MILK Brief #26: The Business Case for Health Microinsurance in India: The Long and Winding Road to Scale and Sustainability

Executive Summary[1]

The MicroInsurance Centre's MILK project studied a group of Indian health microinsurance programs (HMIs) to determine if a business case is evolving. The study group included both private HMIs and publically supported HMIs. MILK found that without government subsidized benefits, even long established, private HMIs in India are struggling to achieve scale and sustainability. The emergence of RSBY (Rashtriya Swasthya Bima Yojna program), a government funded scheme for the poor, is having a competitive impact on private HMIs, forcing them to consider offering complementary services. In contrast, RSBY and other older government supported schemes, such as Yeshasvini, achieve scale well beyond what the private HMIs have. However, these subsidies appear to drive higher loss ratios than those seen in non-subsidized programs. MILK observed that the publically supported programs have little or no outpatient benefits while at least one private HMI with outpatient benefits, UPLIFT, is achieving lower claims costs; this can be seen as early evidence that spending on prevention and access to primary care reduces overall costs including the cost of inpatient services. Lastly, while high loss ratios are a significant problem for the business case, MILK finds that high distribution and administrative costs, to varying degrees in both private and public HMIs, are more severe hurdles to sustainability. In sum, **RSBY is a game changer, and while private HMIs struggle to adapt, the ingredients for a business case for health microinsurance have not come together for either private or public HMIs to date.**

[1] This MILK Brief was prepared by Richard Koven, Taara Chandani and Denis Garand (Sept 2013).

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1. Background and introduction

Health microinsurance is especially challenging from a business case perspective. The high cost of healthcare and the infrastructure needed to effectively distribute and administer health insurance and pay for covered services reflect a uniquely complex set of challenges. Although many see health insurance as an obvious need for the poor, progress for private programs remains limited. In India and elsewhere, in an effort to fill this gap in the health financing needs of low-income people, the government has begun to play a role. In India, the government role takes the form of subsidized health microinsurance programs (HMIs) through the Rashtriya Swasthya Bima Yojna (RSBY) program (see box), in addition to a number of state-run programs.

Features of RSBY

RSBY is the joint Federal-State Health Insurance program for the poor in India, intended to cover all Indians living below the poverty line. Since inception in 2008, RSBY has enrolled 40 million Indians.

The program provides hospitalization coverage of up to USD 700 (INR 30,000) annually for most inpatient medical and surgical needs. The premium is paid by the government, and beneficiaries are required to pay only a nominal registration fee.

Licensed insurers and TPAs bid in competitive tenders to participate in the program on a District by District basis. Healthcare providers are paid on a fee-for-service basis.

Source: http://www.jointlearningnetwork.org/content/rashtriya-swasthya-bima-yojna-rsby

As a part of its effort to understand the business case for microinsurance, the MicroInsurance Centre's Microinsurance Learning and Knowledge (MILK) project is exploring the influence that this type of government involvement can have on the business case for health microinsurance programs (HMIs). We seek to understand the business case for the private entities that take part in the government programs and for those competing with or complementing them, and how these programs interact with one another.

Our investigation focuses on a cluster of four HMIs in India, two private and two publicly supported business models: UPLIFT Mutual, Self Help Promotion for Health and Rural Development (SHEPHERD), ICICI Lombard Commercial Insurance and Yeshasvini Cooperative. The MILK team closely examined financial outcome data for the years 2008-2011 and held detailed interviews with management to provide additional context and nuance. While the analysis in each case includes the insurer or risk taker, it also examines payments made by HMI sponsors to other participants along the insurance value chain, such as TPAs and distributors, and incorporates financial data for all of these participants to the extent available.

We complement the lessons learned from these four programs with those of several others that could not be included in the core analysis either because sufficient financial data was not available or because the programs have been discontinued. Nonetheless, these additional stories (which include VimoSewa, MicroEnsure, Basix, SAS and ICICI Lombard's Weavers and Artisans), complement the core cluster of studies, shedding additional light on when and how a business case may emerge.

Section 2 below summarizes MILK's findings on each of the four HMI programs in turn, beginning with a brief description of the program and followed by the business case observations of our analysis. Section 3 provides additional insights from several other existing and discontinued programs, and Section 4 contains our observations and analysis across programs. Section 5 concludes, summarizing what we have learned to date (as well as the open questions) concerning the drivers of business case (or lack thereof) as HMIs travel the long and winding road to scale and sustainability.

2. Business case analysis of four HMIs in India

This section describes the four HMIs, representing a range of different models and product types:

- **UPLIFT India Association (UPLIFT)**: A non-profit company administers mutual health funds that deliver inpatient and outpatient coverage through MFI distribution partners; the program was supported by a donor subsidy, but that subsidy expired in 2012.
- **Yeshasvini Farmers Health Cooperative Trust (Yeshasvini)**: A partnership between farmer cooperative societies and the state government of Karnataka providing coverage for surgeries; administrative functions are outsourced to a TPA and the state government subsidizes the program.

- **ICICI Lombard General Insurance (ICICI)**: A large private insurer offers microinsurance through government programs, including RSBY and the Weavers and Artisans programs; ICICI takes on risk from RSBY (which is why MILK considers it a business) and performs most administrative functions in-house, but outsources enrollment to a separate firm.
- **Self Help Promotion for Health and Rural Development (SHEPHERD)**: A community based model which offers a hospital cash product; until recently SHEPHERD utilized both a partner-agent model and a mutual model to deliver benefits in Tamil Nadu, but has now dropped the partner-agent model.

Our quantitative analysis focuses on 1) growth in membership and premium revenues, 2) unit economics along the value chain, and 3) the program's trend to profitability over time viewed through claims and administrative expenses as well as subsidies contributed relative to premium earned. We complement this analysis with insights drawn from our conversations with managers and staff within each program.

a) UPLIFT India Association

> **"Local engagement is the key to sustainability in microinsurance. UPLIFT is there to help the community; we are guardians of health." *-UPLIFT***

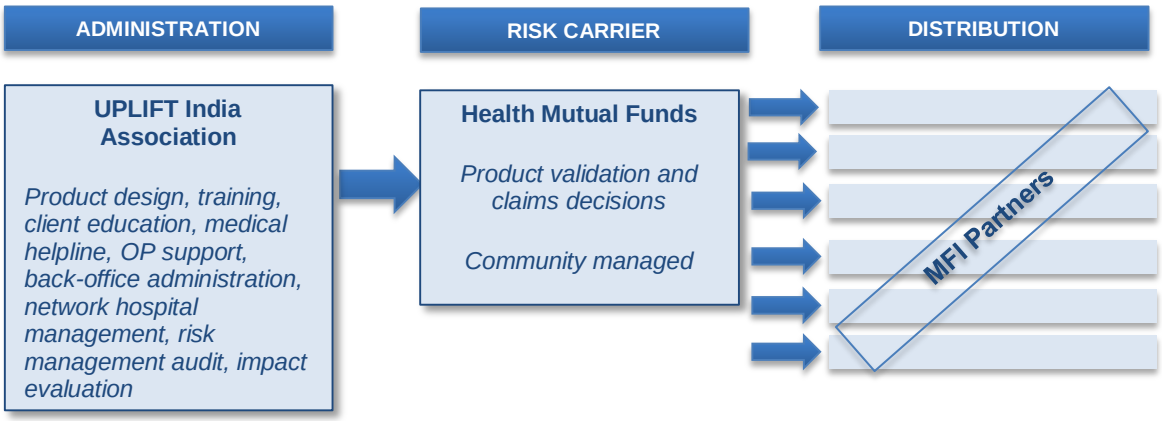
Figure 1: UPLIFT Program Highlights

Headquarters/ Service Area	Pune/Maharshtra	**Enrollment Basis**	MFI Group Enrollment (Mandatory)
Program Age	8 years	**Subsidy**	Philanthropic/InterAide
Scale	170,000	**Competition**	None
Business Model	Self-funded Mutual	**Value Chain**	UPLIFT→Mutual→MFI
Distribution	MFIs	**TPA/Intermediary**	UPLIFT provides T/A & capacity
Risk Taker	Trust	**Cost**	INR 100/ life year With options up to INR 480/yr
Product Features	IP coverage limit is INR 30,000 (USD 500). Private hospitals are reimbursed 50% and public 100% Preventive care: • Health camps and talks • Free screenings / check-ups during camps • Telephone hotline serviced by an MD		

The program

UPLIFT is a not-for-profit company that administers mutually owned health protection funds, serving low-income urban and rural communities. UPLIFT was founded in 2004; as of September 2012 it was working through six MFI distribution partners and covering over 170,000 lives in Maharashtra and Rajasthan (three MFI partnerships that have been in place since 2008 are included in this study). The value chain for this program (see Figure 2) includes UPLIFT, which performs a variety of supporting services, the Health Mutual Funds, which underwrite the risk, the MFIs, which earn fees for distribution efforts and InterAide, a donor that provided supporting funds until recently. UPLIFT provides capacity-building services to the Health Mutual Funds; it also offers the mutual a full range of shared services including feasibility studies, product design, staff training, client education and back-office support – including claims administration, risk-management, information systems, access to a telephone hotline for consultations and referrals, empanelment of hospitals and monitoring of the scheme.

Figure 2: UPLIFT Value Chain



The product reimburses hospitalization expenses (i.e., it is not cashless) as well as discounted outpatient care and medicines. Coverage also includes a broad range of additional services designed to promote health, improve access to health care and keep members' and program costs low. These include a 24/7 helpline, a full-time "beat doctor" who visits members in the field for consultations, health camps, client education, efforts to improve healthcare quality through monitoring of providers and assistance throughout the claims process. Figure 3 below demonstrates that in fact UPLIFT has the lowest claims cost per member of all the comparable[2] HMIs MILK examined.

Figure 3: Cost of Claims per Member per Year

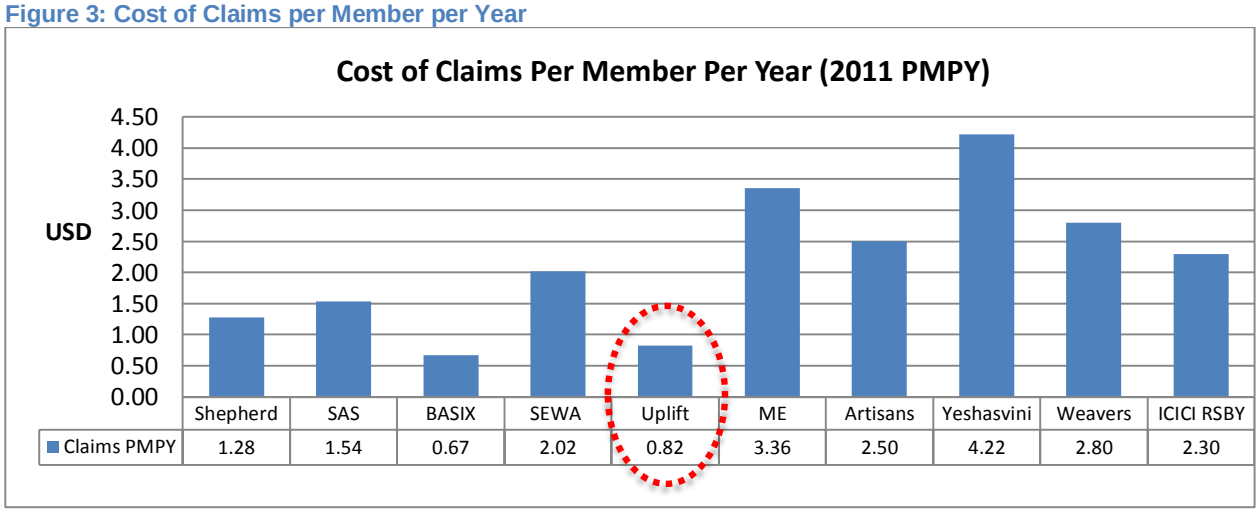
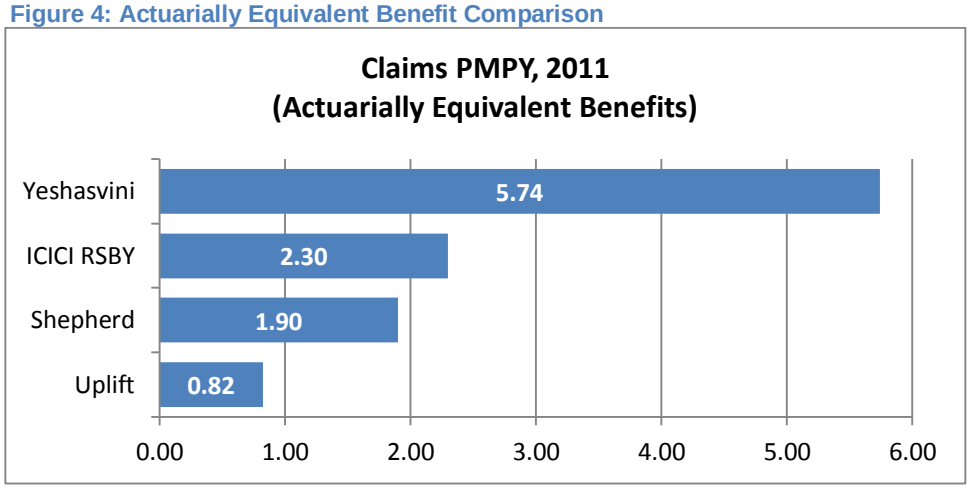


Figure 4 below represents the actuarially equivalent[3] claims cost per member of the four plans we studied in detail. This reflects a more refined or "apples to apples" comparison. UPLIFT's claims costs are the lowest. Based on how each of these plans is managed and based on our experience reviewing other health plans, we believe that the work done on early intervention and guiding OP care results in reduced IP care costs. In addition, the community management of the scheme involves approval of claims where members themselves have an incentive to ration so as to meet the budgeted claims target. While this is not direct proof (which requires additional research), it does suggest that OP coverage can reduce IP cost. This suggests that there is a very important link that other health plans should consider. RSBY does have one pilot plan that links OP and IP and seeks to demonstrate lower IP cost.

[2] The Basix program has lower claims cost, but its benefits are "hospital cash" and therefore more limited than what others provide.
[3] To derive actuarial equivalence, UPLIFT and RSBY were seen as having comparable IP benefits at INR 30,000; SHEPHERD was adjusted by a factor of 1.25 to account for its lower IP benefit and Yeshasvini was adjusted by a factor of 1.36 to account for its surgery only benefit design.

Figure 4: Actuarially Equivalent Benefit Comparison

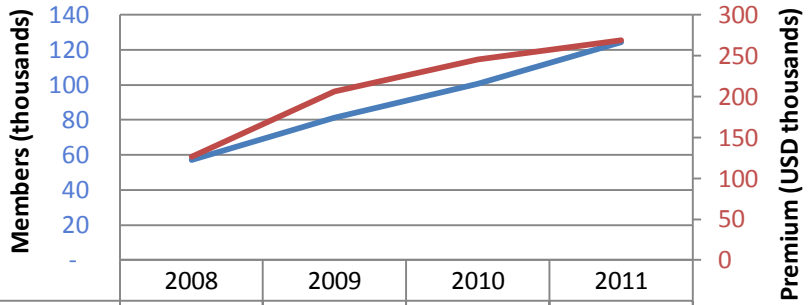


Two of UPLIFT's three MFI distribution partners enroll members automatically in the scheme when the member takes out a loan—thus, it is group-mandatory coverage. As such the distribution cost undertaken by these MFIs is very low relative to other programs that have voluntary enrollments. Nonetheless, significant efforts are made to educate clients about the program and to measure their satisfaction going forward, which is reflected in the average renewal rate of 70%. Of course the insurance is renewed along with the loan, which means that it "follows the fortune" of the loan availment. The decision to offer mandatory coverage reflects the MFIs' belief that premiums remain low enough not to interfere in the competitive MFI lending environment.

Analyzing the business case

Scale. As Figure 5 demonstrates, UPLIFT's program is growing but remains modest in scale, reaching an enrollment of nearly 125,000 as of 2011. This somewhat limited scale – for India – reflects a reliance on the MFIs for outreach. UPLIFT is careful to select partners that are "right fit" for an HMI project and for UPLIFT's mutual approach. This requires that the MFIs have a strong social orientation and actively promote health education for clients, organizing health camps and facilitating access to UPLIFT's doctors who conduct medical check-ups.

Figure 5: UPLIFT: Growth of Premium (USD) & Membership



	2008	2009	2010	2011
Members	57,089	81,115	100,469	124,458
Premium (Contributions to Claims & Admin Funds)	126,000	205,908	245,619	268,590

Revenues. Members pay a premium, which averages approximately INR110 (about USD 2), of which INR 70 (USD 1.15) is deposited in the Mutual's claims fund and INR 40 (USD 0.66) pays the service and administration fee. The fee is split between UPLIFT and the MFI distribution partner (each receiving INR 20), and is used to fund health services (not claims) as well as distribution and other administrative costs (see Figure 6). As membership increased during the study period, so did premium contributions, amounting

to USD 268,590 in 2011 (a 13% increase over premiums collected in 2008). Until 2012 (and through the entire period included in this analysis), UPLIFT received about USD 60,000 in grant funds from InterAide, which were mostly used to cover staff salaries.

Costs. Both claims and administrative expenses leveled off in 2011, allowing UPLIFT to achieve sustainable (albeit subsidized) financial results for the first time. Efforts to keep claims in check while meeting clients' needs, such as providing wellness programs and other outpatient interventions, may be paying off, as claims are well controlled. Still, expenses are high: UPLIFT spends more on services and administration than on claims (see Figure 6), which is not optimal, but is due in part to the fact that it provides many complementary services, such as health camps and a hotline, among others. In 2009, an UPLIFT management study determined that while operational (administrative) costs were 30% of total cost, an additional 19% was spent on services meant to foster member health and lower claims costs. An ILO study[4] calculated that in 2008 the cost of services and administration together was INR 73 (USD 1.50) vs. the budgeted allocation of INR 40 (USD 0.66); the shortfall was covered by the grant funding. Nonetheless, as the program grew from 2008 through 2011, expenses came down, and it is possible that as it continues to grow, further efficiencies may be realized, even in the absence of subsidies.

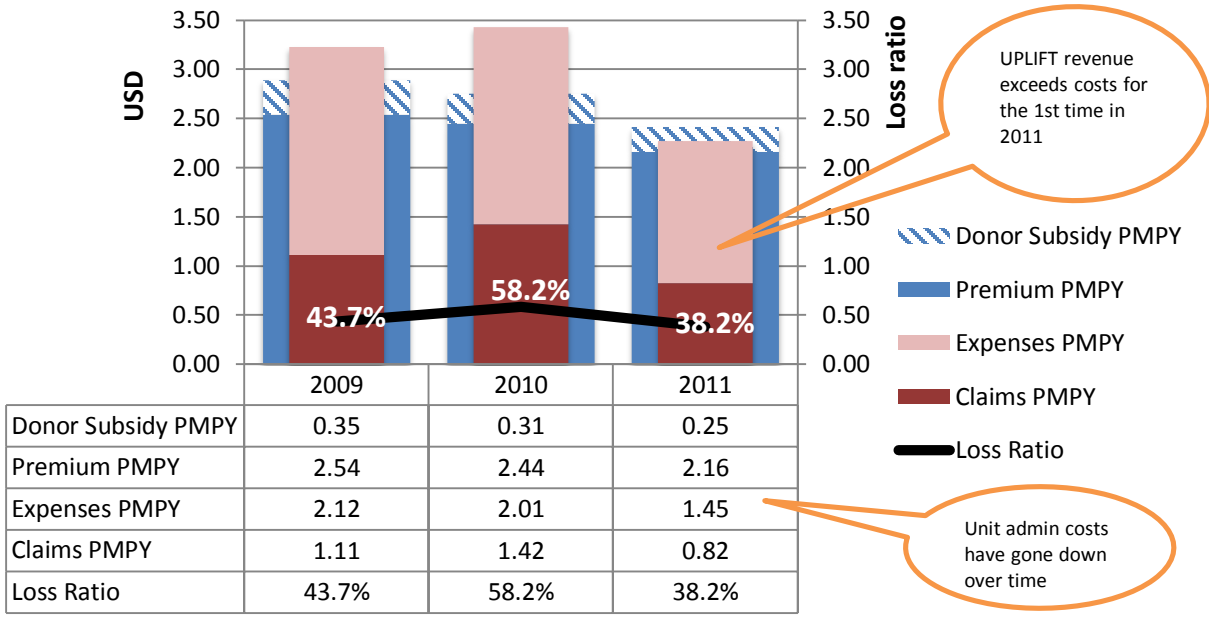
Figure 6: 2011 UPLIFT Value Chain Unit Economics

As Figure 6 above demonstrates, donor funds bring the costs and revenue into balance, so that in 2011 the UPLIFT group of mutuals showed a gain when the donor subsidy was included. Without this subsidy, it showed a loss of only USD 0.11, a sign that it is quite close to achieving sustainability.

[4] Joyce Tong. (2010). Analysis of admin fees and costing of members service. International Labor Organization (ILO). (unpublished)

Figure 7 below shows the substantial progress UPLIFT has made over time toward financial sustainability. Expenses and claims, on a per member basis, dropped in 2011. Further, reliance on the subsidy has also abated over time.

Figure 7: UPLIFT Financial Highlights per Member per Year, 2009-2011



	2009	2010	2011
Donor Subsidy PMPY	0.35	0.31	0.25
Premium PMPY	2.54	2.44	2.16
Expenses PMPY	2.12	2.01	1.45
Claims PMPY	1.11	1.42	0.82
Loss Ratio	43.7%	58.2%	38.2%

Key findings on UPLIFT's business case

The UPLIFT HMI is characterized by modest scale, with its cautious selection of MFI partners. It has increased the number of its partnerships between 2009 and 2011 from three to six, but also lost a large MFI partner that decided to go on its own, as it apparently no longer required UPLIFT for its administration services. This client had an enrollment of 104,000 lives and thus was a significant portion of UPLIFT's membership. Nonetheless, UPLIFT has had steady growth, promising increases in premium contributions and reductions in costs (though still high) over the years studied. As a result of these trends, in 2011 it showed a gain when its donor subsidy is included, and only a small loss without the subsidy. At the same time, the program appears to offer substantial client value (McGuinness, 2011).

While it is close to the breakeven mark, UPLIFT will need to consider the cost effectiveness of its services, particularly its administrative expenses, more carefully in order to become sustainable in the long term. In the alternative, perhaps the template UPLIFT has established can be replicated over a larger number of carefully selected MFI sponsors, thereby spreading fixed costs more efficiently over a larger membership base.

UPLIFT appears to be moving toward sustainability and may provide clues to the ingredients for an effective private health scheme. UPLIFT's comparative "success" is due, at least in part, to these factors:

- Mandatory enrollment keeps distribution costs low and may reduce anti-selection to keep loss ratios controlled
- Inclusion of preventive health measures may keep some people out of the hospital, and the program's education efforts and helpline may help clients to use services effectively
- The use of shared services may provide a platform for expansion to a larger, more efficient scale

Many of the programs we reviewed have solved only one component of the health care puzzle, resulting in different cost structures. UPLIFT's is a more comprehensive package than most, integrating preventive and primary care with inpatient coverage in an effort to better meet clients' healthcare needs and with the possible result of improving its own financial viability by reducing the number of costly inpatient claims.

Given these findings, UPLIFT may be a program to look to as an exception to the growing dominance of government sponsored and subsidized programs. Its progress in the years following elimination of the subsidy will shed further light on the open questions about the business case for the UPLIFT model and what drives it.

b) Yeshasvini Cooperative Farmers Health Care Trust

> **"Yeshasvini was a revolutionary program…in one shot they got almost one million members." *-TPA Manager***

Figure 8: Yeshasvini Program Highlights

Headquarters / Service Area	Bangalore/Karnataka	**Enrollment Basis**	Co-op Group-Enrollment
Program Age	8 years	**Subsidy**	State Government
Scale	3,000,000	**Competition**	None
Business Model	Self-funded trust	**Value Chain**	Trust→TPA→Co-ops
Distribution	Co-ops	**TPA/Intermediary**	MediAssist
Risk Taker	Trust	**Cost**	Premium is INR 210 per member; families of 5 or more receive a 15% discount.
Product Features	Covers in-patient surgical procedures only — 805 noted surgeries, including cardiac surgery and deliveries. The coverage limit is INR 200,000 (USD 3,355) per person per year; no waiting period to access coverage. Free consultations for all types of medical events and up to 50% discount on all laboratory tests.		

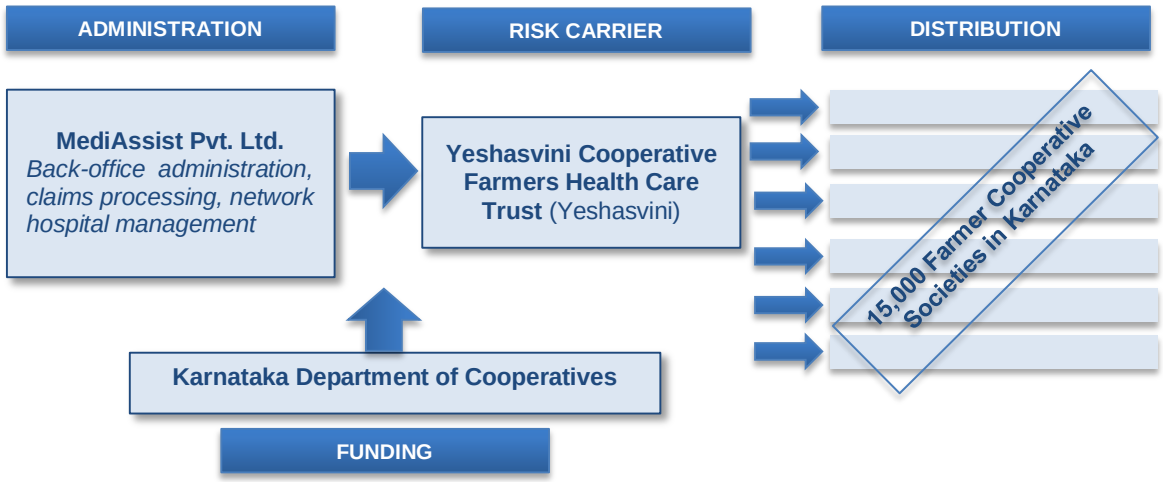
The program

Yeshasvini Cooperative Farmers Health Care Trust (Yeshasvini) is a partnership between the Farmer Cooperative Societies in Karnataka and the State Government offering a health insurance program for members of Cooperative Societies (above and below the poverty line). This private trust was launched in 2003 and operates in 31 districts of the state, reaching over three million members. The state government subsidizes the scheme, which is overseen through its Department of Cooperatives, with a contribution of approximately USD 6,400,000 each year. Yeshasvini carries the risk, and outsources administrative functions to a TPA, MediAssist. The TPA empanels hospitals and manages enrollment and claims. The Cooperative Department of the state of Karnataka works with dairy, agriculture, credit and craft societies. Dairy societies comprise the majority of Yeshasvini's enrollment (representing 60% of beneficiaries), followed by agricultural societies. In most cases the premium is deducted from the sale of goods, such as milk or produce.

The target population is large, with approximately 15,000 cooperative societies involved, which in turn enroll their members, making the distribution of the product relatively low cost. The scheme utilizes a network of nearly 500 public and private hospitals.

Yeshasvini's product provides cashless inpatient surgical benefits for 805 different surgeries, including procedures for gastrointestinal, orthopedic and cardiovascular conditions. The coverage limit is INR 200,000 (USD 3,800) and includes free outpatient consultation as well as 25% discount on clinical investigations. The premium is INR 210 per person (approximately USD 4) per year. Each additional family member is required to pay INR 210, but families receive a 15% discount when five or more members enroll. From the per person premium, INR 10 (USD 0.17) is transferred to the co-op for marketing and enrollment. The enrollment window is four months each year, while premium is collected once each year and transferred from the co-ops to Yeshasvini.

Figure 9: Yeshasvini's Value Chain

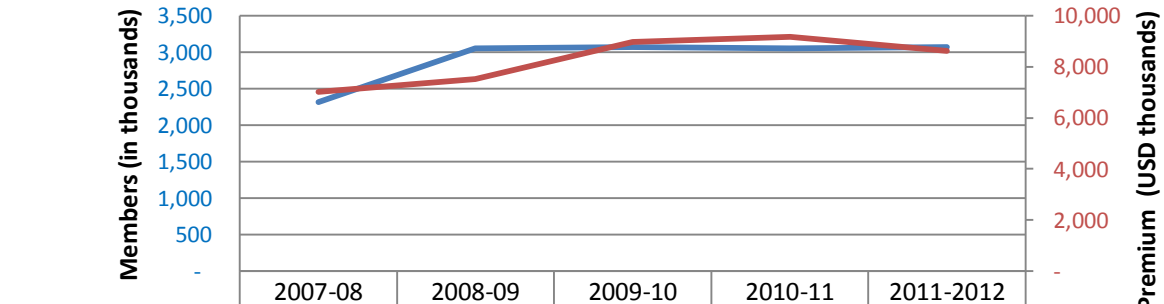


The TPA, MediAssist, itself has grown substantially in recent years. It made a strategic decision to enter the government sponsored HMI sector and won the Yeshasvini contract in a competitive bidding process, taking the business from an incumbent TPA at a lower price than had been in force. In addition to the Yeshasvini contract, MediAssist has been awarded 21 districts under the RSBY program. MediAssist earns INR 2.2 (USD 0.04) per member each year in fees for the Yeshasvini contract. This is significantly lower than the costs MILK has observed for other similar services provided to other programs.

Analyzing the business case

Scale. Yeshasvini's enrollment has plateaued at about three million members, with essentially no growth since 2008 (see Figure 10). Penetration among the eligible population is 25%. The enrollment target set for the officers by the department is around the same, and hence incentives for officers to increase that number are limited. Although funding has not been a limitation for the Trust, expansion does not seem to be a high priority for other stakeholders, including the government and the cooperatives. Two other schemes, Vajapayee Arogyashree (VA) and RSBY, have attracted certain segments of Yeshasvini's target market, as providers sometimes steer members to these competing programs. Additionally, hospitals have been encouraging the VA scheme because it offers more favorable reimbursements. Different co-op societies manage enrollment differently, but all active members of a federation can be enrolled automatically. This is in effect a "group all or none" approach and has resulted in high efficiencies and the potential for rapid scale-up and further growth, where expansion is a priority.

Figure 10: Yeshasvini: Growth of Premium (USD) & Membership



	2007-08	2008-09	2009-10	2010-11	2011-2012
Members	2,318,000	3,047,000	3,069,000	3,047,000	3,070,000
Coop Premium	7,017,896	7,504,788	8,975,047	9,166,903	8,613,536

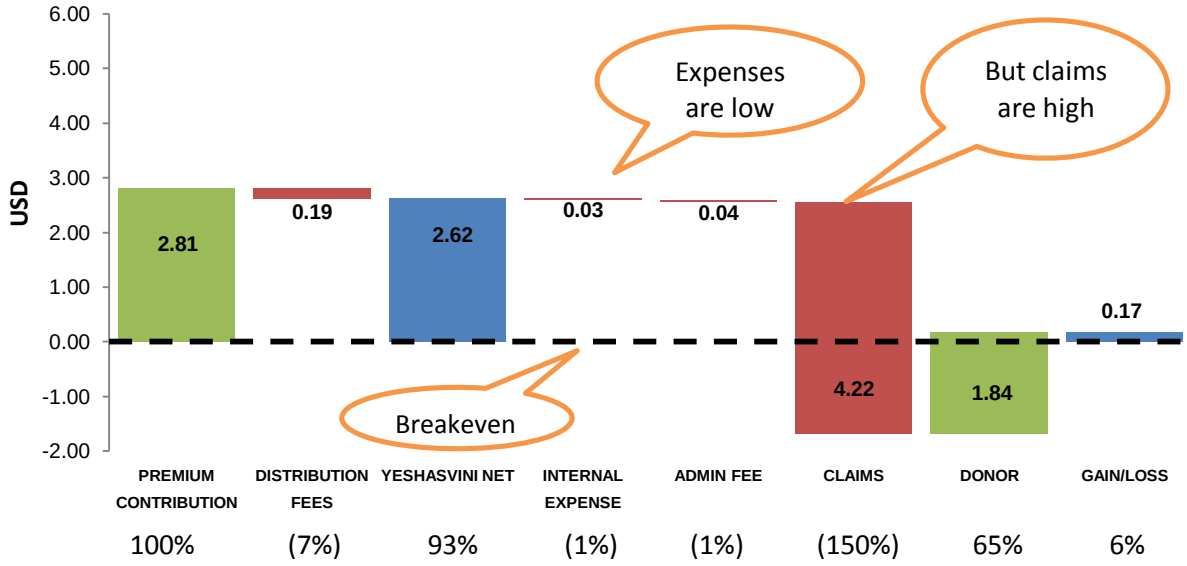
Revenues. Members pay a premium of INR 210 per year (about USD 4). However, the total contribution from members that is transferred from the co-ops to the Trust is typically an estimate rather than an amount tied to a specific number of lives enrolled. As shown in Figure 11, this results in actual premium collected

of USD 2.81, as opposed to the stated premium of USD 4. One reason for the difference between the premium charged and the premium collected is the group enrollment and payment method, whereby co-ops enroll members as a group and automatically deduct their contributions from the sale of milk or other produce. Individual premium payments are not always made or tracked. These premiums are supplemented by the state government subsidy, which amounted to approximately INR 149 (USD 1.84) per member in 2011-2012, accounting for about 43% of total program cost.

Costs. Given its unique distribution arrangement with the co-op societies and its streamlined enrollment and premium payment procedures, Yeshasvini has the advantage of reaching large scale with very limited distribution cost, at just 4.4% of the total program cost. It also pays a low price for its TPA administration as a result of the competitive tender process noted above.

While its expenses are quite low, Yeshasvini experiences higher claims costs than the non-government subsidized programs we studied. Although it has a relatively modest 2.5% claims frequency, the high claims costs may be the result of a focus on surgical procedures, some of which comprise tertiary level care and entail a relatively high payout. There is also less emphasis on preventative and outpatient services. Though most surgical procedures are capped at INR 24,000 (USD 400), Yeshasvini's annual coverage limit is far higher than other schemes, at INR 200,000 (USD 3350), compared to the more typical INR 30,000 (USD 500) limit. However, this has a limited impact on costs.[5]

Figure 11: Yeshasvini Value Chain Unit Economics, 2011

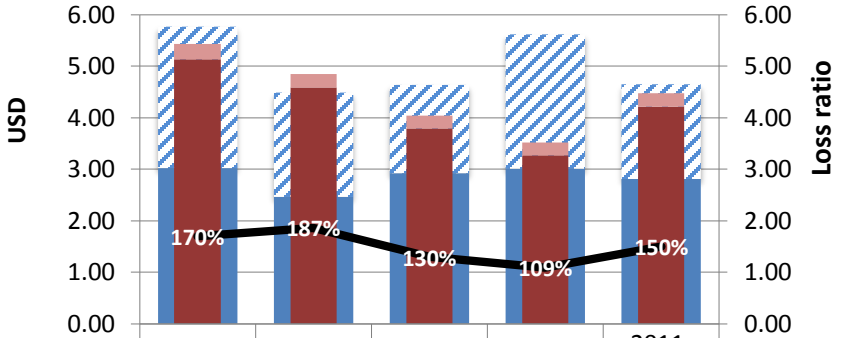


With the advantages of scale, group enrollment and low cost administration in place, it is somewhat surprising that the Trust itself is unable to cover its claims costs from contributed premium and requires a subsidy from government. The loss ratio without government subsidy has averaged about 150%.

Further, as Figure 12 below demonstrates, unlike UPLIFT, there is not a clear trend toward decreasing costs over time, moving toward sustainability or reducing its reliance on the subsidy. Given the very low administrative costs throughout the value chain, any such movement toward sustainability without the subsidy would require an increase in the premium paid by members, which might reduce outreach and scale, and / or a reduction in coverage level or other cost control strategies. There is no indication that any of the program's stakeholders intend to move the program in that direction; the subsidy is intended to be a permanent government contribution and thus must be considered as a long term requirement for sustainability.

[5] The cost of claims over INR 30,000 (USD 500) adds 16% to claims costs. Five percent of claims are over INR 30,000.

Figure 12: Yeshasvini Financial Highlights per Member per Year, 2007-2011



	2007-08	2008-09	2009-10	2010-11	2011-2012
Gov't Contribution	2.74	2.03	1.72	2.61	1.84
Contribution PMPY	3.03	2.46	2.92	3.01	2.81
Expenses PMPY	0.30	0.26	0.25	0.24	0.26
Claims PMPY	5.14	4.59	3.79	3.28	4.22
Loss Ratio (w/o/Gov't)	169.7%	186.5%	129.5%	108.9%	150.4%

Key findings on Yeshasvini's business case

Despite very low distribution and other administrative costs, including a fee from the TPA that may be so low as to be unsustainable, the Yeshasvini program remains heavily reliant on the government subsidy. The program was initiated to respond to a great perceived need among the target population (Kuruvilla & Liu, 2007), and there is evidence that it is effectively responding to this need, increasing utilization of the covered services and improving financial and health outcomes among clients (Aggarwal, 2010). While there may be no business case for this program *without* the subsidy, it is possible that a business case exists assuming that the government subsidy is permanent and not a temporary catalyst, as is intended for many donor supported programs. Given the steady enrollment of three million people (5% of the state's population) over a number of years, there is a strong incentive for the Karnataka government to continue the subsidy. As of the end of the most recent fiscal year, the Trust had a surplus balance of approximately USD 17.3 million, or more than a year's worth of claims to serve as a cushion. The corpus of the Trust has grown in recent years and is a strong sign of financial stability. The program's efficient distribution, enrollment, and premium collection processes as well as the competitive bidding for TPA services help to keep administrative costs very low, further supporting the business case.

Nonetheless, this program may face some challenges to long-term sustainability, notably:

- Its reliance on state government subsidy makes it vulnerable to political changes, and funding may be cut for reasons beyond the control of the non-government stakeholders.
- In addition to state subsidy, the Trust also relies on cooperative remittances; with the advent of RSBY, which enjoys federal subsidy and requires a very modest member contribution, we would not be surprised if there was pressure on a state member-funded program such as Yeshasvini to merge with RSBY.
- The fee charged by MediAssist is far lower than what other TPAs charge for comparable services, and may not be sustainable in the long term. The TPA services were secured through a public tender, which MediAssist won at a lower price than the original incumbent.
- Although it has reached substantial scale, the program has reached only 25% of its target market. Growth has been limited in recent years, and there does not appear to be significant incentive for any of the stakeholders to push for growth. Further growth may require additional investments in marketing and outreach.

These challenges are unlikely to be resolved in the near term, but we expect the program's development over the next few years to lead to some interesting insights, especially regarding the sustainability of its very low administrative costs and its ability to reach more clients or possibly merge with another overlapping government program.

c) ICICI Lombard General Insurance (ICICI)

> **"We insurers take the risk in RSBY if claims and administrative costs exceed premium paid by government. NGO door-to-door distribution is too expensive. In microinsurance we can break even only if all our processes are incredibly efficient" *-ICICI Lombard***

Figure 13: ICICI Program Highlights

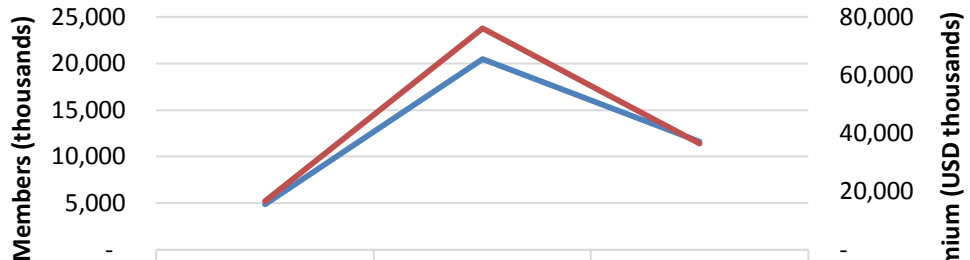
Headquarters / Service Area	Mumbai/ Multiple States	**Enrollment Basis**	Gov't / Workers Groups
Program Age	5 years	**Subsidy**	Federal & State Gov't
Scale	24 million	**Competition**	Public sector and other insurers
Business Model	Insurer	**Value Chain**	Gov't-Insurer / NGO-Insurer
Distribution	Gov't with private enroller	**TPA/Intermediary**	TTK Healthcare Services
Risk Taker	Insurer	**Cost**	INR 400 (Gov't) INR 30 (Member)
Product Features	Covers up to 5 family members with cashless services, up to a limit of INR 30,000 per family / year. Only secondary hospitalization care is included, including maternity care. No OP benefits		

The program

ICICI's HMI portfolio is dominated by its government contracts under RSBY (covering 3.6 million families), and the Weavers and Artisans schemes (two older, state supported programs covering 2.4 million families combined). ICICI has worked under RSBY since RSBY was launched in 2008 and under the Weavers and Artisans schemes since 2006. ICICI is the risk-carrier as well as the TPA and works through local government channels to enroll families for the respective schemes. Under RSBY, ICICI outsources enrollment to FINO Tech, a private company that raises awareness about the scheme, registers eligible populations below the poverty line and produces a biometric "smart" ID card on the spot. ICICI holds roughly 16% of the RSBY market and operates in seven states.

RSBY is a tender-driven business and has moved through several pricing cycles since its advent in 2008. In the first pricing cycle, insurers were somewhat cautious and there were fewer competitors; the resulting higher prices supported lower loss ratios and reasonable margins. By 2010 there were 14 insurance companies and 17 TPAs in RSBY and competition heated up: rates went down, loss ratios rose and many insurers lost money (Premasis Mujkherjee, 2012). ICICI management reports that its significant downturn in enrollment (see Figure 14) in RSBY in 2011 resulted from competitive bidding. In other words, ICICI was unwilling to maintain those contracts at prices it felt would not support a reasonable margin – or at least not lock in losses. While there is some debate as to whether RSBY should be classified as microinsurance or social insurance, we consider it to be microinsurance because the product is targeted for the poor and private insurers share financial risk**.**

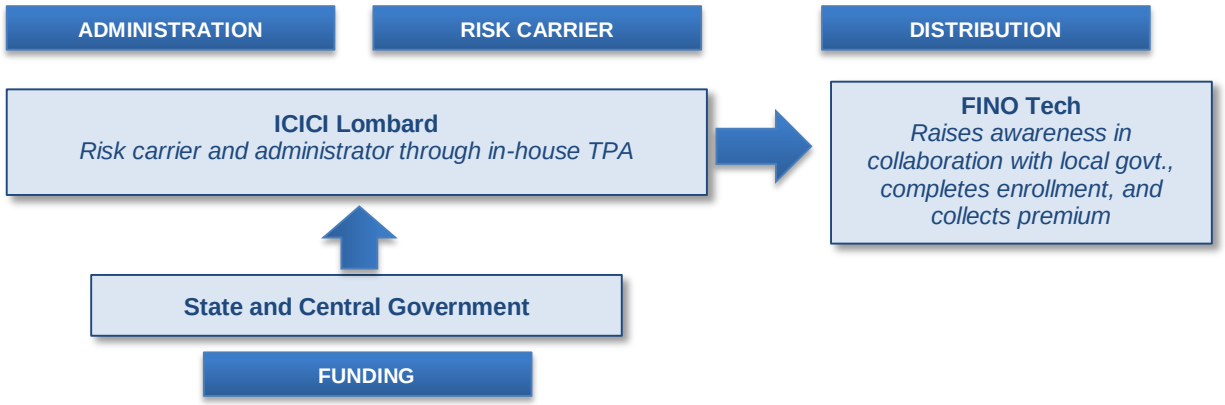
Figure 14: ICICI Growth of Premium (USD) and Membership



	2008-9	2009-10	2010-11
Members enrolled (assumes lives 3.25 per family)	4,875,000	20,475,000	11,570,000
Actual premium collected	16,755,867	75,948,276	36,398,210

Rather than use an outside firm as does Yeshasvini, ICICI created an in-house TPA to manage RSBY and its other publically-funded HMI programs. ICICI's management believes that keeping the TPA in house keeps costs down and ensures greater control over processes. The enrollment function outsourced to FINO Tech is conducted in a highly structured and standardized manner. For example, FINO Tech transports a small team of staff with an enrollment kit (including a printer, thumb reader and smart card reader) to villages during enrollment days. Local district officials raise awareness and inform the community about the RSBY scheme, preparing for a large turnout of people for the scheduled enrollment. The enrollment process is usually completed in one day and entails the following steps: local district officials verify that villagers seeking coverage are on the approved list of people below-the-poverty-line, Fino Tech collects a registration fee (premium) from eligible members and produces an ID card on the spot.

Figure 15: ICICI Value Chain (RSBY)



Analyzing the business case

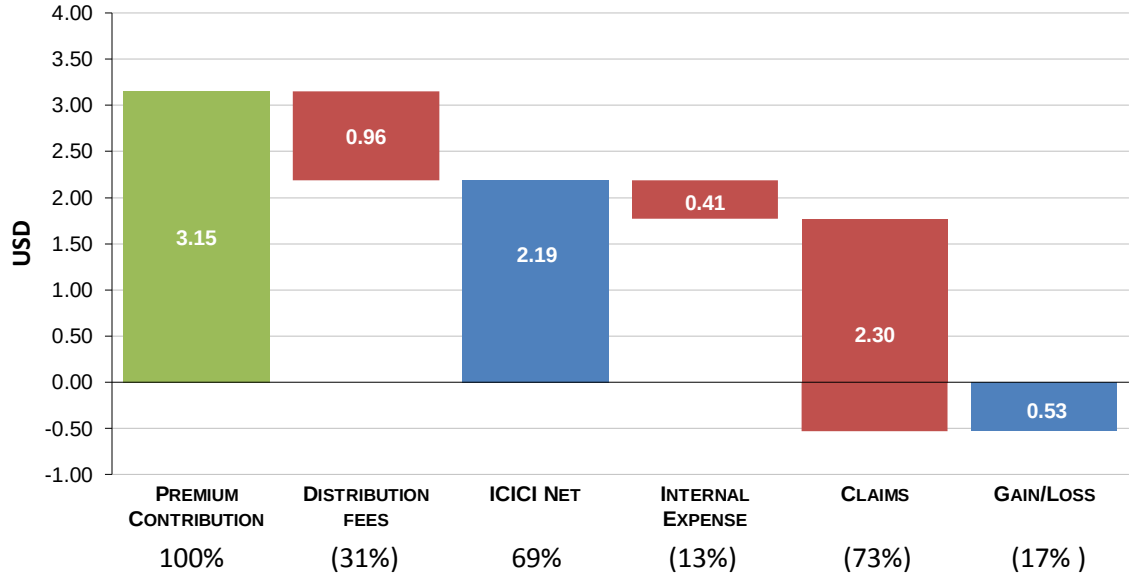
Scale. A key advantage of the RSBY scheme lies in its ability to scale into the millions (of people) very quickly, enabling firms to - in theory - keep admin costs low. One driver of the ability to scale is the broad eligibility for the program: virtually all below-poverty-line individuals are eligible, while membership in other HMI programs is often limited to the membership bases of the distribution channels used. Given the small contributions from clients (INR 30 (USD 0.50) per family), the cost of enrollment is rarely expected to be a financial barrier; moreover, clients are afforded a higher benefit limit than many private HMI schemes, which may also help to drive enrollment. This advantage is reflected in the 51% participation rate that RSBY achieves, which is far higher than what is typical for private HMIs with voluntary enrollment.

Revenues. RSBY premiums, except for the members' small annual contribution of INR 30 (USD 0.50) per family, are paid by the government. These premiums are set by a competitive bidding process on a regular

basis. Premium rates established in public tenders have consistently come down as competition has intensified (from as high in some districts as INR 750 (USD 12.50) in 2008 to an average of around INR 350 (USD 5.87) in 2011). As a result, ICICI's premium per member per year has actually declined in the most recent year of our study. With the decrease in market-based premiums, loss ratios are increasing and the cost of distribution is high, so it is not clear how the current pricing can be supported. As seen in Figure 16 below, ICICI's costs have exceeded premiums, including government contributions, in all years since inception.

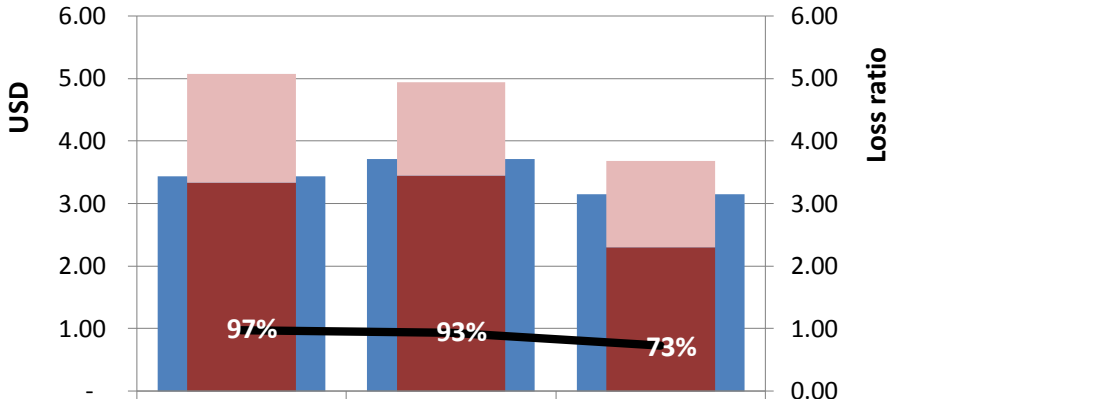
Costs. In response to the highly competitive market in RSBY, ICICI has endeavored to build significant efficiencies in its enrollment, in-house claims management and fraud control to manage those costs within the market premium rates. The scale at which ICICI operates has contributed to its ability to do so and cost per member have come down form USD 1.53 in 2009 to USD 1.38 in 2011 (See Figure 17 below). Nonetheless, costs - especially distribution costs - remain high. A broader study of RSBY by CIRM[6] noted a 143% combined ratio driven by higher than expected claims and a drop in premium fueled by competitive bidding. In this context, ICICI and other insurers will look to see bid prices rationalize as the program matures, and for distribution costs to abate as renewals become more routine.

Figure 16: ICICI RSBY Value Chain Unit Economics, 2011



[6] Krishnaswamy, Karuna & Ruchismita, Rupalee. (2011). Performance trends and Policy Recommendations: an Evaluation of the Mass Health Insurance Scheme of Government of India. IFRMR Research Centre for Insurance and Management.

Figure 17: ICICI RSBY Financial Highlights 2008-2011



	2008-9	2009-10	2010-11
Premium PMPY	3.44	3.71	3.15
Expenses PMPY	1.74	1.49	1.38
Claims PMPY	3.34	3.45	2.30
Loss Ratio	97%	93%	73%

Key findings on ICICI's business case

ICICI has tapped in to a growing segment in publically funded HMIs. It has a significant share of the RSBY program. This market, however, is a highly competitive one. The government awards RSBY contracts per district to the lowest insurance bidder, thus incentivizing firms to increase efficiencies across their supply chains and keep costs down.

- RSBY's ICICI program scaled very quickly. Not surprisingly, its administrative costs, on a unit basis, have dropped as the program has grown and as ICICI management is incredibly focused on efficiency and processes. However, it appears that ICICI will need to become even more efficient to be profitable.
- Distribution in RSBY, especially with government support, is very effective. But it is also expensive, far more so than any of the other programs we studied. It will be interesting to see if the cost of enrolling members declines as RSBY matures.

d) Self Help Promotion for Health and Rural Development (SHEPHERD)

Figure 18: SHEPHERD Program Highlights

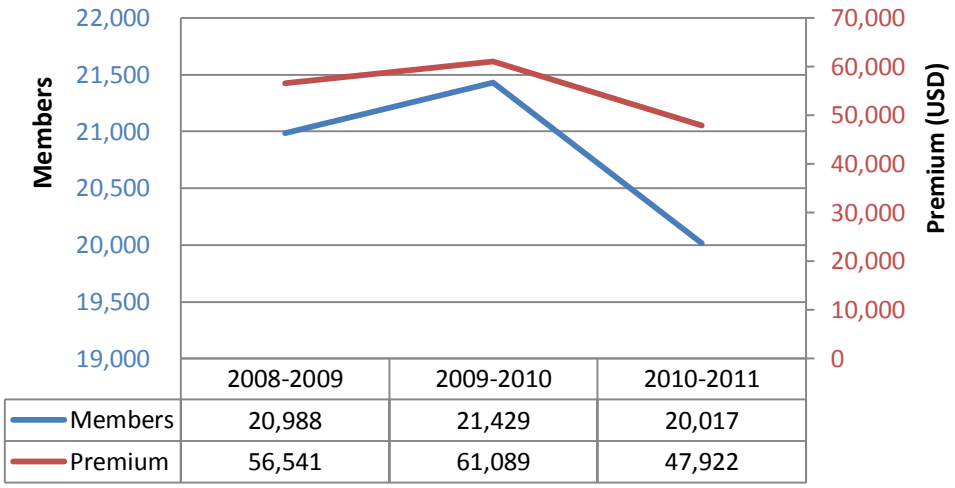
Location	Trichy / Tamil Nadu	**Enrollment Basis**	SHG's Group Enrollment (all or none)
Program Age	11 years	**Subsidy**	Philanthropic (Ford Foundation)
Scale	20,000	**Competition**	Government Scheme
Business Model	PA/Mutual; as of 2012 only mutual	**Value Chain**	NGO / MFI
Distribution	NGO / MFI	**TPA/Intermediary**	None
Risk Taker	Mutual or Insurer	**Cost**	INR 260
Product Features	The coverage is hospital cash for hospitalization - INR 1000 (USD 16) per day for up to 2 days, INR 2500 (USD 40) for 3 days; the limit is INR 10,000 (USD 160) or 80% of the hospital bill.		

The Program

SHEPHERD is a community-based organization that works to promote self-help groups in Tamil Nadu. Founded in 1995, it is comprised of two legal entities: one is Naniya Surabhi Development Financial

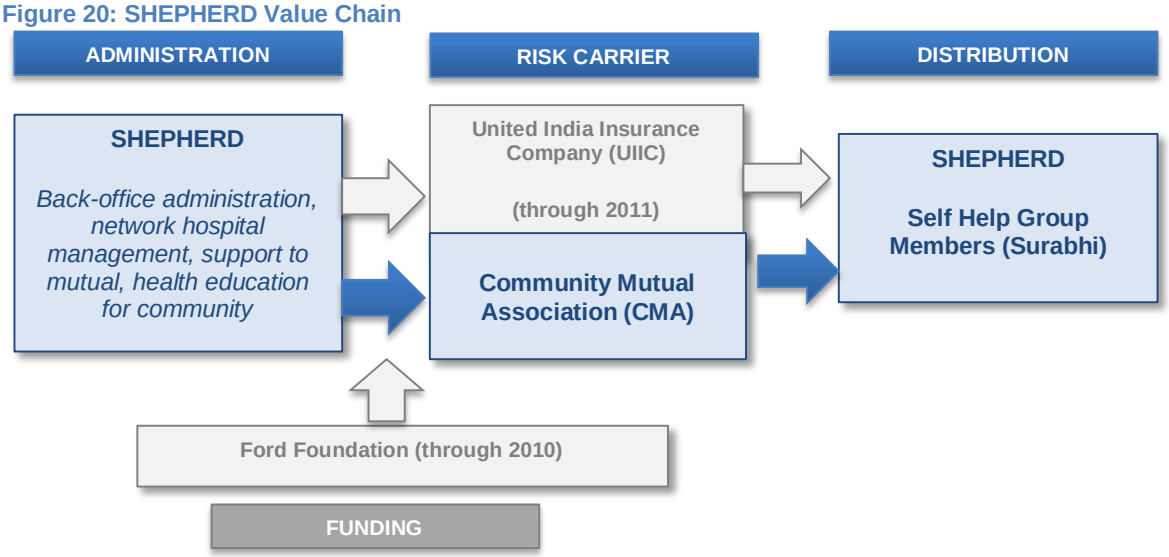
Services (NDFS), a section 25 company that manages credit activities for self-help group members, and the second is Social Security Assurance for Empowerment (SSAFE), an arm that offers microinsurance service to members, including management of a Community Mutual Association. Until 2012, SHEPHERD also worked through an insurance company - United India Insurance Company (UIC) - using a parallel partner-agent delivery structure. SHEPHERD recently ended the partnership with UIC because management believed that the premiums paid out to the insurance company were too high, so all risks are now assumed by the mutual.

Figure 19: SHPHERD Growth of Premium (USD) & Membership



	2008-2009	2009-2010	2010-2011
Members	20,988	21,429	20,017
Premium	56,541	61,089	47,922

Figure 20: SHEPHERD Value Chain



As of the end of 2011, SHEPHERD insured approximately 20,000 members, of which 12,000 were covered by UIC and 8,000 were covered by the mutual. Enrollment is voluntary—though accomplished on a group all or none basis. This means that individual members cannot opt out of coverage. SHEPHERD instituted this group enrollment policy in 2011 to avoid adverse selection. Premiums are INR 260 (USD 5) annually per family with coverage up to INR 10,000 (USD 170). Some members have the option to pay INR 365 (USD 6) for a higher INR 20,000 (USD 335) limit.

SHEPHERD received a grant of INR 4.5 million (USD 82,000) from the Ford Foundation, paid in roughly even installments of USD 20,500 every year for four years (2007-2010). The grant was used to cover routine operating expenses, including staff salaries, to manage the scheme. Given that SHEPHERD is now

managing the scheme without a subsidy, they have had to downsize their team. Management also recognizes that achieving sustainability will require that they increase premium, improve efficiency and significantly expand their membership base.

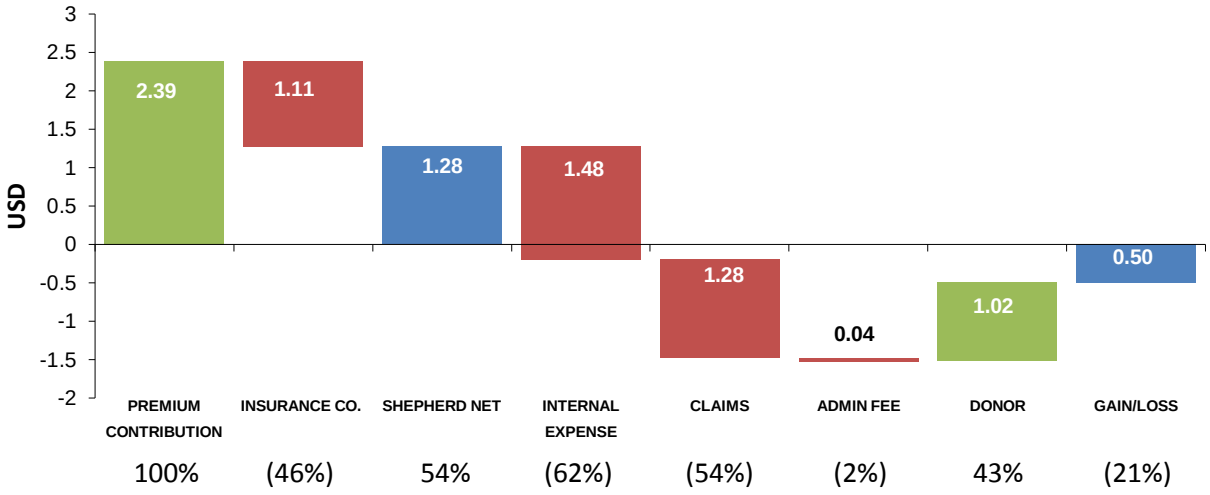
Analyzing the business case

Scale. At 20,000 members, SHEPHERD is the smallest HMI program we studied in India. The program has not seen any appreciable growth in recent years, and neither internal nor external stakeholders expect the program to grow much in the future.

Revenues. Like UPLIFT, SHEPHERD used donor subsidy to support its startup phase, but must now do without that support. Like UPLIFT, but unlike Yeshasvini and ICICI RSBY, SHEPHERD does not have the advantage of government support, so all its costs must be supported by its premium of about USD 2.50 per member.

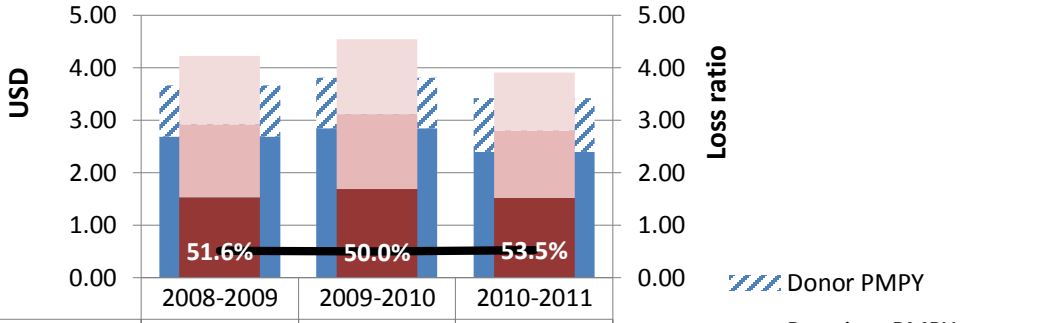
Costs. Uniquely among the programs we studied, SHEPHERD initially worked with a commercial insurance company, UIC, through a partner agent arrangement, a prevalent business model in India. Management reports that the premiums paid to UIC exceeded the claims it paid, so that it felt that the net cost of insurance was a barrier to achieving sustainability. Conversely, the self-insured portion of the program demonstrates well-controlled loss ratios with no additional margin paid to the insurer. Nonetheless, the benefit levels offered are relatively low (INR 10,000 or USD 170) compared with other programs MILK studied.

Figure 21: SHEPHERD Value Chain Economics 2011[7]



[7] In 2011 SHEPHERD maintained a partner-agent relationship with UIC. In 2011 the cost of premiums reflected in this chart covered the claims and the insurer margin under the insured portion of the program. Beginning in 2012 the insured portion of the program was terminated.

Figure 22: SHEPHERD financial Highlights, 2008-2011



	2008-2009	2009-2010	2010-2011
Donor PMPY	0.98	0.96	1.02
Premium PMPY	2.69	2.85	2.39
Insurance Co.	1.30	1.43	1.11
Claims PMPY	1.39	1.42	1.28
Expenses PMPY	1.54	1.70	1.52
Claims Ratio (wo/Donor)	51.6%	50.0%	53.5%

Key findings on SHEPHERD's business case

In many ways SHEPHERD is emblematic of the MFI-affiliated health microinsurance programs that sprouted up throughout India in the 2000's. It has not grown much past its initial enrollment plateau and has yet to bring its costs in line with expenses. Scale is a challenge as its market is defined and constrained by its MFI affiliation. Further, balancing revenue and expenses will be ever more difficult now that its donor subsidy is gone. While these challenges do not rule out the possibility that a small-scale grass roots program like SHEPHERD could achieve a business case, they do present significant barriers to sustainability.

- Bringing all the insurance risk in house and shedding the cost of paying insurance company premiums could, in theory, support the bottom line. However, SHEPHERD was successful in bringing on only about one third of the 12,000 people formerly enrolled in UIC into the mutual programs, so that now (2013) total enrollment has fallen below 12,000 lives. We do not yet know if the 8% loss ratios that the self-funded mutual has achieved (contrasted to the 70% loss ratio in the UIC program) will be sustained when this insured cohort is folded in. If it is, SHEPHERD may yet prove that a small self-contained program is sustainable.
- Another strength of SHEPHERD's program is its affordable price point. This strength is offset, not surprisingly, by a modest benefit schedule. It is always a concern with limited benefit programs that members see enough return over time (especially when running such low loss ratios as the mutual has) on the premiums they pay. Further, it will be critical for SHEPHERD to hold onto its members, as it cannot afford to lose scale. If, like other programs (such as VimoSewa, described below), its members experience some common hardships, renewal rates could plummet and jeopardize the program.

3. Additional existing and discontinued programs

a) Existing programs

MicroEnsure

"Microinsurance needs for one entity to take control of the project and have permission to drive it forward. The driving entity needs to understand microinsurance, and that is not always the insurance company." -*MicroEnsure*

The global microinsurance intermediary MicroEnsure made several attempts to develop HMI in India, but has recently retrenched due to sustainability challenges, including low demand for its products and costly distribution and administration. It began operations in India in 2009, focusing on providing cashless in-patient health insurance, initially via smaller MFIs, where economies of scale proved impossible, and then large MFIs, which proved unable to engage their memberships and generate sufficient demand for the insurance products. MicroEnsure later turned to alternate distribution partners, such as church based groups and District Cooperative Banks. However, despite a significant investment in resources to support enrollment efforts and member services, other problems ensued. For example, some service providers refused to comply with the 'cashless' part of the product and made clients pay up-front. Since the program was purely voluntary, these service problems led to poor uptake and sponsor dissatisfaction. Further, management recognized that although distributors, TPAs and insurers typically received 90% of the premium revenues, and MicroEnsure only 10%, MicroEnsure provided direct and in-kind support all along the value chain without commensurate compensation. In the end the advent of RSBY, with its government supported benefits, proved to be too great a competitive hurdle.

VimoSewa

> **"We may have spread ourselves too thin geographically – increasing cost of service and acquisition cost, which depend on scale. The cost of a voluntary individually sold HMI without scale is too high to sustain." -*VimoSewa***

VimoSewa is one of the oldest stand-alone voluntary HMIs in India. It offers members of the Self Employed Women's Association (Sewa) a bundled multi-cover product, which is delivered through a hybrid business model including both partner-agent and full service, as well as community mutual approaches. At an early stage the program suffered setbacks when a catastrophic earthquake in Gujarat caused claims to soar, yet also resulted in a jump in enrollment.

Despite the program's mature age, VimoSewa is struggling to reach scale, and indeed enrollment in the program has dropped over the past few years, from a high of 180,000 in 2007 to current membership of around 100,000.[8] VimoSewa has sought to expand, but also struggles to become sustainable in the wake of competition from RSBY and other government programs. VimoSewa is currently exploring the possibility of offering a hospital cash program as an RSBY top off – a strategy to prosper in the competitive environment it now faces, rather than attempting to compete directly with the heavily subsidized programs.

BASIX

BASIX is an MFI that offers several insurance products: credit life, hospitalization cash and life insurance. At its peak BASIX had 3.5 million customers, but due to the Andhra Pradesh crisis in 2010 the customer base declined to 1.1 million. Of these, nearly 200,000 clients (over 500,000 including their dependents) were enrolled in their retail health care product, which was undertaken beginning in 2006. The product is offered in over 15 states, through the BASIX MFI following the partner agent model. There is a mandatory credit linked product with Aviva and a voluntary health insurance product with Royal Sundaram. The health product offers "hospital cash" that entails a flat reimbursement for hospitalization stays of up to 14 days, at INR 500 (USD 8) or INR 1000 (USD17) per day, depending on the plan selected.

By 2013, the program enrollment dropped dramatically to approximately 40,000 as BASIX focused on other priorities.

[8] The reduction is directly related to VimoSewa's expansion strategy where it was insuring large MFI's under group policies and some of those they acquired subsequently dropped off.

SAS Poorna Arogya Healthcare (SAS)

> "**We don't see RSBY as a competitor: they've done us a favor by raising awareness about the need for health insurance." -*SAS***

SAS is a private limited company that acts as a "service provider" in the health insurance value chain. SAS handles back end claims processing and hospital network management — functions more common to a TPA. However, unlike a TPA, SAS does not tie up with an insurance company. SAS works through NGOs/MFIs – including Grameen Koota – to enroll clients. SAS registered a separate trust that manages the risk for its programs. Some clients such as Grameen Koota have also created separate trusts and thus SAS simply acts as a TPA for them.

SAS primarily works in the state of Karnataka where it has empaneled a network of 89 hospitals. As of early 2012, about 147,000 lives were covered, of which Grameen Koota represented 80,000 lives. Under the Grameen Koota scheme, coverage is voluntary and members are enrolled on a group basis. Coverage under the Grameen Koota scheme includes cashless IP (including common surgeries) and discounts for outpatient consultations. The premium is INR 160 (about USD 3) per individual per annum, with every additional family member paying the same amount. Coverage begins at INR 5,000 (USD 84) with a family floater[9] up to INR 25,000 (USD 419). Eight people can sign up in one family. OP care can also be availed through a 25% discount on consultations and tests at network hospitals, with an INR 10 (USD 0.17) co-payment. 45% of enrollees have utilized OP services, and inpatient incidence is at 2%.

The SAS model is unique in that the organization operates without donor or government subsidies; it has chosen to partner with NGOs that maintain a strong social orientation and is able to deliver products that provide strong value for clients (See MILK Brief #12).[10] As SAS scales up with new partners, it is an organization worth following.

b) Discontinued programs

Swasth India

Swasth India, a private health care financing provider, partnered with Swayam Shikshan Prayog (SSP) to implement a "Community Health Fund." The program received funding from the ILO and was launched in 2008. Based in Maharashtra, the program targeted members of SSP, offering inpatient and outpatient services through a network of community health workers and private clinics. Enrollment was purely voluntary and only reached 2,100 members over a three year period and loss ratios were between 100% and 200% (ILO, 2011). Due to the limited demand and high claims, the program is no longer operational. Swasth is now piloting an out-patient clinic network in Mumbai.

Bajaj Allianz

Bajaj Allianz (BA) is affiliated with the German insurer Allianz and initially got involved in microinsurance in response to the tsunami relief effort in Tamil Nadu in 2005. The German business community established a EUR 500,000 (USD 590,000) fund for relief efforts, working with the Indian arm of the multinational NGO CARE International. BA completed a demand study and determined that health insurance was in great need following the initial relief efforts in response to the catastrophe. BA set up an office with CARE to build local insurance capacity. The program started with a bundled product (life, accident, and health) using a community mutual fund with insurance overlay after INR 10,000 (USD 170); the total sum insured was INR 50,000 (USD 840). The product had a total premium of INR 100 (USD 2), INR 70 (USD 1.30) of which was allocated to the mutual sponsored by CARE and INR 30 (USD 0.56) to BA.

[9] Floater is the term used in India – any single person can utilize up to the full amount of the family benefit.

[10] Magnoni, Barbara, Zimmerman, Emily, & Chandani, Taara. (2012). "Condensed MILK #12 - Doing the Math with Health Microinsurance in Karnataka, India." Microinsurance Centre - MILK Project. <http://www.microinsurancecentre.org/milk-project/milk-docs/doc_details/910-condensed-milk-12-doing-the-math-with-health-microinsurance-in-karnataka-india.html>

Unfortunately, the program did not scale up, as CARE was not as focused as BA initially thought it would be, and the community did not respond. Management felt that other tsunami relief money had a crowding out effect on the need for insurance and thus demand was weak. The program closed in 2010 with 500 families enrolled (around 2000 lives); the balance of the funding was used to develop storefront clinics.

Following this experience, BA's management takes the position that, especially in light of competition from RSBY and other state schemes, HMI is not viable without a strongly tied market and reports that to date it has not found any strong partner in NGO/MFI spaces to distribute microinsurance.

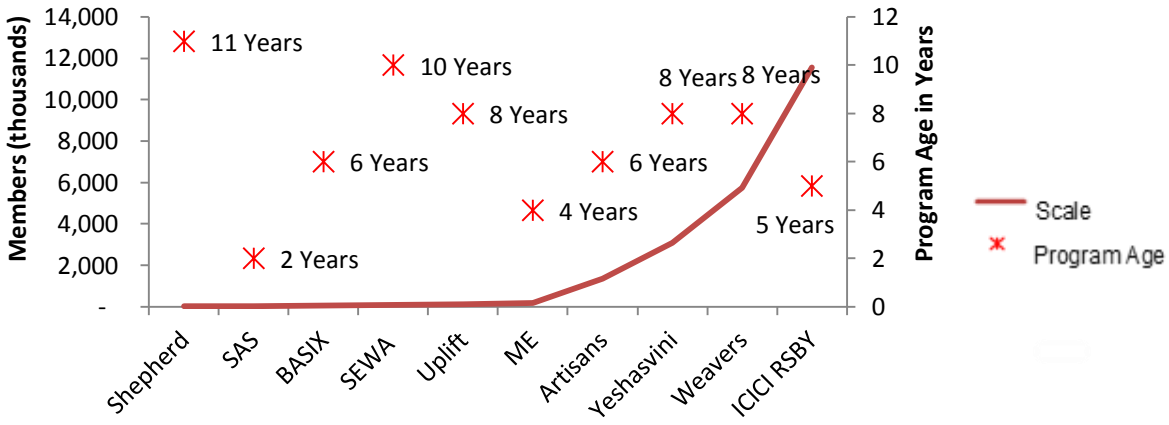
4. Observations and Analysis

Below, we outline some of the main lessons gleaned from our analysis of the HMIs MILK studied, paying particular attention to the eight criteria that MILK has identified as potential drivers of business case: program age, scale, business model, product design, distribution, subsidy, competition and enrollment mode. We begin with analysis of what drives scale, which MILK and many observers have assumed to be critical in keeping unit costs down and making HMIs viable.

Program age appears to have little correlation with the ability to scale or a move toward financial sustainability. Other factors such the presence of a government subsidy and the mode of enrollment have much greater impact on the programs we studied. As seen in Figure 23, scale is related to government subsidy and not age, as all of the one million plus member programs in India are government supported, but have not necessarily been present in the market longer than their smaller counterparts.

Nonetheless, we note that UPLIFT has progressed over time to achieve lower unit costs (see Figure 5). This is the first indication that the UPLIFT model, perhaps uniquely among the private HMIs, is overcoming the disadvantages of small scale.

Figure 23: Program Age and Scale



The support of a government subsidy clearly drives scale if not business case itself. Scale also distinguishes government subsidized from private programs. The stand-alone HMIs without government subsidy that we studied have not achieved large scale, and now seem constrained by the membership limits of their distribution partners and the nationwide presence of the highly subsidized and widespread RSBY. Figure 24 shows that the top seven HMIs in India and all of the programs over one million lives are public. If we look at the top 100 HMIs it is evident that the average size of a government program is over 4 million lives, while the average size of a private program is about 70,000 lives. In fact, the majority of private programs are under 50,000 lives covered.

Figure 24: The Top 20 HMIs in India (Ranked by 2009 Enrollment)[11]

Rank	Organization	Enrollment[12]	Subsidy
1	Arogyashree Yojana Trust (AYT)	36,700,000	Gov't
2	**RSBY**	33,997,270	Gov't
3	Weavers	6,120,000	Gov't
4	Ministry of Health – Madhya Pradesh (MoH&FW-MP)	5,490,000	Gov't
5	**Yeshasvini Trust**	3,047,000	Gov't
6	Artisans	2,700,000	Gov't
7	Students Health Home (SHH)	1,587,000	Gov't
8	Village Welfare Society (VWS)	766,716	n/a
9	SKDRP	721,130	n/a
10	BASIX	525,000[13]	n/a
11	SKS	472,000	n/a
12	Andhra Pradesh State Police Trust (AP-SPT)	400,000	Gov't
13	Rajasthan Dairy Cooperative Federation (RDCF)	384,000	n/a
14	Karnataka State Police Trust (K-SPT)	350,000	Gov't
15	Self Help Groups Federation – Kerala (SHGF-K)	225,970	Gov't
16	SEWA	195,472	n/a
17	BISWA	183,180	n/a
18	Grameen Koota	175,119	n/a
19	Solapur Cooperative Federation (SCF)	170,000	n/a
20	Sampoorna Kutumba Arogya Pathakam (SKAP)	170,000	n/a

Achieving scale, which we have indicated is a function of public subsidy, appears to drive down unit costs. As a result, private HMIs spend a considerably higher percentage of premium on administration than do the publically supported programs, which have lower overall unit costs for administration (see Figure 25). On a composite basis the administration costs for a private program are USD 2.56 per member per year vs. USD 0.76 per member per year for publically supported programs.

Figure 25: 2011 Administrative Costs per Member

Program	Admin Cost (USD)	Public/Private
Yeshasvini	0.07	Public
Artisans	0.52	Public
SAS	0.65	Private
Weavers	0.66	Public
ME	1.04	Private
ICICI RSBY	1.38	Public
UPLIFT	1.45	Private
SEWA	1.80	Private
BASIX	2.00[14]	Private
SHEPHERD	3.08	Private
Composite Public	**0.74**	**Public**
Composite Private	**2.56**	**Private**

[11] India's Report on Health Micro-Insurance Schemes: Diversity, innovations and trends
[12] Enrollment data from A national review 2009, ILO
[13] As of 2012 enrollment in BASIX had dropped to 41,000
[14] MILK estimate

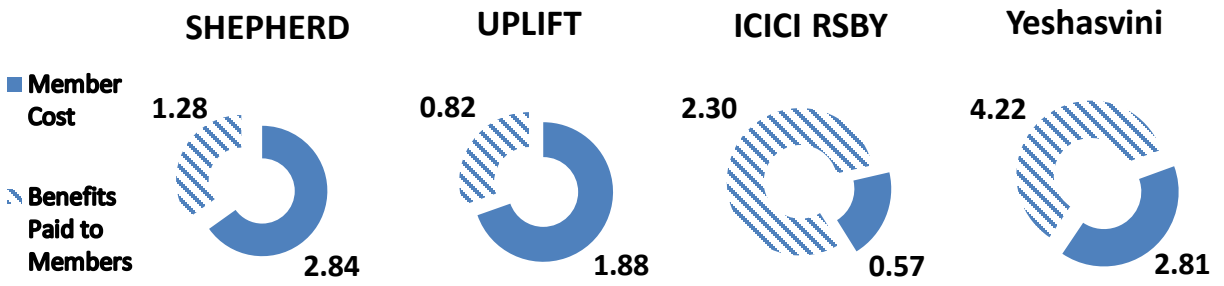
Competition also drives down costs. The public HMIs we studied have lower costs, and we ascribe this in part to the advantages of scale (See Figure 26). However, beyond that, the open bidding process undertaken by RSBY and Yeshasvini assure that TPAs and insurers will keep costs and prices down. We can directly observe a reduction in cost to HMI sponsors (e.g. state or federal governments) as a result of public competitive bidding. However, we do observe evidence that some TPAs may be bidding below cost, which would not be sustainable. We have not observed any private HMIs that undertake tenders to insurers or TPAs, but perhaps it is a strategy that should be considered.

Figure 26: Composite Public & Private HMIs: Claims and Admin Costs (USD, 2011)

2011	Scale	Premium	Claims	Admin	Claims %	Admin %	Comb %
All programs *- average*	2,226,871	3.21	2.15	1.26	67%	39%	***106%***
All programs *- composite*	22,268,710	3.44	2.69	0.82	78%	24%	***102%***
Public *- composite*	21,757,500	3.45	2.72	0.77	79%	22%	***101%***
Private *- composite*	511,210	3.21	1.51	2.56	47%	80%	***127%***

Achieving scale, and its benefits, is also a function of uptake, which requires a plan design that balances low premiums and attractive coverage. From the insurer's perspective, the RSBY program has the advantage of significantly higher benefits paid to members than programs without government subsidy. Higher premiums support richer benefits, and along with government supported enrollment processes, have led to much greater enrollment and scale than the HMIs who lack this support. Non-subsidized programs struggle on this front. Without government support, premiums must be very low for the poor to be able and willing to buy insurance, while in RSBY the member pays less than 10% of the cost. However, low premiums, without subsidy, cannot support broad coverage. Where products are more limited (for example, covering only limited events, or providing only discounts and not full coverage), they are not viewed as useful by the target population, who in turn do not buy (or renew) coverage, leading to further scale challenges. In Figure 27 below we see how stark the contrast is from the members' point of view; for the private HMIs the members' cost far exceeds the average pay-back in benefits, while in the public HMIs the reverse is true.

Figure 27: Member Cost vs. Member Benefit (USD, 2011)



Given the particularly high costs of healthcare and the widespread presence of subsidized programs, private HMIs find it difficult to offer valuable products at affordable prices without subsidy. Particularly in the face of the substantial competition created by RSBY, private HMIs have struggled to strike the balance mentioned above. Forced by cost and affordability considerations to have relatively limited coverage, few have made significant progress toward the scale needed for financial sustainability in HMI. However, lessons from some of the programs we studied may reveal a path to generating greater demand (and consequently scale) while keeping costs in check. For example, UPLIFT provides some outpatient care that clients may see as appealing, and that may also help to keep hospitalization costs down by helping clients to avoid hospitalization. The outpatient benefits and other unique product features offered by UPLIFT are a means of distinguishing it from other programs, including RSBY. The experimentations with hospital cash insurance mentioned by VimoSewa are another interesting

approach; these products are far cheaper than comprehensive health insurance, but also meet a distinct need and as such do not compete directly with the subsidized programs.

Individual voluntary enrollment does not lead to significant and sustained participation, and thus is not a viable strategy - especially for private HMIs targeting relatively small populations. Group enrollments gain far better results as seen in Figure 28. The lowest enrollment yields result from voluntary enrollments of MFIs. The "group all or none" approach used by Yeshasvini, for example, is also effective. In this case, each co-op decides whether its members are in or out rather than each member deciding. The large public programs like Artisans and Weavers achieve excellent results with their group enrollment processes. Lastly, UPLIFT (again) demonstrates effectiveness with mandatory enrollments.

Figure 28: HMI Participation Rates[15]

HMI	Target Population	Uptake %	Enrollment	
			Yield	*Mode*
BASIX	524,000	8%	41,135	Individual
SHEPHERD	111,206	18%	20,017	Individual[16]
Yeshasvini	12,280,000	25%	3,070,000	Group
SEWA	300,355	33%	99,117	Individual
ICICI RSBY	22,686,275	51%	11,570,000	Group
ME	333,333	57%	190,000	Group
SAS	62,902	58%	36,483	Group
Artisans	1,500,000	91%	1,365,000	Group
Weavers	6,119,681	94%	5,752,500	Group
UPLIFT	124,458	100%	124,458	Group
100 HMIs Composite	***418,812,608***	***23%***		

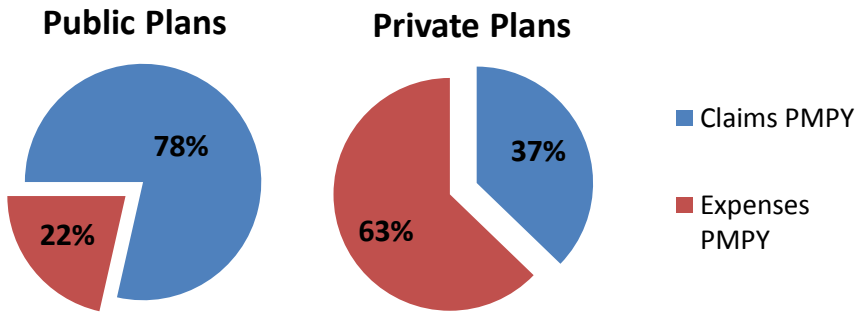
Admittedly each program and distribution channel requires different efforts to accomplish enrollments and administer the plan. Still, we found a great deal of variation in administrative and distribution costs along the value chain among the four HMIs we studied. External distribution costs begin at zero, as in the case of VimoSewa and SHEPHERD, which do their own enrollments and have yielded limited results. At the same time some HMIs pay 7% to 10% commissions to MFI and co-op distribution partners, also yielding limited results. Yeshasvini pays 7% of premium for distribution which is "automatic," requiring limited member interface. By contrast, ICICI pays its outsourced enrollment firm, which collects the premium, as do the milk co-ops, a total of 36% of (a higher) premium for a much more intensive level of member contact. Nonetheless, the cost-effectiveness of distribution seems to be more determinative of success. It has been virtually impossible to achieve scale with purely voluntary individual enrollments. The MFI crisis seems to have slowed down growth of HMIs using MFI distribution, but may be a good opportunity for experiments with alternate distribution and programs with higher benefit values as well as products that wrap around the public programs.

With or without public subsidy, Indian HMIs are struggling to find a workable business model. Overall in 2011 for the HMIs MILK examined, costs exceed premiums with a composite combined ratio of 102% (See Figure 26). Programs get to that unsustainable result differently, with smaller private HMIs spending more on administration and the larger, publically-supported HMIs weighted down with high claims costs (See Figure 29). As described above, there is a great deal of variability with respect to both distribution and pure administrative costs. For some programs (like SHEPHERD) employing the partner-agent model, the cost of insurance may also be a barrier to sustainability. For SHEPHERD, the 30% gross margin that its insurer was earning was seen as not worth the risk protection afforded and so it cancelled the insurance cover and self-insured.

[15] The data in this figure comes from the ILO Subregional Office for South Asia, New Dehli. (2009). "India's Report on Health Micro-Insurance Schemes: Diversity, innovations and trends. Global Extention of Social Security (GESS)" <http://www.social-protection.org/gimi/gess/RessShowRessource.do?ressourceId=16812>

[16] Converted to group enrollment in 2011

Figure 29: Administrative Expense Levels Public vs. Private HMIs



Expense ratio and not loss ratio is the primary driver of losses and lack of sustainability. Lack of scale in private programs constrains efficiencies that can control costs. The government-supported programs, on the other hand, do achieve scale and as a result have more controlled administrative costs relative to premium. Subsidy can reduce (or even eliminate) financial barriers to enrollment of the target population. Further, the subsidized programs, and in particular, RSBY, target a very broad base of potential clients, which also helps to increase outreach and scale. Private programs, by contrast, tend to target a narrower base of potential clients (typically existing clients of the delivery channels those programs employ); such targeting can help to minimize distribution costs by tapping into existing channels, but can also constrain scale.

We have discussed some of the disadvantages that private HMIs have with respect to scale. The UPLIFT model uses a shared resources model to support the small community-based mutual it works with. UPLIFT offers expertise and capacity building to these independent mutuals from a resource base that is spread among a number of trusts. SAS uses a similar model. In theory, UPLIFT should be able to replicate its template over a great number of independent groups and geographic territory. This is, again in theory, one way that stand alone private HMIs might be able to offset the advantage of scale that larger government supported entities have.

Scale is a key component of the business case for microinsurance, yet scale in and of itself does not guarantee a business case. None of the HMIs we studied has achieved profitability without subsidy. Both large and small programs struggle to balance costs with revenues. Many factors have to come together to make an HMI profitable: distribution has to be effective and low cost (like Yeshasvini); claims have to be well controlled (like UPLIFT); benefits have to be robust so members perceive value (like ICICI RSBY); administration and service have to be effective, and all of this has to be accomplished at a price point that members can afford (like SHEPHERD) and will stick with at renewal. None of the HMIs we studied have put all these pieces together.

5. Conclusions and Follow ups

Although a relatively young industry, Indian HMIs have evolved through a series of developmental fits and starts. A number are now defunct, unable to meet the significant challenges that confront these organizations, many due to failures of distribution, others due to high loss ratios and some for both reasons. Private HMIs have struggled to achieve scale and keep administrative costs down and are experimenting with different business models. As of now, all require some form of subsidy to continue, but in some cases donor subsidies are drying up. It does seem that early models of private HMIs with purely voluntary individual enrollment, typically tied up with MFIs, will never be workable. And while group all or none enrollments are very effective, other observers have worried that such modes do not allow members to truly understand and appreciate what they are buying. Lastly, and importantly, UPLIFT and other private HMIs have a chance to achieve a business case with mandatory group enrollments, an integrated approach to effective health care, integrating public health strategies, IP assistance, monitored OP, and shared resources that allow small community based programs to take advantage of larger scale. In sum, at this point the jury is still out on whether private HMIs in India without government or other subsidy can be viable.

Many questions remain for publically supported programs as well. For RSBY to continue to grow it will obviously require continued government support. We wonder if pressure will mount for RSBY to add an OP benefit, and when that happens and prices begin to rise, whether funding constraints will cause government to pull back on RSBY. Another issue is pervasive insurer losses in RSBY; from low TPA fees to tenders that yield lower prices and insurers that do not appear to be making money. MILK formed the impression that these players were making an "investment" in RSBY, which still has a huge upside with many millions of BPL Indians remaining to be enrolled in the program. If price pressure continues unabated, it's not clear how long insurers and TPAs will remain committed to the HMI market. Conversely if prices in the next round of tenders rise in response to carrier losses, just as they dropped in early tenders when RSBY seemed more profitable, we again wonder if government will continue to (essentially) fully subsidize the program. The impressive role that technology plays in RSBY and its potential to increase efficiencies could be the key to the sustainability of RSBY. In any case, whether by its indirect impact on private HMIs or by virtue of its own scalability, RSBY and other government programs have played a crucial role in the business case not only for private stakeholders in these government-subsidized programs, but in wholly private programs, as it has influenced the competitive atmosphere in the market. We expect the respective roles of public and private programs, and the business case for each, to continue to evolve as RSBY and other government programs expand their outreach and as private programs begin to adapt.

With or without public subsidy, Indian HMIs are struggling to find a workable business model. Program age appears to have little correlation with the ability to scale or a move toward financial sustainability. The support of a government subsidy, on the other hand, clearly drives scale if not business case itself. Achieving scale, which we have indicated is a function of public subsidy, appears to drive down unit costs. Competition, which the government uses successfully in open tender processes, also drives down costs. This is significant, as expense ratio and not loss ratio is the primary driver of losses and lack of sustainability. Achieving scale, and its benefits, is also in part a function of uptake, which requires a plan design that balances low premiums and attractive coverage. Individual voluntary enrollment does not lead to significant and sustained participation, and thus is not a viable strategy - especially for private HMIs targeting relatively small populations. While scale is a key component of the business case for microinsurance, scale in and of itself does not does not guarantee a business case. Even with subsidy, the low premium levels generated by RSBY's competitive bidding process may not be sustainable in the long term. Nonetheless, as we continue down the long and winding road to a business case for HMIs, MILK believes that RSBY will drive the evolution of health microinsurance in India for years to come.

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Microinsurance Learning and Knowledge (MILK) is a project of the MicroInsurance Centre that is working collaboratively to understand client value and the business case in microinsurance. Barbara Magnoni leads the client value effort and Rick Koven leads the effort on the business case. For more information contact Michael J. McCord (mjmccord@microinsurancecentre.org), who directs the project.