Micro Insurance Academy: Improving Health Insurance Coverage in India

Through training, research and advisory services, this social enterprise empowers the bottom of the pyramid to design and manage their own insurance schemes

WORLD BANK GROUP

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Summary

Faced with inadequate medical services, deficient living conditions and severe shifts in weather patterns, the poor of India are often susceptible to catastrophes without the benefit of any insurance coverage. Healthcare financing largely relies on direct out-of-pocket spending, which causes immense health-related financial burdens for the poor—nearly 39 million people in India are pushed into poverty because of ill health every year (Balarajan, Selvaraj and Subramanian 2011).

Despite recent efforts by the government and the private sector, only 15 percent of the population in India is covered by health insurance (Berman, Ahuja and Bhandari 2010). This dilemma has resulted in the proliferation of micro insurance schemes to protect low-income people against specific perils—from illness to crop failure, death to natural disaster. Recently, community-based health insurance (CBHI) has emerged as a solution to reduce healthcare expenditure vulnerabilities for the poor. A CBHI scheme involves pre-payment and pooling of resources to cover healthcare costs. Some CBHI schemes are operated by non-government organizations (NGOs) as mutual aid societies, whereas other NGOs act as agents of commercial insurance providers.

Though some of these schemes have managed to extend financial protection to rural communities, they have not been able to extend the coverage to the poorest of the poor for several reasons: irregular cash flows of poor households where they are unable to pay premiums; lack of awareness about the benefits of health insurance; and inability of the illiterate population to understand the terms and conditions of the insurance policy.

In India, the Micro Insurance Academy (MIA) extends health insurance at the last mile by providing technical assistance to local NGOs operating mutual aid through a bottom-up approach to the design, implementation and management of CBHI. Through state-of-the-art research, MIA develops a robust understanding of each community, and delivers efficient and customized tools and frameworks that build a community's capacity to self-manage micro insurance schemes. Communities participate in identifying their insurance needs, including the benefit package and premium. Strong local implementations partners—usually a local organization or NGO with established credentials working in the target areas—are chosen through rigorous capacity assessments.

MIA positions itself as a trusted source that does not sell or promote pre-designed market linked products. Rather, MIA bridges the gap between insurers and the bottom of the pyramid (BoP) by providing advisory support and insurance education to establish CBHI. To date, MIA-supported micro insurance schemes cover more than 40,000 people in India and Nepal. The cumulative claims ratio across the schemes is reported at 65 percent, and insurance education and understanding of the community has increased by 80 percent.

MIA offers an independent, grant-based model, and the insurance schemes are finding increasing acceptance among the poor as evident from high enrollment and renewal rates. Going forward, having more evidence of development impact and increased usage and investment in technology will help MIA scale up and leverage partnerships with the government and private sector. Because catastrophic events could wipe out pooled contributions, MIA is investigating creating federated structures and a larger scheme to mitigate this and other risks.

Challenge

In India 81 percent of total healthcare expenditure takes place in private sector clinics and hospitals (Berman, Ahuja and Bhandari 2010), out of which 94 percent is out-of-pocket expenses. It is estimated that in a single year in India more than 40 percent of hospitalized individuals borrow money or sell assets to cover the cost of their healthcare and nearly 39 million people are pushed into poverty because of ill health (Balarajan, Selvaraj and Subramanian 2011).

In fact, "hardship financing" of access to healthcare through borrowing with interest occurs not just in cases of hospitalizations, but also in cases of maternity and even for outpatient care (Binnendijk, Koren and Dror 2012). In India, health insurance as a way to finance healthcare expenditure is a limited practice as compared to other countries where it is an established practice.

The potential is huge for development of health insurance models, particularly for the poor in India. Since independence, governments in India have followed a mix of tax-based schemes and social health insurance mechanisms to improve the penetration of health insurance in the country. In 2001, the Indian insurance sector was opened up for private companies. Since then, private sector and communities (facilitated by voluntary organizations) have developed health insurance schemes. Despite recent efforts in expanding health insurance by government, the private sector, and local civil society organizations, less than 15 percent of the population in India is covered by health insurance (Berman, Ahuja and Bhandari 2010).

Recently, community-based health insurance (CBHI) has emerged as a solution to reduce healthcare expenditure-related vulnerabilities for the poor (Lahkar and Sundaram-Stukel 2010). A CBHI scheme involves pre-payment and pooling of resources to cover healthcare costs. Furthermore, they are designed with a not-for-profit objective to target poor households and treat the household rather than an individual as the unit of insurance (Ahuja and Jutting 2003).

Several CBHI models have emerged and a number of NGOs are involved in operating them in different parts of India (Figure 1). Though some of these schemes have managed to extend financial protection to rural communities, they have not been able to extend the coverage to the poorest of the poor (Jakab and Krishnar 2004). Hence, those sections of the population that are not participating in this contributory model have not obtained any protection from this mechanism.

Some of the challenges of having CBHI include (Kishor 2013; Jakab and Krishnar 2004):

- Irregular cash flows of households where they are unable to pay the premiums.
- Lack of familiarity and trust for the service providers.
- Lack of awareness about the value of insurance among the poor.
- Difficulty of illiterates to understand the terms and conditions of the insurance policy.
- Lack of transport to access hospitals providing services under these schemes.

Figure1. Formats of Health Insurance Schemes in India

GOVERNMENT	PRIVATE	COMMUNITY-BASED
Two contributory health insurance and one fully government subsidized insurance schemes in India: • Central Government Health Scheme introduced in 1954 for the government of India's civil servants (approximately 5.5 million beneficiaries). • Employees' State Insurance Scheme established in 1948 for low-paid industrial workers in the formal sector (approximately 16 million beneficiaries). Eligible people contribute through a payroll tax toward a specific health fund: • Rashtriya Swasthya Bima Yojana (RSBY) is the National Health Insurance targeting BoP families, a recent addition in government-sponsored health insurance (23 million families enrolled in 2013). *[Note: This scheme has been discontinued for at least one year.]*	Offered by commercial organizations: • Voluntary health insurance wherein people enroll and purchase their preferred insurance product, paying a risk-rated premium. • Out of these, Mediclaim, introduced in 1986, is the most sold product. • Subscribers are usually the middle and upper class; there is a tax benefit in subscribing.	Initiated by NGOs and community-based organizations, there are three basic models of community-based insurance: • Provider model: Hospital plays the dual role of providing healthcare and running the insurance programs. Examples include: (1) ACCORD, Gudalur, Nilgiris, Tamil Nadu; (2) MGIMS Hospital, Wardha, Maharashtra. • Insurer model: Voluntary organization is the insurer, while purchasing care from independent providers. Examples: (1) DHAN Foundation, Theni district, Tamil Nadu; (2) Yeshasvani Trust, Bangalore, Kamataka. • Linked model: Voluntary organization plays the role of an agent, purchasing care from providers and insurance from insurance companies. Examples: (1) BAIF, Pune, Maharashtra; Karuna Trust, Mysore District; Karnataka; (2) SECA, 11 district of Gujarat.

Innovation

Micro Insurance Academy (MIA)

In 2007, Sarvajan Unnati Bodhini was established as a charitable trust in New Delhi, India under the Indian Trusts Act to advance the development of micro insurance. To achieve this, Sarvajan Unnati Bodhini created MIA as its implementing body. MIA's mission is to empower and enable poor communities to play an active role in reducing their financial vulnerabilities through innovative approaches in micro insurance. They envision that all people will have access to relevant risk management techniques to improve their livelihoods and lift themselves out of poverty.

Professor David M. Dror is the Founding Chairman and Managing Director of MIA. Professor Dror is an international expert in micro insurance, with over 35 years of experience in social protection and health financing. With about 50 employees in its New Delhi office, MIA is currently the world's largest resource center dedicated specifically to micro insurance, with experience in health, life, agriculture and natural catastrophic risk domains.

Customized Micro Insurance Solutions for the Poor

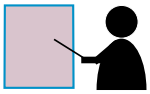
MIA has developed a voluntary and contributory CBHI model that focuses on involving the BoP population (Figure 2). Their objective is to empower communities to assess and manage financial risks through tailored insurance solutions that match their needs and willingness to pay. The key features of the MIA model are:

- **Pooled community money:** The model protects the poor from indebtedness by creating a mechanism wherein the community pools the money (premium) to cover the costs of health-related events. Households pay a premium—typically between USD 1.60 to 4.33 per person per year—for coverage against specific events, such as drought or illness. If the covered event occurs, the household is reimbursed for related costs within the limits of their benefit package.
- **Tailored insurance with community input and local risk data:** The model assesses prevalent disease pattern and willingness of the community to pay. MIA quantifies the risk exposure based on its evidence base and facilitates the community's understanding of the risk exposure. It engages beneficiaries in designing benefits/insurance packages, assessing suitability of the package and facilitating administration of the scheme. Beneficiaries can relate to these customized solutions and choose to implement them with their limited resources.
- **Community-run:** MIA helps to set up the operating infrastructure by training community members to manage the scheme, such as a claims committee and an insurance coordinator to oversee enrollments, claims and reimbursements.

Figure 2. Operating Architecture of MIA's Model of Health Insurance

Local Field Partner

- Usually an NGO with a history of working with BoP in target areas
- Works with claims committee, insurance activists and villagers during implementation and management of scheme
- Provides support to MIA in establishing and maintaining contacts, conducting baseline survey, enrolling members, etc.



Insurance Coordinator

- Locally appointed official manages membership and financial records using MIA's data management software
- Establishes and maintains relationships with healthcare providers
- Salaries paid by field partner with financial support from MIA

Insurance Activists

- Trained frontline workforce provided by field partner
- Go door-to-door in every village to enroll members, collect premiums, provide education and assist insured with availing health services and filing claims
- Number depends on village population, size and terrain
- Salaries paid by field partner with financial support from MIA

Claims Committee

- 6–8 designated representatives by the community from between 10–12 villages
- Manage common fund of pooled premiums
- Assess reimbursement of claims and manage payouts
- Meet once a month and receive sitting fee (administrative cost borne by the scheme)

Villagers

- Work with MIA and partners to design insurance products that meet their product and pricing needs
- Insurance scheme is open to everyone
- Enroll by paying a premium for all family members: typically between USD 1.60 to 4.33 per person per year of coverage
- Submit a claim when necessary

MIA

- Provides ongoing technical assistance and training to communities to operate independent health insurance scheme
- Implements these activities in association with field partner

MIA operates resource centers to connect health insurance actors and combine local knowledge with MIA's expertise and resources. MIA also conducts and circulates action-research to generate findings from implementation projects and field experience.

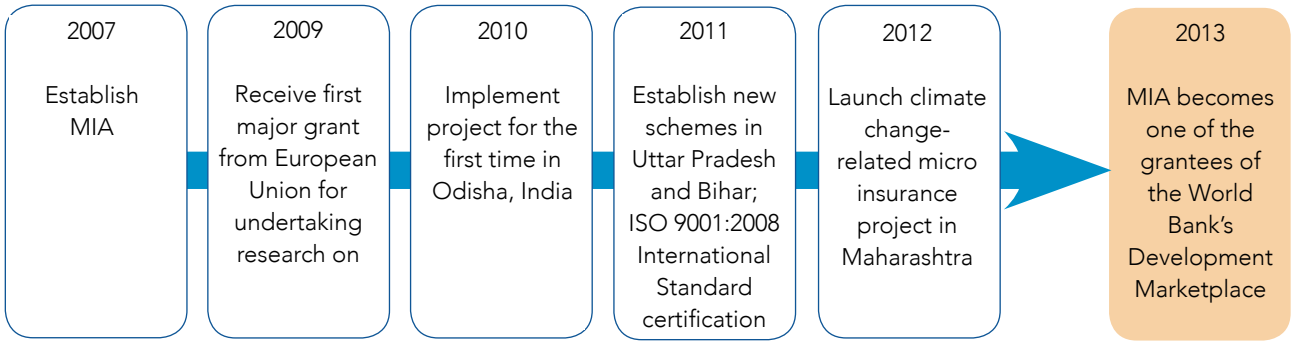
Thus, unlike existing CBHI schemes, MIA acts neither as a provider nor as an insurer or an intermediary. MIA does not underwrite risks or serve as an insurance agent, and it does not charge grassroots communities for services it renders. It simply acts as a catalyst and engages communities to devise and implement CBHI with local resources.

Evolution of the MIA Model

Launch

Two years after its establishment in 2007, MIA received its first research grant from the European Union to undertake research on health-seeking behavior for the rural population (Figure 3). In

Figure 3. Key Milestones of MIA Model



2010, MIA started its first implementation project in the poorest district in India (Kalahandi, Odisha) with financial support from Misereor (Katholische Zentralstelle für Entwicklungshilfe e. V.). The project "Niramaya Community Based Health Insurance Scheme" was launched with field partner Mahashakti Foundation in 52 villages in the Mandanpur Rampur block of the district. In 2011 this scheme experienced its first renewal season. In its two years of operation until 2012, Niramaya reached 3,700 people. The project aims to reach 60,000 people by 2015.

Expansion

In 2011, MIA expanded its operations and launched two schemes with support from the European Union under its seventh research framework program:

- Swasthya Kamal Scheme in Vaishali district (34 villages in Mahua block)—the scheme was implemented with Nidan as the field partner.
- Jeevan Sanjivani scheme in Pratapgarh district (15 villages in Raniganj block) and Kanpur Dehat district (46 villages in Rasoolabad block) in Uttar Pradesh—the scheme was implemented with Shramik Bharti as the field partner.

In addition to implementation, both schemes had a component on impact evaluation. As part of this, MIA carried out a Randomized Control Trial (RCT) to analyze the situation before and after CBHI implementation, which is still underway. In the same year, with funding from Miseror, MIA also launched a CBHI scheme in two districts of Nepal (Dhading and Banke). Nirdhan and DEPROSC were field partners in Nepal.

In 2011, MIA established a non-profit entity in Germany to set up CBHI models for African countries. In 2012, MIA's international office in Bonn received funding from the Swiss Tropical and Public Health Institute and Swiss Development Cooperation to provide technical assistance in strengthening the government of Tanzania's health insurance scheme for the informal sector. They provided technical assistance to strengthen the governance structure of Community Health Funds; to introduce new standard operating procedures; and to design training modules for Community Health Funds staff on health insurance. In the same year, Miseror engaged MIA (Bonn office) to help the Bishops of the Bamenda Ecclesiastical Province, Cameroon in reviewing and redesigning a health insurance scheme.

In 2013, MIA became one of the grantees for the World Bank's Development Marketplace. The objective of the funded project was to create awareness and build capacity of low-income communities in the State of Chhattisgarh (Rajnandgaon district) for protection against adverse financial consequences of illness. The target was to enroll 10,000 members in the CBHI scheme as direct beneficiaries and indirectly benefit another 30,000 members who

could be future participants in the CBHI scheme through awareness campaigns and insurance literacy workshops.

The grant was an important milestone because it helped MIA expand its geographical reach to a new state in India. It also helped MIA to fast track or compress pre-implementation, implementation and post-implementation phases of its delivery model without diluting the quality norms. This has allowed MIA the benefit of a quick rollout, where needed.

Diversification from Other Sectors

In 2012, funding support from the Climate Change and Development Division of the Embassy of Switzerland in New Delhi (DEZA) triggered the process within MIA to move beyond healthcare insurance. Using this fund, MIA, together with Basix Consulting and Training Services Limited (BCTS), started a project (RES-RISK) to enhance the resilience of vulnerable communities to climate change by developing pro-poor micro insurance solutions and piloting in two locations in India.

Beed (Maharashtra) is semi-arid and prone to droughts while Vaishali (Bihar) is prone to water logging and floods. MIA has found that communities do not perceive climate-related risks in isolation: if there is a flood, it not only affects health issues, but it also impacts crop yield, livestock and additional risk categories. In this project, MIA linked climate change with the priorities of the target population to develop customized solutions covering composite risks. Field partners for the project included Nidan and Vaishali Area Small Farmers Association (VASFA) in Vaishali district, Bihar and JVSS (Janvikas Samajik Sanstha) in Beed district, Maharashtra.

Financing

MIA started operating in India in 2007 through a three-year grant received from HIVOS International and an individual contribution from the promoter, Professor David Dror. The grant was used to establish MIA in India and complete all legal formalities for registration in India. Two full-time people (in addition to the promoter) were also hired.

MIA's revenues (grants and research funds) have seen a regular and substantial increase in a seven-year time span, from USD 75,000 to USD 1.3 million per year. There is a significant jump in revenues in 2008–9 due to a grant from the European Union. The other significant spike can be observed in 2012 when MIA received funding support from DEZA for the RES-RESIK project (Figure 4).

There also has been a shift in the allocation of funds. For instance, MIA's funding requirement for operational expenses (core funding in MIA parlance) has reduced from 24 percent

Figure 4. MIA's Revenue in USD

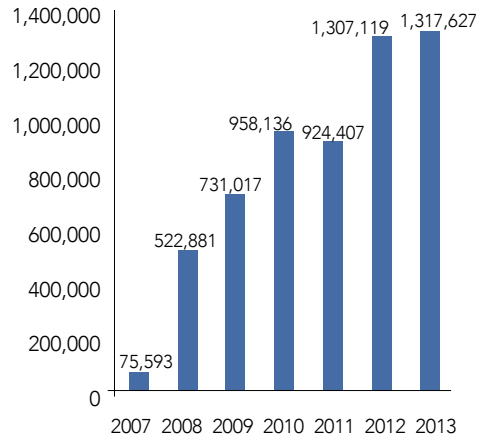
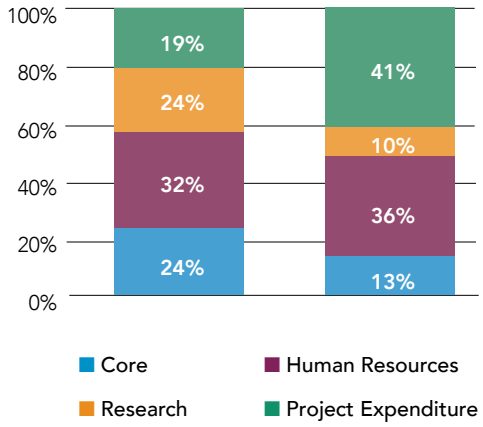
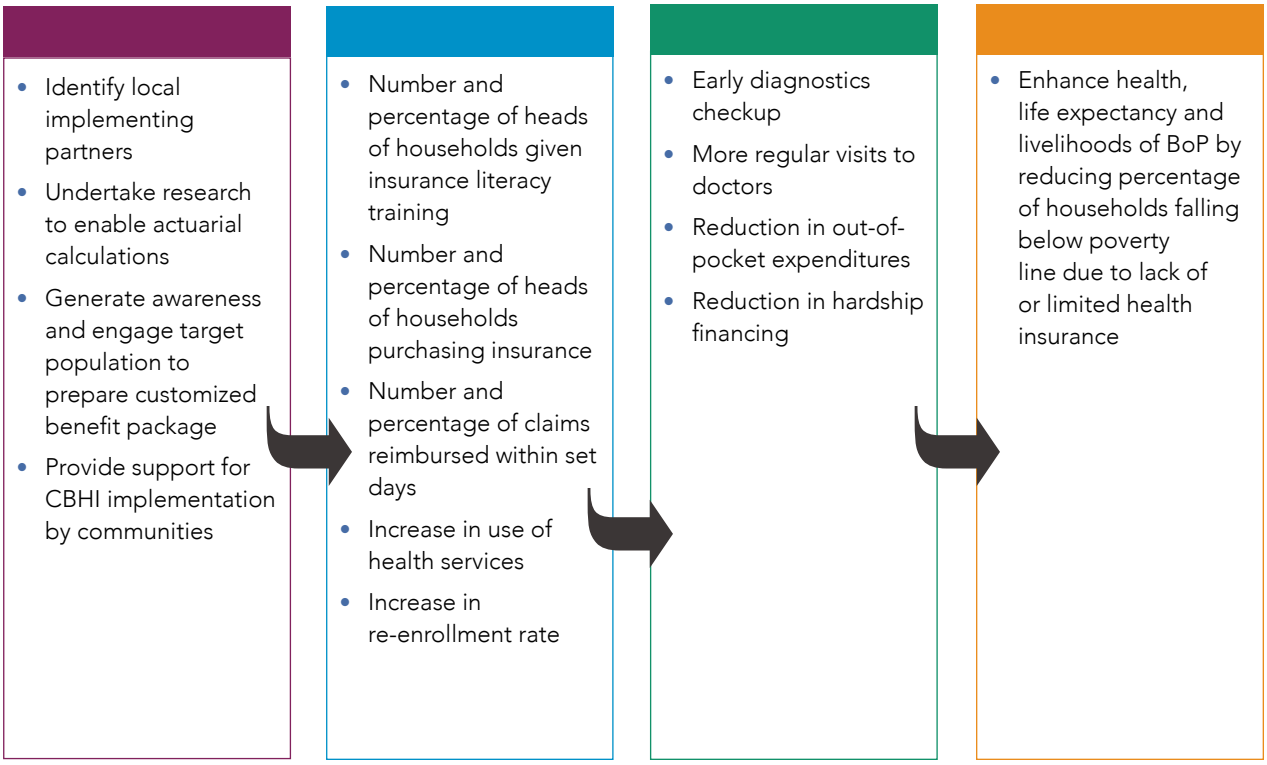


Figure 5. Revenue Allocation



in 2009 to 13 percent of total revenues in 2013. This period also sees a corresponding increase in the funds

Figure 6. Results Chain for MIA Model



Implementation

Analysis of Local Risk Data

Exposure to risks is location-specific, and the estimation of each class of risk requires different information and represents different technical complexities. For example, for health risk exposure there are considerations for morbidity, health-seeking behavior, costs and availability of providers. To assess and quantify these risks, MIA analyzes prevalence of disease, morbidity, use of healthcare services/infrastructure and costs incurred to avail services. They provide this evidence for the assessment of the risk exposure and willingness of the community to pay to design customized insurance packages.

Community Involvement

MIA works together with the communities to create and design insurance products that meet their needs, priorities and levels of willingness to pay. They conduct a comprehensive series of local studies and workshops with the local communities to train, coach and assist them in developing relevant and cost-effective systems and processes. Resources collected from the community for the insurance premium remains within the community, which instills confidence in members that their money will be used for mutual support. This community involvement helps limit adverse selection, moral hazard and fraud, and thus keeps the cost of the product as low as possible.

MIA uses a field-tested, game-like tool called CHAT—Choosing Healthplans All Together—to enable the local community to jointly define the benefit package that covers their most relevant needs (see Appendix III for an example). In CHAT, illiterate and innumerate persons can participate and decide on the composition and price of their health insurance. In this way, the coverage versus premium decision is turned over to the households. The primary beneficiaries of CHAT are BoP communities who are able to help decide on their health insurance priorities.

MIA has a three-tier structure for implementation of their framework. The three-tier structure is based on the principle of subsidiarity: matters ought to be handled by the smallest (or the lowest) competent authority, and a higher (or more central) authority should perform only those subsidiary tasks that cannot be performed effectively at a more immediate or local level. Thus, the MIA model (as illustrated in Figure 2) involves:

- Communities at the grassroots level in the form of a Claims Committee, and Insurance Coordinators and Activists.
- NGOs as field partners at the intermediary level.
- MIA at the apex level as an external technical and resource agency.

The most notable feature of the model is that there is no external insurance provider or insurer involved, and no subsidy support for premiums. Rather, MIA provides its services to

Figure 7. Implementation Phases for MIA Community-Run Health Insurance

community-based schemes through a series of steps, each building on previous ones in succession to create cost-effective and efficient micro insurance units. The framework is implemented in four phases as outlined in Figure 7.

Inclusiveness and Community Rating

Today, many micro insurance schemes work along exclusion rather than inclusion: exclusion of certain groups (such as the elderly and young children); exclusion of certain benefits covered (such as pre-existing diseases and maternity); focus only on the poor in a community (targeted schemes); or excluding them de facto by setting premiums that exceed prevailing ability to pay. Exclusion usually leaves the most vulnerable groups unprotected, and as a result, the whole community suffers because they continue paying for the weaker members out of pocket when the need arises. Existing schemes that include weaker members often discriminate against them by applying a risk rating and thus making membership unattractive by way of higher premiums for perceived higher risks. MIA's model applies community rating and favors inclusion, which allows for a better diversification of the risk and lowering of overall costs.

En-bloc Affiliation

Individual subscription (or group subscription as an aggregation of individual contracts) in micro insurance is often synonymous with adverse selection, since people who expect to be ill ("bad risks") sign up and those that do not expect to be ill ("good risks") opt out. Under such a scenario, actual costs quickly exceed the cost of the (random) risk covered and make the product unattractive or unsustainable.

En-bloc affiliation of entire communities changes this paradigm by expanding the pool and diversifying the risk among all individuals in the group—the "good" and the "bad" risks combined. This has the potential to enable both lower transaction costs and reduced adverse selection. In MIA's approach, communities are only eligible for insurance if they join the en-bloc. This principle draws from the positive lessons learned from peer pressure and social capital in microfinance (Dror 2008).

Action-Research

MIA conducts action-research to collect evidence that can advance the understanding of micro insurance, challenges faced by vulnerable communities and factors affecting the uptake of and demand for micro insurance. The research also helps MIA understand prevalent ground realities and assess the potential impact of the project. For example, the MIA team has developed a novel method to estimate morbidity data needed to calculate premiums (Binnendijk, Gautham, Koren and Dror 2012) and another to estimate willingness to pay for health insurance (Binnendijk, Dror, Gerelle and Koren 2013).

Another important insight gained has been how community buy-in is reached through awareness creation (Panda et al 2015) followed by a process of consensus building, in which the community adopts both a single package and the premium it commands (Dror, Panda, May, Majumdar and Koren 2014). In addition, a new theory of demand for micro health insurance in the informal sector has been formulated (Dror and Firth 2014), in view of the many difficulties to explain behavior by classical demand theories. MIA disseminates its research results through peer-reviewed journals, and works toward leveraging the findings to encourage policymakers and practitioners to push forward the adoption of CBHI schemes.

Insurance Education and Advisory Services

MIA uses innovative techniques such as CHAT, games, songs, plays and murals to create awareness and educate the BoP about health insurance. The campaigns aim to equip the BoP with the skills to design, manage and govern their own insurance scheme in a structured, responsible and affordable manner.

MIA provides consultancy services to organizations involved in insurance, social protection, financial inclusion and risk management. Non-profits, governments and the private sector seek MIA services when they want to reach the BoP population. Advisory services include:

- Creating demand for insurance at the BoP level
- Increasing insurance literacy
- Collecting and analyzing baseline data
- Implementing multi-risk insurance products
- Developing capacity of senior level officials
- Facilitating public-private partnerships
- Advocating for insurance awareness

MIA conducts training on various insurance-related topics, including an overview of micro health insurance; data collection, analysis and research; premium calculation, package design and pricing; insurance operations, including education and awareness, enrollment, claims processing and data management; establishment of an insurance infrastructure; and supervision and regulation.

Resource Centers

MIA operates micro health insurance schemes throughout several parts of the world. Many of these schemes operate in isolation and with limited technical capacity. Recognizing this gap in technical skills, MIA has established member-based resource centers in Cambodia (and signed MOUs to develop similar centers in Bangladesh and Nepal), which should be the main hub for demand-driven access to insurance domain knowledge, independent from any sales function. MIA provides the centers' members with technical assistance to strengthen their operational capacity, advocate for a supportive regulatory environment and develop standardized tools for package design, marketing, enrollment and claims processing.

Partnerships

Implementation Partners

The capacity of the partnering organization—especially the depth of its links with the community—determine the success of the CBHI scheme implementation. Therefore, MIA conducts rigorous due diligence by checking on the potential partners' (1) capacity, (2) experience and (3) trustworthiness before formalizing the partnerships.

MIA appraises partner organizations on the basis of criteria such as:

- *Community focus:* The organization should have established credentials of working with the communities, not merely as a support agency or as a service delivery organization, but as a facilitator/capacity builder of community organizations using community-centered approaches. MIA's partners in India include Mahashakti Foundation (Kalahandi district, Orissa), Nidan (Vaishali district, Bihar), Shramik Bharti (Pratapgarh and Kanpur Dehat districts, Uttar Pradesh) and DEPROSC and Nirdhan Utthan Bank Limited (NUBL) (Dhading and Banke districts, Nepal).
- *Capacity of the organization:* The organization should have the capacity to guide the community in setting up the necessary systems and processes for developing and managing community-based insurance. Other aspects such as governance, leadership quality, management capacity, systems, practices, financial and non-financial performance and track record of making payments to the communities are also assessed.

See Appendix V for the criteria, indicators and means of verification developed by MIA for their partner assessment framework.

Financial Donors

After one year of establishment, MIA began receiving grants from various donor agencies such as the European Union, Malteser International, Misereor (Katholische Zentralstelle für Entwicklungshilfe (KZE), DFID, Save the Children, DGRV (Cooperative Federation of German Cooperatives), Climate Resilience through Risk Transfer using Microinsurance Solutions (RESRISK), the World Bank Development Marketplace and others. Over the years, MIA has managed to expand its donor base and has a mix of implementation and research grants. Donors from Europe provide more than 90 percent of the total funds received due to the strong credibility of the Founding Chairman and Managing Director, Professor David Dror, among donors in Europe.

Impact

MIA does not sell or underwrite insurance. Rather, it has developed a voluntary and contributory CBHI model that involves the BoP in the design and management of the mutual-aid scheme. According to MIA annual reports, MIA-supported micro insurance schemes have covered more than 40,000 people in India and Nepal.

Community Empowerment

MIA solutions are tailored to the local context with heavy involvement from communities. They provide local partners with the technical skills and guidance to design, operate and govern their own insurance schemes, because insurance is more efficient and valuable if it reflects community needs and has full community ownership. Research studies suggest insurance education and understanding of the community has increased by 80 percent, while preventive care awareness and practice has increased by 34 percent and 48 percent, respectively (Panda, Chakraborty, Dror and Bedi 2014).

Evaluations

As of January 2014, MIA, in collaboration with Erasmus University Rotterdam and the University of Cologne, has been analyzing the data from three separate CBHIs (supported by MIA in rural areas of northern India that have been operating since 2011), to establish the impact of being insured on the members. The micro insurance schemes are being implemented by three Indian charitable NGOs (BAIF, Nidan and Shramik Bharti) with technical support from MIA.

Each evaluation is organized as a cluster randomized controlled trial, in which randomly selected members of a network of women's microfinance groups are offered the option to affiliate to a CBHI scheme that they design and manage. Results of these evaluations will provide information on intermediate outcomes and development impacts of enrolling in MIA-supported CBHI schemes. Table 1 provides interim results highlights gathered from published sources.

Table 1. Summary of Impact from MIA Model

An assessment of the MIA business model based on an analytical framework

Reach	• **Coverage:** Since its inception, MIA-supported micro insurance schemes have covered more than 40,000 people in India and Nepal (MIA Annual Report 2013). • **Increasing acceptance among the poor:** There has been an increase in enrollment and renewal rates. For instance, for the CBHI scheme launched in the Kalahandi district of Odisha in 2010, membership increased almost three times in the first two years from 1,397 to 3,700 (MIA Annual Report 2013).

Effectiveness	• **Responsiveness to needs:** MIA's process of involving prospective insurers in package design increased the population's understanding about the insurance and led to different coverage choices than other micro insurance schemes (Dror et al 2014).
	• **Renewal rates:** In India the rates range between 35-50 percent (in 15 villages in Raniganj block, Pratapgarh district-Uttar Pradesh implemented by BAIF, and in 46 villages in Rasoolabad block, Kanpur Dehat district-Uttar Pradesh implemented by Sharmik Bharti). Over 2,000 people were covered under these schemes by the end of 2012 (MIA Annual Report 2012).
	• **Growth rate and claims settlement:**
	  ○ MIA reports that 11,698 insurance claims amounting to USD 119,000 have been settled since 2010 under various schemes in India and Nepal. About 50 percent of the claim amount has been paid for benefits other than hospitalization. Under the Niramaya CBHI scheme, the claims ratio was 82 percent in the first year for reimbursement other than hospitalization expenses (lab tests, imaging, etc.), which are not covered by traditional insurance products being offered by the government or private insurance companies.
	  ○ The Tibetan Medicare Scheme implemented in 39 Tibetan settlements across 13 states in India supports over 10,000 insured members, has a growth rate of more than 15 percent and settles claims within an average of 25 days (MIA Annual Report 2013).
	• **Insurance education:** Research studies suggest insurance education and understanding of the community about insurance has increased by 80 percent, while preventive care awareness and practice has increased by 34 percent and 48 percent, respectively (Panda et al 2014).

Accountability	• **MIA quality management system:** MIA performs due diligence on its NGO partners and conducts baseline studies, trainings for facilitators on how to use CHAT and benefits packages workshops. • **Quality of care:** Qualitative field work of three MIA-sponsored CBHIs revealed that a minority of insured were dissatisfied with the absence of trained medical practitioners in villages, and the uneven quality of service by Rural Medical Practitioners (RMP) they could access. Also, because the insurance did not cover all forms of care, some respondents had to pay fees beyond the amounts insured. Of the 33 CBHI households that were interviewed at regular intervals, 16 reported that they still had to pay for services/medicines provided by the RMPs. Six of these households dropped out of the scheme. This sample is too small to allow for conclusive generalization or disaggregation by site. It points to the confusion that can occur between what members expect from the insurance and what they expect from medical practitioners. It is important to emphasize that CBHIs do not link with providers (the choice of provider is left to each member), do not engage in control of quality of care and do not develop provider payment incentives. Therefore, these aspects of large formal-sector health insurance systems cannot be examined for impact in the case of CBHI.

Cost-effectiveness and Affordability	• **Typical premium:** USD 1.60 to 4.33 per person in the household for one year of insurance coverage. Each year, households can re-enroll in the scheme. • **Complement existing schemes:** A study of MIA-sponsored CBHI indicates that households with greater financial liabilities found CBHI more attractive, and interestingly, enrollment in the national government program did not reduce enrolment to CBHI. This highlights the need for greater development of self-governed and context-relevant insurance solutions for those in rural India, and the importance of designing benefit packages that can complement existing insurance schemes (Panda et all 2014).
Impact on Development Outcomes	• MIA is conducting impact evaluations of the three CBHI schemes that were operated in rural areas of northern India. Results of these evaluations will provide information on intermediate outcomes and development impacts of enrolling in MIA-supported CBHI schemes.
Potential for Sustainability	• Initial findings from an impact evaluation of three MIA-sponsored CBHIs reveal positive effects of CBHI on reduction of self-medication by insured compared to uninsured, and lower health-related borrowing by the insured to deal with out-of-pocket spending. The MIA-sponsored CBHI schemes operated by local NGOs offer limited benefit packages, but they have been successful in dealing with managerial challenges related to the reimbursement of members, at fast turn-around time and with good renewal rates suggesting satisfaction of members with such schemes (Dror et al 2015, forthcoming).
Potential for Scalability	• The adoption of the MIA model in various parts of the world shows that the model can be replicated to serve the BoP population. • MIA plans to continue to work as a non-profit entity and concentrate on generating sufficient evidence and enhancing the confidence of donors to support replication in other geographies within and beyond India.

Sustainability and Scale-Up

MIA offers an independent, grant-based model with sound financial donors. Some factors to consider moving forward include:

Pooling of Community Contributions

In the MIA model, the size of individual units—the community groups where the pooling of contribution takes place—is very small. This puts the individual units at risk in case of catastrophic co-variant events that could wipe out the entire resource pool of the unit. In addition, these units normally receive technical support for the underwriting and managerial skills needed to operate a full-fledged insurance scheme.

MIA believes that scaling-up the model by creating federated structures and capacity-development at "competence center" levels could mitigate these risks. The federated structures would retain the operational autonomy of each scheme while spreading the risks across a larger group. The structures offer several benefits: larger aggregation leading to lower variance, and thus reduction in the cost of risk; reduction in the likelihood of catastrophic events; and avoidance of the need to retain surplus capital by each unit separately. In addition, the structures could potentially benefit from re-insurance, where an established insurance underwrites some of the outlier risks for the federated structure. The federated structure would also add efficiency in allocating technical capacities (e.g. actuarial and ceding decisions) that are needed at the level of each CBHI only from time to time.

Scaling-up through federated structures will require engaging with both the government and private sector. Government should provide the enabling regulatory environment and can fund the outlier risks of catastrophic events, while the private sector can provide the underwriting of risks that go beyond those covered by each CBHI on a mutual-aid basis. The private sector could also have a role in providing technical assistance on aggregation into the federated structure.

Partnerships for Scale-Up

MIA is devoting resources to research to generate evidence on impact of CBHI for its beneficiaries, and the results could be leveraged for partnering with the government and private sector. These partnerships in turn could ensure that government and private sector schemes offer and encourage more supply of insurance options that the target population of CBHI considers both relevant and affordable; this would help improve insurance penetration in the informal sector even when the basis of transacting is voluntary and contributory enrollment to insurance.

MIA envisions that the government could support the outlier risk for catastrophic events, and the private sector could provide its knowledge and experience in redistribution of risk through reinsurance. Specifically, the partnership with the government will help mainstream

micro insurance by creating and establishing regulations that are proportional to the risks covered under CBHI. The regulations will further help create an enabling environment for reinsurance and establishing direct links between the community and reinsurance service providers. The partnerships would also generate the capital needed to take CBHI to scale.

MIA also contributed to a study, "Factors Affecting Voluntary Uptake of CBHI Schemes in Low- and Middle-Income Countries (LMIC)." The findings from the study suggest that LMIC governments can play a proactive, non-financial, role in extending the outreach of social protection by creating a CBHI-friendly regulatory and political environment.

Financial Sustainability

The financial sustainability of the CBHI schemes themselves is secured from premium income, since the CBHI schemes do not benefit from premium subsidies. The process of generating sufficient revenues to constitute contingency reserves takes several years and depends on the number of members and level of the premium. All MIA-supported CBHI schemes have recorded increases in premium income due to a higher number of members and, to a lesser extent, to a higher premium per person per year. In the initial years, MIA subsidizes the administrative costs of the schemes, but this support is temporary, and the income of the CBHI is supposed to cover the local administrative costs once the CBHI has reached operational maturity.

MIA's financing model is grant-based. The model relies on funding from donor agencies to initiate activities and meet the costs of providing technical assistance. Technical assistance includes conducting research to understand the health-seeking behavior of people in the area, and facilitating design and selection of insurance packages.

In a scenario where external funding is not available, it would not be possible to continue to deliver technical assistance. In this case, MIA will find it difficult to geographically expand the base of its model. From a policy viewpoint, the question is whether the cost of supporting MIA's services is more advantageous than direct interventions at grassroots level. The results of the CBHI (solvent demand created, and voluntary and contributory enrollment where there was neither demand nor insurance cover before) are desirable outcomes, but the dependence on donor funding represents a certain vulnerability for MIA's model.

MIA has analyzed the data available to it from several years of CBHI activities in India and Nepal to develop a business case for CBHI. The study, once it passes peer review, will provide quantitative evidence of how much reserve each new scheme needs at inception, how large is its potential to scale, and how long it would take for the scheme to function as a viable profit-sharing entity.

MIA plans to continue to work as a non-profit entity and concentrate on generating sufficient evidence and enhancing the confidence of donors (including government) for funding support for replication in other geographies within India.

Use of Information Technology

To take the innovation to scale, MIA requires making a substantial IT investment to support:

- **Periodic monitoring on a real-time basis.**
- **Renewal alerts/automatic renewal.** Currently renewal or reinforcement at the end of the policy period is done through paper records, and managing this manually requires much effort.
- **Awareness generation beyond CHAT.** Due to the nature of CHAT and its standard operating procedures applicability, the time taken to administer the tool is substantial. This limits scalability when seen as a function of time. Therefore, there is a need for

standardized approaches/tools that use IT and support awareness generation at scale in less time.

In 2016, MIA developed an e-learning facility, MIA ONLINE, to share knowledge and best practices about CBHI schemes and give people access to insurance education without financial constraints. MIA ONLINE offers courses on micro insurance, in four "streams"—Core, Advanced, Implementation, and Management Information Systems for micro insurance. The Core stream has been accessible free-of-charge since the end of 2016, and additional courses within this and the other streams will be added over time. To assist in mainstreaming micr insurance studies, MIA is reaching out to academic institutions to establish cooperation on course accreditation and delivery.

Lessons Learned

Importance of Raising Community Awareness

MIA's model is based on an assessment of beneficiaries' willingness to pay for health insurance that follows a process of interactions through which they are made fully aware about the purpose and benefits of insurance and assisted in prioritizing needs. This assessment enables the beneficiaries to make collective and conscious decisions about the insurance package.

MIA has demonstrated that dedicated efforts to raise community awareness to the value of insurance and to its operating rules is the essential first entry point; void of the awareness campaign, other community insurance schemes failed to achieve similar buy-in as they failed to realize that most of the target population has never been exposed to the concept of micro insurance and were uncomfortable to agree to pay for something they are not able to relate to. MIA has designed insurance education and willingness-to-pay assessment tools to implement tailored insurance packages with community engagement.

BoP Populations Prefer Health Insurance to Cover Events that Cost Little but Occur Multiple Times

Independent studies conducted by MIA highlighted the requirement of the BoP population for health insurance coverage of events such as the cold or flu that happen multiple times and eventually turn out to be more expensive (when aggregated, due to the cost of medicines, consultation fees, etc.), as compared to covering only rare events such as hospitalization for major ailments (that may be expensive but have low probability of occurrence). Many people felt that rare events are covered under government-sponsored healthcare schemes in any case, whereas outpatient care was not. This discrepancy indicated the need for customized packages under CBHI to provide coverage for common, low-cost outpatient expenses.

Disseminate Research for Greater Recognition and Replication

MIA needs to disseminate its model, research methods and findings more proactively. This can be done through annual seminars and experience-sharing workshops at different centers with donors, administrators, scholars, opinion makers and insurers. The dissemination will help MIA build synergies with other development organizations as well as fundraise with donors. MIA should also enhance their efforts working with policymakers to increase the visibility of micro insurance and build links to explore scaling-up operations.

APPENDIX I

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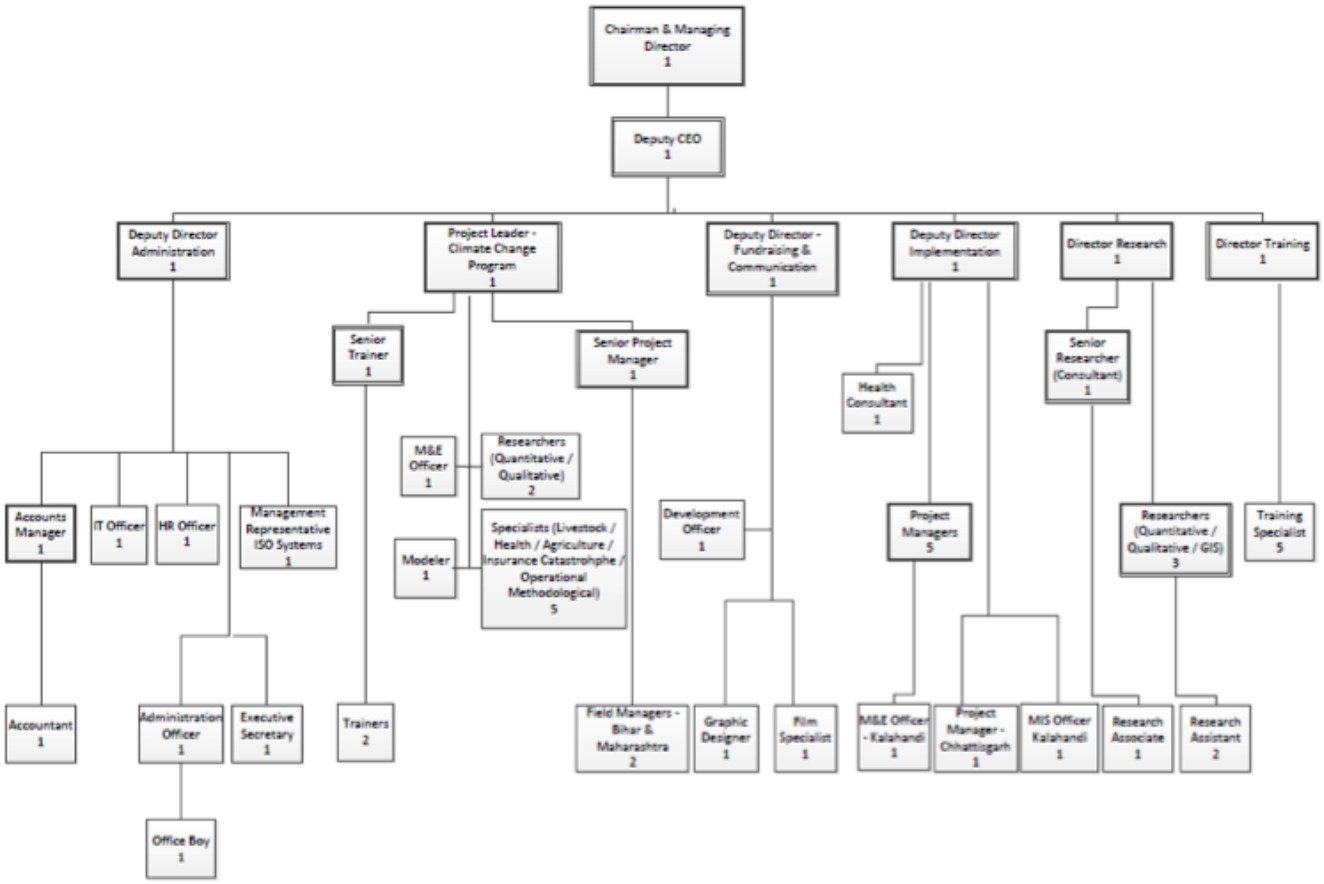
APPENDIX II

Organizational Structure



APPENDIX III

Example of the CHAT Decision Tool

MIA uses the CHAT tool to facilitate group discussions and decision-making around the micro-insurance scheme options and trade-offs within a limited budget. It is designed like a game, built around a circular board that displays insurance benefit options as slices of a pie chart. The CHAT exercise makes complex decisions more feasible by incorporating complicated data such as actuarial costs into a simply presented exercise board. Using CHAT helps in designing health care plans that reflect community priorities. MIA customized the CHAT tool as part of the EU-India Economic Cross-Culture Programme project, "Strengthening micro health insurance units for the poor in India."

APPENDIX IV

Revenue and Expense Sheet

SARVAJAN UNNATI BODHINI

INCOME & EXPENDITURE ACCOUNT FOR THE YEAR ENDED MARCH 31, 2014

EXPENDITURE	AMOUNT (Rs.)	INCOME	AMOUNT (Rs.)
Amount written off / back	17,533.43	Donations received	6,78,04,795.62
Audit fees	3,37,080.00	Miscellaneous receipts	18,188.00
Awareness creation expenses	8,13,439.00	Interest on savings bank	3,35,502.00
Bank charges	7,481.10		
Conveyance charges	2,85,700.00	Excess of expenditure over	8,15,616.56
Depreciation	6,72,046.00	income	
Diwali expenses	31,897.00		
Donation paid	49,00,000.00		
Field expenses	26,54,882.00		
IT support expenses	2,22,550.00		
Honorarium paid	4,70,000.00		
Membership & subscription	70,383.31		
Miscellaneous expenses	5,20,898.74		
Office expenses	98,172.00		
Postage & courier expenses	67,495.00		
Printing & stationary expenses	5,16,168.00		
Legal & professional expenses	1,10,51,604.00		
Provident fund	17,08,549.00		
Rent	52,03,854.00		
Repair & maintenance	14,36,304.38		
Research expenses (including survey)	30,38,774.50		
Salary & allowances	2,61,14,518.00		
Staff insurance	11,45,868.09		
Staff welfare	10,75,366.00		
Telephone & internet charges	4,91,277.63		
Travelling expenses	42,43,275.00		
Water & electricity expenses	9,93,161.00		
Workshop & seminar expenses	7,85,825.00		
	6,89,74,102.18		6,89,74,102.18

Significant Accounting Policies and Notes to Accounts : Schedule "E"

The schedules referred to above form an integral part of the Income & Expenditure account

for Sarvajan Unnati Bodhini

(Ashutosh Kaushik)
Deputy Director of Admn.

(Dharmendra Kumar)
Trustee

As per our report of even date
for Vijay Deepak & Co.,
Chartered Accountants
(Firm Reg. No. 001405N)

(Yogesh Jain)
Partner
M.No. 097139

Place: New Delhi
Date : 25.07.2014

APPENDIX V

Partner Assessment

This framework provides the criteria, indicators and means of verification developed by MIA for partner assessment.

Criteria	Level	Indicators	Means of Verification
Community focus	Basic	• Promotion and nurturing of community-based organizations • Working through community groups (self-help groups, federations, cooperatives etc.) • Belief in the ability of community; enabling approach	• Vision and mission of promoter NGO • Forms and number of community-based organizations promoted by NGO • Activities pursued by community-based organizations
	Advanced	• Belief in the principle of subsidiarity • Responsive to community's needs • Willingness to listen to community and design appropriate products • Openness to listen to new ideas • Willingness to explore new initiatives	• Discussions with various stakeholders (including community) to see whether the promoter NGO is actually using subsidiarity mechanisms in operations • Minutes of meetings held at CBO level • Records and MIS maintained at CBO level
Characteristics of community	Basic	• Poor, with some capacity to pay (cash economy to a reasonable extent) • Not endemically affected by serious epidemics • Most members suffering from same health hazard • Communities targeted	• Economy of the area, livelihood sources and BPL data • Studying health history of the area (health records/official statistics where available)
	Advanced	• Having faith in the organization/ federation/cooperative, microfinance institution	• Proxies of ability to pay (spending) • Discussions with community and other stakeholders on HH goods, etc.
Capacity of NGO	Basic	• Scale and outreach • Execution and background of Chief Executives and core team • Education and background of Promoters/Board of Directors • Years of existence • Representation in government/ autonomous organizations	• Annual reports • Website • Other publications
	Advanced	• Quality of Management/Chief Executive Officer • Extent of professionalism, knowledge and skill set • Quality of reporting and monitoring systems; quality of programs undertaken • Financial and non-financial; sources of funds	• Discussions with CEO/core team • HR management and development systems and policies • Management Information System reports • Annual progress report for financial performance: balance sheet, and repayment rate, dropout rates etc. • Discussions with various stakeholders including community

Criteria	Level	Indicators	Means of Verification
Existence of Community organizations	Basic	• Number of community organizations • Forms of community organizations • Roles and responsibilities of community organizations	• Promoter NGOs Annual Reports of last 2-3 years • Website/donor website or donor reports
	Advanced	• Level of acceptance among members • Relationship with primaries • Extent of dependence on promoter; financial dependence • Day-to-day management • Locus of control: internal, external • Who is the CEO? NGO professional • Community selected • Kind of activity undertaken: financial; social • Sustainability: financial; institutional • Ability of community organization to influence members to pay premiums regularly • Role divisions (subsidiarity) • Role of apex	• Records and minutes books of CBO; Financial records of CBO; Other reports, publications • Location of office of community organization • Discussions with member • Discussions with leaders, and CEO of community organization • Discussions with external stakeholders such as bankers, government officials, etc., in case CBO is a financial intermediary • Discussions with staff of promoter NGO • Income and expenditure statements of community organization and other financial statements
Assurance of payment	Basic	• Capacity to pay • Good financial performance of microfinance program, in case there exists one • Corpus with SHGs/Cooperatives	• Review secondary data on the overall economy of the area, livelihoods of people, and income sources • Annual reports published by promoter NGO
	Advanced	• Willingness to pay • Availability of corpus, revolving fund, other saving mechanisms available with groups, federations and co-operatives • Faith of members in apex body • Past record of payment for services by community	• Studying various reports, MIS, financial reports of SHGs, cooperatives and federations • Discussions with community and other stakeholders
Other factors	Basic	• Existence of reasonable health infrastructure: SHCs, PHCs, referral facilities • Opportunity to dovetail other insurance schemes/products • NGO/MFI/Apex structure already involved in insurance by self or in partnerships • Relatively developed local economy • Availability of training infrastructure locally, with NGO	• Secondary data on health infrastructure, local economy • Details of programs run by NGO on insurance • Number of policyholders served by NGO under partner-agent model
	Advanced	• Opportunity to dovetail other insurance schemes/products • NGO/MFI/Apex structure already involved in insurance by self or in partnerships • How important is the income from partner-agent model for the NGO	• Details of programs run by NGO on insurance • Number of policy holders served by NGO under partner-agent model

In India, healthcare financing largely relies on direct out-of-pocket spending, which causes immense health-related financial burdens for the poor. Despite recent efforts by the government and the private sector, only 15 percent of the population in India is covered by health insurance.

The Micro Insurance Academy (MIA) extends health insurance at the last mile through a bottom-up approach to the design, implementation and management of community-based health insurance. MIA develops an understanding of each community and delivers customized tools and frameworks that build a community's capacity to self-manage micro insurance schemes.

MIA bridges the gap between insurers and the bottom of the pyramid by providing advisory support and insurance education to establish insurance schemes. To date, MIA-supported micro insurance schemes cover more than 40,000 people in India and Nepal.

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