimize adverse selection.

Family Health Planning Limited (FHPL), is the Third Party Administrator (TPA) for processing and servicing claims by the Yeshasvini clients. FHPL is owned by Apollo Group and is a has TPA license from IRDA. Yeshasvini Trust provides it an annual lump sum fee (Rs50 lakh for 2007-8) for its services. Majority of the partner hospitals of Yeshasvini are also networked with FHPL. The process of checkup and preauthorization is usually completed on the same date so that the person who is ill need not travel and incur extra expenses. The bill clearance of the hospitals does not take more than one month. FHPL

stations one coordinator for each district to handle the cases. They report to the head office of FHPL located in Bangalore on weekly basis.

At present Yeshwasini have 322 member hospitals spread all over Karnataka, except three which are located in Hyderabad for the convenience of the people in the districts bordering Andhra Pradesh. Among these 322 hospitals 38 are government hospitals and two are cooperative owned hospitals. For each surgery the hospitals charge a fixed pre-decided amount. They are encouraged to provide free OPD and provide 25% discount on diagnostics. It is made sure that the policy holders do not need to pay any advance amount towards treatment. For one surgery in a year the maximum cover is of Rs100,000 and for more than one the cover is Rs200,000.

The CEO of Yeshasvini Trust admitted that the programme can become sustainable only with large scale enrolment of healthy people. To promote this 50% rebate is being provided to the person from whose family five or more people have enrolled. Apart from this an incentive of Rs10 per policy is provided to the cooperative society which encourages the cooperative society to promote the scheme.

There are few other issues that need attention. There is pressure from the government to include all the SC/STs in the scheme irrespective of their being member of any cooperative. This would increase the client base of Yeshavini Trust many fold but the organization neither has the capacity not is ready to handle such an increase in outreach. Government is also proposing that 100% subsidy will be provided to the SC/ST. The Trust is vehemently opposing this move as it fears that this could lead to large scale dissatisfaction and therefore dropouts.

Micro-pensions

Unit Trust of India (UTI) is the first public sector company to introduce a "Micro-Pension" plan for the unorganised sector. UTI has collaborated with several private sector organizations and cooperatives (The Bihar State Co-operative Milk Producers' Federation Ltd) and MFIs (SEWA Bank and SHEPHERD) to implement its micro-pension scheme on a trial basis. Under this arrangement clients of these agencies contribute a small amount on a monthly basis thus accessing investment opportunity through the UTI-Retirement Benefit Pension Fund. Members will contribute up to the age of 55 years and would then receive pension in the form of pension income/cashflow after they reach the age of 58 years. The monthly savings provides an opportunity to poor members for a regular income during their old age. The minimum amount of investment under this scheme of Rs50 and in the multiples of Rs50 thereafter. [63]

UTI-Retirement Benefit Pension Fund is an open-end tax saving-cum-pension fund. The scheme has been **notified** by Central Government in the Gazette Notification dated November 3, 2005 **as a Pension Fund eligible under sub-section (2), clause (xiv) of section 80C of Income- tax Act, 1961** for assessment year 2006-07 and subsequent assessment years**.** The investment objective of the scheme is to primarily provide pension in the form of periodical income/cashflow to the members to the extent of redemption

[63] UTI Mutual Fund Press Release, 12 April 2006

value of their holding after they attain the age of 58 years. The scheme invests minimum 60% and maximum 100% in debt and balance in equity.

ICICI Prudential Mutual Fund also launched 'Micro Systematic Investment Plan' (MSIP) on 25 April 2007 in association with KAS Foundation, a micro-finance institution, to offer a mutual fund investment plan which allows a rural investor to take exposure to the booming stock market for as little as Rs50 every month. KAS Foundation is one among the 200 non-governmental organizations (NGOs) through which ICICI Bank has pioneered micro lending and borrowing in rural India. It follows the same structure of UTI 'Micro-Pension' plan in which an aggregator is the interface between the mutual fund and the small rural investors.[64]

Life Insurance Corporation of India

LIC entered the micro-insurance sector with a specialized micro-insurance product "Jeevan Madhur." This is a low premium endowment policy launched in September 2006.

The product – Jeevan Madhur

This product is targeted to cover the low income group and especially those who have no fixed and stable income. "Jeevan Madhur", is available without any medical examination and is a simple savings related life insurance plan covering individuals in the age group of 18 to 60 years. Minimum sum assured under the plan is Rs5,000 and maximum sum assured is Rs30,000. Mode of payment of premium can be even weekly/fortnightly in addition to other regular modes to suit the needs of people with low income. Minimum premium is Rs25/per week, Rs50/per fortnight or Rs100/per month. The term of policy ranges between 5 to 15 years. The maturity benefit is in proportion to the amount of premium, term of policy and age of the life assured. The policy, if kept in full force, is entitled to the simple reversionary bonuses depending upon Corporation's experience. Accident benefit is also applicable as per terms and conditions of the policy. After premiums are paid for 2 years, Auto Cover facility that is continuance of cover even in case of inability to pay premium up to 2 years from the date of first unpaid premium becomes available to take care of contingencies and uncertainties of income. At present, the plan is being marketed through micro-insurance agents only. LIC says that this product is targeted at enhancing the penetration of life insurance for low income families in the country.

A different approach

LIC entered the micro-insurance business a little late compared to some private companies. The reason has been an extra cautious approach in the selection of micro-insurance agents. While most of the insurance companies have been selling their products through partnerships mainly with for-profit MFIs, LIC has tried to do it in accordance with the directives of the micro-insurance regulations. In fact LIC has gone an extra step ahead in laying out more stringent norms for selection of agents. However, in both

[64]The Wall Street Journal. 26 April 2007. "ICICI MF Launches Small Investment Plan for Rural Market"

cases the common link has been the MFIs as this provides the insurance company to access the large client base of these organizations.

The criteria used by LIC to select agents includes long experience of the NGO (more than 6-7 years against 3 years stipulated by the regulation), infrastructure (genuine office having computer and other communication facilities) and adequate staff resources. LIC feels that these requirements are critical in maintaining client database, processing of policy documents and claims settlement. LIC has also stressed on offering their products strictly on voluntary basis and not tagged compulsorily with loans or similar products. LIC officials feel that it is important to establish awareness and faith in the market for the product to remain sustainable in the long run.

The outcome

LIC being the most trusted player in market due to its long presence, many organizations approached them for becoming their agents. But LIC has selected a very few. During visits to LIC clients by the study team in the Bangalore region it was observed that product uptake is very good even though it is a standalone product. Customer awareness was also high with 90% of respondents knowing about the product terms. Though people were slightly surprised at LIC doing small premium insurance, there seemed to be a strong demand for this product. Customers now inquire about the product from LIC offices directly also.

Collaborations in the Bangalore region

LIC is working with 16 micro-insurance agents in Bangalore region as of now. All these organizations have a long experience of working with the community. Their domain area varies from implementation of government projects to international donor based work to livelihood training from donations and internal accruals. All the agents are new to micro insurance sector with experience spanning from a fortnight to 10 months. The table shows various types of organizations as micro-insurance agents and their member base

Organisation type	No.	Average age of Organization (years)	Av. period of association with LIC (months)	Client base/ Policies sold
MFI*	11	10.4	2.6	55,000/1,331
NGO	4	11.2	1.9	39,000/966
Research organisation	1	17.0	1.0	N.A/13

*Organizations registered as Societies/Trusts but microfinance being a major part of their activity mix

Capacity building of micro-insurance agents

LIC provides 25 hrs of mandatory training to all the selected micro-insurance agents spread over a period of 4-5 days. Training is provided to the specified persons (staff of micro-insurance agents) as well. LIC officials are personally present at training of specified personnel of the agents. This may make

the outreach process slow but it instills confidence in the field staff which came out very clearly during discussions. One specified person spelled the terms of the policy verbatim as it was mentioned in the policy document with not even slightest hesitation.

In addition to training to micro-insurance agents, LIC has also provided all agents with a software package free of cost. This package is helpful in maintenance of customer database which is updated daily. Before commencement of operations agent's personnel are trained by LIC on use of the software. LIC officials are contactable anytime for trouble shooting and advice. Policy is activated once name of client is uploaded in the database. So far, lag in premium payment and activation has been a constant complaint from customers and agents for other companies. This facility is expected to overcome the delays. LIC is also planning to consider payment of premiums at the nearest LIC branch by the micro-insurance agents. At present, all policies have to be sent to the DO1 or DO2 in Bangalore zone. This is likely to bring down the cost and reduce the time lag between payments and start of policy.

Agent's perspective

A majority of the agents (with whom the study team interacted) viewed micro insurance as a financial support mechanism for their clients. Around 30% of the agents perceived micro insurance as a business opportunity. Agents were of the opinion that at least 1,000 policies need to be running for managing micro-insurance business on a sustainable basis.

At present, the micro-insurance agents do not employ fulltime staff for micro-insurance activity. The people involved are basically staff of the MFI/NGO that are working on other projects as well. Commission on sale of insurance is generally shared equally between the NGO and staff/specified persons.

All agents believe that once credibility of the product as well as the NGO as micro-insurance agent is developed, the product off take will be huge. The agents feel that the credibility would increase immediately if they are allowed to provide receipts (having LIC logo) to the clients upon receiving the payment. At present the premiums are recorded in passbooks provided to the clients and an annual receipt is provided b LIC the end on each policy year. Reduction in documentary requirement and additional products for health were also demanded by agents as well as customers. Agents also feel that higher cover policies should also be introduced.

Aafat Vimo scheme of All India Disaster Mitigation Institute (AIDMI)

The organization was started in 1989 after a series of droughts hit Gujarat. It was formally registered as trust in 1995. They are at present functioning in four states namely Gujarat, Tamil Nadu, Jammu and Kashmir and Bihar. The organizations do not work in scale. It is more into generating innovative ideas and piloting them. Once the pilot is successful they provide the local institutions and government bodies to take up and scale them. The organization at present have staff strength of 60.The programmes they develop are based on ensuring four type of security for the poor disaster victims. They are food security, water security, shelter security and livelihood security. The organization is also doing evaluation of impact of disaster.

The insurance product was launched in 2003. It was observed by the organization over time that to address the disastrous conditions sort term relief approach was being taken up. Once the relief was withdrawn the people were at the square round situation. A survey was conducted in September 2003 within 14 earthquake affected slum communities in Bhuj Gujarat. This survey revealed that only 2% of the people surveyed were insured and around 74% were interested in availing insurance.

After prolonged negotiations with different insurance companies partnership was struck with Life Insurance Company (LIC) for covering life Oriental Insurance Company (OIC) for non life cover. The scheme was formally launched in August 2004 with 829 beneficiaries in Bhuj.

Following is the typical profile of a policyholder

- Disaster affected.
- Livelihood Relief Fund beneficiary.
- Low income household-average annual income Rs12,000-18,000
- Engaged in microenterprise in the unorganized sector.
- Average asset worth Rs9,000
- Average savings Rs200-Rs400

The product being offered is a composite one. The annual premium is Rs280 per household. Life insurance cover is Rs20,000 which covers the life of leading earning member of the family. For accidental death the cover is Rs25,000. In case of non life insurance for house the cover is Rs20,000, House content is Rs20,000 and business assets is Rs10,000.

Around 5,500 families in four states have been benefitted so far by this product. The claim ratio is around 70% and renewal rate is 81%.But there are problems such as migration, inability to pay, and not perceiving benefit in availing insurance which affect the renewal. There is another insurance product promoted by AIDMI is school insurance. The schools are selected based on their location in disaster prone areas and the economic profile of the students studying in the schools.

This insurance covers all the people in the pay roll of the schools and the all the students. This life cover is applicable even for the disasters happening outside the school premises. The over is of Rs25,000. This is being provided by OIC. This programme is also being seen as a means of capacity building and spreading awareness about being insured. The students are explained about insurance and they are asked to collect Rs15 as annual premium from their parents. In this process each child explains about insurance to their respective families. Knowledge is spread.

So far 29 schools and around 8,500 children have been covered under this programme.

AIDMI considers itself as an intermediary in this process. It is like a connecting bridge between the local organizations which are actually providing the services to the clients and the insurance company. The insurance company and AIDMI works on the basis of profit sharing if any. Around 65% of the profit is transferred to AIDMI. AIDMI provides technical assistance to the ground level MFIs and NGOs and they process the claims. A certain percentage is paid by AIDMI to these institutions for providing service.

Aviva's experience in selling insurance through the cooperative bank channel

A senior official of Aviva cited that the insurance companies' usually follow three types models for selling their insurance products – (i) direct sales, (ii) alternate channels and (iii) bank assurance. Direct sales and alternate channel need pre-existing data base which is not readily available in most areas. Bank assurance is a model where bank (or financial services providing company) and brokers are used. This is also called as referral business tie-up. Here existing client data base of the financial service provider is available with the insurance companies, to work with. Aviva has used the third channel of bank assurance extensively for selling its products in rural areas. This includes tie-ups with Cooperatives (Banks, Societies) and Regional rural Banks (RRBs) in various parts of India.

Cooperative tie-ups of Aviva

Aviva is using cooperatives (co-op) channel for its insurance business since 2002. In fact it was the first company to experiment and introduce this channel in India. In this channel RRBs and District Cooperative Bank (DCBs) customer base is used for selling insurance products. Pan India Aviva has tie-ups with 27-30 RRBs and DCBs for using their client base to sell its insurance products. Other companies are also using this model now. It is cost effective for the insurance companies and provides them with a higher scale of business. Last year 60-70 % of total business of AVIVA came from this channel.

Aviva's experience in Bihar

The study team visited Aviva's office in Patna to understand the working of this model. In Bihar there are 3 major RRBs and Aviva is working with one of them – Bihar *Ksetriya Grameen* Bank (BKGB) – to provide insurance to its clients. In all Aviva has 10 channel partners in Bihar. These include Canara Bank, Punjab and Sind Bank (PNSB) and Indus-Ind Bank. Broker channels are established with organizations which sell financial products. For example, Bajaj Capital is one such organisation with which AVIVA is working. This model is also similar to the coop model, which allows insurance companies to use the existing database of their partner.

BKGB is spread over the 8 districts of Munger, Bhagalpur, Banka, Jamauy, Sheikhpura, Lakhisarai, Begusarai and Khagaria. Aviva tied-up with BKGB in January 2007 and the business activities started in March. Aviva sells around 500-550 policies per month through this partnership and till now 2,500 policies have been sold. The average ticket size is around Rs20,000. There has been only one claim in the last 6 months and no case of false claim so far.

Partiputra Central Cooperative Bank (PCCB) tie-up started in October 2006. At that time there was pan India tie-up only with PNSB and Canara Bank. With PCCB average ticket size is Rs8,000. Other than the

co-op channels, average ticket size is around Rs25,000. Overall, ticket size varies from Rs 8,000 to Rs150,000. Banks are paid a fixed percentage on basis of premium deposited. These percentages vary from bank to bank, on basis of numbers, type of policy, term and frequency of premium payment (not disclosed by Aviva).

In Bihar Aviva has appointed 5 sales managers with cooperatives. In addition, 80 advisors are also working at the bank branches to collect reference, "lead" from the banks and work further in contacting and explaining the policies to the customers. Around 5-6 visits are required to explain and convince the customers.

Premium collections from co-op channel in Bihar have consistently been 2nd or 3rd highest for all Indian states. Affordability has not been a problem for the borrowers from BKGB because land is very fertile. Moreover, it is safe to assume that the borrowers are mostly well-off rural farmers who can afford a monthly premium of Rs500. Aviva prefers annual premium collection since quarterly and monthly collection lead to chances of policy lapse going high. This is because income is mostly from agriculture which gives seasonal returns. One month of grace period is given by Aviva for premium payment. Annual premium also reduces the cost of premium collection.

How this model works

Banks/Coops acts as the facilitators for selling Aviva's life insurance products. In each branch a representative of Aviva is provided a desk and he is allowed to interact with the client of the bank in the office itself. Apart from this the insurance company is provided access to the client database of the bank. Using this database, Aviva personnel contact prospective clients. Most of the clients for Aviva are from middle and upper middle class segment living in semi-urban and rural areas. Mostly, individual policies are sold by the agents. People have strong faith on the bank and often come to the bank officials for consultation regarding the products offered by Aviva and the bank officials also (kind of) certify the genuineness of Aviva. For all these services a certain service charge is paid to the bank.

Clients always like to cross check authenticity of the company with the bank. Trust is a major issue while purchasing financial products and insurance is no different. Customers inquire with the banks about the insurance company and the bank staff assures them about authenticity and reliability of the insurance company (Aviva in this case). Aviva also gets access to a large prospective client base through these banks. Also, the banks serve as assurance for the customers which would have been difficult if people were approached directly. Conversion rate (number of people who are actually contacted and who finally buy the products) differs across branches. Aviva's conversion rate is 35-40% which is it considers as reasonable. This may appear very high in compassion to urban areas, which is due to the low level of competition in rural areas. However, this scenario is changing as a number of life and non-life companies are planning enter the eastern states in a big way now.

Customer awareness & claim processing

Aviva customers seemed aware mostly about money back policies and were more interested in returns after maturity. Inclination is mostly towards money back benefits rather than the insurance cover

provided by the policy. It has also been experienced by Aviva that less than 5% clients read the finer details of the policies. In their opinion customer education is important and insurance companies should be doing themselves since it is for their own benefit. Aviva does this by providing brochures to customers in Hindi as well as in English. Its agents also explain the clients about the terms of the products before selling. Generally 5-6 visits to customers are needed to finally sell the product. Option of free look cancellation is provided under IRDA guidelines. Within a period of 15 days from purchase, customer can return the policy back if s/he is not satisfied with the terms.

As of now, companies ask for declaration of good health (DGH) certificate from clients. This is a 1 page document signed by customer declaring their non-suffering from certain diseases. Claim processing is done by Aviva. Nominee or family member has to give a written statement with death certificate. Normally claim processing is done within 15 days.

Healing Fields Foundation – a unique model for health insurance

Healing Fields Foundation (HFF) is a registered non-profit society, headquartered in Hyderabad in Andhra Pradesh. Its mission is to make quality health care accessible and affordable to all people in India. In 2005, after extensive research and deliberations with various insurance providers, HFF came up with a unique health insurance product "*Parivar Suraksha Bima*" (family safety insurance) in partnership with HDFC CHUBB for members belonging to rural groups.

The delivery of the product involves various stakeholders including a group of tertiary and secondary care hospital network (providers) and community based organizations/NGOs (including SHGs, federations, labour-nets and cooperatives). HFF is the facilitator and HDFC is the insurer that underwrites the risk.

The community is enrolled into the programme by the NGOs with the payment of premium and selected hospitals are rated and networked with pre-negotiated rates and a HFF facilitator is placed to d all the documentation, health education and hand holding of the insured. Hospitalisation process is coordinated by facilitator and monitored by HFF Medical Management Team and claims are also administered by HFF. HFF is also supported by USAID in this "Helathcare Financing and Delivery Project".

<u>Salient features of the product</u>

The scheme has covered 57,893 lives in the past two years. It is run with 18 network hospitals and many NGOs managed by 15 MFI-NGO partners in the states of Karnataka, Uttaranchal, Uttar Pradesh, Jharkhand, Kerala and West Bengal. It covers people in the age group of 90 days to 65 years. The total premium an individual has to pay is Rs346 (including Rs10 of registration fee) for a hospitilisation cover of upto Rs20,000. The product offered by Healing Fields has certain unique features.

The treatment of each enlisted disease has fixed pre negotiated rates. This is followed irrespective of the actual cost incurred. It follows a model called Diagnostic Related Group (DRG) which is a payment system based on the diagnosis of the patient. This model uses the average cost of hospitalization in a

period and the incidence of a particular disease in that period. Healing Fields has enlisted pregnancy and childbirth under the 43 treatable conditions. Post hospitalization benefits are provided so that the medicines do not discontinue after release from the hospital. The insured person is expected to pay 25% of the treatment cost as co-insurance. Pre authorization is required for hospitalization. This reduces indiscriminate use of the facilities and help Healing Fields avoid false claims.

There is also personal accident cover (death benefit –Rs25,000 and others Rs12,500). On death of the primary member of the family each child, who is studying gets Rs5,000. If she is a girl child, she gets and additional Rs5,000 for marriage. Wage compensation for a maximum of 15 days per year at Rs100 per day is available for the earning members of the family. There is also transportation reimbursement for the tribal groups upto Rs300.

At present, HFF receives a service fee of Rs101 per policy of which Rs30 is passed on to the NGO doing the selling. Now they are in process of developing a profit-sharing model with the insurer so that the money can be used to build a corpus which can be utilized for treatment of the diseases beyond the one enlisted.

Services provided by Healing Fields

Healing Fields plays the catalytic role (a health service provider), who facilitate all the stakeholders – insurer (HDFC CHUBB), health providers (hospitals) and community mobilizers (NGOs/MFIs) – to come together. The medical management team of HFF negotiates with the hospitals regarding pricing and fix cost of treatment for each enlisted aliment. This team also functions as a check against misdiagnoses and incorrect treatment. The hospitals are rated before the tie up. The criteria for rating are utilization of the capacity, service provided, competency of the personnel and structural facilities. The ratings does not translate into different type of price fixation, rather it is used as minimum acceptable quality of the health providers. Generally in rural and tribal areas the health providers do not negotiate on the quoted price for treatments but in the urban areas Healing Field faces tough bargaining by the health providers. In case any complex situations arise the hospitals consult the medical management team of Healing Fields. There are instances where the hospitals were dis-impaneled because the doctors did not treat the people properly. There are also cases where hospitals spent on upgrading their facilities and service to get them in the panel.

Healing Fields employ facilitators who are selected from the villages and then trained. They help clients with the process of enrolment, claim, hospitalization and other obligations. They remain available in the hospitals throughout the day. Their assistance makes the whole process of availing the insurance benefits hassle free. The facilitators also visit the communities to impart health education.

With the database of HFF they have been successful in avoiding outbreak of epidemics like typhoid and malaria in their operational areas by informing the government. HFF foundation feels that the micro health insurance helps the community to take charge of their own health care and well being at the same time pressuring the public and private health care providers for quality services.

Sustainability

The operations of HFF are not financially sustainable at present. As estimated by them a client base of 500,000 will make them financially independent and at this level the product will not require any subsidies. HFF is confident that with a client base of 500,000 the organization will also be able to fund the health education programme on its own.

Vimo SEWA

SEWA was set up in 1972 as a means of organizing poor women in the informal economy. These women constitute 94% of the female labour force but have none of the legal benefits provided to those in the formal economy. SEWA's purpose is to mobilize these women to help them gain economic (employment and income) and social (access to housing and health care) security, as well as providing them tools to become more autonomous and self-reliant both economically and in terms of their decision-making ability. SEWA's focus on insurance stems from this mission of protecting poor women from the vulnerabilities of everyday life. Around 80% members of SEWA are from the low income families.

History

In 1977 SEWA started observing detrimental impact of client and family death to their loan portfolio. For women risks are especially high from health family and calamities, both natural as well as manmade. In response to this Vimo SEWA was formed on principles of full employment and self reliance in economic as well as decision making. This is true for individuals as well as groups. Vimo SEWA offers a broad range of insurance coverage (life, disability, health, and property) under one product with life coverage provided as an agent and the others provided under a full service model. Another reason cited by SEWA Insurance management for bringing insurance in-house was because of delays from the insurer of 3-4 months for payment of claims. General client dissatisfaction led SEWA, in 1995-96, to take over the health insurance scheme. The SEWA health program (a separate unit from the insurance operations), works closely to promote insurance and to integrate their services with the insurance program. SEWA health care workers therefore will provide advice on preventive care, referrals to doctors and hospitals, and assistance in the processing of claims.

Insurance

SEWA bank started its operations with its first members as vendors. These vendors had capital needs on daily basis which were previously being met from money lenders at interests of 10% per day. There were cases of non repayment of loans due to crises and disasters in families of these vendors. Due to these reasons, idea of insurance came up. At this time only public sector companies were allowed in insurance sector and poor were not the focus area. After Malhotra committee's recommendations in late 1980s, companies started intervening in poor client areas. In early 1990s United India Insurance Company helped SEWA to design a product suitable to its clientele. In 1992, 7000 women were insured under group insurance where spouse, children and health were also covered.

Another benefit of bundled products is one window service. Special premium collection campaigns are run from September to November. Then a follow up campaign is run. Till now these drives were done by SEWA only in cities but now partners are also planning to run similar campaigns. Cover starts from January. Premiums are also fixed after premiums are collected. There is no tie up between insurance companies at their level to provide composite products.

More than mere insurance

Health is a major issue that impacts livelihoods and lives of poor in multiple ways. Health care services in India are not available to the degree desired. So SEWA recognised that mere insurance will address only part of the problem. To bring in true benefits it needed to work actively in health services domain as well. SEWA started its health cooperatives in 1984. These cooperatives are located in member areas and are involved in traditional medicine production and drug shops. In addition, it has trained 400 health workers (traditional birth attendants) for awareness creation, antenatal, child immunisation, HIV awareness and other health issues. Currently SEWA is one of the largest partners of government in providing health services. In addition it also shares its expertise with Mittal foundation and Agha khan foundation.

Product development process

For its clients SEWA has developed a bundled product providing cover for life, non-life. It provides an easy one window processing which is crucial for clients who are uneasy with cumbersome paper work and long delays. Every year, based on previous 3 years' experience SEWA, in consultation with insurance companies, formulates terms for product to be offered in that given year. So SEWA has provided need based social security to poor on their doorsteps.

At present, two packages of insurance are being offered – Scheme 1 and 2. Both the schemes have similar risks covered and the only difference is the amount of coverage – see table below.

Cover	**For**	**Scheme 1**	**Scheme 2**
Life	husband and wife	Rs7,500 each	Rs20,000 each
Mediclaim	husband & wife	Rs2,000	Rs6,000
	all children	Rs2,500	Rs2,500
Accidental death	husband & wife	Rs4,000 each	Rs65,000
Asset		Rs10,000	Rs20,000
Premium		Rs325 per family	Rs600 per family

Around 97% of the clients are covered under Scheme 1. SEWA membership is almost a million now and total of 1, 54,219(around 2% of total membership) people are insured till February 2007. Clients can join

the schemes on a quarterly basis in cities in Gujarat but this is being adopted by partners also. Reason for low overall insurance is extremely low insurance among clients in states other than Gujarat. This is because there are other organisational focus areas in these regions. The table below shows the two main products offered by SEWA to its own members.

In all 5-6 products are being offered to partners based on their unique requirements essentially these are variants of the composite product that SEWA has developed with the insurance companies.

Operations

Operationally, SEWA claims processing time is faster than the processing by the formal insurers. The total duration from event to benefit receipt is important especially to vulnerable clients. SEWA's health insurance program works best where their separate unit on primary and preventive care is also active. This is because these services are essential to bring claim ratio lower and provide actual benefits intended for clients.

Management

SEWA follows a decentralised system of management. This is done through SHGs, Cooperatives and associations. Partner organisations are also allowed to participate in claim processing. This is the most cost effective and viable mode due to unavailability of conventional channels.

Tie-ups

SEWA has tied up with many insurance companies to provide the best deal to its clients. These tie-ups are reviewed every year and tendering and quotations are called for. Among the various companies are ICICI Prudential, ICICI Lombard, LIC and reliance life and non-life. SEWA has a considerable bargaining power due to its volumes. Throughout its history SEWA has worked with people's organisations, government bodies and private sector. It has been in constant touch with both the grass roots as well as policy level. In the last 5 years, these schemes have been offered to NGOs in other states and SEWA intervention areas in other states also. These organisations are called partners. Partner's primary role is enrolment but lately they are also taking an active role in claim settlement also. In this model partners (NGOs) collect money. Difference in this model is that here VIMO SEWA is allowed to do the claim servicing as well. Now there are plans to provide claim settlement at decentralised (NGO) level also. But there is reluctance on part of the NGOs due to lack of manpower and expertise.

For year 2008, ICICI Lombard and reliance general are covering non-life insurance and LIC, Bajaj Allianz and Kotak Mahindra are covering life insurance. Tenders are called for, from insurance companies to decide on which company will provide insurance to clients in a given year.

Benefits

A strong benefit to SEWA is in their apparently low level of attrition. Two-thirds of their clients are part of the "lifetime" membership program so these are retained without effort. The fixed deposit account

has a very positive impact in retaining clients for SEWA. At the same time there is great flexibility in product formulation and operations.

View on regulations

SEWA feels that regulations currently are not geared to the realities facing the micro-insurance sector. SEWA gets paid a service fee rather than commission for clients covered. SEWA is of the opinion that an initial push is required to create awareness and feeling of need. Capacities and numbers of insurance teams of various organisations further constrain spread of insurance. SEWA also feels that capital requirement for becoming insurance providers is very high and should be in tune with risk covered. They feel that service tax should also be removed from micro-insurance sector. SEWA feels that it is equipped to underwrite risks on its own in life but not in health and disaster as risks are comparatively higher in the last two. They also feel that more experience and competence is required to underwrite health risks.

Insurance potential

Based on its long experience SEWA strongly feels that there is great need for insurance to the poor. There is willingness to pay also. But the missing link in conversion of potential into reality is availability of right kind of products and terms suited to the unique needs of disadvantaged communities.

Health insurance products offered by the Government

The prominent health insurance schemes offered by the Government (both Central and state governments) in India for low-income families are the following[65]:

- Central Government Health Scheme (CGHS)
- Employee State Insurance Scheme (ESIS)
- Universal Health Insurance Scheme
- Other health insurance schemes funded by State governments and Ministries

The Central Government Health Scheme was introduced in 1954 as a contributory plan, with the aim of providing comprehensive medical care to central government employees, ex-Members of Parliament and some others such as journalists. The contribution by the employees has remained nominal (maximum of Rs50 per month) and the scheme is subsidized by the Government to a significant extent. CGHS is operated out of 24 cities across the country, through a network of 331 dispensaries mostly in major towns. In addition, several hospitals in and around New Delhi have been empanelled and beneficiaries can avail of treatment at these hospitals, which is later reimbursed by the Government. As

[65] Chakraborty, Manab. 2005. "Study on Linkages between Statutory Social Security Schemes and Community Based Social Protection Mechanisms to Extend Coverage: India Case Study". ILO/SSA/AIM

of June 2007, CGHS had 55 such hospitals on its panel, mostly in and around Delhi. Benefits under the scheme include medical care at all levels and home visits/care as well as free medicines and diagnostic services.[66] The CGHS has been described as a cost-intensive scheme (with staff salaries accounting for nearly one-third of the total expenditure on the scheme) and its outreach among the low-income families is very limited (since it is restricted to Central government employees).[67]

The Employee State Insurance Scheme, launched in 1952, was originally applicable to non-seasonal factories using power and employing 20 or more persons; but it is now applicable to non-seasonal power using factories employing 10 or more persons and non-power using factories employing 20 or more persons.

The scheme has also been extended to shops, hotels, restaurants, and cinemas including preview theatre, road motor transport undertakings and newspaper establishment employing 20 or more persons. The existing wage-limit for coverage under the ESIS is Rs10,000 per month (with effect from 01 October 2006).[68]

The ESI scheme, through the Employee State Insurance Corporation, not only provides free medical care (including coverage for cost of consultation and diagnostics, supply of special medicines and out-patient care) but also provides other facilities such as large-scale immunization against common diseases and family welfare services (surgeries facilitating family planning). Insured persons and members of their families are also provided special aids in case of need. These include artificial limbs, hearing aids and artificial appliances like spinal supports, cervical collars, walking calipers, crutches, wheel chairs and cardiac pace makers.

The ESI scheme also provides for sickness benefit in the form of periodical cash payments during the period of certified sickness, when the insured person cannot attend work. Sickness benefit is roughly 50% of the average daily wages and is payable for 91 days during 2 consecutive benefit periods. In addition, maternity benefit is provided to insured women workers in case of their inability to work (for a maximum period of 12 weeks), miscarriage or medical termination of pregnancy (for a maximum period of 6 weeks) and sickness due to pregnancy (for a maximum period of one month). Maternity benefit is roughly equal to the average daily wage. Apart from these benefits, ESIS also provides for cash benefits in case of disability arising out of work, due to any accident or occupational disease. The disability benefit is about 85% of average daily wages and is payable as long as temporary disablement lasts and significant improvement by treatment is possible. The scheme also provides for benefits to dependents (Rs14 per day for a fixed period depending on the age of the dependent) in case the insured person dies due to injury occurred while at work.

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[66] Rao, Sujatha K 2005. Published in "Background Paper: Financing and Delivery of Health Care Services in India". Section IV. "Health Insurance in India". National Commission on Macroeconomics and Health

[67] Ibid

[68] http://esic.nic.in

The scheme is financed from contribution from employers and employees. Employers are required to contribute 4.75% of the salary and employees contribute 1.75% of the salary. Employees drawing a daily average wage up to Rs50 are exempted from payment of the contribution. Employers have still to contribute their own share in respect of these employees.

The table below gives the outreach details of the Employee State Insurance Scheme (as on 31 March 2006).

Number of insured family units	9,148,605
No of employees insured	8,400,526
Total number of persons covered	35,496,589
Number of insured women	1,543,250
Number of employers	300,718

Source: The Employees State Insurance Corporation.

Outreach of the Employee State Insurance Scheme

The Universal Health Insurance Scheme was launched in 2003 by the central government, exclusively for families below the poverty line (BPL). Implemented through the four subsidiary companies of the state-owned General Insurance Corporation of India[69], the scheme provides for reimbursement of hospitalisation expenses upto Rs30,000 to an individual/family with sub-limits (maximum per illness, Rs15,000). The benefit of the family operates on floater basis, i.e. the total reimbursement of Rs30,000 can be availed of individually or collectively by members of the family. In addition to medical re-imbursement, the scheme also provides for accident cover of Rs25,000 in case of the death of the main earning member of the family; and also provides disability cover if the earning head of the family is hospitalised due to an accident/illness. A compensation of Rs50 is paid per day of hospitalization upto a maximum of 15 days after a waiting period of three days.

The premium under the scheme is Rs165 per annum for an individual, Rs248 per annum for a family of five and Rs330 per annum for a family of seven persons. In several states, the Government pays the premium of Rs248 per annum (for a family of five) for all BPL families covered by the companies.

Apart from the main insurance schemes discussed above, several State governments and Ministries under the state governments as well as the central government offer their own health insurance schemes. For example, the central Ministry of Textiles introduced a Health Insurance Scheme[70] for 300,000 weavers in 2005, providing cover to the weaver, his wife and two children for all pre-existing diseases. Out of the total annual premium of Rs1,000, the Central government contributes Rs800 and the weaver has to pay the remaining Rs200.

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[69] GIC has four subsidiary companies: National Insurance Company Ltd, New India Assurance Company Ltd, Oriental Insurance Company Ltd and United India Insurance Company Ltd

[70] Chakraborty, Manab. 2005. Op cit, pg 4

Another example is the health insurance scheme for the poor launched by the Government of Kerala around July 2006, but was revoked by the new state government in November 2006.[71] The scheme was envisaged to cover 25 lakh below poverty line families and provide a package of benefits that included Rs30,000 a year as the total medical expenses for a family of five; up to Rs60,000 a year for treatment at home, if required; up to Rs15,000 a year for maternity needs; a subsistence allowance of Rs50 a day (if the bread-winner is hospitalised); a bystander allowance of Rs50 a day; coverage of all "existing" illnesses; and cashless medical treatment on production of the photo identity cards supplied by the insurer. The scheme also included an accident insurance benefit of Rs100,000 ($2,500) for death or full disability and Rs50,000 ($1,250) for partial disability. The insurance cover was provided by ICICI Lombard General Insurance Company Ltd.

The total premium for a "typical" five-member below poverty line family (in this scheme) was Rs399 ($10) a year. The beneficiary's contribution was Rs33($0.80). A Central government subsidy of Rs300 under the Universal Health Insurance Scheme (UHIS) and an additional subsidy of Rs33 each from the State government and the local body concerned accounted for the balance amount. The scheme was to be implemented through “neighbourhood groups” (similar to Self-Help Groups) under the state government sponsored “*Kudumbasree*” programme.

[71] www.hinduonnet.com/fline/fl2322/stories/20061117001305000.htm

Appendix 3: Client Perceptions of Micro-Insurance

Introduction

Since the purpose of this study is to develop principles for micro-insurance regulation that would facilitate the growth of the sector, a client assessment module was included to obtain the perceptions of the ultimate clients – low-income families – targeted by micro-insurance programmes[72].

The field study designed for this purpose was mainly qualitative in nature as a scientifically designed quantitative survey would be both time consuming and resource intensive. This study was undertaken to understand the attitudes of low income clients to insurance and, thereby, to understand their needs for such insurance. The study was undertaken mainly through interaction with the intermediary that was associated in the delivery of micro-insurance products to clients and with those people (the clients) who have bought micro-insurance products. Separate discussions were also conducted with non-clients to understand the reasons for their not having insurance cover. The study team related the feedback thus obtained with its interactions with the private and public sector insurance companies and with IRDA.

Research methodology

This primary field research module of this study included personal interaction with focus groups of clients and non-clients, representatives from insurance companies, aggregators/micro-insurance agents, network organisations and a mini-workshop with micro-insurance agents. The design for undertaking the client survey involved the

- Selection of location
- Selection of survey tools and
- Selection of respondents

Selection of location

India being a large country with considerable cultural diversity, preferences change across different states and regions. In order to make the study representative, it was essential to capture the opinions of clients from various parts of the country. The field work was, therefore, carried out in various parts of India broadly divided into five regions – North, East, West, South (NEWS) and North East (NE). This follows the commonly accepted regional division of the country as a whole.

[72] Micro-insurance programme means micro-insurance products launched by commercial insurers, government programmes and schemes and community based insurance programmes (mutual insurance).

Selection of survey tools

The tools used for the research were

- Individual interviews with representatives of NGOs/MFIs and local officials of insurance companies
- Focus group discussions (FGD) with clients and non-clients
- Mini conference with MI agents

Individual interviews were conducted with representatives of NGOs/MFIs and insurance companies using a checklist of questions. The interactions with aggregators covered regulatory issues as well as discussions on clients' perception and needs, their relationships (partner-agent or micro-insurance agent) with the insurers and operational issues in distributing micro-insurance products.

The focus group discussions were with clients of the NGO/MFIs and non-clients in their operational areas. The opinion of non-client groups was taken to differentiate the views of the clients who were using the insurance products from those who chose not to (or were unable to) subscribe. Each FGD had an average 10 respondents. An unstructured checklist of questions guided the process. The discussion was to understand

- the level of awareness of the clients about insurance as a financial service,
- their expectations from the product they were using, and
- their need for other insurance products as well as features they would like incorporated in these products.

A mini workshop was organised by the LIC Divisional Office at Bangalore to interact with their micro-insurance agents. This was helpful for the study team to understand the operations of the micro-insurance agents and also to get their perspective on the roles, responsibilities and commissions for agents outlined in the micro-insurance regulations.

Selection of respondents

The selection of respondents – in the selected locations – was undertaken to ensure a reasonable mix of various economic groups, geographical location (urban, semi-urban and rural), and gender. The selection of NGO/MFIs in the selected locations (the five regions) preceded the selection of clients and it was done on the basis of the domain knowledge of M-CRIL about microfinance in India. Discussion with insurance companies about their micro-insurance products contributed to this selection of institutions for the field study. These mainly included organisations that had significant experience of providing micro-insurance services to their members. The **table overleaf** summarises the profile of organisations selected for the study and indicates the diversity of institutions and situations selected for the study.

Since the clients were members of the MFIs/NGOs it was possible for the study team also to take into account aspects like the occupational profile of the clients, distance of the urban/semi-urban/rural centre from the MFI/NGO and literacy levels before selecting FGD members. The **table** below presents the diversity of the respondent groups.

Profile of selected organisations

Region and location	Organisation	Legal status	Activities of the Organisation	Providing insurance since
North: Varanasi	CASHPOR	MFI (NBFC)	Microfinance and livelihood promotion	2003
East: Patna	Nidan	NGO (Society)	Work with both rural and urban poor on hygiene issues, legal support, microfinance, livelihood promotion	2003
	COMPFED	Milk Federation (Society)	Federation of milk producer's cooperatives	2006
West: Ahmedabad	SEWA	MFI (Cooperative)	Microfinance, social security (within this micro-insurance), housing, livelihood promotion	1992
	AIDMI	Trust	Disaster management research & training	2004
South: Hyderabad	Healing Fields	NGO (Society)	Administer the micro health insurance product of HDFC CHUBB	2005
South: Bangalore	Yeshasvini Trust	Government Trust	Provide micro-health insurance to the members of all types of rural cooperatives in Karnataka	2003
	Micro-agents of LIC	NGO (Society)	Various activities like livelihood promotion, garbage collection and minor irrigation projects	2007
North-east: Guwahati	Asomi	MFI (Society)	Microfinance, entrepreneurship promotion of livelihoods	2005
	Prochesta	NGO (Society)	Microfinance, livelihood promotion	Not yet started

The FGD respondents' profile

Location	Occupation	Socio-economic Status	Urban/ Rural	Gender	Distance
Varanasi, U.P, NI	Wage labour in carpet manufacturing units	Very poor	Rural	All women	45 Km from Varanasi
Patna, Bihar, EI	Petty trader, house maids, vegetable vendors	Poor	Urban slum	Men & Women	Within Patna city
Patna, Bihar, EI	Small and large farmers, livestock rearing	Self-sufficient	Rural	All men	25 Km from Danapur
Ahmedabad, Gujarat, WI	(i) Vegetable vendors, tailors & wage labourers (ii) Daily wage labourer, vegetable vendors, migratory labourers	Self-sufficient Poor	Urban slum Urban slum	All women Men & women	Within Ahmedabad city
Warangal, A.P, SI	Wage labour, marginal farmers	Poor	Rural	All women	300 Km from Hyderabad
Kolar, Karnataka, SI	Micro-entrepreneurs - tailors, auto rickshaw drivers, vegetable vendors; daily wage labourers	Mixed - poor and self-sufficient	Semi-urban	All women	70 Km from Bangalore city
Rural Bangalore,	Patients admitted in Narayan	Self-sufficient	Semi-urban	Men &	20 Km from

Karnataka, SI	Hridayalaya Hospital			Women	Bangalore city
Guwahati, Assam, NEI	Weaving, small and marginal farmers	Self-sufficient	Rural	All women	30 Km from Guwahati

Note: NI-North India, EI-East India, WI-West India, SI-South India, NE-North East India

The socio-economic status of the clients groups was assessed on parameters like occupation, cash-flow pattern, ownership of assets, family size and quality of house construction. Information on these aspects was obtained during the FGDs and observation of the households at the location where FGDs were conducted was used to come to a conclusion about the respondent's overall status. The **table** below summarises the socio-economic status of the respondents. The study team made a purposive attempt to cover either micro-insurance clients themselves or low income families who could potentially become MI clients in the future.

Socio-economic status of the respondent groups

Category	**North**	**East**		**West**		**South**			**North East**
Client group of	**Cashpor**	**Nidan**	**COMPFED**	**AIDMI**	**Vimo SEWA**	**Healing Fields**	**Yeshasvini Trust**	**LIC agents**	**Asomi**
Occupation	Daily wage earner	Daily Wage Earner	Farmers	Daily wage earners	Daily wage earners	Farmers	farmers	Daily wage earners	Farmers
Flow of income	Regular	Regular	Seasonal	Not regular	Regular	Seasonal	Regular	Not regular	Seasonal
Assets possessed (land and others)	minimal	Minimal	Average	Minimal	Average	Minimal	average	good	minimal
Family size (average)	5-6	5	6-7	4-5	4-5	6	5-6	5	7
Type of house	Mud, thatch roof	Mixed	Brick	Mixed	Brick	Mud	mixed	Stone	mud
Overall status	Very poor	Poor	Self Sufficient	Poor	Self Sufficient	Poor	Poor	Mixed	Self Sufficient

Source: Focus group discussion and observation

It is evident from the table above that the respondents' profile was quite diverse. For example, the respondents in Patna were economically well-off in comparison to those in Hyderabad who were poor landless agricultural workers. Respondent groups at Warangal (Healing Fields), Varanasi (Cashpor) and Guwahati (Asomi) were all women while at Patna (Nidan) separate discussions were conducted with men and women and at COMPFED (near Patna) the respondents were all male. Respondent groups in Varanasi, Guwahati and Hyderabad had a long involvement with MFIs whereas respondents in rural Patna had none.

The sample

The study team interacted with around 115 clients through 10 FGDs and 75 non-clients through 9 FGDs. In addition to this, the study team interviewed senior officials from 10 aggregators (including organisations registered as Societies, NBFCs and Cooperatives), 16 micro-insurance agents of LIC and 9 insurance companies. The **table** below presents the sample of respondents covered by the field study.

Limitations

- Interpreters helped the team to communicate with the respondents of FGDs conducted in the southern region (Hyderabad and Bangalore). This made the process slow and dependent on the level of understanding of the interpreters.

- Respondents being poor, attending the FGD entailed some wage loss for them. Hence, the meetings were kept as brief as possible.

- There is a level of subjectivity in the quantification of responses, some of which are based on the FGD facilitators' perception, while the others are based on voting/hand counts and general observations.

Sample of respondents

Zone	Aggregators/ Micro-insurance Agents	Clients		Non-clients		Insurance Companies[#]
		FGDs	No. of respondents	FGDs	No. of respondents	
North	1	1	10	1	15	3
East	2	2	22	2	10	1
West	2	2	25	2	15	2
South	4*	4	43	3	25	3
North East	1^	1	15	1	10	3
Total	**10**	**10**	**115**	**9**	**75**	**12**

*Though the study team interacted with 16 micro-insurance agents in Bangalore, only 2 of them were visited for a detailed study

^ Only one of the organisations visited in Guwahati was providing micro-insurance services to its clients

Counts interaction with head quarter and branches separately

Findings from the field study

Client interaction

FGDs were conducted with the client groups of the MFIs/NGOs in various regions of India. The average group size for FGDs was around 10 respondents. The checklist of questions was designed to obtain responses on awareness about insurance as a product, product knowledge and risk coverage needs.

Though the information collected through FGDs was mainly qualitative in nature, an effort was made to quantify the opinion of the respondents through participatory techniques like voting/hand counts. The findings from the client interaction are presented below.

Awareness of insurance as a financial product

The conclusion from the FGDs is that the general awareness level of low income families about insurance as a financial product is low but this varies widely across regions. Overall, the team observed that the level of awareness depended on access to financial services, remoteness and exposure to insurance companies but not as much on the economic status of respondents.

While the FGD respondents (particularly clients) were able to differentiate between different risks faced by them and the need for risk cover, for them insurance is a sunk expense which is not going to give them any returns. However, in areas where respondents had received benefit through claims the understanding of the utility of insurance was much greater. As expected, the awareness level of respondents who had bought some kind of insurance is comparatively higher than that of non-clients. The awareness of insurance amongst respondents from the Southern region is much higher – the reason being a high concentration of microfinance operations in South India and, hence (since the MI regulations did not have any regional quotas) these were the first targets of most insurance companies. The table below shows the awareness level of respondents on various aspects of interest for this study.

Awareness level of respondents

Regions	Awareness about insurance		Awareness about products offered to them by parent MFI/NGOs		Awareness about other MI/insurance products available in the market	
	Client	Non- client	Client	Non-client	Client	Non-client
North	20%	7%	80%	7%	10%	1%
East	23%	10%	68%	10%	18%	1%
West	20%	13%	40%	0%	4%	0%
South	23%	12%	70%	8%	19%	1%
North East	13%	10%	33%	0%	13%	0%

Note: The awareness level has been measured as a proportion of total clients and non-clients covered by the FGDs

It is apparent that clients were well aware of the insurance products offered to them by the intermediary institutions with whom they have direct contact. Aspects like the term of insurance, sum assured, premium value and associated benefits were generally well known. However, the clients were not able to name the actual insurer (the insurance company underwriting the risk). In fact it was only the LIC – due to its long history as a provider of insurance services in India – that featured prominently as an insurance company known by the respondents. In South India a few of the respondents seemed aware of some private insurance companies because of the greater exposure to insurance there than in other regions.

Risk coverage priorities

During the FGDs participatory discussions were facilitated to enable the respondents to think of commonly faced risks in their lives and the strategies adopted by them to cope with those risks. While most of the respondents who had some sort of insurance cover acknowledged that insurance is one strategy to cope with the risks, other respondents only admitted its usefulness when this was explained by the study team. However, the priority attached to covering a certain type of risk was mainly based on its frequency of occurrence. It is for this reason that health insurance was top priority for most of the respondents while life coverage was far behind. **Table A2.7** shows the risks identified by the groups and prioritisation in the context of insurance.

Health was a top priority for 61.6% of respondents as they associate illness with unplanned expenses as well as loss of income causing a huge impact on their cash-flows. The more aware groups (in the South and West) were able to break this preference down further and for them cover for common illnesses (as out-patients) was the most important risk that requires cover. This is in contrast to the tendency for most insurance companies to offer cover only for in-patient care of selected health service providers. In Bihar, for the COMPFED group which is involved in dairy, livestock insurance is of prime importance as it is directly linked to their livelihoods. Similarly crop insurance was considered as important by the marginal farmers who were dependent on rains for agriculture and for them crop failure causes a major financial setback. In the West, cover for life and assets risks is important since people had faced losses in recent years on account of natural calamities.

(a) Prioritisation of risks faced by the respondents

Location	Respondent's profile	Products being offered	Risk (in order of priority)
North			
Cashpor, Varanasi	Marginal farmers, landless labourers, most of them involved in carpet weaving All women respondents	Money back policy for life insurance (Birla Sunlife)	Health Life (money back) Asset
East			
Nidan Patna	Urban workers, mostly housemaids, petty traders, rickshaw pullers & vegetable sellers All women respondents	Composite product for health, life, asset (SEWA) Money back life policy (LIC)	Health Asset Life (money back)
COMPFED, Patna	Small and large farmers, most of them involved in dairy. All men respondents	Micro-pension scheme (UTI) Money back life policy (LIC) Cattle insurance	Crop Cattle Health Life (money back)
West			
Vimo SEWA Ahmedabad	Vegetable vendors, petty traders, casual labourers	Composite product for health, life, asset insurance (SEWA)	Health Asset (natural calamity)

Location	Respondent's profile	Products being offered	Risk (in order of priority)
AIDMI Ahmedabad	Daily wage earners, vegetable vendors, migratory labourers	Composite product for life, house, household assets, stock in trade and personal accident	Life Asset Life Accident
South			
Healing Fields Hyderabad	Marginal farmers, main source of livelihood is wage labour. All women respondents	Credit linked micro-health policy (HDFC CHUBB) Money back life (LIC, Bajaj Allianz)	Health Life Cattle Crop
Yeshasvini Trust, Bangalore	Farmers, weavers, Fishermen and milk producers (all members of cooperatives)	Micro-health policy (Yeshasvini)	Health Life (money back) Crop
LIC agents Bangalore	tailors, garbage collector, auto-rickshaw driver, vegetable vendors	Endowment policy of life insurance (LIC)	Life Health Cattle Enterprise
North East			
Asomi, Guwahati	Small & marginal farmers & landless labourers; most involved in tasar silk weaving activities All women respondents	Credit linked term policy for life (LIC)	Health Life (money back) Asset Cattle

(b) Risks identified by the respondents and priorities

Types of risk	Priority (as % of respondents interacted with)			
	Top	Second	Third	Last
Health	61.6%	22.1%	13.7%	2.6%
Livestock	6.3%	22.6%	16.3%	7.4%
Crop	2.1%	5.3%	5.3%	4.2%
Life	14.2%	32.6%	33.7%	19.5%
Accident/natural calamity	2.6%	7.9%	6.3%	4.2%
Business/enterprise assets	4.7%	12.6%	18.4%	14.2%
Household assets	6.8%	12.1%	10.0%	5.3%

Note: Total will not add up to 100% because of overlapping responses

Overall, life insurance came in next as the second priority (14.2%) but this was very low compared to the priority accorded to health as a large number of respondents felt that the benefit of their death goes to their family and not to them; their concern is more with what happens if they live than with what happens if they die. The risks which could be clubbed together as the third priority include livestock

(6.3%), household assets (6.8%) and business/enterprise assets (4.7%). The other risks identified by the groups were crop and loss due to accidents/natural calamities.

Product priorities

The respondents were more inclined to buy products which provide them some returns. It is for this reason that the preference for savings linked life insurance products was high. Pure risk policies were seen mainly as a forced option for respondents who had obtained loans from MFIs. This was observed mainly in South India. However, the understanding of the respondents on benefits and drawbacks of pure risk and savings-linked policies was low. For them the only differentiating factor was that pure risk is a sunk cost while savings-linked policies provide returns in addition to cover.

The preference for composite products was high particularly if there was a health component attached to it. Affordability of premium was also an important factor for the respondents to make decisions and the average acceptable level of premium was reported to be around Rs350-400. The occupational profile of the respondents also defined their priorities; farmers prefer crop insurance, dairy entrepreneurs want cattle insurance.

The respondents were not able to distinguish between group-based and individual insurance products. The delivery mechanism for insurance products (for groups as well as individuals) has been mainly through groups except for some instances when the LIC micro-insurance agents and Aviva staff (through Bancassurance) target individual clients. The general perception is that each one them is covered individually. However, in urban areas some of the respondents were able to differentiate between group and individual products particularly those who are involved in agriculture and allied activities as these products have been sold to them on an individual basis.

Reasons for not subscribing to micro-insurance products

The main reasons for not subscribing to MI products were found to be lack of awareness, lack affordability, low perceived benefit from insurance and lack of trust in that order. Around 53% of clients did not take up insurance because of the lack of awareness (this was even higher for non-clients). Affordability and low perceived benefit are somewhat correlated to lack of awareness as most of the clients/non-clients did not know what was on offer and how insurance is a useful risk mitigation mechanism. Low perceived benefit was also the major cause of policy lapses and the respondents felt that since they did not benefit from the policy in a particular year there was no need to renew it. Similarly, in the case of areas like Gujarat (earthquake) prone to natural disasters, the SEWA experience shows that the product uptake went up significantly just after the earthquake of 2001. The table overleaf quantifies the responses on these factors.

Lack of trust was commonly found in urban areas where the products are sold on an individual basis. In rural areas the respondents who are members of intermediary institutions (NGO/MFIs) place a lot of trust in their organisations and usually follow the path shown to them. In urban areas the respondents mentioned they are not comfortable making payments without receipts to unknown persons even if

they are interested in an insurance policy. Even illiterate respondents stated that receipts and policy documents instil a feeling of security in them. However, some (in urban areas) were also against a lot of paper work (AML requirements like proof of address and proof of age) which they do not have and, therefore, limits their eligibility to buy insurance.

Reasons for not subscribing to micro-insurance products

Reasons for not subscribing	North	East	West	South	North East	Overall
No knowledge of insurance products	53%	60%	60%	52%	40%	53%
Too costly product/low affordability	13%	20%	33%	20%	30%	22%
Low perceived benefits	27%	10%	13%	12%	10%	15%
Lack of trust on insurance providers	7%	0%	0%	8%	10%	5%
Lot of paper work	0%	10%	0%	0%	0%	1%
Unsure source of income	0%	0%	0%	8%	10%	4%

Willingness to pay for insurance

The willingness to pay for insurance (table below) was found to be high among the respondents who were members of intermediary organisations (NGO/MFIs) in comparison with non-clients. In urban areas the willingness to pay was higher than in rural areas and it also varied on the basis of product preferences; the willingness to pay for health insurance was high at all locations followed by asset (particularly livelihood assets like cattle) and life. However, it did not convert into actual buying of insurance due to lack of knowledge/awareness amongst other factors (discussed above).

Willingness to pay

Region	Preferred distribution channel	Willingness for pay		Affordable premium size (Rs)
		Clients	Non-clients	
North		80%	40%	250-400
Cashpor, Varanasi	MFI/NGO			
East				
Nidan, Patna	NGO	100%	30%	250-500
COMPFED, Patna	Cooperative	100%	50%	500-1,000
	Directly from insurance company			
West				
Vimo SEWA, Ahmedabad	Vimo SEWA	100%	40%	250-500
AIDMI, Ahmedabad	NGO	80%	30%	250-300
South				400-700
Healing Fields, Hyderabad	MFI	90%	50%	
	Directly from insurance company			
Yeshasvini Trust, Bangalore	Cooperative	100%	Did not cover	Upto 200

LIC Agents	NGO/LIC	100%	30-40%	400-500
North East				
Asomi, Guwahati	MFI	90%	30%	500-1000

Source: Focus group discussion

Interaction with aggregators

The study covered 10 organisations in detail – including 2 MFIs (one with an NBFC licence and the other registered as a Society), 5 NGOs (registered as Societies), a government Trust and 2 cooperatives. The study team also interacted with around 15 organisations that were micro-insurance agents of LIC through a mini-workshop. The table on the following page presents the features of insurance products being offered by these organisations to their clients/members.

As the table shows, most of the organisations provide insurance facilities to their clients through some sort of partnership with insurance companies. Except for the LIC agents who are micro-insurance agents (as per the definition in the micro-insurance regulations), all other organisations provide services to their partner insurance companies for which they are paid service fees (not commissions). Yeshasvini Trust has no insurance partners and it provides insurance cover through the pooling of risks with substantial subsidy support from the state Government of Karnataka. COMPFED's pension plan is also not pure insurance cover but more in the nature of social security cover for its members.

Among the organisations covered by the study, a majority had partnered with insurers for philanthropic reasons rather than with a commercial motive. Even among the LIC agents around 80% had become micro-insurance agents to provide additional services to their members rather than to make money out of this activity. This is due to the perception that the people they were dealing with belonged to the "bottom of the pyramid" and had very limited resources but varied needs. However, a couple of organisations had taken up the activity with a commercial orientation as well and felt that micro-insurance makes good business sense if the client base is scaled up quickly. For the MFIs micro-insurance is mainly a loan safeguard mechanism rather than risk cover for their members. However, one of the MFIs covered by this study had a more social (rather than commercial) orientation.

There was a general feeling among aggregators/agents that women are easier to convince and sell insurance products to because they are more concerned to save however small the amount because of their concern for the well-being of their families. For the same reason, the policies which cover the spouse and children have better acceptability amongst potential clients.

The main bottleneck these organisations face in delivering and servicing insurance products is the lack of capacity. The smaller organisations not only lack human resources but also technical knowhow about insurance which severely limits their capacity to act as aggregators/agents. Lack of infrastructure (particularly banks and health services) has added to the operational problems faced by aggregators/agents on account of the time lag between collection and payment of premium, in addition to the regulatory limitation on the participation of for-profit organisations as agents.

Features of products offered by aggregators to their clients/members

Organisation visited	Insurance Partners	Products offered	Client base	% insured	Premium size /annum (Rs)	Maximum cover (Rs)
North						
Cashpor, Varanasi	Birla Sunlife (Bima Kavach)	Micro life insurance, money back policy with accident rider, maximum term of three year	252,000	10% of the client base (50% of Mirzapur clients)	100	10,000
East						
Nidan, Patna	Provided by SEWA	Composite product, voluntary product but Nidan is thinking of making it credit linked	No info	No info	125-500	65,000
COMPFED, Patna	UTI mutual Fund	Micro pension scheme, Unit Linked Pension Plan, voluntary product	3,00,000	13% of client base (~40,000)	30	Variable
PCCB, Danapur	AVIVA Life Insurance	All products, no specific micro insurance product is there at present	20 such branches, around 20,000 members/ branch	Less than 1%	Variable	Variable
West						
Vimo SEWA, Ahmedabad	Life: LIC, Kotak Mahindra & Bajaj Allianz Non-life: ICICI Lombard, Reliance	Composite product, voluntary product, group coverage – covering health, life asset and accidental death	1,000,000	16%	325-600	65,000
AIDMI Ahmedabad	Life: LIC Non life : Oriental Insurance Company	Composite product, voluntary product, individual product covering life, asset, accident	No info	5,576	280	95,000
South						
Healing Fields, Hyderabad	HDFC CHUBB	Micro health insurance product, credit linked for the people taking loan but voluntary for others, group product, term insurance	Client base of 15 MFI/NGO partners	57,893 policy holders	346	20,000
Yeshasvini Trust, Bangalore	In house Product	Micro health security, term product for one year	5,000 rural cooperatives of Karnataka	2,320,000 policy holders	130	2,00,000
LIC Agents Bangalore	LIC (Jeevan Madhur)	Life endowment policy with accident rider , 5-15 year term, 18 to 60 year old are eligible , voluntary product, not credit linked	Not yet estimated	Plan to cover 50 million by Mar-08 nationally	1,200	30,000
North East						
Asomi	LIC	Credit linked micro life insurance policy, term policy, compulsory group product	250,000	100%	34	10,000
Prochesta	In process of negotiation	Micro life insurance preferably credit linked with health and accidental death rider	60,000	Will cover in phased manner	200-250	

Source: Personal interaction with NGOs/MFIs

Appendix 4: Institutional approaches followed by MFIs in India

Institution Type	Description	Delivery model
Society[73]	Registered under the Societies Registration Act, 1860 – technically established by a group of 7 individuals with the common objective of engaging in a charitable activity with a public (non-commercial) purpose	SHG/ Grameen
Trust	Registered under the Indian Trusts Act, 1882 – for microfinance, mainly public charitable trusts with no individuals specified as beneficiaries	SHG/ Grameen
Saving & Credit Cooperatives (SCC)	Established under the Multi-State Cooperatives Act of 1911 or state cooperatives laws by groups of individuals agreeing to undertake joint activities such as pooling their savings for the purpose of on-lending within or outside the group. These cooperatives operate on a for-profit basis in theory and distribute profits on the basis of an equal contribution to equity by all the members. Such cooperatives are subject to significant degrees of control by state level Registrars of Cooperatives.	Individual banking
Mutually Aided Cooperative Societies (MACS)	"New model" cooperatives so called simply to distinguish them from the cooperatives established under the conventional cooperative laws. Such cooperatives are not subject to any significant degree of state control. The bye laws of MACS must adhere to cooperative principles and contain names, objectives, eligibility as well as termination criteria for membership, division of profit and other details that govern the relationship of members amongst themselves. Unlike the conventional cooperatives, in a MACS the ultimate authority of the cooperative society vests in its general body which consists of all its members. Membership is voluntary and open to all those who can make use of its services and are willing to accept the responsibilities of membership.	Individual banking
Urban Cooperative Banks (UCB)	For profit institutions registered under the Cooperative Societies Acts of the respective states or the Multi-State Cooperative Societies Act of 2002. It must have at least 3,000 members and paid up capital and reserves of at least Rs1 lakh. UCBs have the Reserve Bank of India as their regulatory and supervisory authority for their banking operations while administrative and managerial supervision is under the jurisdiction of state level cooperative departments or the central government (for multi-state cooperatives)	Individual banking
Not for profit companies (Sec25 Co)	Under Section 25 of the Companies Act, 1956 established with a purpose such as the promotion of commerce, science, art, religion, charity or any other useful purpose and, therefore, regarded as a non-commercial entity earning profits but not allowed to distribute dividends. Such companies are not required to be registered with the Reserve Bank of India provided they do not accept deposits.	Various
Non-Bank Finance Companies (NBFCs)	For profit companies established under the Companies Act, 1956 and required to raise a minimum equity capital of Rs2 crores and to register as NBFCs with the RBI	

[73] In practice, there is no significant difference between these two types – Society and Trust – of institutional registration (from the perspective of institutional motivation and MFI management)

Appendix 5: Health insurance schemes in India

	Designation	Start Year	Initiator	State	Area of Int.	Sch. Type	Sch.	Risks Covered	Total Ben.	Memb. Type
1	Arthik Samatha Mandal (ASM)	2003	NGO	Andhra Pradesh	Rural	In-House	S.I	Health Care	31,627	Voluntary
2	Youth For Action (YFA)	2004	NGO	Andhra Pradesh	Rural	Partn-Agent	S.I	Health Care, Accidental Death, Disability	2,715	Voluntary
3	Working Women's Forum (WWF)	1983	NGO	Andhra Pradesh, Karnataka, Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care	3,649	Voluntary
4	Family Plan Health Limited (FHPL)	2003	TPA	Andhra Pradesh	Rural/Urban	In-House	S.I	Health Care	350,000	Voluntary
5	Healing Fields Foundation (HFF)	2004	NGO	Andhra Pradesh	Rural/Urban	Partn-Agent	S.I	Health Care, Accidental Death, Disability	15,900	Voluntary
6	Naandi Foundation	2004	NGO	Andhra Pradesh	Urban	In-House	S.I	Health Care	49,000	Voluntary
7	Samskar - Plan International (India) Nizamabad Project	2005	NGO	Andhra Pradesh	Rural	In-House	S.I	Health Care	5,303	Voluntary
8	Mallur Health Cooperative	1973	CBO	Karnataka	Rural	In-House	S.I	Health Care, Maternity Prot.	20,000	Voluntary
9	Organization for the Development of People (ODP)	1993	NGO	Karnataka	Rural	Partn-Agent	S.I	Health Care, Life, Disability	1,137	Voluntary
10	Yeshasvini Trust	2002	HP	Karnataka	Rural	In-House	S.I	Health Care	1,473,576	Voluntary
11	Sri Kshetra Dharamsthala Rural Development Project	2004	NGO	Karnataka	Rural	Partn-Agent	S.I	Health Care	186,000	Voluntary
12	Karuna Trust	2002	NGO	Karnataka	Rural/Urban	Partn-Agent	S.I	Health Care, Loss of Income	118,808	Voluntary
13	Arogya Raksha Yojna Trust	2004	NGO	Karnataka	Rural/Urban	Partn-Agent	S.I	Health Care	56,411	Voluntary
14	Manipal Health System	2005	HP	Karnataka	Rural/Urban	Partn-Agent	S.I	Health Care	62,500	Voluntary
15	Praghati Grameen Bank Chitr.	2004	MFI	Karnataka	Rural	Partn-Agent	S.I	Health Care	11,320	Voluntary
16	Myrada	2005	NGO	Karnataka	Rural	In-House	S.I	Health Care	3,831	Voluntary
17	Gandhi Samaraka Grama Seva Kendrum	2002	NGO	Kerala	Rural	In-House	S.I	Health Care	3,567	Voluntary
18	Self Help Association for Development and Empowerment (SHADE)	1993	NGO	Kerala	Rural/Urban	Partn-Agent	S.I	Health Care	75	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.II	Health Care	4,200	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.III	Health Care	6,665	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.II	Health Care	1,200	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.IV	Health Care	4,325	Voluntary
19	Indian Association for Savings and Credit (IASC)	2002	MFI	Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care	12,911	Voluntary
20	Anisha Microfin Association	2002	MFI	Tamil Nadu	Rural	Partn-Agent	S.I	Health Care	3,744	Voluntary
21	Voluntary Health Services (VHS)	1961	HP	Tamil Nadu	Rural/Urban	In-House	S.I	Health Care, Maternity	124,715	Voluntary

	Designation	Start Year	Initiator	State	Area of Int.	Sch. Type	Sch.	Risks Covered	Total Ben.	Memb. Type
								Prot.		
22	League of Education and Development (LEAD)	2000	NGO	Tamil Nadu	Rural	Partn-Agent	S.I	Health Care, Life	4,320	
23	Association for Sarwa Sewa Farmers (ASSEFA)		NGO	Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care	20,000	Voluntary
24	Activists for Social Alternative (ASA)	2003	MFI	Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care	217	Voluntary
25	Development of Human Action Foundation (DHAN)	1997	CBO	Tamil Nadu	Rural/Urban	In-House	S.I	Health Care, Maternity Prot.	13,685	Voluntary
26	Self-Help Promotion for Health and Rural Development (SHEPERD)	1999	MFI	Tamil Nadu	Rural	Partn-Agent	S.I	Health Care	8,540	Voluntary
27	Action for Community Organization, Development and Rehabilitation (ACCORD)	1990	NGO	Tamil Nadu	Rural	Partn-Agent	S.I	Health Care, Life, Disability, Housing, Assets	12,500	Voluntary
28	New Life	1995	NGO	Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care, Accidental Death, Disability	17,860	Vol./Comp.
29	Kagad Kach Patra Kashtkari Panchayat	1998	TU	Maharashtra	Urban	Partn-Agent	S.I	Health Care	4,210	Voluntary
30	Kasturba Hospital	1978	HP	Maharashtra	Rural	In-House	S.I	Health Care, Maternity Prot.	14,390	Voluntary
31	Mathadi Hospitak Trust	1982	CBO	Maharashtra	Urban	In-House	S.I	Health Care	110,000	Compulsory
32	Society for Provisions of Area Resources (SPARC)	1997	NGO	Maharashtra	Urban	Partn-Agent	S.I	Health Care, Accidental Death, Disability, Assets	2,000	Voluntary
33	Caps Plan International	2003	MFI	Maharashtra	Rural	In-House	S.I	Health Care	25,000	Vol./Comp.
34	Uplift Mutual Fund	2004	NGO	Maharashtra	Rural/Urban	In-House	S.I	Health Care	16,062	Voluntary
35	Maharashtraal Foundation	2004	NGO	Maharashtra	Rural	Partn-Agent	S.I	Health Care	3,424	Voluntary
36	BAIF	2002	NGO	Maharashtra	Rural	In-House	S.I	Health Care	1,500	Voluntary
37	MD Indian Healthcare Services	2003	TPA	Madhya Pradesh	Urban	Partn-Agent	S.I	Health Care	49,419	Voluntary
38	Rajgarh Ambikapur Health Association (RAHA)	1980	HP	Chattisgarh	Rural	In-House	S.I	Health Care, Maternity Prot.	58,334	Voluntary
39	Health Programme of Aga Khan Health Services	1995	CBO	Gujarat	Rural	In-House	S.I	Health Care, Maternity Prot.	5,635	Vol./Comp.
				Gujarat	Rural	In-House	S.II	Health Care, Maternity Prot.	9,185	Vol./Comp.
40	Self-Employed Women's Association (SEWA)	1992	NGO	Gujarat	Rural/Urban	Partn-Agent	S.I	Health Care, Life, Accidental Death, Assets, Maternity Prot.	164,346	Voluntary
41	Seba Cooperative Health Society		HP	Gujarat	Rural/Urban	Partn-Agent	S.II	Health Care, Life, Accidental Death, Assets, Maternity Prot.	9,658	Voluntary
				West Bengal	Rural	In-House	S.I	Health Care	800	Voluntary

	Designation	Start Year	Initiator	State	Area of Int.	Sch. Type	Sch.	Risks Covered	Total Ben.	Memb. Type
42	Mayapur Trust/Sri Mayapur Vikas Sangha	2003	NGO	West Bengal	Rural	Partn-Agent	S.I	Health Care	1,022	Vol./Comp.
43	Students Health Home (SHH)	1952	GOV	West Bengal	Rural/Urban	In-House	S.I	Health Care	1,587,890	Voluntary
44	Goalpara	1994	NGO	West Bengal	Rural	In-House	S.I	Health Care	1,247	Voluntary
45	Nidan	2000	NGO	Bihar	Rural/Urban	Partn-Agent	S.I	Health Care, Life, Disability, Housing, Assets	10,203	Voluntary
46	Bihar Federation of Milk Cooperatives	2004	CBO	Bihar	Rural	Partn-Agent	S.I	Health Care, Accidental Death, Disability	55,000	Voluntary
47	CYSD	2005	NGO	Orissa	Rural	In-House	S.I	Health Care	15,468	Voluntary
48	People's Rural Education Movement (PREM)	2003	NGO	Orissa	Rural	In-House	S.I	Health Care	108,000	Voluntary
49	Seva Mandir	2004	NGO	Rajasthan	Rural	In-House	S.I	Health Care	401	Voluntary
50	Emanuel Hospital Association (EHA)	2004	HP	Uttaranchal	Rural	Partn-Agent	S.I	Health Care, Accidental Death, Disability, Daughter's Marriage	600	Voluntary
51	Family Plan Health Limited (FHPL)	2003	TPA	J & Kashmir	Urban	In-House	S.II	Health Care	200,000	Voluntary

Source: ILO (2006), ILO/STEP, New Delhi

Appendix 6: Compliance with rural and social sector regulations

Rural obligations

	2002-3				2003-4				2004-5			
Life insurer	**Target**	**Achieved**	**No. of pol.**	**Prem. u/w (Rs lakh)**	**Target**	**Achieved**	**No. of pol.**	**Prem. u/w (Rs lakh)**	**Target**	**Achieved**	**No. of pol.**	**Prem. u/w (Rs lakh)**
Allianz Bajaj	9%	17%	19,366		12%	13%	24,003		14%	16%	45,649	
ING Vysya	9%	35%	3,883		12%	13%	12,073		14%	15%	16,936	
AMP Sanmar/Reliance Life	9%	9%	1,510		12%	13%	6,137		14%	16%	5,710	
SBI Life	9%	15%	2,747		12%	14%	12,135		14%	22%	28,490	
Tata AIG	9%	10%	9,140		12%	14%	23,032		14%	18%	41,201	
HDFC Standard	12%	12%	15,355		14%	19%	39,076		16%	21%	59,031	
ICICI Prudential	12%	12%	29,381		14%	15%	64,775		16%	16%	98,348	
Brila Sunlife	12%	16%	10,420		14%	17%	25,985		16%	24%	47,609	
Aviva	7%	1%	95		9%	19%	13,298		12%	20%	16,725	
Kotak Mahindra OM	9%	16%	5,171		12%	14%	7,150		14%	16%	9,977	
Max New York	12%	12%	9,342		14%	17%	24,108		16%	2%	37,917	
Met Li[74]fe	9%	26%	2,916		12%	27%	6,826		14%	16%	7,315	
Sahara									3%	27%	-	
Private	**10%**	**15%**	**109,326**		**12%**	**16%**	**258,599**		**14%**	**18%**	**414,909**	
LIC	16%	19%	4,545,841		16%	23%	6,146,023		16%	23%	5,488,592	
Overall life	**10%**	**15%**	**4,655,167**		**13%**	**17%**	**6,404,621**		**14%**	**18%**	**5,903,502**	
Non-life insurers	**Target**	**Achieved**	**No. of pol.**	**Prem. u/w (Rs lakh)**	**Target**	**Achieved**	**No. of pol.**	**Prem. u/w (Rs lakh)**	**Target**	**Achieved**	**No. of pol.**	**Prem. u/w (Rs lakh)**
Royal Sundaram	3%	3.9%		700	5%	6.1%		1,582	5%	6.1%		2,004
Tata AIG	3%	3.1%		737	5%	5.6%		1,975	5%	8.0%		3,742
Reliance General	3%	3.0%		561	5%	2.7%		433	5%	5.1%		821
IFFCO Tokio	5%	5.4%		1,156	5%	5.6%		1,647	5%	7.4%		3,709
ICICI Lombard	3%	2.2%		476	5%	5.3%		2,670	5%	5.6%		4,957
Bajaj Allianz	3%	5.9%		1,698	5%	5.7%		2,729	5%	9.4%		8,047
HDFC Chubb	2%	1.1%		10	3%	3.0%		335	5%	5.1%		941
Cholamandalam	2%	0.1%		2	3%	4.5%		431	5%	5.2%		888
Private	**3%**	**3.1%**		**5,339**	**5%**	**4.8%**		**11,803**	**5%**	**6.5%**		**25,110**
New India	5%	8.3%		32,625	5%	6.3%		25,366	5%	6.2%		26,149
National	5%	8.4%		24,111	5%	7.8%		26,516	5%	8.6%		32,565

[74]

United India	5%	7.1%	21,133	5%	11.5%	34,938	5%	12.6%	37,072
Oriental	5%	4.8%	13,247	5%	5.0%	14,104	5%	5.3%	16,115
ECGS									
Public	**5%**	**7.2%**	**91,115**	**5%**	**7.6%**	**100,924**	**5%**	**8.2%**	**111,902**
Overall non-life	**4%**	**4.4%**	**96,455**	**5%**	**5.7%**	**112,726**	**5%**	**7.0%**	**137,011**

Note:

Rural obligation targets for life-insurance companies are a proportion of total policies sold. For non-life companies the rural obligation is a proportion of gross premium underwritten. The proportion is dependent on the number of years of operation of a life/non-life company

Social obligations

Life insurer		2002-3		2003-4		2004-5
	Target*	Achievement*	Target	Achievement	Target	Achievement
Allianz Bajaj	7,500	11,111	10,000	24,052	15,000	16,355
ING Vysya	7,500	7,500	10,000	10,000	15,000	16,314
AMP Sanmar	7,500	7,572	10,000	31,683	15,000	29,108
SBI Life	7,500	37,478	10,000	80,927	15,000	1,222,572
Tata AIG	7,500	11,825	1,000	1,413	15,000	16,117
HDFC Standard	10,000	10,490	15,000	17,184	20,000	28,432
ICICI Prudential	10,000	17,964	15,000	15,050	20,000	20,139
Brila Sunlife	10,000	11,857	15,000	16,651	20,000	22,024
Aviva	3,750	2,370	7,500	84,939	10,000	260,925
Kotak Mahindra OM	7,500	32,499	10,000	3,387	15,000	26,326
Max New York	10,000	15,669	15,000	15,654	20,000	23,318
Met Life	7,500	851	10,000	24,000	15,000	17,220
Sahara**					2,083	2,380
Private	**96,250**	**167,186**	**128,500**	**324,940**	**197,083**	**1,701,230**
LIC	754,816	761,752	754,816	1,739,722	754,816	4,212,804
Overall life	**851,066**	**928,938**	**883,316**	**2,064,662**	**951,899**	**5,914,034**
Non-life insurer	**Target**	**Achievement**	**Target**	**Achievement**	**Target**	**Achievement**
Royal Sundaram	7,500	10,902	10,000	66,903	15,000	27,288
Tata AIG	7,500	8,609	10,000	10,778	15,000	18,249
Reliance	,500	8,797	10,000	14,000	15,000	28,698
IFFCO Tokio	10,000	827,334	10,000	824,280	20,000	899,210
ICICI Lombard	7,500	16,660	10,000	119,724	15,000	140,063
Bajaj Allianz	7,500	14,053	10,000	34,689	15,000	16,724
HDFC Chubb	2,500	-	10,000	8,221	10,000	48,864
Cholamandalam	2,500	-	10,000	36,085	10,000	39,061
Private	**52,500**	**886,355**	**80,000**	**1,114,680**	**115,000**	**1,218,157**
New India		27,539,481		11,325,337		2,963,879
National		1,531,384		2,919,487		151,021
United India		467,166		599,812		630,103
Oriental		3,619,274		5,126,330		5,332,167
Public		**33,157,305**		**19,970,966**		**9,077,170**
Overall non-life		**34,043,660**		**21,085,646**		**10,295,327**

*Number of lives covered

Source:

Rajya Sabha Unstarred Question No.4016, dated 23.05.2006

IRDA Monthly Journals for May 2003, 2004, 2005 and 2006

**The Insurer was in business during the last five months of the financial year 2004-05

Appendix 7: Main features of products of life/non-life insurance companies targeting the rural sector

Life insurance products

Insurer	Products	Risks covered		Policy term (years)		Sum assured (Rs)		Entry age (years)		Other benefits				
		Life	Dis-ability°	Min	Max	Min	Max	Min	Max	Maturity†	Payment options*	Tax benefit	Freelook period	Surrender value$
Bajaj	Alp Nivesh Yojana	Yes	Yes	10	15	5,000	30,000	18	60	S,B	A,H,Q,M	Yes	15 days	3Y if 3p
	Jan Vikas Yojna	Yes	No	10	15	10,000	50,000	18	60	125% P	S	Yes	15 days	P
	Saral Suraksha Yojna	Yes	Yes	10	15	10,000	50,000	18	60	RP	A,H,Q,M	Yes	15 days	3PP if 3p
Birla	Bima Dhan Sanchay	Yes	Yes	5	15	5,000	50,000	18	60	RP	A,H,Q,M	Yes	15 days	2PP if 2p
	Bima Kavach Yojana	Yes	No		3			18	50	P + B	S	No	NA	Year spec.
	Bima Suraksha Super	Yes	Yes	5	15	5,000	50,000	18	60	N	A,H,Q,M	No	NA	No
HDFC	Development Issurance Plan	Yes	Yes		1			18	50	N	S	No	NA	No
ICICI	Suraksha	Yes	No	3	5	5,000	20,000	18	45	N	A, H	No	NA	No
	Suraksha Kavach	Yes	No	3	5	5,000	25,000	18	55	N	S	No	NA	No
LIC	Jan Shree Bima Yojana ◊	Yes	Yes			30,000	75,000	18	59	N	A	No	NA	No
	Jeevan Madhur Plan	Yes	Yes	5	15	5,000	30,000	18	60	S,B	W, F,A,H,Q,M	Yes	15 days	2PP if 2 p
	Shiksha Sahyog Yojana Δ	NA	NA		4				^		NA	No	NA	No
MAX	Easy term	Yes	No		1		5,000	20	50	N	S	Yes	NA	No
	Max Mangal TM endowment Plan	Yes	Yes	12	15	50,000	233,236	18	50	110% S	A,H,Q,M	Yes	NA	3 Y
	Max Suraksha	Yes	No		5	1,000	5,000	18	45	N	S	Yes	NA	No
	Max Vriksha : Maney Back Plan	Yes	Yes		16	50,000	250,000	18	50		A,H,Q,M	Yes	NA	3Y
Kotak	Kotak Gramin Bima Yojana	Yes	No		15			18	45	150% P	S	Yes	15 days	No
TATA AIG	Ayushman Yojana	Yes	No		10	5,000	50,000	18	60	125%P	S	Yes	15 days	Any time

	Navkalyan Yojana	Yes	No		5	5,000	50,000	18	60	N	A,H,Q,M	Yes	15 days	No
	Sampoorn Bima Yojana	Yes	No		15	5,000	50,000	18	60	RP	A,H,Q,M	Yes	15 days	If 3 p
AVIVA	Amar Suraksha	Yes	No	5	20	20,000	100,000	18	45	RP	A,H	No	NA	If 3p
	Jana Suraksha	Yes	No	5	10	20,000	50,000	18	45	N	S	Yes	15 days	No
SAHARA	Jan Kalyan ◊	Yes	No		1	10,000	25,000			N	S	No	NA	No
	Sahara Sahyog	Yes	No	5	15	5,000	30,000	18	60	S	A,H,Q	No	NA	3Y

Note:

◊ Group policy. Rs200 p.a/member 50% of the premium i.e. Rs.100 will be contributed by the member and/or Nodal Agency/State Government. Balance 50% will be borne by the Social Security Fund.

Δ For the children of those who are covered under Jan Shree Bima Yojana. Scholarship of Rs300/quarter/child will be paid for maximum period of 4 years. The benefit is restricted to 2 children/member(family) only.

^ Students studying in clases between IX and XII

* A= Annual, H= Half Yearly, Q= Quartly, M= Monthly, F= Forth nightly, W= Weekly, S=Single premium

° Accidental permanent/partial disability

$ Minimum no. of years the policy has to be in force for guaranteed cash value on non-renewal, Y=year, PP= policy period, p=paid premium

† S= Sum assures, B= Bonus, N= No benefit, P= of Single Premium. RP=Refund of premium

Non-life insurance products

Insurer	Type	Types of policies	Broad features			
			Scope	Beneficiary	Risk	Key Benefits
Oriental	Live Stock Insurance	2	All indigenous, cross bread animal/ Birds	Animal/ Poultry Owner	Accident/ Death of animal or birds	Assured money or perentage of market price of animal or bird
	Building or Agricultural Equipment Insurance	2	Pump set up to 30 HP or Cart	Owner	Accidental or Natural Losses	Sum Insured or market Value prior to loss whichever is less
	Accidental or Health Insurance	3	Individual	Individual	Death/Permanent total disablement/Total & irrecoverable loss	Percentage of sum assured on case by case basis
	Plantation Insurance	1	Trees/plants/shoot/vegetative part only for crop duration or 12 months whichever is shorter.	Owner	Natural Causes	Input cost and recurring cost upto date of loss
	Women and/or Children Insurance	3	Parent of girl child or Women	Girl child or insured women	Death/Permanent total disablement/Total and irrecoverable loss	Limit based risk covered
United India*	Live Stock Insurance	5	All indigenous, cross bread animal/ Birds except non descriptive birds	Owner	Loss/ Death/ Damage of Insured Bird/ Animal	Loss or Damage Covered
	Building or Agricultural Equipment Insurance	1	Pump set up to 25 HP	No Info	Theft or Natural Causes	No Info
	Plantation Insurance	2	Tea Plant or Horticulture Crop	No Info	Loss or damage due to Natural Causes	No Info
National	Live Stock Insurance	2	Mulched Animal / Mulberry Silk Worn	Rural People of India	Death due to disease or accident/ Total loss/Partial loss	Death Covered and/ or additional PTD
	Building or Agricultural Equipment Insurance	1	Pump set up to 25 HP	No info	Theft or Natural Causes	Coverage as per sum insured
	Accidental or Health Insurance	1	Individual	Individual	Accident resulting in Death/Permanent total disablement /Total or irrecoverable loss of use of	As per sum assured or on case by case basis

Insurer	Type	Types of policies	Broad features			
			Scope	Beneficiary	Risk	Key Benefits
					limb/Loss of eye sight	
	Plantation Insurance	1	Trees	No Info	Loss or Damage to the insured tree due to fire	Loss or damage cover
ICICI	Building or Agricultural Equipment Insurance	1	Insurance for only the building (structure), or only the contents (belongings) or both.		Losses due to natural calamities/Burglary/ And some other additional and optional cases.	Maximum coverage is up to Rs100,000 for up to 6 months
	Accidental or Health Insurance	3	Coverage against medical emergency	Individual/ Family	Medical Expenses during hospitalization /Pre-hospitalization /Post-hospitalization	The entire family is covered under one Sum Insured, any number of times/ Tax Benefit
	Weather Insurance	1	Indemnity for losses incurred in agriculture activity due to abnormal weather conditions.	No Info	No Info	No Info
IFFCO	Weather Insurance	1	covers the anticipated deficiency in crop yield on account of rainfall deficiency	No info	Rainfall deficiency	The quick claims process/flexibility to choose the sum insured based on his premium paying capacity
HDFC	Live Stock Insurance	2	Cows, bullocks or buffaloes, sheep and Goat	Owner, Member of MFI and NGO's others	Loss of life due to accident or diseases even in case o, epidemics and other natural calamities.	Death Cover/ Permanent Disability cover.
	Building or Agricultural Equipment Insurance	1	Submersible and non-submersible pump sets not beyond 25 H.P	No info	Covers Theft or Natural Causes	Loss or Damage cover
	Accidental or Health Insurance	2		Individual/Spouse/Family	Accidental death/ Permanent disablement /Hospitalization	Accidental Death cover / Permanent disablement cover/Hospitalization expenses covered
	Weather Insurance	1	Agricultural Produce	Farmer and Member of MFI, NGO's and others	Diminished agriculture output	Cover against diminished agriculture output
TATA	Building or Agricultural	1	Housing Societies &	No Info	Pre-underwritten/ packaged	Coverage up to Sum Insured

Insurer	Type	Types of policies	Broad features			
			Scope	Beneficiary	Risk	Key Benefits
	Equipment Insurance		Commercial Buildings / Offices / Shops / Hotels and Restaurants / Multiplexes, Shopping Malls / Manufacturing Units - Package Policy		product consisting of Property, Crime, Casualty (including Workmen Compensation), Accident & Health, Marine and Financial Lines	
STAR	Accidental or Health Insurance	1		Individual	Hospitalization	Hospitalization cover /Surgeon's, consultants, Anesthetist's fee/Associated expenses
Royal*	Live Stock Insurance	1	Cows, buffaloes, bullocks, camels, sheep, goats, horses, ponies and mules	Farmer	Covers Death or PTD	Sum Insured or market Value prior to loss whichever is less
		1	All kind of pump sets.		Loss or damage to pump set	Reimbursement of actual expenses incurred due to mechanical/electrical breakdown including coil burn

Note:
* one more comprehensive package plan offered by Insurance provider which covers livestock, health and asset insurance

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