Microinsurance In India: Outreach And Performance

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ABSTRACT

Poor people are the most vulnerable to shocks arising from sickness, accidents, death or loss of assets due to natural calamities and riots, etc. With barely any risk-management tools such as savings or insurance; they are compelled to borrow from informal markets at very high rates of interest, getting trapped in the vicious cycle of poverty. It is surprising that despite such compelling needs of risk management, the poor do not seek insurance coverage. In India, 90% of the population does not have any kind of social security, and insurance still remains a 'to be sold' rather than a 'to be bought' product. With the liberalization of the Indian economy in the 1990s, and the government's stance of inclusive growth, the Insurance Regulatory and Development Authority Act was passed in 1999, and the insurance sector was opened for the private sector. Subsequently, microinsurance regulations were introduced in 2005. With these government initiatives to provide risk coverage to the poor, there has been a significant increase in insurance penetration and density in India. These regulatory measures have not only brought positive changes in the provision of social security to the poor, but have also brought a paradigm shift in the attitude of insurance providers. Earlier, the insurance providers had to provide microinsurance products to meet mandatory social sector obligations imposed by the regulator; now, it is seen as a profitable opportunity. This paper presents a review of various studies on different aspects of microinsurance – demand, supply, constraints and issues concerning product design, pricing and the Government's policy on microinsurance.

Keywords: Microinsurance, Microfinance, Health Insurance, Risk Assessment
JEL Classification : G21, G22, G28

INTRODUCTION

Poor people are the most vulnerable to shocks such as sickness, accidents, death in the family or loss of assets due to natural calamities, riots, etc. Their vulnerability stems out of the nature of their employment, which is either in the informal sector bereft of any social security benefits, irregular income flows, susceptibility to diseases due to unhygienic living conditions in an urban set up or due to their engagement in primary sector activities with uncertain income flows in the rural areas. Equipped with barely any risk-management tools such as savings or insurance, they are compelled to borrow from moneylenders at very high rates of interest leading to indebtedness. Microinsurance provides poor households a hedge against unforeseen shocks. Recently, it has become the main talking point in microfinance landscape in India, especially with respect to achieving the target of inclusive growth. How is microinsurance different from commercial insurance? The answer lies in – for whom the provision of cover is meant. Churchill (2006) affirmed that microinsurance is generally for those persons who are ignored by mainstream commercial and social insurance schemes. It refers to the provision of cover to those working in informal economy having no access to commercial insurance and social security benefits provided either by the employer directly or by the government through employers. Churchill (2006) defined microinsurance as "the protection of low-income households against specific perils in exchange for premium payments proportionate to the likelihood and cost of the risk involved." In line with Churchill (2006), Dercon et al. (2008) defined microinsurance as, "an insurance that **(i)** Operates by risk-pooling **(ii)** Is financed through regular premiums and is **(iii)** Tailored to the poor who would otherwise not be able to take insurance."

Microinsurance can be perceived as a risk-management strategy operating by risk-pooling and is especially designed for low-income people to reduce their vulnerability to various shocks.

MICROINSURANCE DEVELOPMENT IN INDIA

Microinsurance came into existence in India with the liberalization of the insurance sector by the government and with the passing of the Insurance Regulatory and Development Authority (IRDA) Act in 1999. In 2000, the insurance penetration (total premium as a percentage of GDP) in India was just 2.1%, and the coverage was limited to only well-

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off people in the country (IRDA, 2011). With the 'development' word included in the acronym of IRDA, it sought to take steps to not only widen the insurance coverage geographically, but also across all economic classes. In 2002, IRDA introduced 'Obligations of Insurers to Rural or Social Sectors Regulations' and adopted minimum requirements for insurers to serve the Below Poverty Line (BPL) rural poor. Each private insurance company offering life and non-life insurance products is required to serve 25000 BPL households by the end of fifth year of its operations. Despite these measures, the desired results to increase insurance penetration and density could not be obtained due to genuine roadblocks faced by the insurers. In 2003, the Government of India set up a 'Consulting Group' to examine the existing insurance schemes for the rural sector, which gave its recommendations, culminating into Insurance Regulatory and Development Authority (Microinsurance) Regulations, 2005. The essence of these regulations are as follows:

a) Partner-agent model is allowed, whereby the insurer can provide technical knowledge of the sector and underwriting facilities, and the agent can provide network, reach and trust of the community.

b) A new set of agents such as Non-Government Organizations (NGOs), Self-Help Groups (SHGs) and Microfinance Institutions (MFIs) are allowed to take up distribution of microinsurance products.

c) Differential commission rates to the agents, relaxation regarding qualifications, examination and licensing of agents is allowed by the insurer, but mandatory 25 hours of training to the microinsurance agents is kept as it is.

d) Composite products covering various risks of low-income households such as life, health, accident, dwelling, livestock and tools & implements could be covered under a single policy through a tie-up between life and general insurers.

e) Sum assured limits have been defined for products to qualify as microinsurance to ensure that the products cater specifically to the needs of the microinsurance segment.

The government permitted private insurers to raise money by entering into collaboration with foreign companies that could hold up to 26% stake. The minimum capital requirement is kept at ₹100 crores for the new microinsurance providing company.

DEMAND FOR MICROINSURANCE

According to the United Nations Development Programme (UNDP) Report (2007), around 90% of the Indians (950 million people) do not have any social security coverage, which makes one ask, why the poor do not seek insurance cover. The plausible answer to this question lays in the socio - economic conditions of the people at the Bottom of the Pyramid (BOP) and the asymmetries prevailing in the insurance markets. Low level of income with barely any surplus to pay insurance premium, lack of awareness due to illiteracy, absence of sales agents amidst them, lack of suitable products from insurers, ignorance of what insurance can or cannot do for them coupled with mistrust are some of the reasons for low demand.

A comprehensive analysis of demand for microinsurance, using traditional theory of insurance, was provided by James Brau (2011) in his recent study. He avers that there are three factors that determine risk premium. First, an individual's response to risk aversion determines the risk premium he would be willing to pay to cover the expected losses. The higher the degree of risk aversion, the greater the risk premium an individual would be willing to pay. The second factor determining premium is the size of loss relative to initial wealth and the probability of the loss. The third factor is the initial level of wealth. Brau (2011) maintained that individuals at the Bottom of the Pyramid (BOP) have very high utility from wealth, indicating high demand for insurance as long as the transaction costs in the insurance market are kept low, insurance policies are simple and are designed to cover critical risks, and the individuals are educated about their insurance profile.

Brau (2011) admitted that demand for microinsurance depends on an individual's capacity to deal with multiple sources of risk, limited availability of existing safety nets and risk of ruin (insurer's insolvency). An individual or a family operating at the BOP is faced with idiosyncratic risks such as death, accidents, sickness, etc. affecting the individual and his family, and systematic risks such as floods, earthquakes and fire, etc. affecting not only one individual, but all individuals in the locality, region or a country. The ability to manage and ensure these risks differs considerably. Therefore, how a utility maximizing individual commits his scarce resources for managing risks would determine the risk premium. Commenting on the safety nets available to those at the BOP, Brau (2011) [quoting Miskin (1999) ; Linnerooth and Bayer (2007)] stated that in the emerging markets, safety nets available to the BOP are

incomplete and may not be universal. In the event of a systematic risk, the safety net may not be available to an individual. This fact lowers the utility maximizing an individual/family's willingness to pay.

Brau (2011) maintained that the risk of ruin (insurer's solvency) also plays an important role in demand for microinsurance. If an individual commits a significant portion of wealth for risk transfer (i.e. pays a premium), he must receive a certain amount of payment when the loss occurs. Finally, the demand for microinsurance is also affected when the subjective probability of loss of the insured does not coincide with the objective probability of loss to the insurer, which is based on actuarial analysis.

Brau (2011), therefore, advocated that micro insurers should position their products in such a manner that they are able to cover an insured person's full losses in all situations, and yet remain solvent at all times. He claims that catastrophic risks (risks that would reduce the economic well-being of an individual/family) might be more viable for microinsurance than focusing on small period losses.

Roth et al. (2007) asserted that the demand for microinsurance arises out of the two broad categories of risk management – the ex-ante and the ex-post risk. The ex-ante risk management involves taking such actions which reduce the risk in the future such as buying a lock to prevent theft. Ex-post risk management is related to reducing the impact of the risk after it has occurred, e.g. taking an emergency loan to meet funeral expenses, etc. While estimating the demand for microinsurance, the strategies adopted for these two types of risk management should be taken into consideration. Lack of awareness of consumers about microinsurance is cited as the single most important hindrance in the way of low penetration of microinsurance.

DZror et al. (2006) analysed the demand for microinsurance at the BOP from the perspective of the insurers' willingness to pay (WTP). Their study showed that the rural Bottom of the Pyramid (BOP) population was willing to pay at least 1.35% of the median household income per year or at least 1.8% of the median non-health expenditure per household per year as insurance premium. Their findings also indicated that the nominal willingness to pay (WTP) was ₹ 230 per person per year in case of small households and ₹ 150 per person per year when the household size count was up to six persons or above. These WTP levels are higher than the premium charged by some schemes introduced by the Karuna Trust, UpliftHealth and the Jan Arogya Bima scheme. Their study pointed to untapped health insurance potential of the under-served population in India. Their study also explored the relationship between WTP and income and WTP and education. They held that the household is the most important determinant of WTP and insured persons from microinsurance units accepted higher WTP than the uninsured.

One can conclude from these studies that demand for microinsurance is determined by an individual/family's risk management strategy, level of wealth, availability of safety nets and willingness to pay.

SUPPLY OF MICROINSURANCE

Microinsurance in India is more supply driven and is sold rather than bought by poor households. Microinsurance, in fact, is an offshoot of microfinance. It was initially packaged with micro credit by the Microfinance Institutions (MFIs) as a risk-management tool to protect themselves against defaults in case of death of a client. Now, insurers consider it as a business opportunity besides meeting their social sector obligations. Microinsurance can be of two types – one, offered as a social security to low-income households in the absence of government schemes; and two, offered as a financial service on a commercial basis to low-income households to earn profits. C. K. Prahalad (2005) in his book "Fortune at the Bottom of the Pyramid" stated that around four billion people live on less than US$ 2 per day provide market opportunity to multinational firms to innovate products and services for the BOP segment of the society. There is a debate on whether MFIs should offer microinsurance. Brown (2001) argued that MFIs are most likely not equipped with the expertise to offer microinsurance. Therefore, they should enter into a partnership with the existing insurance providers rather than developing their own products. Brown's belief was based on five principles which are essential for the success of microinsurance products – one, a sufficiently large number of clients must demand microinsurance products; two, insurance can be offered only against such risks for which loss probability can be computed; three, risks should not be covariant i.e. should not have the potential to occur simultaneously to make the insurer bankrupt; four, the insurer must have control over moral hazards, especially in case of property and health insurance; and five, the insurer must create a portfolio that controls adverse selection. As opposed to Brown (2001), Torkestani and Ahadi (2008) were of the opinion that MFIs are capable of offering microinsurance.

Churchill (2007) opined that commercial insurers may not be interested in serving the small ticket customers due to

lack of economies of scale, regulatory barriers and major obstacles posed by lack of awareness and pre-conceived negative notions about microinsurance among the clients. He suggested that microinsurance should be highly regulated to ensure its success, but the insurers need to be innovative to cater to a different set of clientele.

Llanto (2007) listed four primary risks for microinsurance schemes – adverse selection, fraud, moral hazard and covariant risk. He suggested that these risks can be mitigated with level contributions, level benefits, frequent and affordable premium payments, simple product design, uniform benefit packages and low overhead expenses.

OUTREACH OF MICROINSURANCE IN INDIA

Insurance penetration (ratio of premium to GDP) and density (ratio of premium to population) indicate the proportion of population covered by insurance in a country. However, it is difficult to know the extent of microinsurance coverage due to lack of reliable data. Annual reports of IRDA and studies conducted by the International Labour Organization (ILO) and independent researchers provide useful information about coverage of microinsurance services.

❖ **Penetration And Density of Microinsurance :** Insurance penetration in India was 5.10%, and insurance density was USD 64.4 in 2010-11, which is very low as compared to the world average of 7.5% and USD 607.7 respectively (IRDA, 2010). However, in the Asian region, India's performance is relatively better than other countries, and it is making fast progress in the field. There is a big leap in insurance penetration and density from 3.14% and US$22.7 in 2005 to 4.80% and US$38.4 in 2006 respectively after introducing IRDA (Insurance and Regulation) Act. In 2010, insurance penetration increased to 5.10% and insurance density increased to US$64.4 (Table 1).

Table 1: Insurance Penetration And Density In India

Year	Life		Non-life		Industry	
	Density (USD)	Penetration (Percentage)	Density (USD)	Penetration (Percentage)	Density (USD)	Penetration (Percentage)
2001	9.1	2.15	2.4	0.56	11.5	2.71
2005	18.3	2.53	4.4	0.61	22.7	3.14
2006	**33.2**	**4.10**	**5.2**	**0.60**	**38.4**	**4.80**
2010	55.7	4.40	8.7	0.60	64.4	5.10

Source: IRDA, 2010-11 resourced from: Swiss Re, Various Issues.

* Insurance density is measured as ratio of premium (in US Dollar) to total population.
* Insurance penetration is measured as ratio of premium (in US Dollars) to GDP (in US Dollars).
* The data of Insurance penetration is available with rounding off to one digit after decimal from 2006.

Table 2: Registered Insurers In India (As on 30th September, 2011)

Type of Business	Public Sector	Private Sector	Total
Life Insurance	1	23***	24***
General Insurance	6*	18**	24
Re-insurance	1	0	1
Total	**8**	**41**	**49**

Source: IRDA 2010-11

* Includes specialized insurance companies - ECGC and AIC.
** Includes three Standalone Health Insurance Companies – Star Health & Allied Insurance Co., Apollo Munich Health Insurance Co. and Max Bupa Health Insurance Co.
*** Include Edelweiss Tokio Life Insurance Company Limited. Edelweiss Tokio Life Insurance Company Limited was granted registration in 2011-12.

❖ **Registered Insurers In India :** At the end of September 2011, there were forty-nine insurance companies operating in India; of which twenty four were in the life insurance business, and another twenty four were in the general insurance business. In addition, GIC is the sole national re-insurer. Of the forty-nine companies presently in operations, eight in the public sector are composed of two specialized insurers; namely, Export Credit Guarantee Corporation (ECGC) and Agriculture Insurance Company of India Ltd. (AIC), one life insurance company, four general insurance companies and one re-insurance company. Out of the remaining forty one companies in the private sector, 23 are life insurance companies and 18 are general insurance companies (IRDA, 2010) (Refer to Table 2).

❖ **Life Insurance Schemes :** As on 31st March, 2011, 24 life insurers had 16 individual and 12 group microinsurance products in their basket, while an equal number of general insurers had launched a total of 66 products. The Life Insurance Corporation of India (LIC) plays a major role in the microinsurance sector, with 99.57% share. Out of 5469 individual schemes, it offers 5446 schemes, covering 13.2 million lives with 29.51 lakh policies and a premium amount of ₹ 12305.76 lakh in 2010-11. Only 23 schemes out of 5469 schemes are offered by private sector microinsurance companies. In 2006, LIC launched its first microinsurance product 'Jeevan Madhur' and in 2009, it launched another term insurance plan, 'Jeevan Mangal', with a refund of premium facility. Jeevan Madhur is a low premium endowment policy with accident cover. In this policy, if two full-year premiums have been paid, the cover will prevail for two years from the date of the first unpaid premium. Jeevan Mangal is a term insurance plan with a refund of premium. The minimum sum insured is ₹ 10000, while the maximum cover is up to ₹ 50000. The International Labour Organization (ILO) provides useful insights on the microinsurance sector by conducting a series of case studies at its South Asian regional office through its programme – Strategies and Tools Against Social Exclusion and Poverty (STEP). ILO prepared an inventory of statistical information on the sector in 2003-04. It listed around 83 microinsurance products that are providing coverage for accidental death, health care, asset protection and accidental expenses (2004a) in India. A single product is offered by 46 schemes, while 37 schemes offer two or more products. An estimated less than five million BPL households are covered by microinsurance in India (Garand, 2005). Another inventory also prepared in 2003-04 provides information to about 51 organizations, which were already providing microinsurance schemes and another nine, which were planning to offer microinsurance products in the near future. A third of these organizations were offering microfinance and 31% were NGOs supporting a wide range of development activities at the grassroots level. Of the rest, 23% were Community-Based Organizations (CBOs), and 12% were providers of health care (ILO, 2004b).

❖ **Non-life Insurance Schemes :** The social security schemes of the Government are better administered through insurers due to cost-efficiency and better accountability. As such, three of the flagship social security schemes of the Government of India, targeted at low-income/microinsurance segments viz. Aam Aadmi Bima Yojana (AABY), Janashree Bima Yojana (JBY) and Rashtriya Swasthya Bima Yojana (RSBY) have been handed over to insurers for administration (IRDA, 2011). Besides, there are various healthcare schemes offered by Community Based Organizations (CBOs), non-governmental organizations (NGOs), Microfinance Institutions (MFIs), public trusts and public departments.

A working paper on microinsurance, "Health Micro-Insurance Schemes: Diversity, Innovations and Trends" published by ILO in 2009 provided comprehensive data on 100 health insurance schemes in India. It claimed that out of 100 Micro Health Insurance Schemes (MHIS), 43 schemes are offered by Non-Governmental Organizations (NGOs), 18 by Community Based Organizations (CBOs), 10 by Public Departments (PDs), eight by Health Providers (HPs), another eight by Private Trusts (PTs), seven by Microfinance Institutions (MFIs), four by Public Trusts (PTs), and two by Trade Unions (TUs). Sixty two schemes have been developed for the rural areas, 12 for the urban areas and 26 for both rural and urban areas. The study also reported that fifty eight organizations out of 100 (58%) had less than 5 years of experience in providing MHIS. Four South Indian states – Tamil Nadu, Karnataka, Andhra Pradesh and Kerala offer 78% of MHIS, with Tamil Nadu having the highest share (31%). These schemes are offered in mostly two models such as 'partner-agent model' (62 schemes) and 'in-house model' (38 schemes). In case of partner-agent model, 36 out of 62 schemes are linked with private insurance companies and 26 with public insurance companies.

The numbers of MHIS had increased to 100 and they were providing healthcare benefits to 97 million people across the country in 2009. This is a spectacular growth, however, still, 332 million vulnerable people are in urgent need of healthcare.

PERFORMANCE OF THE MICROINSURANCE SECTOR IN INDIA

Despite low density and penetration of microinsurance, India is one of the most dynamic economies that is making progress at a fast pace to provide insurance coverage to the BOP. Regulatory changes since the beginning of the new century have led to an increase in the density and penetration of microinsurance. Microinsurance individual policies registered a positive growth in terms of number of policies from 2.98 million to 3.65 million, but the premium amount has declined from ₹ 158.22 crores to ₹130.40 crores. However, the group microinsurance policies have declined in terms of a number of policies from 16.84 million to 15.25 million and premium amount from ₹ 234.81 crores to ₹ 155.23 crores during 2009-10 and 2010-11. The IRDA regulations 2005 permits a new breed of microinsurance agents such as SHGs, MFIs and NGOs to operate in the microinsurance sector. In 2008, there were 4584 microinsurance agents and 10482 in 2011, showing an increase of 54.7%.

❖ **Performance of Microinsurance (Life Products) :** Initially, microinsurance products were introduced by new entrants in the private sector to meet social sector obligations, and by NGOs and MFIs, to protect themselves against losses in the event of death of the loanee. Growth registered by the life microinsurance products in the individual as well as the group category indicates that microinsurance products not only enable insurers to meet their social sector obligations, but also improve their bottom line. There are 28 micro insurance life products offered by 23 registered life insurance companies (IRDA, 2010).

Table 3: New Business Premium (Life Products) (Amount in ₹ crores)

Year	Individual		Group		
	No. of Policies	Premium Amt.	No. of Schemes	No. of Lives	Premium Amt.
2007-08	937768	18.23	7598	12242027	201.27
2008-09	2152069	36.56	6997	12551809	205.95
2009-10	2983954	158.22	5207	16842070	234.81
2010-11	3650968	130.40	5469	15259001	155.23

Source: IRDA (2010-11)

New business under microinsurance surged rapidly between 2007 and 2010, both with respect to policies as well as the premium (around 768% rise in premium) of individual policies. While in case of group insurance schemes, there was only 11% growth. However, between 2009-10 and 2010-11, growth in premium of both individual and group insurance schemes declined (Table 3).

Table 4: Microinsurance Claims (Life Products) (Amount in ₹ crores)

Year	Individual		Group	
	No. of Claims Paid	Amt. of Claims Paid	No. of Claims Paid	Amt. of Claims Paid
2007-08	439 (87.80)	0.62 (88.38)	43688 (99.86)	120.88 (99.91)
2008-09	2527 (95.83)	3.31 (86.03)	50338 (99.64)	154.62 (99.71)
2009-10	7508 (99.13)	8.19 (95.55)	43463 (98.74)	177.68 (99.09)
2010-11	11283 (99.05)	16.79 (98.51)	50250 (98.91)	206.35 (99.00)

Source: IRDA (2010-11)

There was an appreciable increase in the number of microinsurance claims over a period of four years, i.e. from 2007 to 2011 from 87.80% to 99.05% in case of individual policies, but it is the reverse in case of group policies as the number of claims as well as the amount paid in claims (in per cent) declined over the same period as is visible from the Table 4.

❖ **Performance of Microinsurance (Non-Life Products) :** There are 24 non-life insurance companies (six public

Table 5: Microinsurance Premium and Claims (Non-life) (Amount in ₹ crores)			
Year	Gross Written Premium	Gross Incurred Claims	Gross Incurred Claims Ratio
2009-10	193.14	126.65	65.57%
2010-11	393.38	309.90	78.78%
Source: IRDA (2010-11)			

sector and 18 private sector) offering 66 products providing insurance cover ranging from health, assets, livestock and crops. In case of non-life products, microinsurance premium and claims have grown from 65.57% to 78.78% over a period of two years (Table 5) .

Apart from the data provided by the IRDA on the microinsurance sector, the performance of the microinsurance sector can be gauged through a few studies conducted by NGOs, CBOs and MFIs.

Dror et al. (2009) studied the performance of three microinsurance entities – Bharat Agro Industries Foundation (BAIF) and UpliftHealth in Pune city in Maharashtra, and Nidan in Patna, Bihar. The study showed that the microinsurance units, despite less funding and professional resources, have provided protection to their insured populations through the mobilization of context – relevant social processes.

Sudarshan and Selvaraj (2007) analyzed microinsurance schemes offered by Karuna Trust in Karnataka, one of the finest examples of public-private partnership in providing Community Health Insurance (CHI) services. The Karnataka government has entrusted the management of Public Health Care (PHC) to voluntary organizations (VOs) and private medical colleges. Karuna Trust manages 25 PHCs in Karnataka and nine PHCs in Arunachal Pradesh. Ministry of Health and Family Welfare (MHFW), the Government of India (GOI), United Nations Development Programme (UNDP), Department of Health and Family Welfare, Government of Karnataka, Karuna Trust CPD and National Insurance Company are the partner organizations for Community Health Insurance (CHI).

The study results showed that Karuna Trust charged a premium of ₹ 22 per person per year, which is shared by the community, milk co-operatives, SHGs, UNDP and Gram Panchayats, with a no-exclusion policy, which included all age groups and all diseases. A compensation of ₹ 50 per day was paid to the patients for daily wages lost due to sickness and ₹ 50 was paid to the hospital for extra drugs per day of hospitalization, with the amount paid to the patients every day through the revolving fund at each hospital. Ambulance services and referrals were also covered for a maximum of 25 days of hospitalization. The claims were settled by the National Insurance Company (NIC) once a week. The main ingredients of success of this scheme are – strong presence of the CBO, dissemination of information through various programmes to the public, involvement of SHGs, no exclusions and low premium.

Devadasan et al. (2006) studied the performance of ten CHIs initiated by NGOs. Their findings indicate scanty evidence of impact of CHI schemes on the performance of the health care system. However, there is some evidence of increased access to hospital care for the insured from Action for Community Organization, Rehabilitation and Development (ACCORD)'s scheme and reduced catastrophic health expenditure among the insured of Self Employed Women's Association (SEWA)'s health insurance scheme (Ranson, 2002). Devadasan et al. (2006) suggested that it may be imperative for the government health services to join hands with the for-profit and not-for-profit organizations to provide health services to the needy as it cannot cope with the demand pressures.

Roth et al. conducted a study commissioned by the "Good and Bad Practices in Microinsurance" project, managed by ILO's Social Finance Programme for the Consultative Group to Assist the Poor (CGAP), an independent policy and research centre dedicated to advancing financial access to the world's poor in 2005. Microinsurance products of three MFIs – Activists for Social Alternatives (ASA), Self-Help for Promotion of Health and Rural Development (SHEPHERD) and Spandana Sphoorty were selected for the study. ASA, an NGO established in 1986 for the development of drought prone area of central Tamil Nadu experimented with in-house and partner-agent schemes at different time periods. In 2000, ASA collaborated with the United India Insurance Company (UIIC) to offer cover for accidental death to the clients at a premium of ₹15 in addition to its in-house product, covering natural death for a premium of ₹ 60 per annum.

In 2001, ASA joined hands with LIC and offered Janashree Bima Yojana (JBY) to its clients at a subsidized premium of ₹100 per annum, with a matching amount to be paid from the government's trust fund. Despite these attractive benefits, ASA's experience with LIC was not positive as the working of LIC was very bureaucratic, policy documents were very lengthy and complicated and there were problems with claims settlement.

ASA decided to provide in-house insurance for natural death. It combined a cover of ₹ 20000 for natural death with an accidental death cover of ₹ 50000 from General Insurance Corporation (GIC) and ICICI Lombard. In 2002, ASA joined hands with Bajaj Allianz, Max New York Life and AMP-Sanmar to offer various products to their large client base. The overall client satisfaction levels with ASA's microinsurance schemes was satisfactory, though the clients wanted their spouses also to be covered by insurance.

Another MFI included in the CGAP study is SHEPHERD, which was registered under the Societies Act in 1995 in Tiruchirapalli, Tamil Nadu. Initially, SHEPHERD provided microinsurance to its clients by joining hands with the LIC in 1999. In 2001, it entered into a partnership with HDFC-Chubb and ICICI Prudential. This association didn't work due to poor after-sales services by both the companies. In 2002, it entered into a partnership with LIC and offered its clients Janashree Bima Yojana (JBY), General Social Security Scheme (GSS) and Ordinary Group Insurance (OGI).

An important feature of SHEPHERD's life insurance is that it is really voluntary. Like ASA, SHEPHERD too had problems with LIC, but instead of severing ties, it took a proactive step and invited LIC officials to meet its clients. This proactive move worked, and LIC allowed SHEPHERD to pay claims in advance and got reimbursed later.

SHEPHERD created a Sugam Fund for providing soft loans up to ₹ 3000 to pregnant women for delivery. The fund is capitalized by Friends of Women's World Banking (FWWB), and is managed by SHG members who pay ₹ 5 with every premium. With UIIC, it provides UniMicro Policy. SHEPHERD also provides livestock insurance and life insurance to non-members, especially spouses of members. SHEPHERD's clients have mixed perceptions about health insurance products. Some of them feel why they should pay a premium for a year for the services they may not utilize, while others feel that it would be nice if someone else in need benefits from their contributions. However, SHEPHERD's proactive role in providing microinsurance services to its clients is appreciable.

Insurance products provided by Spandana Sphoorty are the simplest. It provides in-house insurance products. Its approach is quite basic, with an emphasis on credit life. It created a scholarship scheme which generated a positive image, but it does not benefit people who pay a premium. The biggest advantage of in-house insurance is that the clients get their claims settled fast.

This case study shows that the proactive role played by the MFIs can get good microinsurance deals for their clients as is the case of ASA and SHEPHERD. Efficiency is less dependent on the delivery model, but more on the simplicity of the product. It is better for an MFI to first start with simple life insurance products and after gaining knowledge, it can offer more products to the clients. To know whether the product is right, they should know the requirements of clients and how much they are willing to pay. MFIs should also persuade the insurers to drop as many exclusions as possible (Roth et al., 2005). Denis Garand (2005) studied the microinsurance scheme "VimoSEWA", offered by Self Employed Women's Association (SEWA) to its women clients. VimoSEWA offers insurance to their women clients who can get coverage for their husbands and children. A discount of ₹ 20 is offered, if a woman takes cover for her husband and children. VimoSEWA has mainly three products – one for the BPL families and two for the low income group households. Members have two ways of payment of premium, annual payment or a fixed deposit (FD) account in the SEWA bank. The interest on FD pays for the insurance premium. Constant contact of VimoSEWA's Aegewans with the SEWA members to know their needs and designing suitable insurance policies for them has led to an improvement in the insurance products.

Garand and Wipf (2006) declared that important indicators for preliminary assessment of microinsurer's operations and practices are – marketing and distribution, financial management and viability, efficiency and client value and investment management. On the basis of indicators in these four key areas, they developed a potential score to rate an insurer. Yeshasvini in India had the highest potential score and rating score of 82% followed by VimoSEWA, with a rating score of 76%, Tata AIG, 75%, Spandana, 55% and Karuna Trust, 43%. These studies bring out the fact that despite many lacunae in microinsurance schemes, the role of NGOs and CBOs in providing risk coverage to the poor is appreciable. They still have to achieve many milestones in product design, pricing and delivery mechanism; nevertheless, they have taken initiatives to provide risk coverage to the poor.

PROBLEMS/CONSTRAINTS RESTRICTING THE OUTREACH OF MICROINSURANCE

There are various reasons behind the limited outreach of microinsurance at the Bottom of the Pyramid (BOP). These

problems are mainly related to the design and pricing of the products and claims, e.g.:

a) There is a service tax on microinsurance products recoverable from clients. It makes premium costlier for those who already find it difficult to pay it at regular intervals.

b) No grace period is provided for renewal in case of lapse of policy.

c) Age proof is required at the time of claims. Claims are rejected if any discrepancies are found in age proof.

d) Lengthy procedures for registration and claims.

e) Lack of awareness about various social security schemes.

f) Illiteracy among the BOP populace (microinsurance clients), making it difficult for the insurers to get their message across.

g) Inconvenient premium payment system.

h) Lack of proximity to the financial institution.

i) Lack of trust on the staff of the insurance provider.

j) Lack of interest of the insurance personnel to spread awareness and impart information about various microinsurance schemes to the clients.

k) MFIs as delivery channels are efficient in delivering the insurance product, but not in providing after sale services.

l) Low demand for microinsurance is mainly due to lack of tailor-made policies.

m) Lack of reliable data about the potential of microinsurance at the BOP.

n) Government subsidies cannot be sustained for a long time. Improved actuarial services and other means of funding of microinsurance products and offering them to clients at the BOP is required.

o) Health insurance premium is not refundable, which makes it an unattractive product.

p) There are problems related to the authenticity of the documents submitted by the clients.

q) Claims are rejected for pre-existing diseases.

r) Claims are admissible for settlement only for patients who are admitted in the hospital for more than 24 hours.

SUGGESTIONS

The inability of the poor to buy microinsurance products despite the compelling need for insurance shows that there is something seriously wrong in the pricing, design or delivery system of the product. The following suggestions may help to improve the product design and delivery channels:

a) Service tax on microinsurance products should be waived off.

b) The policy should be allowed for a minimum of 5 years once the premium is paid.

c) While issuing the policy, age proof condition should be satisfied properly.

d) At least 50% of the premium amount should be refunded in case of health insurance.

e) Documents certified by NGOs and SHGs should be considered for claim settlement.

f) The Insurer should consider the authenticity of SHG report of diseases.

g) Claims for less than 24 hours of hospitalization should be settled by the insurer.

h) Payment of premium should be made convenient by using local resources such as kirana shop owners, SHGs and postmen, who can collect it at clients' door steps.

i) To keep transaction costs low, appropriate technology should be used.

j) Insurers should deliver simple customized products with flexibility in premium payment.

k) The government should lower the minimum capital requirements for microinsurance companies.

l) NGOs and MFIs providing microinsurance products should be allowed to raise capital from the market.

m) Emphasis should be laid on spreading awareness about microinsurance schemes, taking into consideration that 32% of the population is illiterate and does not have access to print and visual media (newspapers and television sets).

n) A separate body like IRDA can be created for the microinsurance sector. It can involve all stakeholders in designing appropriate products for the poor.

CONCLUSION

Microinsurance is still in its nascent stage, but is rapidly gathering momentum in India. The GOI has taken many proactive steps since 1999 by regulating the insurance sector and opening it to the private sector in 2005 to improve its outreach. A pragmatic approach with out-of-the- box solutions is required to make it provide insurance coverage to all vulnerable people at the Bottom of the Pyramid (BOP). While designing microinsurance products, the think tank should include all stakeholders – MFIs, NGOs, CBOs, government representatives, social workers and representatives of the public from the bottom of the pyramid. In addition to the subsidies provided by the government, the government should assist the sector with capacity building of microinsurance entities, product development, research and development, technical assistance in the form of actuarial services, risk funds and reinsurance (Ghate, 2007). IRDA should work on building up an inventory of reliable data by roping in researchers/experts in the insurance field. A flexible approach towards the new-age insurance providers such as MFIs, NGOs and CBOs enthusiastic to offer innovative products along with stringent regulatory framework can achieve the desired results. With a vast, yet to be covered population of 320 million people, the potential for microinsurance is enormous. The government cannot go solo on it. It has to join hands with for-profit and not-for-profit organizations to provide risk cover to the poor.

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